TN Department of Health

OFFICE USE ONLY	
707 – EMR	
718 – EMT, 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**).

*PAYMENT SHOULD BE MADE PAYABLE TO **TDH-EMS***

ACTION	EMR	EMT	AEMT	PARAMEDIC	EMD	PM CRITICAL CARE	INSTRUCTOR
Application Fee*	☐$20.00	☐$50.00	☐$70.00	☐$75.00	☐$30.00	☐$75.00	☐$35.00
License Fee	☐$25.00	☐$75.00	☐$80.00	☐$100.00	☐$30.00		
Reciprocity Fee	☐$100.00	☐$100.00	☐$100.00	☐$100.00			
Renewal Fee	☐$24.00	☐$65.00	☐$65.00	☐$75.00	☐$45.00	☐$90.00	
Late Fee	☐$25.00	☐$25.00	☐$25.00	☐$25.00	☐$25.00	☐$25.00	
Reinstatement Fee	☐$50.00	☐$100.00	☐$100.00	☐$100.00	☐$100.00	☐$100.00	
Returned Check Fee	☐$20.00	☐$20.00	☐$20.00	☐$20.00	☐$20.00	☐$20.00	

NOTE: APPLICATION FEE IS NON-REFUNDABLE.

TOTAL FEE = $ _____

*If no Social Security number you must submit verification of citizenship and/or qualified alien status. (U.S. Code § 1641.)
"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."

PH-2397 (Rev 3-2019) **RDA-10137**

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