APPLICATION FOR EMERGENCY MEDICAL SERVICE (EMS) RECIPROCITY AND/OR ADVANCED LIFE SUPPORT (ALS) AFFILIATION

State Form 67 (R11 / 1-14)

INSTRUCTIONS:

1. *This application is for individuals wishing to become certified Indiana EMS responders based upon a certification in another state.*
2. *This application is also for ALS EMS personnel who are affiliated with an ALS provider organization.*
3. *In order to gain an active status of either an Advanced EMT or Paramedic, personnel must have their ALS provider organization attest to their affiliation. If an applicant for reciprocity meets all other requirements other than the ALS affiliation, then his/her certification will be granted in an inactive status until he/she becomes affiliated with an ALS provider, submits this completed form to the EMS certifications office, and receives notification that they are now granted active status.*
4. *Please type or print clearly all information. Incomplete forms will be returned to applicant.*
5. *Applicant must indicate the Emergency Medical Services (EMS) certification level for which he/she is applying.*
6. *Submit the completed application to emscertifications@dhs.in.gov or mail to Indiana Department of Homeland Security, EMS Certifications, 302 West Washington Street, Room E239, Indianapolis, IN 46204.*

ADDITIONAL ITEMS TO SUBMIT WITH THIS APPLICATION:

1. *Applicant must submit a copy of his/her current National Registry and/or state EMS certification with this application.*
2. *The applicant must submit State Form 19634, Verification of EMS Status for Reciprocity, to his/her state; and the responding state must send State Form 19634 directly to the Indiana Office of Emergency Medical Services.*
3. *Paramedics must submit a copy of the ACLS certification with this application.*
4. *Military personnel must submit a copy of form DD214 and the EMS curriculum (i.e. syllabus, book ISBNs, protocols, etc.) with this application.*
5. *The reciprocity process will not begin until all of the required documents (as described above) are received by the Indiana Office of Emergency Medical Services.*

Type of certification *(Check one, if applicable.)*	Advanced life support *(Check one, if applicable.)*
☐ Emergency Medical Responder Certification based on reciprocity ☐ Emergency Medical Technician Certification based on reciprocity ☐ Advanced Medical Technician Certification based on reciprocity ☐ Paramedic License based on reciprocity	☐ Advanced Medical Technician Certification Affiliation ☐ Paramedic License Affiliation

APPLICANT INFORMATION

Name of EMS applicant			Public Safety Identification (PSID) number	
Driver's license number	Date of birth *(month, day, year)*	E-mail address		
Address *(number and street, city, state, and ZIP code)*			Telephone number ( )	
Have you ever been arrested for or convicted of a crime that has not been expunged by a court? *(Excluding minor traffic violations)*			☐ Yes	☐ No
For military personnel: Have you ever been the subject of a court martial or a non-judicial punishment?			☐ Yes	☐ No
Are you currently certified at any EMS level in another state or National Registry?			☐ Yes	☐ No
If yes, certification number	State	Expires *(month, day, year)*	National Registry number	Expires *(month, day, year)*
Name of training institution where course was taken				
Course number	Start date *(month, day, year)*	Completion date *(month, day, year)*		
In signing this form, I declare that all of the information I have provided is true, correct, and complete.				
Signature of applicant			Date *(month, day, year)*	

ADVANCED LIFE SUPPORT / PROVIDER ORGANIZATION INFORMATION

For Advanced Emergency Medical Technicians (AEMT) and Paramedics ONLY: The information below is filled out by the provider. By signing, the provider is attesting that the applicant above is affiliated with the organization below.

Name of Indiana state certified EMS provider organization	Provider certification number
Address *(number and street, city, state, and ZIP code)*	Telephone number ( )
Signature of medical director	Date *(month, day, year)*
Printed name of medical director	
Signature of organization CEO	Date *(month, day, year)*
Printed name of organization CEO	