

**RENEWAL APPLICATION FOR EMS PERSONNEL**

- \_\_\_\_\_ EMT/DRIVER
- \_\_\_\_\_ PARAMEDIC/DRIVER
- \_\_\_\_\_ PARAMEDIC
- \_\_\_\_\_ SYSTEM STATUS CONTROLLER
- \_\_\_\_\_ KCFD FIRST RESPONDER
- \_\_\_\_\_ KCFD EMT/FIRST RESPONDER
- \_\_\_\_\_ KCI EMT/FIRST RESPONDER

TELEPHONE NUMBER \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW LONG AT PRESENT ADDRESS? \_\_\_\_\_

**HEALTH ASSESSMENT**

ARE YOU TB "POSITIVE?" \_\_\_\_\_ IF YES, ARE YOU CURRENTLY ON MEDICATION OR TREATMENT? \_\_\_\_\_

UNDER WHAT PHYSICIAN OR AGENCY? \_\_\_\_\_

LIST AND DESCRIBE ANY PAST HOSPITALIZATION: \_\_\_\_\_

IF YOU HAVE BEEN SUBJECT TO ANY ACUTE OR CHRONIC DISEASES OF THE FOLLOWING CATEGORIES, DESCRIBE THE PARTICULAR HISTORY: HEART DISEASE, LUNG DISEASE, GI DISEASE, KIDNEY DISEASE, BACK OR JOINT DISEASE, NEUROLOGIC OR MUSCULAR DISEASE, PSYCHIATRIC ILLNESS.

IN GENERAL, EVALUATE YOUR HEALTH: \_\_\_\_\_

THIS IS TO CERTIFY THAT ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE. I AM NOT ADDICTED TO THE USE OF DRUGS OR ALCOHOL. I ACKNOWLEDGE AND CONSENT TO THE RELEASE OF ALL DOCUMENTS REQUIRED FOR EVALUATION OF THIS APPLICATION TO THE APPROPRIATE KCMO HEALTH DEPARTMENT OFFICIALS.

SIGNATURE OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_