

Identifying Information

Name: _____
Surname (Please Print Clearly) Given Name(s) Second Given Name

Mailing Address: _____
Street or PO Box Number

City/Town Province Country Postal Code

Email Address _____ Birthdate: ____/____/____ Sex: M F
(Please Print) YYYY MM DD

Telephone No.: (____) _____ (____) _____
Primary Extension Alternate Extension

Please indicate if your name, mailing address, and email address may be shared with the Paramedic Association of Manitoba.
 Yes No

TYPE OF LICENSE REQUESTED:

<input type="checkbox"/> Technician <input type="checkbox"/> Technician - Medical First Response <input type="checkbox"/> Technician - Dispatch <input type="checkbox"/> Technician - Paramedic <input type="checkbox"/> Technician - Advanced Paramedic	<input type="checkbox"/> Aeromedical Attendant <input type="checkbox"/> Air Ambulance Pilot - Captain <input type="checkbox"/> Air Ambulance Pilot - First Officer <input type="checkbox"/> Stretcher Attendant
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DECLARATION:

To the best of my knowledge I, the applicant, declare that I have read and understood the instructions and that all the information given on this application is true and I understand that any false or misleading information may cause my license to be suspended.

Signature of Applicant Date

The personal information which you are requested to provide is being collected under the authority of the legislation *The Emergency Medical Response and Stretcher Transportation Act* under the jurisdiction of the Minister of Health. It will be used by MHHL to determine suitability for a license provided by the Emergency Medical Services Branch of Manitoba Health. The information is protected by the Protection of Privacy provisions of *The Freedom of Information and Protection of Privacy Act* and may only be disclosed for verification purposes (44(1)(j)) or as otherwise authorized in the legislation. If you have any questions about the collection of personal information, please contact the Access and Privacy Coordinator, Manitoba Health, 1st Floor, 300 Carlton, Winnipeg, MB R3B 3M9 or telephone (204) 786-7237.

SEND COMPLETED APPLICATION FORM AND DOCUMENTS TO:

Personnel Licensing
 MHHL, Emergency Medical Services
 1680 Ellice Avenue, Unit 7
 Winnipeg MB R3H 0Z2

For additional information call (204) 945-5300

FOR MHHL USE ONLY

Date Received _____ License No. _____
 Expiry Date _____

REQUIREMENTS FOR AEROMEDICAL ATTENDANT

- Proof of Age** – Provide documentation along with this application form. Applicants must be a minimum of 18 years of age.
- Proof of Criminal Records Check** – Provide an original document of a criminal records check including the Vulnerable Sector Screening along with this application form. Evidence of a criminal records check from a law enforcement agency is required dated no more than 60 days before submitting this application
- Proof of Child Abuse Registry Check** – Provide an original document along with this application form. Evidence of a child abuse registry check from Family Services and Housing is required dated no more than 60 days before submitting this application.
- Education** – Provide an original document of satisfactory completion of an educational program(s) or equivalent (relevant to license classification). See the instructions for details on educational qualifications, required documentation and approved education programs. Please complete the following information required as per the license you are applying for. **A copy of your nursing diploma/degree is not required.**

Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French
	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

- Nursing Registration** – It is required that you maintain a valid registration with the College of Registered Nurses of Manitoba. Provide a copy of your registration and complete the following information:

Registered Nurse College of Registered Nurses of Manitoba (CRNM) Membership # _____ Expiry Date: _____

Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
<u>Canadian Aerospace Medicine and Aeromedical Transport Association (CAMATA)</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

Must have successfully completed one (1) of the following three (3) options:

1. Critical Care Course

Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

2. Emergency Nursing Course

Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

3. Place of employment for two years of related nursing experience.

Employer Name & Address	Contact Name & Phone Number	From Date	To Date

- Advanced Care Paramedic** – It is required that you maintain a valid license as a Manitoba Technician - Advanced Paramedic. Provide a copy of your license and complete the following.

Technician - Advanced Paramedic	License # _____	Expiry Date: _____
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Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
<u>Accredited Advanced Care Paramedic Program</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French
<u>Canadian Aerospace Medicine and Aeromedical Transport Association (CAMATA)</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

- This section is to be completed by all applicants:**

Name of Educational Institution & Address <i>(name, street, city/town, province/country, postal code)</i>	Date of Graduation <i>Year / Month / Day</i>	Language of Instruction
<u>Basic Cardiac Life Support (BCLS)</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French
<u>Advance Cardiac Life Support (ACLS)</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French
<u>Basic Trauma Life Support (BTLS) or Trauma Nursing Core Curriculum (TNCC)</u>	____/____/____	<input type="checkbox"/> English <input type="checkbox"/> French

- Disciplinary Action** – Complete this information if you have ever had your registration/license cancelled, suspended, restricted or subjected to individual terms and conditions by any health profession/jurisdiction.

Name and Address of Organization _____
Reason for Disciplinary Action _____
Nature of the Disciplinary Action _____ Date _____
Terms of Conditions _____
Will you grant the MHHL Emergency Medical Services Branch the right to contact the above for further clarification if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No