APPLICATION FOR EMERGENCY MEDICAL TECHNICIAN

State Form 555 (R6 / 1-08)
INDIANA DEPARTMENT OF HOMELAND SECURITY

Reset Form

INSTRUCTIONS:
1. *Please type or print clearly.*
2. *Complete all items below that pertain to the type of certification you are requesting.*
3. *You will be notified by mail after the Indiana Department of Homeland Security had reviewed your application.*
4. *After completion, send the original application to:* *Indiana Department of Homeland Security*
   302 West Washington Street, Room E239
   Indianapolis, IN 46204-2721
5. *You will receive a letter notifying you of the information required.*

Pursuant to IC 16-31, the EMS Commission requires the completion of each item on this form.
Failure to complete any item will result in this form being returned. Upon submission, this form becomes a public record.
BOTH MISREPRESENTATION OF INFORMATION PROVIDED ON THIS FORM AND FAILURE TO COMPLY AND MAINTAIN COMPLIANCE WITH ANY APPLICABLE STANDARDS OR REQUIREMENTS ARE CAUSES FOR SUSPENSION OR REVOCATION OF YOUR CERTIFICATION.

APPLICANT INFORMATION

Name of Applicant (*last, first, middle*)		Driver's License or State Identification Number
Address (*number and street, city, state, and ZIP code*)		
Telephone Number ( )	County of Residence	Date of Birth (*month, day, year*)
Have you ever been charged or convicted of a crime other then minor traffic violations? ☐ Yes ☐ No	If yes, have you previously reported the details of this crime(s) to the Indiana Department of Homeland Security? ☐ Yes ☐ No	

TYPE OF APPLICATION

☐ Initial Certification ☐ Certification through Reciprocity / Waiver ☐ Certification for Physicians

INITIAL CERTIFICATION

Basic EMT Training Course Number	Date of Completion (*month, day, year*)	Training Institution

CERTIFICATION PROVIDED THROUGH RECIPROCITY / WAIVER

State / Organization where training was obtained	Certification Number	Date of Expiration (*month, day, year*)

CERTIFICATION FOR PHYSICIANS

Do you possess a valid unlimited license to practice medicine in the State of Indiana and do you lead an active role in the delivery of emergency care in an emergency medical services facility approved by the State to provide such care? ☐ Yes ☐ No	If yes, indicate name of facility.

AFFIRMATION - *Applicant's signature is required.*

I hereby swear and affirm that I am the person named above and that I will comply with all State laws governing this type of certification and that the statements contained herein are true.

Signature of Applicant	Date (*month, day, year*)