New Jersey Department of Health
Office of Emergency Medical Services
P. O. Box 360
Trenton, NJ 08625-0360

EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC PROVIDER RECIPROCITY APPLICATION

VERIFICATION OF EMT-PARAMEDIC TRAINING AND CERTIFICATION

Instructions: Return this completed form to the OEMS Certification Section at the address given above, as part of your completed EMS-54, EMT-Paramedic Provider Reciprocity Application.

SECTION I – APPLICANT INFORMATION *(TO BE COMPLETED BY CANDIDATE)*		
Name of Applicant		Date of Birth
Mailing Address *(Required for OEMS Use Only. Must be a physical address; no PO Box or Mail Stop numbers accepted.)*	Public Address *(Optional - the Department will provide this address for requests of government records.)*	
Initial Training Institution		Date of Initial Certification
Date of Recertification	Expiration Date of State Certification	Expiration Date of NREMT

SECTION II – CERTIFICATION VERIFICATION *(TO BE COMPLETED BY STATE CERTIFICATION OFFICE/AGENCY)*	
Certification/License Number	Expiration Date of Certification
Is this certification based on reciprocity? ☐ Yes ☐ No If Yes, from where? _____	

Has the applicant completed recertification requirements since initial certification?	Is the applicant's certification considered to be valid?	Has the applicant's certification ever been suspended or revoked?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you know of any reason that the applicant should be denied EMT-P certification in New Jersey?
☐ Yes ☐ No
Comments: _____

Name of Individual Verifying (Print)	Title	
Signature	Telephone Number	Date

SECTION III – TRAINING PROGRAM VERIFICATION *(TO BE COMPLETED BY TRAINING INSTITUTION)*		
Course completion: US DOT EMT-P 1999 revision? ☐ Yes ☐ No Other: _____		
Training Hours: Didactic: Clinical: Field: Comments: _____		
Name of Individual Verifying (Print)	Title	
Signature	Telephone Number	Date