

# Consent to Shorten License Cycle Time Acknowledgement

## Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or  
Fax to 208-334-4015



Name \_\_\_\_\_ Gender  F  M  
Last Name First Name Middle Name/Initial

Idaho EMS License Number \_\_\_\_\_ or Social Security # if you do not know your license Number - -

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Mailing Address \_\_\_\_\_  
City State Zip County

**Request:**

I request to shorten the license cycle time on license # \_\_\_\_\_, to expiration date of \_\_\_\_\_.

By shortening my license period, I acknowledge that the same license renewal requirements are in place had I not chosen to shorten my time frame, which include the transition of scope of practice requirements. All continuing education hours for license renewal upon expiration of the shortened license cycle must be completed between the effective and expiration dates on the newly issued EMS license and submitted prior to the expiration date.

I agree to return any and all other Idaho EMS licenses I hold prior to receiving my new EMS license with the effective shortened licensure renewal cycle.

**Signature:**

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature \_\_\_\_\_ Date \_\_\_\_\_