

## RECIPROCITY REQUIREMENTS FOR EMS PROFESSIONAL LICENSE

### INDIVIDUALS APPLYING FOR AN EMS LICENSE IN TENNESSEE MUST:

- Obtain a Criminal Background Check  
A criminal background check (CBC) is required before a license can be issued. If you are in Tennessee or plan on visiting prior to your move you can obtain the information on how to get a state of Tennessee criminal background check from our web site at: <https://www.tn.gov/health/health-professionals/criminal-background-check.html>  
On the website there is also an option if you are out of state and you should select the “Living Outside the State of Tennessee” and follow the instructions. Under enrollment services if your state does not offer digital fingerprinting you can contact the TN EMS office for further information. The CBC must be submitted to our office **directly from the vendor** identified in the licensure application materials.
- Hold Current License/National Registry Certification  
You must hold a current license in another state **and** hold or have held a current national registry certification for the level in which you are applying **or**;  
Have received your training while employed at a federal agency **and** hold a current national registry certification for the level in which you are applying.
- 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 package will be reviewed upon receipt of written verification from the issuing EMS licensing agency of your current EMS license or upon receipt of written verification from a federal training agency. The Office of EMS does not issue temporary licenses for employment.

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

### **There are two options for submitting your packet.**

Online registration at: [lars.tn.gov](https://lars.tn.gov) where you can create an account, open an application and upload all the required documents (excluding the verification form(s) and CBC mentioned above).

### **OR**

Mail your completed packet to:

***Tennessee Department of Health  
Office of Emergency Medical Services  
665 Mainstream Drive, Suite 1700  
Nashville, TN 37243  
Attn: Reciprocity***

## APPLICATION PROCESS

**NOTE: The reciprocity packet is valid for two (2) years from the date of submission. If all requirements are not met within this timeframe your file is considered null and void and will be destroyed. You must re-apply for licensure.**

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. For online submission allow 5-7 business days for processing.
2. Absent of any complicating factors, the average application processing time is **7-14 business days** from receipt of all the documentation. ***This includes state or federal verification forms and CBC.***
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 website ([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. You must hold a current EMT, AEMT or Paramedic license before you can practice in Tennessee therefore, it is not recommended that you make arrangements to accept employment in Tennessee until you are granted a license by this office.

## **RECIPROCITY CHECKLIST**

The items listed below are requirements that must be met and documents that must be submitted by all EMT, AEMT and Paramedic levels:

➤ *Items 1 – 11 below can be submitted by mail OR online by going to [lars.tn.gov](http://lars.tn.gov).*

1. ☐ **Application for Licensure Form**
  - a. *Mailing Option-*
    - i. If you choose to complete the paper application (PH-3784), it must be signed and dated and all questions answered before processing will begin.
  - b. *Online Option-*
    - i. If you choose to apply online you do *not* need to submit or upload the paper application.
    - ii. You do need to be prepared to upload the other documents listed in 3-11 below.
    - iii. Once you submit your online application you cannot go back and make any changes.
  
2. ☐ **EMS Professional Fees**
  - a. *Mailing Option-*
    - i. If you choose to complete the paper fee form (PH-Pending), it must be submitted with a check or money order for all applicable fees, to include the application fee, license fee **and** reciprocity fee for the appropriate level you are applying. (The application fee is non-refundable.)
    - ii. The form must be signed and dated and all questions answered.
    - iii. The business name refers to employment with an Emergency Medical Service or similar organization. If not employed, indicate Not Applicable.
  - b. *Online Option-*
    - i. If you choose to apply online you do *not* need to submit or upload the paper fee form.
  
3. ☐ **Medical Statement** *(if applying online, completed form must be uploaded)*
  - a. The medical statement (PH-0130) must be completed and physician must verify sufficient health requirements by signing form.
  
4. ☐ **Current Professional or EMS State License** *(if applying online, copy of card must be uploaded)*
  - a. Submit a copy of your current EMS license that verifies the expiration date.
  - b. This is not required if you are a federally trained applicant.
  
