STATE OF NEW JERSEY
OFFICE OF EMERGENCY TELECOMMUNICATIONS SERVICES
EMERGENCY MEDICAL DISPATCH PROGRAM
RECERTIFICATION APPLICATION

(*ALL INFORMATION MUST BE TYPED OR CLEARLY PRINTED*)

APPLICATION DATE: _____

RECERTIFICATION APPLICATION SUBMITTED BY:

☐ EMD Agency ☐ Individual EMD ☐ Other _____

APPLICANT INFORMATION:

Name: _____

SS # (Last 4-Digits)

_____

Address Questions and Forward Correspondence to:

Name: _____

Address: _____

_____

_____

Phone: _____ Fax:_____

REQUIRED DOCUMENTATION (attach photocopies):

☐ Current CPR Card

☐ EMD Certification Record and Tracking Form (with proofs of completion attached where available)

****************************OETS USE ONLY************************

☐ Recertification Approved
☐ Recertification Approval Denied Pending:
  ☐ Documentation of_____
  ☐ Completion of_____hours CTE
☐ Recertification Denied Due to:_____

NOTICE OF RECERTIFICATION DETERMINATION SENT TO:

☐ EMD Agency ☐ Individual EMD ☐ Other _____