County of Santa Cruz

HEALTH SERVICES AGENCY
Public Health Division
Emergency Medical Services

1800 Green Hills Road, Suite 240
Scotts Valley, CA 95066
Phone: (831) 454-4120 TDD/ TTY: Call 711
hsaems@santacruzcountyca.gov
santacruzhealth.org

APPLICATION FOR MICN AUTHORIZATION

First Name:	Last Name:
Address:	City:
State:	Zip:
Phone Number:	Social Security #:
Employer:	Employer Phone #:
Email:	State RN License #:
County MICN #:	MICN Expiration Date:

Are you currently on probation as a result of a certification, license, or credential disciplinary action? _____ Yes _____No

If yes, please explain:

You must provide copies of the following documents with this application:

- Driver's License.
- Current AHA or ARC CPR/AED
- Copy of current MICN card (only when renewing).
- Fee - $150, cash, cashier's check or money order payable to Santa Cruz County Treasurer. No personal checks, no credit/debit cards.

Please read carefully before signing:

I hereby certify that all statements in this application are true and complete. I understand this application will be used to verify my qualifications for MICN Authorization in Santa Cruz County. I authorize investigation of all information contained in this application. I have read and understand the requirements for MICN Authorization as described in EMS Policy #207- Mobile Intensive Care Nurse Continuing Education and Continuing Service Requirements.

Signature:	Date:

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****TO BE COMPLETED BY THE BASE STATION PRE-HOSPITAL LIASON NURSE****

Signing below is verification that this applicant has met all education and training requirements to receive authorization as an MICN and proof of affiliation with the following:

Base Station Hospital:	Print Name/Title:
Signature:	Date:

DECLARATION OF UNDERSTANDING OF CONDITIONS OF SANTA CRUZ COUNTY EMS PROGRAM, MICN AUTHORIZATION

(a) The medical director of the local EMS agency may, in accordance with regulations adopted by the authority, deny, suspend or revoke any MICN authorization certificate issued under this division, or may place any MICN certificate holder on probation, upon the finding by that medical director of the occurrence of any of the actions listed in subdivision (b).

(b) Any of the following actions shall be considered evidence of a threat to public health and safety and may result in the denial, suspension, or revocation of a MICN authorization certificate issued under this division, or in the placement on probation of a MICN authorization certificate holder under this division.

(1) Fraud in the procurement of any certificate or license under local EMS agency policy.
(2) Gross negligence.
(3) Repeated negligent acts.
(4) Incompetence.
(5) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel.
(6) Conviction of any crime that is substantially related to the qualifications, functions, and duties of MICN personnel. The record of conviction or certified copy of the records shall be conclusive evidence of such conviction.
(7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.
(8) Violating or attempting to violate any federal or state statute or regulation, which regulates narcotics, dangerous drugs, or controlled substances.
(9) Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
(10) Functioning outside the supervision of medical control policies established by the local EMS Agency.
(11) Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

READ CAREFULLY BEFORE SIGNING:

I certify that all statements made in this application are true and complete. I understand this application will be used in determining my qualifications for accreditation. I authorize investigation of all matters contained in this application and approve the release of information from other sources as needed to the County of Santa Cruz.

Signature of Applicant:	Date: