

VERIFICATION OF NATIONAL REGISTRY CERTIFICATE

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

TO THE APPLICANT:

Complete the APPLICANT section, mail to the: *NATIONAL REGISTRY OF EMERGENCY MEDICAL TECHNICIANS,
and request a "Historical Status Verification"*
P.O. Box 772000
Detroit, MI 48277-2000
(Attn: Executive Director)

| | | | | | |
|-------------|---|------------------------------|---|---------------------|--------------------|
| APPLICANT | Name (First, Middle) | | (LAST) | Social Security No. | |
| | Address (Include apt. no., city, state & zip code) | | School of Graduation & Address (EMT, AEMT or EMT-P) | | Birthdate |
| | | | | | Date of Graduation |
| | EMT Cert. No. & Date Issued | AEMT Cert. No. & Date Issued | Paramedic Cert. No. & Date Issued | | |
| | I authorize the NREMT to provide the Hawaii Medical Board a Historical Status Verification. | | | | |
| Date: _____ | | SIGN HERE: _____ | | | |

To NREMT: Return this form **directly** to the Hawaii Medical Board by email at medical@dcca.hawaii.gov
or by mail to: P.O. Box 3469, Honolulu, HI 96801