



**Application for Certified Rapid Response Healthcare Professional (CRRP)**

Date: \_\_\_\_\_

Name (as it appears on your license): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip/Country: \_\_\_\_\_

Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

I attest to the following (please initial each):

\_\_\_\_ I am a state or nationally licensed (or equivalent outside the U.S.) professional as outlined in Criterion 1.1 of the CRRP certification standards

\_\_\_\_ My professional license is current and in good standing as outlined in the Evergreen Certifications Code of Ethics

\_\_\_\_ I have completed the required 18 education hours as outlined in Criterion 2.1 of the CRRP certification standards

\_\_\_\_ I have worked in critical care, emergency medicine, ALS/critical care transport, or part of a code/rapid response team for at least 2,080 hours within the past 2 years (equivalent to 1-year full time work).

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted.

I understand that information submitted with this application may be verified for accuracy by Evergreen Certifications. I also agree to contact Evergreen Certifications if I no longer meet the requirements to be a Certified Rapid Response Healthcare Professional.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_