



**OHIO DEPARTMENT OF PUBLIC SAFETY**

- Administration
- Bureau of Motor Vehicles
- Emergency Management Agency
- **Emergency Medical Services Division**
- Office of Criminal Justice Services
- Ohio Homeland Security
- Ohio Investigative Unit
- Ohio State Highway Patrol

**Ted Strickland, Governor**  
**Nancy J. Dragani, Acting Director**  
**Richard N. Rucker**  
*Executive Director*

Emergency Medical Services  
1970 West Broad Street  
P.O. Box 182073  
Columbus, Ohio 43218-2073  
(614) 466-9447 • (800) 233-0785  
[www.ems.ohio.gov](http://www.ems.ohio.gov)

Dear EMT Reciprocity Candidate:

Thank you for your interest in providing emergency medical care in Ohio. Attached is the reciprocity application you requested.

An applicant for an Ohio certificate to practice must have completed a U.S.D.O.T. National Standard Curriculum course of instruction, which is substantially similar to the curriculum requirements of Ohio. If there are any areas of deficiency identified in the curriculum or certification standards, you will be required to correct these deficiencies through an Ohio **accredited** training institution prior to receiving a certificate to practice. At the EMT-Basic level, *most* applicants will need to complete additional training in advanced airway insertion prior to receiving Ohio certification. (A complete listing of accredited facilities is available on our website at [www.ohiopublicsafety.com](http://www.ohiopublicsafety.com))

**NOTE:** *Any candidate with areas of deficiencies will be notified by the Division of EMS. In the event that you require additional training, the division shall provide you with the appropriate documents that will need to accompany you to the training facility.*

**Applicants who completed training in another state:**

- Complete the reciprocity application and **attach a copy of a current state certification and a valid National Registry card at the level for which certification is sought.**
- **The Verification Form is to be forwarded (by the candidate) to the state certifying agency of the state in which initial training was completed, as well as any other state in which you hold, or have ever held, certification.** The verification form will be used to determine if additional course work is needed to meet Ohio curriculum requirements.
- Mail all documents (application, state card, and National Registry card) to the address listed above.

**Applicants who are or were a member of the United States armed services and who received their EMT training while in the military:**

- Complete the reciprocity application and attach a copy of a valid National Registry card at the level for which certification is sought. **Proof of military membership (DD Form 214, current military ID badge, statement of service) or proof of armed services training is required at the time the application is submitted.** If you are a Department of Defense (DOD) candidate, a valid letter from the Directorate of Personnel attesting that you have military affiliation must accompany the initial submission of the application.
- The Verification Form is to be forwarded for completion to the military site where training was conducted. **A copy of the course outline, including topic areas and hours of instruction in each topic area, must be included with the form.** The verification form, and course information, will be used to determine if additional course work is needed to meet Ohio curriculum requirements.

**Mission Statement**

*"to save lives, reduce injuries and economic loss, to administer Ohio's motor vehicle laws and to preserve the safety and well being of all citizens with the most cost-effective and service-oriented methods available."*

## Ohio Department of Public Safety

- Mail all documents (application, National Registry card, proof of military status, completed Verification Form and course outline) to the address listed above.

Please review the application carefully before submitting to ensure the application is complete and all the required documentation is attached. All documentation must be submitted before your application can be processed. You may not function as an EMT in Ohio until you have been issued an Ohio certificate to practice.

**\*\*\* NOTE: The information submitted to the Division of EMS will remain 'active' for a period of six (6) months. Should your application process require additional time, you must contact the division and obtain a new candidate application form.**

If you have any questions regarding the application process, please contact the Ohio Division of EMS at the address and phone numbers listed above.



## EMERGENCY MEDICAL SERVICES (EMS) RECIPROcity APPLICATION CHECK SHEET

*Please refer to the initial application for clarification of needed information.*

### **Application Procedure:**

### **Documentation Needed:**

Before mailing, did you . . .

- Complete the application in its entirety (both front and back)?
- Complete Part I of the Verification Form, then forward it to the state (or military installation) where you received your original training, as well as any other state(s) that you have held (or currently hold) certificates?
- Copy your National Registry certification and attach it to the application?
- Copy your current state(s) certification and attach it to the application?
- (if military personnel) Copy of your military DD214 or current Military ID Badge and attach it to the application?

