AND	MA DEPARTMENT OF PUBLIC HEALTH OFFICE OF EMS RSA Tower, 201 Monroe Street, Suite 1100 Mail to: P.O. Box 303017 Montgomery, AL 36130-3017 EMS Individual Licensure Application			
Application Type	Identification			
Paramedic	Social Security Number			
Intermediate	Date of Birth / /			
Advanced EMT	Alabama EMS License #			
	National Registry Number			
EMR	National Registry Expiration Date / /			
Paramedic Endorsement	Personal Information			
Transfer Drugs	Last Name			
Expanded Scope of Practice	First Name MI			
ESP Application must be attached				
Application Classification	Home Address			
Initial License \$12	City State Zip			
Renewal - Active \$12	City State Zip Mailing Address			
Reclassification <b>\$0</b>	(If Different) Street			
Reinstate - Disciplinary Call	City State Zip			
Reprint/Name Change <b>\$12</b>	E-mail Address@			
Citizenship Form	Race Gender Phone Numbers			
Is Required one time only	Native American □ Black □    Male □     Home Phone()        Asian □ White □    Male □     Work Phone ()			
Citizenship Form Included (Separate ADPH Form Required)	Hispanic   Other   Female   Cell Phone   -			
Citizenship Document Included	EMS Office Use: Fee Information			
Must be a very legible copy				
State DL/ID (AL,FL,GA,TN,MS,LA are approved, otherwise see list)	Check Fee Fee Received By:			
$\Box$ U.S. Birth Certificate	Money Order Amount Received			
Valid Green Card	Bulk Payment allocated of Date:			
Other (See approved lists on form)	Payer Name Deposit #			
	Licensure Disclosure			
If you answer "YES" to a	ny question, you must provide official documentation that fully describes the			
	he current status and disposition of the case, and a detailed personal statement.			
	with, or do you have a medical, physical, mental, emotional, or psychiatric <b>Received Date</b> pur ability to safely practice as an EMS professional?			
Have you ever been convicted of any criminal act? (Do not include minor traffic violations)				
Have you ever had any type of professional license revoked, suspended, or surrendered?				
Are you now, or ever been	addicted to the use of intoxicating liquors or controlled substances?			
Check if you would like the Alabar	na Department of Public Health, Office of EMS, to keep your personal information confidential.			
	on in this form is correct and complete to the best of my knowledge. Contact Us y information may be grounds for denial or revocation of my license.			

Date:	/
Date:	/

Phone: (334)206-5383 Fax: (334)206-0364 Revised Aug 1, 2016

## This form is to only be filled out by first time applicants

STATE OF	RELEASE FORM			
COUNTY OF		ABI -46 (3/94)		
My name is	I reside	e at		
	, state of			
of sound mind and legally competent Public Safety to release any and all cr of Public Health, Office of EMS, 20	riminal history information th	hey have on me to A	labama Department	
I do hereby for myself, my heirs, exec Department of Public Safety and its o which may arise as a consequence of	fficers and agents from any	and all claims, action		
I certify that I have read this release a thereof I have voluntarily signed my				
	Signature SSN			
	Date of Birth	Race	Sex	
Witness				
Address	Filled out by Notary Public			
City State Zip				
	Sworn to and subscrib	bed before me on		
	this		, 20	
Witness				
Address	Notary Public			
City State Zip	My Commiss	My Commission Expires		

## PLEASE NOTE: THIS DOCUMENT MUST BE WITNESSED BY TWO (2) WITNESSES, OR NOTARIZED BY A NOTARY PUBLIC.

Below Line for OEMS Office Use

Office of EMS Director

## ALABAMA DEPARTMENT OF PUBLIC HEALTH DECLARATION OF U.S. **CITIZENSHIP AND LAWFUL PRESENCE OF AN ALIEN**

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non- exempt 'qualified aliens" (and sometimes only particular categories of qualified aliens), non immigrants, and certain aliens paroled into the United States are eligible to receive covered state or local public benefits.

With certain exceptions, Alabama Act 2011-535 prohibits aliens unlawfully present in the U.S. from receiving state or local benefits. Every U.S. Citizen applying for a state or local public benefit must sign a declaration of Citizenship, and the lawful presence of an alien in the U.S. must be verified by the Federal Government.

Act 2011-535 also requires every individual applying for a permit or license to demonstrate his/her U.S. citizenship or if the applicant is an alien, he/she must demonstrate his/her lawful presence in the United States.

Directions: This form must be completed and submitted by applicants for health care benefits/services that are not exempt or excluded from citizenship/lawful presence verification requirements. Medicaid/Medicare clients are not required to complete this form as eligibility to receive services has already been determined by Medicaid/Medicare. This form must also be completed by individuals applying for licenses or permits. An individual includes a sole proprietorship, but does not include other business entities such as corporations.

	SECTION I APPLICAI	NT INFORMATION	
NAME:			
(Print or Type) (Las	st)	(First)	(M.I.)
DATE OF BIRTH:			
APPLYING FOR (Check one	e): License/Permit	Health Service	
	SECTION II U.S. CITIZENS	HIP OR NATIONAL STATUS	6
Are you a citizen or nation	nal of the United States (check	one) 🛛 Yes 🗌 No	
checked YES and are applyi		de an original or legible copy	nal documentation required). If you of a document from attached List A or ete Section IV.
Name of document provided If you checked <b>NO</b> : Complet			
	SECTION III - A	LIEN STATUS	
Are you an alien lawfully	present in the United States? (	Check one) Yes	No
B or other document that		in the United States, and	f any) of a document from attached L (2) Complete Section IV. Information e United States Government.
Name of document provided If you checked NO: Complet			
	SECTION IV D	ECLARATION	
I declare under penalty of true and correct to the be		State of Alabama that the	answers and evidence I provided are
APPLICANT OR LEGAL RE	PRESENTATIVE SIGNATURE	_	DATE
IF SIGNED BY LEGAL REP	RESENTATIVE, RELATIONSHIP	TO PATIENT	Health Dept. Employee
	1		0.1.1

Preliminary Guidance on Implementation of Immigration Law for Licensing/Permitting Programs

October 2011