5. ☐ **National Registry Certification** *(if applying online, copy of card must be uploaded)*
  - a. You must **currently hold or have held** a National Registry certification at the level of licensure for which you are applying. You must 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 licensure for which you are applying. You must submit a copy of the National Registry card that verifies the expiration date.
  
6. ☐ **Verification of Education** *(if applying online, copy must be uploaded)*
  - a. Submit a copy of one of the following: a High School Diploma, a Graduate Equivalency Diploma (GED Certificate), or a college transcript/degree.

7. ☐ **Letters of Moral Character (Excludes EMT Level)** *(if applying online, letters must be uploaded)*
- Submit two (2) original letters **signed** by a medical professional attesting to your personal character. *Must be an original signature; electronic/typed signatures are not acceptable.*
  - Letters must be completed within the past 12 months.
8. ☐ **Proof of Current CPR Training** *(if applying online, copy of card or verification must be uploaded)*
- Submit a copy of your current CPR card for a Basic Rescuer or equivalent.
  - Verification of an electronic copy of your CPR card is also acceptable.
9. ☐ **Knowledge of Destination Determination** *(if applying online, completed form must be uploaded)*
- All applicants must read the trauma destination guidelines. These documents are included in the packet (pages 8-11) and must be verified by signing the acknowledgement sheet (page 12).
10. ☐ **Declaration of Citizenship** *(if applying online, completed form and copy of identification document must be uploaded)*
- Form must be notarized and required identification submitted.
11. ☐ **Criminal Background Disclosure Form (PH-3856) (if applicable)**
- Complete and/or submit **only** if you have a criminal history. *(if applying online, completed form can be upload, if applicable)*

➤ **Items 12 – 13 must be submitted according to direction below and cannot be sent directly to our Office or submitted online.**

12. ☐ **State Verification of License or Federal Agency Training Verification**
- Mail the verification of licensure form (PH-3607) or Federal Agency Training form (PH-3936) to the appropriate state(s) in which you hold or have held a license or to the Federal Agency where you received your training.
  - The verification form must be returned to our office by the verifying state or agency.
13. ☐ **Criminal Background Check**
- All applicants applying for initial licensure in Tennessee are required to obtain a criminal background check through the State of Tennessee selected vendor.
  - You may register online or by telephone. Electronic print locations are available at <https://www.tn.gov/content/tn/health/health-professionals/criminal-background-check.html>

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

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

**Questions?  
Contact the Office of EMS  
Telephone: (615) 253-3165**



## EMS LICENSURE/CERTIFICATION RECIPROCITY APPLICATION

LIC/CERT LEVEL REQUESTING: ☐ EMR ☐ EMT ☐ AEMT ☐ PARAMEDIC

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

**Please print legible or type:**

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
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:		GENDER:	HIGH SCHOOL DIPLOMA:	
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Male	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Female	GED:	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other		<input type="checkbox"/> Yes	<input type="checkbox"/> 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."

## RECIPROCITY EMS PROFESSIONAL FEES

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ NREMT Number: \_\_\_\_\_  
MM DD YYYY

Name: \_\_\_\_\_  
Last First Middle (Jr., Sr., Etc.)

Address: \_\_\_\_\_  
(Street /PO Box/Route) (City/State/Zip)

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

Current EMS Employer: (if applicable) \_\_\_\_\_

Do you wish to receive notification, including renewal notification, 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 3 boxes under the level in which you are applying and submit all fees with this form by a personal or certified check (**no cash**).

**PAYMENT SHOULD BE MADE PAYABLE TO TDH-EMS**

ACTION	EMR	EMT	AEMT	PARAMEDIC
Application Fee (non-refundable)	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$70.00	<input type="checkbox"/> \$75.00
License Fee	<input type="checkbox"/> \$25.00	<input type="checkbox"/> \$75.00	<input type="checkbox"/> \$80.00	<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

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

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## MEDICAL STATEMENT For Emergency Medical Services Professional License

The Office of Emergency Medical Services is the state agency responsible for the licensing of emergency medical services personnel. The mission of the agency is to oversee the delivery of pre-hospital emergency care and to safeguard the public from inappropriate or incompetent medical care in the pre-hospital environment. When issuing a license, it is understood that the individual can meet the demands, duties, and responsibilities listed below and **examiner performing the evaluation is a licensed physician, nurse practitioner or physician assistant**.

