INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

EMT/AEMT SUPPLEMENTAL CE FORM

NAME: _____ **CERT #:** _____

Course Title	Provider Name	CE Provider #	Date	Hours

I hereby certify under penalty of perjury that I have read and understand the requirements for certification as an EMT, and am eligible for such certification in accordance with Sections 100057-100086, not consecutive, of Title 22, Division 9, Chapter 2 of the California Administrative Code I also declare that I have successfully passed the final certifying examination after successful completion of all components of the course. I understand that any fraudulent entry on this application may be considered cause for denial or subsequent revocation of my certification without the opportunity of appeal and I hereby authorize ICEMA and/or its affiliates and/or any one or more of the Inland Counties' Health Departments, permission to verify any and all information contained herein.

I also hereby authorize verification of any and all information contained herein and authorize release of any and all information as deemed relevant to my certification process to my employer. I agree to hold ICEMA harmless from any act or action resulting from the release of the information as stated above.

_____ _____

Signature **Date**