



TENNESSEE DEPARTMENT OF HEALTH
 DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
 665 MAINSTREAM DRIVE, 2ND FLOOR
 NASHVILLE, TN 37243
 TELEPHONE: (615) 741-2584

OFFICE USE ONLY

707 – EMR _____
 718 - AEMT, PM _____
 719 – EMD _____

EMS PROFESSIONAL FEES

Class Number: (If Applicable) _____ SSN: _____ - _____ - _____ Birthday: _____ / _____ / _____

Name: _____
 LAST FIRST MIDDLE (JR., SR., ETC.)

Address: _____
 (STREET /PO BOX/ROUTE) (CITY/STATE/ZIP)

Personal Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

EMS Employer: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? YES NO

Email Address: _____

If you answer yes to any of the questions below, give details on a separate sheet including circumstances with appropriate dates. Attach a certified copy of court records if convicted of any law violation.

Have you ever been convicted, for a violation of the law other than a minor traffic violation? YES NO

Have you ever or are you now addicted to any drugs or alcohol? YES NO

Has your license/certification to practice in any state ever been reprimanded, suspended, restricted, revoked or is it under threat of disciplinary action? YES NO

I certify that all information in this form is correct and complete to the best of my knowledge. I understand that falsification of any information may be grounds for denial or revocation of my certification/license.

Signature: _____ Date: _____

THIS APPLICATION MUST BE SIGNED AND DATED AND ALL QUESTIONS ANSWERED TO INSURE PROCESSING.

Please check the appropriate box(es) and submit this form with the total fee(s) by a personal or certified check (**no cash**). This form must be submitted fifteen (15) days prior to your examination date. Failure to comply with these instructions will result in a delay of your license approval.

PAYMENT SHOULD BE MADE PAYABLE TO TDH-EMS

ACTION	EMR	EMT	AEMT/ EMTIV	PARAMEDIC	EMD	PM CRITICAL CARE	INSTRUCTOR
Application Fee	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$70.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$30.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$35.00
License Fee	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$80.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$30.00		
Renewal Fee	<input type="checkbox"/> \$24.00	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$45.00	<input type="checkbox"/> \$90.00	
Late Fee	<input type="checkbox"/> \$25.00						
Reinstatement Fee	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$100.00					
Reciprocity Fee	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00			
Returned Check Fee	<input type="checkbox"/> \$20.00						

NOTE: APPLICATION FEE IS NON-REFUNDABLE.

TOTAL FEE = \$ _____

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."