### GENERAL DUTY REQUIREMENTS:

The general environmental conditions in which emergency medical service personnel work includes a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push, or lift and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having times to lift, move, carry and balance while moving in excess of 125 pounds (250 pounds 2 person lift). Motor Coordination is dexterity to bandage, splint and move patients, including properly applying invasive airways and administering injections.

Driving in a safe manner, accurately discerning street names, map reading, and the ability to correctly distinguish house numbers or business locations are essential tasks. Use of the telephone or radio for transmitting and responding to physician's advice is also essential. The ability to concisely and accurately describe orally to health professionals the patient's condition is critical. The provider must also be able to accurately summarize all data in the form of a written report.

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TYPE / PRINT APPLICANTS NAME

**HAS BEEN EXAMINED AND DEMONSTRATES SUFFICIENT HEALTH TO PERFORM THE ESSENTIAL FUNCTIONS IN THE PRE-HOSPITAL ENVIRONMENT AS DESCRIBED IN THE GENERAL DUTY REQUIREMENTS ABOVE INCLUDING VISUAL ACUITY, SPEECH, HEARING, AND THE USE OF EXTREMITIES.**

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PRINT PROVIDER NAME

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PROVIDER'S LICENSE NUMBER

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STATE

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PROVIDER'S SIGNATURE

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DATE

### AUTHORIZATION FOR RELEASE OF INFORMATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE EXAMINER NECESSARY FOR QUALIFICATION TO MY EMPLOYER FOR DETERMINATION OF MY ELIGIBILITY BY THE DIVISION OF EMERGENCY MEDICAL SERVICES.

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SIGNATURE OF APPLICANT

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SOCIAL SECURITY NUMBER

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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."

## **DESTINATION DETERMINATION GUIDELINES**

**YOU MUST READ THE FOLLOWING AND SIGN AND RETURN THE ENCLOSED VERIFICATION OF SUCH WITH YOUR APPLICATION PACKET.**

1200-12-01-.21 Destination Determination – Sick or injured persons who are in need of transport to a health care facility by a ground or air ambulance requiring licensure by the State of Tennessee should be transported according to these destination rules.

- (1) Trauma patients - The goal of the pre-hospital component of the trauma system and destination guidelines is to minimize injury through safe and rapid transport of the injured patient. The patient should be taken directly to the center most appropriately equipped and staffed to handle the patient's injury as defined by the region's trauma system. These destinations should be clearly identified and understood by regional prehospital personnel and should be determined by triage protocols or by direct medical direction. Ambulances should bypass those facilities not identified by the region's trauma system as appropriate destinations, even if they are closest to the incident.
- (2) Beginning no later than six (6) months after the designation of a trauma center in any region, persons in that region, who are in need of transport who have been involved in a traumatic incident and who are suffering from trauma or a traumatic injury as a result thereof as determined by triage at the scene, should be transported according to the following rules.
  - (a) Adult (greater than or equal to fifteen (15) years of age) and Pediatric (less than fifteen (15) years of age) Trauma Patients will be triaged and transported according to the flow chart labeled "Field Triage Decision Scheme" in "Resources For Optimal Care of the Injured Patient: 1999," or any successor publication. The Pediatric Trauma Score shall be used as published in "Basic Trauma Life Support for Paramedics and Other Advanced EMS Providers," Fourth Edition, 2000. Copies of the charts are available from the Division.
    1. Step One and Step Two patients should go to a Level 1 Trauma Center or Comprehensive Regional Pediatric Center (CRPC), either initially or after stabilization at another facility. EMS field personnel may initiate air ambulance response.
    2. Step One or Step Two pediatric patients should be transported to a Comprehensive Regional Pediatric Center (CRPC) or to an adult Level 1 Trauma Center if no CRPC is available. Local Destination Guidelines should assure that in regions with two CRPC's or one CRPC and another facility with Level 1 Adult Trauma capability that seriously injured children are cared for in the facility most appropriate for their injuries.
    3. For pediatric patients, a Pediatric Trauma Score of less than equal to 8 ( $\leq 8$ ) will be considered as a cutoff level for Step One patients.
    4. Local or Regional Trauma Medical Control may establish criteria to allow for non-transport of clearly uninjured patients.

