Tennessee Department of Health Emergency Medical Services
Critical Care Paramedic Certification Exam – Registration

First Name	
Middle Initial	
Last Name	
Social Security Number	- -
Address 1	
Address 2	
City	
State	
Zip	
Phone#	
Alternate Phone#	
EMail	
Date of Birth (MM/DD/YY)	
Ethnicity	☐ **Caucasian** ☐ **African American** ☐ **American Indian** ☐ **Hispanic** ☐ **Asian** ☐ **Other**
Gender	☐ **Male** ☐ **Female**
Location where you completed your State Approved Critical Care Paramedic Program	