County of San Diego Emergency Medical Services
Mobile Intensive Care Nurse Application
(MICN)

.

Last Name: _____First Name: _____MI: _____

Residential Address

Street Address: _____

City: _____State: _____ Zip Code: _____-_____

Mailing Address (if different from mailing address)

Street Address: _____

City: _____State:_____Zip Code: _____-_____

Phone Number: _____ Mobile Phone Number: _____

Email Address: _____

Social Security Number: _____Date of Birth (MM/DD/YYYY):_____

County of San Diego EMS System Employer: _____

Failure to disclose requested information may result in denial or loss of MICN authorization.

YES NO Has your existing Nursing license, or MICN authorization lapsed?
If YES, enter the date lapsed: _____ Checked by: _____

YES NO Is your Nursing license or MICN authorization currently on probation or suspension?
If YES, enter date of action: _____ Checked by: _____

YES NO Have you ever had a Nursing license or MICN authorization suspended, denied or revoked, placed on probation or been under investigation**?**
If YES, **you must attach with this application a written explanation that describes the action, and any corrective action, and/or remediation as a result of the action**. Checked by: _____

I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of any rights to a Mobile Intensive Care Nurse Certificate (MICN) in the State of California. I understand all information on this application is subject to verification and audit, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an MICN in the State of California.

Signature: _____Date:_____

County of San Diego Staff to complete:

License/Authorization:	Issue Date:	Expiration Date:	Govt. Issue I.D. Checked:
RN License number:	RN License Expiration Date:	Data Entry/Checked By	Q.A. Completed by:

MICN AUTHORIZATION

MAIL TO: COUNTY OF SAN DIEGO EMS
6255 MISSION GORGE ROAD
SAN DIEGO, CA 92120-3599
ATTN: CERTIFICATION PROCESSING

Office (619) 285-6429
Fax (619) 285-6531

Initial Authorization
- Attach proof of completion MICN training,
- Attach copy of current ACLS card
- Attach verification of ride-along and orientation to base hospital
- Copy of current RN license

Reauthorization – Complete education section below

If processing reauthorization via mail please include:
- Digital photo
- Copy of current RN license
- Check, cashier's check or money order for $17
- A stamped self-addressed envelope
- Completed Table below

(Not necessary for initial authorization) – Complete the Continuing Education Table below. (Must list a minimum of 24 hours of field care activity)

Date	Provider Name	Title of Course	Hours	BLS/ALS

Updated 07/01/2010