

## RECIPROCITY REQUIREMENTS FOR EMERGENCY MEDICAL RESPONDER

### INDIVIDUALS APPLYING FOR AN EMERGENCY MEDICAL RESPONDER (EMR) CERTIFICATION IN TENNESSEE MUST:

- Hold a current EMR certification in another state and hold or have held a current national registry certification at the EMR level or;  
Have received your training while employed at a federal agency and hold a current national registry certification at the EMR level.
- Submit all of the required documentation on the enclosed checklist.
- Pay all required fees.
- Complete any additional training which may be required.
- Successfully pass any examinations that may be required.

Your application packet will be reviewed upon receipt of written verification from the issuing EMS certifying agency of your current EMS certification or upon receipt of written verification from a federal training agency. The Office of EMS does not issue temporary certifications for employment.

All the required documentation and fees must be submitted as one packet. The only exceptions are the *state or federal verification form*.

**NOTE:** the Criminal Background Disclosure Form (PH-3856) should only be submitted if you have criminal history.

**Mail your packet to:**

**Tennessee Department of Health  
Division of Health Licensure and Regulation  
Office of Emergency Medical Services  
665 Mainstream Drive  
Nashville, TN 37243**

## APPLICATION PROCESS:

**NOTE: The reciprocity packet is valid for two years from the date on the application. If all requirements are not met within this timeframe you must re-apply for a certification.**

With your cooperation, we will make every effort to expedite your application.

1. Allow 14 business days for information mailed to our office to be received and placed in your file. The Federal Special courier services will not appreciably reduce the process time. If you would like confirmation that the Office has received your application packet, it is recommended that you mail the packet certified mail with return receipt requested.
2. Absent of any complicating factors, the average application processing time is *7-14 business days* from receipt of all the documentation. *This includes the state or federal verification form.*
3. **We will discuss the application status with the APPLICANT only.** Please inform potential employers and any others that application status updates must be obtained from you.
4. Examination information for National Registry testing can be acquired from the NREMT web site ([www.nremt.org](http://www.nremt.org)) or by calling the Registry at 614-888-4484.
5. If an address change occurs at any time during the application process you must notify this office in writing or go online at [lars.tn.gov](http://lars.tn.gov).
6. **Anyone practicing as an EMR must first obtain a valid certification in Tennessee.** Therefore, it is recommended that you do not make arrangements to accept employment in Tennessee until you are granted a certification by this office.

## RECIPROCITY CHECKLIST

The following are general requirements that must be met and documents that must be submitted by all EMRs:

### General Requirements:

1.  **Application for Certification**
  - a. The application (PH-3784) must be signed and dated and all questions answered before processing will begin. The signed application is valid for two years from the date on the application.
2.  **EMS Professional Fees**
  - a. Submit the Fee Form (PH-2397) with a check or money order for all applicable fees, which includes the application fee, certification fee and reciprocity fee for the EMR level. If you would like confirmation of receipt of your fees/documents, you should send by certified mail with a receipt requested. (The application fee is non-refundable.)
  - b. The business name refers to employment with an Emergency Medical Service or similar organization approved to operate in the State of Tennessee. If not employed, indicate Not Applicable.
3.  **Current Professional or EMS State Certification** (does not apply to federally trained applicant)
  - a. Submit a copy of your current EMS certification that verifies the expiration date.
4.  **National Registry Certification**
  - a. You must currently hold or have held a National Registry certification and submit a copy of a certificate or card.
  - b. If you are applying for reciprocity through your training from a Federal Agency you must hold a current National Registry Certification at the level of certification for which you are applying. You must submit a copy of the National Registry card that verifies the expiration date.
5.  **Proof of Current CPR Training**
  - a. Submit a copy of your current CPR card for a Basic Rescuer or equivalent.
  - b. Verification of an electronic copy of your CPR card is also acceptable.
6.  **State Verification of Certification or Federal Agency Training Verification**
  - a. Mail the verification of certification form (PH-3607) or Federal Agency Training form (PH-3936) to the appropriate state(s) in which you hold or have held a certification or to the Federal Agency where you received your training.
  - b. The verification form must be returned to our office by the verifying state or agency.
7.  **Declaration of Citizenship**
  - a. Form must be notarized and required identification submitted.

