



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DIVISION OF PUBLIC HEALTH
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Marin County Paramedic Continuous Accreditation

Name:	
Address:	
Work Phone:	Home Phone:
Marin Provider Name:	
Signature:	

Office Use only

Copy of Paramedic License (front/back):		
Number and Expiration Date:		
Proof of Lesser-Used Skills Class:		

Approved by EMS Office for Continuous Accreditation	
Signature:	Date:

Received Date:	Date Issued:	Date of State Notification:	Date Mailed:

Comments recorded on the reverse side.