TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TELEPHONE: 615-741-2584 FAX# 615-741-4217

RECIPROCITY REQUIREMENTS FOR EMS PERSONNEL LICENSE

IMPORTANT NOTICE:
REGULATION CHANGE EFFECTIVE APRIL 11, 2013

INDIVIDUALS APPLYING FOR EMS PROFESSIONAL LICENSE IN TENNESSEE MUST HOLD A CURRENT CERTIFICATION OR LICENSE IN ANOTHER STATE OR HAVE RECEIVED THEIR TRAINING WHILE IN EMPLOYEMENT OF A FEDERAL AGENCY AND HOLD A CURRENT NATIONAL REGISTRY CERTIFICATION AT THE LEVEL WHICH APPLYING.

ALL APPLICANTS SHALL SUBMIT TO THE OFFICE OF EMERGENCY MEDICAL SERVICES, DIRECTLY FROM THE VENDOR IDENTIFIED IN THE LICENSURE APPLICATION MATERIALS, THE RESULT OF A CRIMINAL BACKGROUND CHECK.

HOW TO OBTAIN A CRIMINAL BACKGROUND CHECK FOR TENNESSEE LICENSURE

IF YOU ARE IN TENNESSEE OR PLAN ON VISITING PRIOR TO YOUR MOVE YOU MAY OBTAIN THE INFORMATION ON HOW TO GET A STATE OF TENNESSEE CRIMINAL BACKGROUND CHECK FROM OUR WEB SITE.
http://health.state.tn.us/ems

IF YOU ARE OUT OF STATE PLEASE CONTACT THE OFFICE OF EMERGENCY MEDICAL SERVICES TO OBTAIN THE INFORMATION PACKET ON HOW TO OBTAIN A CRIMINAL BACKGROUND PRIOR TO YOUR ARRIVAL IN TENNESSEE.

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RECIPROCITY REQUIREMENTS FOR EMS PERSONNEL LICENSE

This packet contains the information needed for EMS personnel seeking licensure in Tennessee, who have a current certification or license from other states and are seeking licensure in Tennessee, or have completed their training while employed with a Federal Agency and holds a current National Registry Certification at level applying.

In order for a license to be issued you must:

* Submit all of the required documentation on the attached list.
* 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 Certification/License or upon receipt of written verification of Federal Training agency. The Office of Emergency Medical Services does not issue temporary licenses for employment.

ALL THE REQUIRED DOCUMENTATION AND FEES MUST BE SUBMITTED IN ONE PACKAGE. THE ONLY EXCEPTION IS THE "**VERIFICATION OF EMS CERTIFICATION/ LICENSURE FORM**" or "**VERIFICATON OF FEDERAL AGENCY TRAINING FORM",** WHICH MUST BE MAILED TO THE STATE WHERE YOU HOLD CURRENT CERTIFICATION/LICENSE OR TO THE FEDERAL AGENCY WHERE YOU RECEIVED YOUR TRAINING.

Submit all documentation to:

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

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RECIPROCITY REQUIREMENTS FOR EMS PERSONNEL LICENSE

THE APPLICATION PROCESS

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

PLEASE READ

1. Allow 14 working days for information mailed to our office to be received and placed in your file. 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.

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.***

3. **We will discuss 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) 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 agency in writing.

6. **Anyone practicing as an EMR, EMT, AEMT or Paramedic must hold a valid license from the State of Tennessee, Department of Health, Office of EMS**. Therefore, it is recommended that you do not make arrangements to accept employment in Tennessee until you are granted a license by this agency.

YOU MUST READ THE FOLLOWING DESTINATION DETERMINATION AND SIGN AND RETURN THE ENCLOSED VERIFICAITON OF SUCH WITH YOUR APPLICATION PACKET.

1200-12-1-.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 Medica*l* Control will determine patient destinations within thirty (30) minutes by ground transport of a Level 1 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.

(i) 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
(X) Febrile infant less than two months of age.

(ii) 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.

(iii) 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.*

Paragraph (7) of Rule 1200-12-1-.11 Ambulance Service Operations and Procedures is repealed.

Authority: T.C.A. §§ 4-5-202, 68-140-504, 68-140-505, 68-140-509, and 68-140-521.

2011 Guidelines for Field Triage of Injured Patients

1

Measure vital signs and level of consciousness

Glasgow Coma Scale	≤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)

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.

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

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.

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**

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

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**

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.

NO

Transport according to protocol

When in doubt, transport to a trauma center.

Find the plan to save lives, at www.cdc.gov/Fieldtriage

National Center for Injury Prevention and Control
Division of Injury Response

TENNESSEE DEPARTMENT OF HEALTH
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OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
TELEPHONE: (615) 741-2584

RECIPROCITY
DESTINATION GUIDELINES VERIFICATION

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

I have read and understand the rules regarding destination guidelines.

Print Applicant Name	Social Security Number
Applicant Signature	Date

TENNESSEE DEPARTMENT OF HEALTH
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OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243

RECIPROCITY CHECKLIST

The following are general requirements that must be met and documents submitted by all EMT, AEMT and Paramedic levels:

General Requirements:

1. ☐ Verification of Education

a. Submit a copy of a High School Diploma or a Graduate Equivalency Diploma (GED Certificate). A college transcript or degree may be submitted.

2. ☐ Proof of Current CPR Training

a. Submit a copy of your current CPR card from the American Heart Association or American Red Cross which signifies training in CPR for the Professional Rescuer or Healthcare Provider. Copy of front **and back** of **signed** card is required.