**NOTE:** Fees Are Subject To Change Without Notice.

ALL REQUIRED DOCUMENTATION, FORMS, AND FEES MUST BE SUBMITTED **TOGETHER** AS ONE PACKET.  
(Excluding the State certification or Federal Agency training verification)

**Questions?**  
**Contact the Office of EMS**  
**Telephone: (615) 741-8401**



EMS LICENSURE/CERTIFICATION
RECIPROCITY APPLICATION

LIC/CERT LEVEL REQUESTING: [ ] EMR [ ] EMT [ ] AEMT [ ] PARAMEDIC [ ] EMD

CHOOSE ONE: [ ] Hold current license in another state [ ] Received training from Federal Agency

Please print legible or type:

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ MM DD YYYY

NAME: \_\_\_\_\_ LAST FIRST MIDDLE (JR., II, III)

MAILING ADDRESS: \_\_\_\_\_ (STREET /PO BOX/ROUTE) (CITY/STATE/ZIP)

PERSONAL TELEPHONE: ( ) \_\_\_\_\_ WORK TELEPHONE: ( ) \_\_\_\_\_

Do you wish to receive notification, including renewal notification, from the Department of Health via email? [ ] Yes [ ] No

EMAIL ADDRESS: \_\_\_\_\_

RACE: [ ] White [ ] Black [ ] Native [ ] Asian [ ] Hispanic [ ] Other
GENDER: [ ] Male [ ] Female
HIGH SCHOOL DIPLOMA: [ ] Yes [ ] No
GED: [ ] Yes [ ] No

Are you currently or have you ever been licensed/certified in other states or with the national registry? [ ] Yes [ ] No
If yes, list below:

STATE: \_\_\_\_\_ LEVEL: \_\_\_\_\_ LIC/CERT #: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

STATE: \_\_\_\_\_ LEVEL: \_\_\_\_\_ LIC/CERT #: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

If you answer yes to any of the questions below, give details on a separate sheet including circumstances with appropriate dates. Attach a certified copy of court records if convicted of any law violation.

Have you ever been convicted for a violation of the law other than a minor traffic violation? [ ] Yes [ ] No

Have you ever or are you now addicted to any alcohol or drugs? [ ] Yes [ ] No

Has your license/certification to practice in any state ever been reprimanded, suspended, restricted, revoked or is it under threat of disciplinary action? [ ] Yes [ ] No

I certify that all information in this form is correct and complete to the best of my knowledge. I understand that falsification of any information may be grounds for denial or revocation of my license/certification.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities.

OFFICE USE ONLY	
707 – EMR	_____
718 – EMT, AEMT, PM	_____
719 – EMD	_____

**EMS PROFESSIONAL FEES**

Class Number: (If Applicable) \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MIDDLE (JR., SR., ETC.)

Address: \_\_\_\_\_  
(STREET /PO BOX/ROUTE) (CITY/STATE/ZIP)

Personal Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMS Employer: \_\_\_\_\_

Do you wish to receive notification, including renewal notification, (*excludes EMD level*) from the Department of Health via email?  YES  NO

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

*If you answer yes to any of the questions below, give details on a separate sheet including circumstances with appropriate dates. Attach a certified copy of court records if convicted of any law violation.*

Have you ever been convicted, for a violation of the law other than a minor traffic violation?  YES  NO

Have you ever or are you now addicted to any drugs or alcohol?  YES  NO

Has your license/certification to practice in any state ever been reprimanded, suspended, restricted, revoked or is it under threat of disciplinary action?  YES  NO

I certify that all information in this form is correct and complete to the best of my knowledge. I understand that falsification of any information may be grounds for denial or revocation of my certification/license.

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

**THIS APPLICATION MUST BE SIGNED AND DATED AND ALL QUESTIONS ANSWERED TO INSURE PROCESSING.**

Please check the appropriate box(es) and submit this form with the total fee(s) by a personal or certified check (**no cash**).

*PAYMENT SHOULD BE MADE PAYABLE TO TDH-EMS*

ACTION	EMR	EMT	AEMT	PARAMEDIC	EMD	PM CRITICAL CARE	INSTRUCTOR
Application Fee*	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$70.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$30.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$35.00
License Fee	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$80.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$30.00		
Renewal Fee	<input type="checkbox"/> \$24.00	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$45.00	<input type="checkbox"/> \$90.00	
Late Fee	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$25.00	
Reinstatement Fee	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	
Reciprocity Fee	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00	<input type="checkbox"/> \$100.00			
Returned Check Fee	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$20.00	

\*NOTE: APPLICATION FEE IS NON-REFUNDABLE.

TOTAL FEE = \$ \_\_\_\_\_

"Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities."

## EMS LICENSE/CERTIFICATION VERIFICATION

Complete the **TOP** portion of this form and mail to the State you received your current certification/licensure. Reproduce this form if certification/licensure is held in more than one state.

**ATTENTION:** \_\_\_\_\_ EMS Personnel Certification/Licensure Section  
(STATE)

I am applying for an EMS license in the State of Tennessee and authorize your agency to release the information requested in the lower section of this form. Please mail the completed form to the Tennessee Office of Emergency Medical Services.

