Government of the District of Columbia – Department of Health

Multiple Sponsorship Notification Form

General Instructions

- This form is used to verify multiple sponsorship of an EMS provider
- The EMS Provider is responsible for completing the form and submitting it to the State EMS Officer at the Department of Health.
    - The information must be filled out completely
    - The provider's information is located at the top of the form
    - The provider's primary sponsoring EMS organization's medical director must sign and date the notification form.
    - The provider's secondary sponsoring EMS organization's medical director must sign and date the notification form.
    - The form must be submitted to the State EMS Officer at the EMS Division of the Department of Health at HEPRA.

Submit Form to

District of Columbia Department of Health
Health Emergency Preparedness and Response Administration
EMS Certifications
55 'M' Street, SE, Suite 300
Washington, DC 20003

Government of the District of Columbia – Department of Health

Multiple Sponsorship Notification Form

Provider Information

Last Name: _____ First Name: _____ MI: _____

DC Certification Number: _____ Expiration Date: _____

Certification Level: ☐ EMR ☐ EMT ☐ AEMT ☐ EMT-I ☐ Paramedic

Certification

I hereby certify that the information contained within this form is true and complete to the best of my knowledge and belief. I agree to surrender my certification card to DOH within 30-days upon separation from my primary sponsoring EMS agency.

_____ _____

Signature of the Provider *Date*

Primary Sponsoring EMS Organization: _____

As Physician Medical Director of the Primary Sponsoring EMS Organization named above, I do hereby affix my signature attesting that the provider named above is a member of the primary sponsoring organization named above and is currently authorized as a provider with this organization. They currently demonstrate competence in all the skills outlined by the NREMT at the level for which the applicant is certified, as well as any additional skills included in this organization's protocols. I further understand that the individual is seeking secondary sponsorship with the EMS organization listed below. I agree to communicate with the secondary sponsoring medical director for the purposes of continuing certification, competency in emergency medical care, patient evaluation, and documentation of patient care.

_____ _____

Signature of the Medical Director *Date*

Secondary Sponsoring EMS Organization: _____

As Physician Medical Director of the Secondary Sponsoring EMS Organization named above, I do hereby affix my signature attesting that the provider named above is seeking membership in the secondary organization named above. I understand that the provider is currently sponsored by the Primary Sponsoring EMS organization named above and has demonstrated competence in all the skills outlined by the NREMT at the level for which the provider is certified. I further agree to communicate with the primary sponsoring medical director for the purposes of continuing certification, competency in emergency medical care, patient evaluation, and documentation of patient care.

_____ _____

Signature of the Medical Director *Date*

This form must be submitted to the State EMS Officer of the Department of Health, Health Emergency Preparedness & Response Administration.