

APPLICATION FOR BASE STATION PHYSICIAN

CHECK ONE:

NEW _____ FULL TIME PRACTICE E.M.
RENEWAL _____ E.M. RESIDENT
_____ CHILDREN'S MERCY RESIDENT

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ E-MAIL _____

EMPLOYER _____

EMPLOYER PHONE NO. _____

JOB TITLE _____

MISSOURI MEDICAL LICENSE NUMBER _____

DESCRIBE FORMAL TRAINING AND LICENSES. INCLUDE DATES AND SCHOOLS: _____

EMERGENCY MEDICINE BOARD CERTIFIED? _____ **DATE** _____

EMERGENCY MEDICINE BOARD ELIGIBLE? _____ **DATE** _____

THIS IS TO CERTIFY THAT ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE AND CONSENT TO THE RELEASE OF ALL DOCUMENTS REQUIRED FOR EVALUATION OF THIS APPLICATION TO THE OFFICIALS AT THE OFFICE OF THE EMS MEDICAL DIRECTOR.

SIGNATURE OF APPLICANT _____

DATE _____