**NAME:** \_\_\_\_\_  
Last First Middle

**ADDRESS:** \_\_\_\_\_  
Street City State Zip

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **CERT/LIC #** \_\_\_\_\_

Licensure Level Applying For:

- EMD     EMR     EMT     AEMT     PARAMEDIC     PARAMEDIC CRITICAL CARE

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

### *THIS SECTION TO BE COMPLETED BY CERTIFYING AGENCY*

Did the individual identified above successfully complete an approved curriculum which met the National EMS Educational Standards for the level in which they are licensed in your agency?     Yes     No

If no, did this individual successfully complete an approved transitional course for the level licensure/certification?     Yes     No

**Date Training Completed:** \_\_\_\_\_ **Total Hours:** \_\_\_\_\_

Licensure/Certification Level:

- EMD     EMT     AEMT     PARAMEDIC     OTHER \_\_\_\_\_

Is this certification/licensure current and valid in your state?     Yes     No    **Expiration Date:** \_\_\_\_\_

AEMT Training included: (please mark all that apply)

- IM injections     Sub-Q injections     IV Initiation     Glucagon     D50 Administration     Nitrous Oxide     Epinephrine  
 NTG     Narcotic Antagonist     Intraosseous Access     Inhaled Beta Agonists     Airways Not Intended For Trachea

Did this individual reciprocate from another state?     Yes     No    **State:** \_\_\_\_\_

Has this individual's license ever been restricted, suspended or revoked as a result of disciplinary action?  Yes  No

If yes, Please explain: \_\_\_\_\_  
\_\_\_\_\_

Does your state require criminal background checks for certification/license?  Yes  No

Do you know of any reason why this individual should be denied a certification/license?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**I certify that the information provided is true and correct.**

**Agency Name:** \_\_\_\_\_

**Print Name of Agency Representative:** \_\_\_\_\_

**Signature of Agency Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

Your cooperation is greatly appreciated. If you have questions, please contact the reciprocity section at (615) 253-3165. **Please return this form to the address at the bottom of the first page.**





Do you know of any reason why this individual should be denied a license/certification?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**I certify that the information provided is true and correct.**

**Agency Name:** \_\_\_\_\_

**Signature of Agency Representative:** \_\_\_\_\_

**Print Name of Agency Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Telephone:** (       ) \_\_\_\_\_

Your cooperation is greatly appreciated. If you have questions, please contact the reciprocity section at (615) 253-3165. **Please return this form to the address at the bottom of the first page.**

**DECLARATION OF CITIZENSHIP**  
**MUST ACCOMPANY ALL INITIAL LICENSURE OR RECIPROCITY LICENSURE APPLICATIONS**

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions and contractors), along with every local health department in the State, to verify that *every adult* applicant applying for a professional license is either a U.S. citizen, a "qualified alien" or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

<b>I am applying for a(n)</b> _____ <div style="text-align: center; font-size: small;">Healthcare Profession (Please Print)</div>	_____ <div style="text-align: center; font-size: small;">License number (if applicable)</div>
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**Please Print Legibly or Type**

1. Name: \_\_\_\_\_  

Last
First
Middle
Maiden
2. Mailing Address: \_\_\_\_\_  

Street/P.O. Box
City
State
Zip
3. Phone Number: ( ) - ( ) - \_\_\_\_\_  

Personal/Home
Office
Fax
4. I am a foreign national not physically present in the United States  Yes  No If you answered yes to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.
5. I am a United States Citizen:  Yes  No
6. Applicants claiming United States Citizenship **MUST attach a copy** of *one* of the following:
  - a) A valid Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s e-i above.
  - k) A Social Security Card that is verifiable with the Social Security Administration in accordance with federal law.
7. If you answered "No" to question 5, indicate from the list below which category applies to you: (check one)
  - Permanent Resident
  - A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.)

- Asylees who meet the qualifications set out in 8 U.S.C. 1158.
- Refugees who meet the qualifications set out in 8 U.S.C. 1157.
- Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980.
- Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card or "Green Card")
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Machine Readable Immigrant Visa (with Temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94)
- I-94 (Arrival/Departure record)
- Unexpired foreign passport
- WT/WB Admission Stamp in unexpired foreign passport
- I-20 (Certificate of Eligibility for Nonimmigrant F (1) student status- "student visa")
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

**ALL APPLICANTS MUST SIGN AND HAVE NOTARIZED**

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status, state governmental entities and local health departments must also file a criminal complaint with the Office of the Attorney General and/or the United State Attorney.**

