MMMT Team Membership Registration

Membership Demographics

Name:	
Date of birth:	SSN# Last four:
Primary phone #:	Secondary phone #:
Email #1:	Email #2:
Current Address:	
City:	Zip Code:

Employment Information

Employer:		
Address:		
City:	State:	Zip Code:
Phone:	Extension:	E-Mail:
Department:	Position:	How Long employed?:
Supervisors Name:		Phone:

License and Certification information

Licenses			
License Type:	License Number:	Issuing State:	Exp. Date:
License Type:	License Number:	Issuing State:	Exp. Date:
License Type:	License Number:	Issuing State:	Exp. Date:
License Type:	License Number:	Issuing State:	Exp. Date:

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Certifications		
Certification Type:	Issuing Agency:	Exp. Date:
Certification Type:	Issuing Agency:	Exp. Date:
Certification Type:	Issuing Agency:	Exp. Date:
Certification Type:	Issuing Agency:	Exp. Date:
Certification Type:	Issuing Agency:	Exp. Date:

Experience and Training Please list and explain any experience and/or training pertinent to the MMMT - include ICS classes
Please list any specific sub-specialty training you have i.e. pediatric trauma, environmental safety, languages ect.

Checklist of required documents:	
Copy of drivers license	Date provided:
Completed Emergency Information form	Date provided:
Signed Member Acceptance of Conditions	Date provided:
Signed Employer Authorization	Date provided:
A photograph for id badge and website	Date provided:
Signed Attendance Policy	Date provided:

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My signature below identifies that I acknowledge all the information contained to be true. My signature also identifies that my licenses and certificates are in good standing and there are no adverse actions or restrictions associated with my licensure.

My signature allows the MMMT to conduct a background check and licensure check as required by Minnesota Responds.

If there are any changes to the information provided, I will notify the MMMT of any changes.

I will continue to maintain my registration with Minnesota Responds.

____
Name - printed

____
Name - signature

____
Date

The information required may be submitted by:

Fax: 320-240-3196

Email: shawn.stoen@centracare.com