Upon evaluation of all documentation, EMT-Basics and Intermediates may need to achieve additional training to meet the requirements in the State of Ohio. Applicant submissions and the Verification Form(s) will be the determining factor in the necessity for additional training. If additional training is required, the Division of EMS will provide you with the appropriate forms that will be necessary for completion.



# EMS RECIPROCITY APPLICATION

Please Print Use Ink

## SECTION 1 – GENERAL INFORMATION

LAST	FIRST	MIDDLE	*SOCIAL SECURITY NUMBER		
STREET OR PO BOX		CITY	STATE	ZIP	COUNTY
DATE OF BIRTH	HOME TELEPHONE NUMBER ( )		BUSINESS TELEPHONE NUMBER ( )		
LEVEL FOR WHICH YOU ARE APPLYING:					
<input type="checkbox"/> First Responder	<input type="checkbox"/> EMT – Basic	<input type="checkbox"/> EMT – Intermediate	<input type="checkbox"/> EMT - Paramedic		

*\*Disclosure of social security number is mandatory pursuant to O.R.C. 3123.50 in furtherance of licensing provisions and any other state or federal requirements.*

## SECTION 2 – EDUCATION AND TRAINING INFORMATION

OUT OF STATE EMS CERTIFICATE NUMBER	EXPIRATION DATE	LEVEL
NATIONAL REGISTRY OF EMTS CERTIFICATE NUMBER	EXPIRATION DATE	LEVEL

**Copies of the above card(s) must accompany application**

STATE IN WHICH YOU RECEIVED YOUR INITIAL TRAINING	DATE
STATE(S) IN WHICH YOU RENEWED YOUR CERTIFICATION	DATE(S)
OTHER STATE(S) IN WHICH YOU HAVE HELD CERTIFICATION:	DATE LAST HELD
NUMBER OF CONTINUING EDUCATION HOURS YOU HAVE ACCUMULATED SINCE YOUR LAST CERTIFICATION EXAM OR RENEWAL:	

## MILITARY PERSONNEL ONLY

MILITARY BRANCH	EMS TRAINING OBTAINED AT	CONTACT PERSONNEL/DIVISION	PHONE NUMBER ( )
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**Copies of the National Registry EMT card, and appropriate military documentation, must accompany application (e.g.:DD214 or military ID badge)**

**SECTION 2 – (Continued) EDUCATION AND TRAINING INFORMATION**

*Paramedic Applicants – Please skip to Section 3*

First Responders, EMT - Basics and EMT-Intermediates – Please mark the skills that were included in your training:

FIRST RESPONDER	EMT - BASIC	EMT - INTERMEDIATE
<input type="checkbox"/> Automated External Defibrillator	<input type="checkbox"/> Automated External Defibrillator	<input type="checkbox"/> Automated External Defibrillator
<input type="checkbox"/> Epinephrine Auto-Injector	<input type="checkbox"/> Epinephrine Auto-Injector	<input type="checkbox"/> Manual Defibrillation
<input type="checkbox"/> Oxygen Administration	<input type="checkbox"/> Dual Lumen Airway	<input type="checkbox"/> Epinephrine Auto-Injector
	<input type="checkbox"/> Nasal Gastric Tube Insertion	<input type="checkbox"/> Dual Lumen Airway
	<input type="checkbox"/> Adult Endotracheal Intubation	<input type="checkbox"/> Nasal Gastric Tube Insertion
	<input type="checkbox"/> Pedi. Endotracheal Intubation	<input type="checkbox"/> Adult Endotracheal Intubation
		<input type="checkbox"/> Pedi. Endotracheal Intubation
		<input type="checkbox"/> Epinephrine auto-injection (Epi-pen administration)
		<input type="checkbox"/> Epinephrine Subcutaneous Injection
		<input type="checkbox"/> Peripheral IV's
		<input type="checkbox"/> Intraosseous Infusion
		<input type="checkbox"/> Other Medication Admin/Route
		(List) _____
		_____
		_____

**NOTE:** If your training did not include the above skills, you will have to complete the training at an accredited training institution in Ohio PRIOR to receiving Ohio Certification

**SECTION 3 – CERTIFICATION HISTORY**

Have you ever:

