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:

- ☐ EMT
- ☐ EMT-1
- ☐ Advance EMT
- ☐ Paramedic
- ☐ Other ______________________

Date issued: ______________________

Date license/certificate expires: ______________________

License status:

- ☐ current
- ☐ lapsed since: ______________________
- ☐ inactive since: ______________________

Has this license/certificate ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated? .... ☐ YES ☐ NO
(Please explain "YES" response.)

Do your files contain any derogatory information on this applicant? .... ☐ YES ☐ NO
(Please explain "YES" response.)

COMMENTS:

Signature: ______________________

Title: ______________________

State: ______________________

Date: ______________________

BOARD SEAL

TO THE AGENCY: Return this form **directly** to the Hawaii Medical Board. P.O. Box 3469, Honolulu, HI 96801