



Division of Public Health

Emergency Medical Services Licensure Reinstatement Refresher Course Reimbursement Request

Complete this form, scan, & send it with the required documentation, within **180** days of course completion, to:
wendy.snodgrass@nebraska.gov OR you may mail it to: Nebraska Department of Health & Human Services
 EMS & Trauma Program P. O. Box 95026 Lincoln, NE 68509-5026

SECTION A	
Are you licensed as an out-of-hospital emergency care provider in the State of Nebraska at the level that you are requesting reimbursement for?	YES NO
Are you on the official roster of an emergency medical service that is licensed AND physically located in the State of Nebraska? (will be verified at http://dhhs.ne.gov/publichealth/Documents/EMS_Roster.pdf)	YES NO
IF YOU HAVE ANSWERED YES TO BOTH OF THE QUESTIONS ABOVE, CONTINUE BELOW. IF YOU HAVE ANSWERED NO TO EITHER QUESTION IN SECTION ABOVE, YOU ARE <u>NOT</u> ELIGIBLE FOR REIMBURSEMENT.	
What is your Nebraska out-of-hospital emergency care provider license number?	
What level is your license?	EMR EMT AEMT Paramedic
What is your service's name?	What is your service's license number?
Signature of officer on service:	Officer from service reimburse, who is reimbursed? Student Service

SECTION B	
Your Name:	
Your Phone Number:	Your e-mail:
What refresher (reinstatement) course did you complete?	EMR EMT AEMT Paramedic
What training agency offered your course?	
Course Location:	Date of Course Completion:
Signature of student:	

With this form, you must include copies of:

- Copy of course completion certificate issued by the training agency.
- The attached W-9/ACH form.

<i>For DHHS use only.</i>		
<i>Date application received:</i>	<i>Amount approved to be paid:</i>	
<i>License Verified:</i>	<i>Service Roster Verified:</i>	<i>Within 180 days:</i>
<i>Approved to be paid by:</i>	<i>Date approved:</i>	
<i>Comments:</i>		