



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

State Form 67 (R10 / 9-13)



- INSTRUCTIONS:**
1. This application is for individuals wishing to become a certified Indiana EMS responder 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 or 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](mailto:emscertifications@dhs.in.gov) or mail to Indiana Department of Homeland Security, EMS Certifications, 302 West Washington Street, Room E239, Indianapolis, IN 46204.

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| Type of certification (Check one, if applicable.)<br><input type="checkbox"/> Emergency Medical Responder Certification based on reciprocity<br><input type="checkbox"/> Emergency Medical Technician Certification based on reciprocity<br><input type="checkbox"/> Advanced Medical Technician Certification based on reciprocity<br><input type="checkbox"/> Paramedic License based on reciprocity | Advanced life support (Check one, if applicable.)<br><input type="checkbox"/> Advanced Medical Technician Certification Affiliation<br><input type="checkbox"/> Paramedic License Affiliation |
|--|---|

| APPLICANT INFORMATION   |                                  |   |                            |
|---|----------------------------------|---|----------------------------|
| Name of EMS applicant   |                                  | Public Safety Identification (PSID) number  |                            |
| Driver's license number   | Date of birth (month, day, year) | Telephone number<br>(     )   |                            |
| Address (number and street, city, state, and ZIP code)  |                                  |   |                            |
| Have you ever been arrested for or convicted of a crime that has not been expunged by a court? (Excluding minor traffic violations) |                                  | Are you currently certified at any EMS level in another state or National Registry? |                            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |                                  | <input type="checkbox"/> Yes <input type="checkbox"/> 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  |                               |
|--|-------------------------------|
| <i>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 name applicant above is affiliated with the name organization below.</i> |                               |
| Name of Indiana state certified EMS provider organization  | Provider certification number |
| Address (number and street, city, state, and ZIP code)   | Telephone number<br>(     )   |
| 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   |                               |