5. Trauma Medical/ Control will determine patient destinations within thirty (30) minutes by ground transport of a Level I Trauma Center or CRPC.
- (b) Exceptions apply in the following circumstances:
1. For ground ambulances, when transport to a Level I Trauma Center will exceed thirty (30) minutes, Trauma Medical Control will determine the patient's destination. If Trauma Medical Control is not available, the patient should be transported to the closest appropriate medical facility.
  2. For air ambulances, Step One patients will be transported to the most rapidly accessible Level I Trauma Center, taking safety and operational issues into consideration. Step Two, Three, and Four patients will be transported to a Level I Trauma Center as determined by the air ambulance's Medical Control. The Flight Crew will make determination of patient status on arrival of the air ambulance.
  3. Air ambulances will not transport chemical or radiation contaminated patients prior to decontamination.
  4. If the Trauma Center chosen as the patient's destination is overloaded and cannot treat the patient, Trauma Medical Control shall determine the patient's destination. If Trauma or Medical Control is not available, the patient's destination shall be determined pursuant to regional or local destination guidelines.
  5. A transport may be diverted from the original destination:
    - (1) if a patient's condition becomes unmanageable or exceeds the capabilities of the transporting unit; or
    - (2) if Trauma Medical Control deems that transport to a Level I Trauma Center is not necessary.
- (c) Utilization of any of the exceptions listed above should prompt review of that transport by the quality improvement process and the medical director of the individual EMS providers.
- (d) Trauma Medical Control can be accomplished by a Trauma or Emergency Physician on duty at a designated Trauma Center or by protocols established in conjunction with a Regional Level I Trauma Center.
- (3) Pediatric Medical Emergency - Pediatric patients represent a unique patient population with special care requirements in illness and injury. Tennessee has a comprehensive destination system for emergency care facilities in regards to pediatric patients where there are variable levels of available care, as defined in Rule 1200-9-30-.01.
- (a) There are circumstances in pediatric emergency care as determined by local medical control where it would be appropriate to bypass a basic or a primary care facility for a general or comprehensive regional pediatric center.
1. Examples of such circumstances include, but are not limited to the following

- (i) On-going seizures
- (ii) A poorly responsive infant or lethargic child
- (iii) Cardiac arrest
- (iv) Significant toxic ingestion history
- (v) Progressive respiratory distress (cyanosis)
- (vi) Massive gastrointestinal (GI) bleed
- (vii) Life threatening dysrhythmias
- (viii) Compromised airway
- (ix) Signs or symptoms of shock
- (x) Severe respiratory distress
- (xi) Respiratory arrest
- (xii) Febrile infant less than two months of age.

2. Pediatric medical emergency transport may be diverted from the original destination if the patient's condition becomes unmanageable or exceeds the capability of the transporting unit, in which case the patient should be treated at the closest facility.

3. Pediatric medical emergency air ambulance transports must go to a Comprehensive Regional Pediatric Center.

(b) Pediatric trauma patients should be taken to trauma facilities as provided in paragraph (2).

(4) Any patient who does not qualify for transport to a Trauma Center or a Comprehensive Regional Pediatric Center should be transported to the most appropriate facility in accordance with regional or local destination guidelines.

(5) Adults or children with specialized healthcare needs beyond those already addressed should have their destination determined by Medical or Trauma Control, by regional or local guidelines, or by previous arrangement on the part of patient (or his/her family or physician).

(6) A transport may be refused or an alternate destination requested. Non-transport of the patient, or transport of the patient to an alternate destination shall not violate this rule and shall not constitute refusal of care

**Authority:** T.C.A. §§ 4-5-202, 68-140-504, 68-140-505, 68-140-509, and 68-140-521. **Administrative History:** Original rule filed October 15, 2002; effective December 29, 2002.

