New Jersey Department of Health
Office of Emergency Medical Services (OEMS)
PO Box 360, Trenton, NJ 08625

EMT & PARAMEDIC CLINICIAN RECIPROCITY APPLICATION
VERIFICATION OF EMT & PARAMEDIC EDUCATION AND LICENSURE

Instructions: Return this completed form to the OEMS Education Section at the address given above, as part of your completed EMS-64, EMS Clinician Reciprocity Application.

Section I: Applicant Information *(To be completed by applicant)*

First Name | Last Name | Middle Initial

New Jersey EMS ID # | Date of Birth

Mailing address

City | State | Zip

Home Phone | Cell Phone

Primary email | Secondary email

What certification level are you requesting? ☐ EMT ☐ Paramedic ☐ MICN

Are you currently certified by the National Registry? ☐ YES ☐ NO

If yes: NREMT # | NREMT Expiration Date

Are you currently, or have you ever been certified/licensed by any other state, jurisdiction or country?
If YES, provide the following information for each state.

State	Level EMT/Paramedic	Certification or License Number	Issue Date	Expiration Date

Initial EMT Education Program Information *(To be completed by applicant)*

Name of Education Program/Agency

Address

City | State | Zip

Name of Contact Person *first / last* | Title

Phone # | Email address

Initial Paramedic Education Program Information *(To be completed by applicant)*

Name of Education Program/Agency

Address

City State Zip

Name of Contact Person *first / last* Title

Phone # Email address

I affirm that all of the above information is true and correct. I understand that any misrepresentation of fact may be grounds to deny my NJ EMS certification/endorsement/license.

Applicant Name *first / last* Applicant Signature

Section II: License Verification *(To be completed by every state licensure authority listed in Section I)*

License Number License Expiration Date State

1. Is the applicant's information considered true and correct? ☐ Yes ☐ No ☐ N/A

If NO, please explain

2. Has the applicant completed an approved EMT program to the standards of the National EMS Education Standards, National EMS Scope of Practice, National EMS Core Content, and the most current American Heart Association Emergency Cardiac Care Guidelines? ☐ Yes ☐ No ☐ N/A

If NO, please explain

3. Has the applicant completed an approved Paramedic program to the standards of the National EMS Education Standards, National EMS Scope of Practice, National EMS Core Content, and the most current American Heart Association Emergency Cardiac Care Guidelines? ☐ Yes ☐ No ☐ N/A

If NO, please explain

4. Certification/License Status: ☐ Current ☐ Expired ☐ Inactive ☐ Other _____

5. The above certification/license was issued based upon:

☐ Initial education completed in your state

☐ Reciprocity from another state. If yes where?_____ ☐ Other _____

6. Has the applicant incurred any disciplinary proceedings in your state or are there disciplinary proceedings pending? ☐ Yes ☐ No

If YES, please explain and attach documentation.

ATTACH DOCUAMENTATION

7. Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked? ☐ Yes ☐ No

If YES, please explain and attach documentation.

ATTACH DOCUAMENTATION

8. Is the applicant currently under investigation? ☐ Yes ☐ No

If YES, please explain and attach documentation.

ATTACH DOCUAMENTATION

9. Has the applicant ever been convicted of a crime? ☐ Yes ☐ No

If YES, please explain and attach documentation.

ATTACH DOCUAMENTATION

10. Has the applicant completed relicensure requirements since initial certification? ☐ Yes ☐ No

11. Do you know of any reason that the applicant should be denied EMT or Paramedic licensure in New Jersey? ☐ Yes ☐ No

If YES, please explain.

Name of Official completing this verification form *first / last* Title

Signature of Official completing this verification form Date

Phone number of State Official Email-address

Complete mailing address of state/territory the official represents

City State Zip

Part III: Education Program Verification *(To be completed by the applicant's initial EMT and/or Paramedic education program)*

1. Has the applicant completed an approved EMT Program, through your education center to the standards of the National EMS Education Standards, National EMS Scope of Practice, National EMS Core Content, and the International Liaison Committee for Resuscitation? ☐ Yes ☐ No

2. Has the applicant completed an approved Paramedic Program, through your education center to the standards of the National EMS Education Standards, National EMS Scope of Practice, National EMS Core Content, and the International Liaison Committee for Resuscitation? ☐ Yes ☐ No

EMT Program information ☐ **N/A**

1. When did the applicant complete his or her EMT program with your education center? Start Date End Date

2. How many hours were completed?

- Didactic _____ • Internship _____
- Laboratory _____ • Residency _____

Paramedic Program information ☐ **N/A**

1. When did the applicant complete his or her Paramedic program with your education center? Start Date End Date

2. How many hours were completed?

- Didactic _____ • Internship _____
- Laboratory _____ • Residency _____

Education Program Director Name *first / last* Education Program Director Signature

Complete mailing address of education center Phone number

City State Zip

Please mark the skills that were included in the applicant's education program			
EMT		**Paramedic**	
☐ AED	☐ ASA Administration	☐ Defibrillation	☐ Pacing
☐ Epi-Auto Injector	☐ O2 Administration	☐ Cardioversion	☐ Capnography
☐ CPAP	☐ Nebulizer	☐ 12-Lead Interpretation	☐ Cricothyroidotomy
☐ Transport Vent	☐ Mechanical CPR	☐ Laryngeal Mask Airway	☐ Alternative Airway
☐ Blood Glucose Monitoring		☐ Blood Products	☐ Infusion Pumps
☐ Inhaled Bronchodilators		☐ AV Shunt Access	☐ Chest Decompression
☐ Pulse Oximetry		☐ Rapid Sequence Intubation	
☐ Intranasal/Autoinjectors for the Opiate Overdose		☐ Dual Lumen Airway Device	
☐ Autoinjector Antidotes for Chemical Exposures		☐ Endotracheal Tube Intubation	
☐ Oral OTC Analgesics for Pain or Fever		☐ Central Venous Access	
☐ Acquisition & Transmission of 12-Lead ECG		☐ Nasogastric or Orogastric Tube Insertion	
☐ Other:			

Signature Date Email-address