

VERIFICATION OF LICENSE/CERTIFICATE - EMERGENCY MEDICAL PERSONNEL

Access this form via website at: cca.hawaii.gov/pvl

State of Hawaii
Hawaii Medical Board

APPLICANT	Name (First, Middle)	(LAST)	Social Security No.
	Address (Include apt. no., city, state and zip code)		License/Certificate No.
			Date Issued
	I hereby authorize the licensing agency of the state or county of _____ to furnish the information below to the Hawaii Medical Board. Date: _____ SIGN HERE: _____		

LICENSING AGENCY	This is to certify that the above-named individual was issued license/certificate number _____	
	To practice as an: <input type="checkbox"/> EMT <input type="checkbox"/> Advance EMT <input type="checkbox"/> Paramedic <input type="checkbox"/> Other _____	
	Date issued: _____	
	Date license/certificate expires: _____	
	License status: <input type="checkbox"/> current <input type="checkbox"/> lapsed since: _____ <input type="checkbox"/> inactive since: _____	
	<p>Has this certificate ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated?)..... <input type="checkbox"/> YES <input type="checkbox"/> NO (Please explain "YES" response.)</p> <p>Do your files contain any derogatory information on this applicant? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please explain "YES" response.)</p> COMMENTS: Signature: _____ Title: _____ State: _____ Date: _____	
<i>BOARD SEAL</i>		
TO THE AGENCY: Return this form directly to the Hawaii Medical Board. P.O. Box 3469, Honolulu, HI 96801		