

AFFILIATION VERIFICATION

NOTE: IF YOU ARE CHANGING YOUR AFFILIATION OR ADDING AN AFFILIATION, YOU NEED ONLY COMPLETE THIS SIDE OF THE APPLICATION. NEW STUDENTS MUST SIGN RELEASE STATEMENT ON OTHER SIDE OF THIS FORM.

Check One: ___ Add a new initial affiliation/Verify affiliation
___ Change initial affiliation (drop old affiliation number)
___ Add an additional affiliation (keep current affiliation(s))

Please check one: ALS__ BLS__ EMD__

Name: _____ SSN _____

New Affiliation Identification (copy from Application 1, side 1 or refer to App. B of the Users Manual)

Affil. No. 15 Affil. Name _____

1. **COMPANY VERIFICATION/ MFRI verification** MFRI
To be completed by the company senior EMS Officer

I verify that the candidate named on this form is currently an active EMS member/provider holding membership with this company as of this date. This company approves of this individual's participation in EMS training and/or verifies that this individual will be providing EMS care as a member of this company.

Signature _____ Title EMS T.O. Date _____

Printed Name Capt. Lee R. Silverman Day Telephone 240-773-8214

2. **EMS OPERATIONAL PROGRAM SIGNATURE**
(This section **MUST** be completed by the approved verifying agency representative for all ALS, EMTB, & EMD candidates)

APPROVED EMS OPERATIONAL PROGRAM APPROVED COMMERCIAL SERVICE

I verify by my signature that the candidate named on this form is affiliated with a recognized and appropriate Maryland EMS Operational Program and/or Commercial EMS Service and will be/is authorized to provide EMS care within the company/EMS Operational Program of affiliation.

Signature _____ Title EMS T.O. Date _____

Printed Name Capt. Lee R. Silverman Day Telephone 240-773-8214

3. **MEDICAL DIRECTOR SIGNATURE**
(THIS SECTION **MUST BE COMPLETED FOR ALL ALS CANDIDATES**)

I verify by my signature that the candidate named on this form has met all local and state requirements in order to pursue licensing/certifying with the intent to function in the EMS Operational Program of which I am the Medical Director.

Signature _____ Date _____

Printed Name _____ Day Telephone _____

4. **APPLICANT SIGNATURE** I understand that ALL information on this form is correct to the best of my knowledge, and is subject to verification. Failure to meet any requirements may serve as grounds of ineligibility for certification/licensure.

Applicant's signature: _____ Date _____