# 2011 Guidelines for Field Triage of Injured Patients

1

## Measure vital signs and level of consciousness

Glasgow Coma Scale  $\leq 13$   
Systolic Blood Pressure (mmHg)  $< 90$  mmHg  
Respiratory Rate  $< 10$  or  $> 29$  breaths per minute, or need for ventilatory support ( $< 20$  in infant aged  $< 1$  year)

NO

## Assess anatomy of injury

2

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

NO

## Assess mechanism of injury and evidence of high-energy impact

3

- **Falls**
  - Adults:  $> 20$  feet (one story is equal to 10 feet)
  - Children:  $> 10$  feet or two or three times the height of the child
- **High-risk auto crash**
  - Intrusion, including roof:  $> 12$  inches occupant site;  $> 18$  inches any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist thrown, run over, or with significant ( $> 20$  mph) impact**
- **Motorcycle crash  $> 20$  mph**

NO

## Assess special patient or system considerations

4

- **Older Adults**
  - Risk of injury/death increases after age 55 years
  - SBP  $< 110$  may represent shock after age 65
  - Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants and bleeding disorders**
  - Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center
- **Pregnancy  $> 20$  weeks**
- **EMS provider judgment**

NO

Transport according to protocol

YES

**Transport to a trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

YES

**Transport to a trauma center,** which, depending upon the defined trauma system, need not be the highest level trauma center.

YES

**Transport to a trauma center** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

**When in doubt, transport to a trauma center.**  
Find the plan to save lives, at [www.cdc.gov/Fieldtriage](http://www.cdc.gov/Fieldtriage)

**RECIPROCITY  
DESTINATION GUIDELINES  
ACKNOWLEDGEMENT**

**THIS FORM MUST BE SIGNED AND RETURNED WITH THE RECIPROCITY  
PACKET.**

I have read and understand the rules regarding destination determination.

\_\_\_\_\_  
Print Applicant Name

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## **EMS CERTIFICATION / LICENSE VERIFICATION**

(Please Print Legibly or Type)

Complete the **TOP** portion of this form and mail to the State you received your current certification/licensure. **Reproduce this form if you hold or have held a certification/licensure 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

**BIRTH DATE:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **CERT/LIC #** \_\_\_\_\_

Licensure Level Applying For:

☐ **EMD**   ☐ **EMR**   ☐ **EMT**   ☐ **AEMT**   ☐ **PARAMEDIC**   ☐ **PARAMEDIC CRITICAL CARE**

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

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### ***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 certification/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 Tennessee Department of Health and the address at the bottom of the previous page.**

## EMS TRAINING VERIFICATION WITH FEDERAL AGENCY

Complete the **TOP** portion of this form and mail to the Federal Agency you received your current certification/licensure training.

Please print legible or type

**ATTENTION:** \_\_\_\_\_ EMS Personnel Training Section.  
Federal Agency

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

Licensure/Certification Level Applying For: ☐ **EMD** ☐ **EMR** ☐ **EMT** ☐ **AEMT** ☐ **PARAMEDIC**

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

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### 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 of licensure/certification? ☐ **Yes** ☐ **No**

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

Licensure/Certification Training Level:

☐ **EMD** ☐ **EMR** ☐ **EMT** ☐ **AEMT** ☐ **PARAMEDIC** ☐ **OTHER** \_\_\_\_\_  
(Type)

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

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 Tennessee Department of Health and the address at the bottom of the previous 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.

I am applying for a(n) \_\_\_\_\_  
Healthcare Profession (Please Print)
License number (if applicable)

**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)

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**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.

Department of  
**Health**

NAME: \_\_\_\_\_

EMS CLASS #: \_\_\_\_\_

COURT OF RECORD: \_\_\_\_\_

IF YES, YOU MUST PROVIDE OFFICIAL RECORDS THAT PROBATION/PAROLE WAS SUCCESSFULLY COMPLETED.

[illegible]

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DIVISION OF HEALTH LICENSURE OF REGULATION • OFFICE OF EMERGENCY MEDICAL SERVICES  
665 MAINSTREAM DRIVE • NASHVILLE, TN 37243  
TEL: 615-741-2584 • FAX: 615-741-4217 • WEBSITE: [tn.gov/health/ems](http://tn.gov/health/ems)