3. ☐ Application for Licensure (PH-3784)

a. Answer all questions and sign.
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.
c. The application must be signed and dated before processing will begin. The signed application is valid for two years from the date on the application.

4. ☐ Medical Statement (PH-0130)

a. Complete the form so that the physician's name and address can be verified. The physical exam is valid if completed in the past six months, but information must be explained on the form provided in this packet.

5. ☐ Letters of Moral Character

a. Submit evidence of good moral character. Such evidence shall be two (2) recent (within the preceding 12 months) original letters from medical professionals attesting to your personal character.

6. ☐ State Verification of License/Certification or Federal Agency Training Verification

a. Mail the verification of licensure/certification form (PH-3607) or Federal Agency Training form (PH-3936) to the appropriate state(s) in which you hold a license/certification 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**.**

7. ☐ Current State License/Certification

a. Submit a copy of your existing license that should be valid for at least 3 months after you apply.

8. ☐ National Registry Certification

a. You must **currently hold or have held** a National Registry certification at the level of licensure for which you are applying. 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.

9. ☐ Knowledge of Destination Guidelines

a. All applicants must read the trauma destination guidelines. These are included in the packet and must be verified by signing the appropriate sheet.

10. ☐ EMS Professional Fees (PH-2397):

a. Submit the Fee Form (PH-2397) with a check or money order for all applicable fees, which includes the application fee, license fee and reciprocity fee for the appropriate level you are applying. If you would like confirmation of receipt of your fees/documents, you should send by certified mail with a receipt requested.

***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 verifying form)**

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

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
TELEPHONE: 615-741-2584

EMS LICENSURE/CERTIFICATION
RECIPROCITY APPLICATION

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

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 certification/license.

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."

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
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NASHVILLE, TN 37243

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.

_____

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.

PRINT PROVIDER NAME	PROVIDER'S LICENSE NUMBER	STATE

PROVIDER'S SIGNATURE	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.

SIGNATURE OF APPLICANT	SOCIAL SECURITY NUMBER	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."

TENNESSEE DEPARTMENT OF HEALTH
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TELEPHONE: (615) 741-2584

EMS CERTIFICATION/LICENSE 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**

Do you wish to receive notification, including renewal notification, from the Department of Health via email?

☐ **YES** ☐ **NO** **Email Address:** _____

SIGNATURE: _____ **DATE**: _____

THIS SECTION TO BE COMPLETED BY CERTIFYING AGENCY

Did the individual identified above successfully complete an approved current National Department of Transportation Curriculum or Educational Standard for the level in which they are licensed in your state? ☐ **Yes** ☐ **No**

Certification/Licensure 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 ☐ Glucogon ☐ 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 licensing section at (615) 253-3165. Please return this form to the address at the top of the first page.

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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.

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** ☐ **EMT** ☐ **AEMT** ☐ **PARAMEDIC**

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

Date Training Completed: _____ **Total Hours:** _____

Licensure/Certification Training Level:

☐ **EMD** ☐ **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 address at the top of the first page.**

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE OF REGULATION
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665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

CRIMINAL BACKGROUND DISCLOSURE DOCUMENTATION AND INFORMATION

Please complete the information below and submit with your Application for Licensure form. **You must attach a certified copy of your court records.**

NAME _____

SOCIAL SECURITY # _____

EMS CLASS # _____

DATE OF CONVICTION _____

COURT OF RECORD _____

WERE YOU PLACED ON PROBATION OR PAROLE? ☐ YES ☐ NO
IF YES, YOU MUST PROVIDE OFFICIAL RECORDS THAT PROBATION/PAROLE WAS SUCCESSFULLY COMPLETED.

NATURE OF CONVICTION: **YOU <u>MUST</u> PROVIDE A DETAILED EXPLANATION OF YOUR CONVICTION <u>IN YOUR OWN WORDS</u>.** (You may attach extra pages if necessary.)

_____

_____

_____

_____

_____

_____

_____

PLEASE REMEMBER TO ATTACH A CERTIFIED COPY OF YOUR COURT RECORDS.

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

TENNESSEE DEPARTMENT OF HEALTH
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NASHVILLE, TN 37243
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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, 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**). This form must be submitted fifteen (15) days prior to your examination date. Failure to comply with these instructions will result in a delay of your license approval.

PAYMENT SHOULD BE MADE PAYABLE TO TDH-EMS

ACTION	EMR	EMT	AEMT/ EMTIV	PARAMEDIC	EMD	CRITICAL CARE	INSTRUCTOR
Application Fee	☐$20.00	☐$50.00	☐$70.00	☐$75.00	☐$30.00	☐$75.00	☐$35.00
License Fee	☐$25.00	☐$75.00	☐$80.00	☐$100.00	☐$30.00		
Renewal Fee	☐$24.00	☐$65.00	☐$65.00	☐$75.00	☐$45.00	☐$90.00	
Late Fee	☐$25.00	☐$25.00	☐$25.00	☐$25.00	☐$25.00	☐$25.00	
Reinstatement Fee	☐$50.00	☐$100.00	☐$100.00	☐$100.00	☐$100.00	☐$100.00	
Reciprocity Fee	☐$100.00	☐$100.00	☐$100.00	☐$100.00			
Returned Check Fee	☐$20.00	☐$20.00	☐$20.00	☐$20.00	☐$20.00	☐$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."