



Practitioner Reinstatement Application

Personal Information	Name: (Last, First, MI)			Sex: Male Female	
	Social Security #:	Date of Birth: (MM/DD/YY)	PA Certification Number	Certification Level: FR EMT	
				Expiration Date	
	Address:			County of Residence	
	City:		State:	Zip Code:	
	Telephone:		E-mail address:		

Please provide completed application along with the following:

- _____ Completed Criminal History Form (must be signed)
- _____ Copy of Photo ID
- _____ Copy of a current CPR card (ARC Professional Rescuer, AHA BLS for Healthcare Provider, etc.)
- _____ Proof of Previous Certification (Copy of Certificates and/or Certification Card)

I affirm that the information included in this application is truthful and accurate.

Signature of Applicant: _____ Date: _____

Regional Council Use Only		
Date Received:	Date Processed:	Processed By:
Requirements:		
<input type="checkbox"/> Completed Application	<input type="checkbox"/> CPR Card	
<input type="checkbox"/> Criminal History	<input type="checkbox"/> Photo ID	
	<input type="checkbox"/> Proof of Previous Certification	
Comments:		