

**ARKANSAS DEPARTMENT OF HEALTH
SECTION OF EMERGENCY MEDICAL SERVICES
5800 W. 10TH STREET SUITE 800
LITTLE ROCK AR 72204-1763**

EMT NUMBER _____

~OFFICE USE ONLY~

FEE PAID _____
EXPIRES _____
APPROVED _____

- BACKGROUND CHECK
- ID CARD
- CERTIFICATE
- EIC—CERTSCAN
- DOCUWARE
- REGULATORY _____

**EMSP Licensure Tracking Sheet
PRINT IN INK OR TYPE**

--OFFICE USE ONLY--

Customer # _____

Fee Paid: _____ Amount Received: _____

CHECK LEVEL(S)

- EMT
- ADVANCED EMT
- PARAMEDIC
- EMT-INSTRUCTOR
- RECIPROCITY
- INITIAL LICENSURE
- LICENSURE RENEWAL

_____ Current Expiration Date

_____ Initial Certification Date

NAME _____
Last First MI

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____ HOME and/or WORK PHONE _____

EMAIL ADDRESS _____

BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

SOC SEC# _____ DRIVER'S LICENSE# _____ STATE _____
(Photo ID must be presented at State exam)

**EMERGENCY MEDICAL SERVICES PROVIDER – MEDICAL TRAINING
(ONLY WHAT APPLIES TO THIS LICENSURE PERIOD)
*ATTACH DOCUMENTATION***

COURSE TITLE	COURSE #	NUMBER OF HOURS Class/Clinical/Field	END OF COURSE DATE	PLACE (City)	INSTRUCTOR
EMT					
ADVANCED EMT					
PARAMEDIC					
INSTRUCTOR					