- Had disciplinary action taken against your EMS personnel certification?  Yes  No
- Been suspended/revoked in any state?  Yes  No
- Been denied certification in any state?  Yes  No

Previously received reciprocity in any state(s)  Yes  No

If yes, list which state(s): \_\_\_\_\_

**SECTION 4 – FELONY/MISDEMEANOR INFORMATION** *(All applicants are required to complete this section)*

**ALL APPLICANTS ARE SOLELY RESPONSIBLE FOR THEIR CERTIFICATE TO PRACTICE AND ALL ASSOCIATED REQUIREMENTS TO MAINTAIN A CURRENT CERTIFICATION.**

1. Do you, as the person accepting responsibility by signing this form, have charges pending or have a conviction for a felony or misdemeanor other than a minor traffic violation or a judicial finding of eligibility for treatment in lieu of conviction (even if expunged or sealed)?  Yes  No
2. Have you committed any act in another state that, if committed in Ohio would be applicable to caption (1.) listed above?  Yes  No

*If you answered "yes" to either question above, then you must submit documentation and court records to explain the circumstances in your case. Documentation should include a certified judgement entry from the court where the conviction occurred and a copy of the police investigative report.*

**SECTION 5 – ATTESTED SIGNATURE AND DATE**

I attest that all information provided is true and accurate to the best of my knowledge and I understand that a false statement on this application constitutes falsification under Section 2921.13 of the Revised Code and is a misdemeanor of the first degree and may also be grounds for denial, suspension or revocation of my certificate to practice. I further attest that I satisfy the requirements for certification to practice at the level sought in this application as set forth in 4765.30 of the Revised code and Chapter 4765-8 of the Ohio Administrative Code and that I am solely responsible for my certificate to practice. I understand that I must maintain records relating to the requirements for continuing education and that such records are subject to audit by the State board of EMS. I further attest that I have no conditions that will prevent me from performing duties consistent with my certificate to practice. I hereby give permission to the Ohio Department of Public Safety, Division of Emergency Medical Services to verify any of the above information.

SIGNATURE <b>X</b>	DATE
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## VERIFICATION OF EMT STATUS

Applicants with out-of-state certification are to complete Part I and mail this form to the issuing state certification board. Part II is to be completed by the state certifying agency. **This form must be forwarded to the state where initial training was completed, as well as any other state the applicant has held or currently holds EMT certification.**

### PART I. - TO BE COMPLETED BY APPLICANT

PLEASE INDICATE THE LEVEL OF CERTIFICATION FOR WHICH YOU ARE REQUESTING VERIFICATION:

First Responder     
  EMT – Basic     
  EMT – Intermediate     
  EMT - Paramedic

APPLICANT'S FULL NAME – FIRST		MIDDLE	LAST	
CERTIFICATION/LICENSE NUMBER	STATE	EXPIRATION DATE	SOCIAL SECURITY NUMBER	

**\*ARMED SERVICES APPLICANTS** – have form completed by training officer at site where training was completed. **You MUST attach a copy of course outline with numbers of hours in each topic area. If training was completed at more than one site, forward a copy of this form to each site from which credit for training is sought.**

### PART II. - TO BE COMPLETED BY THE STATE CERTIFYING AGENCY

CERTIFICATION/LICENSE TYPE	NUMBER	EXPIRATION DATE
First Responder		
EMT – Basic		
EMT - Intermediate <input type="checkbox"/> '85 <input type="checkbox"/> '99		
EMT - Paramedic		

### CERTIFICATION/LICENSE STATUS

Current     
  Lapsed     
  Inactive

THE ABOVE CERTIFICATION/LICENSE WAS ISSUED BASED UPON:

Initial training completed within your state     
  Recertification through continuing education  
 Reciprocity from (state): \_\_\_\_\_     
  Other (please explain): \_\_\_\_\_

DID THE TRAINING MEET USDOT CURRICULUM GUIDELINES?

Yes       No     
 Total number of hours in training: \_\_\_\_\_

HAS THE APPLICANT INCURRED ANY DISCIPLINARY PROCEEDING IN YOUR STATE, OR ARE THERE DISCIPLINARY PROCEEDINGS PENDING?

Yes (if yes, please attach certified copies of any actions)     
  No

HAS THE APPLICANT'S CERTIFICATION/LICENSE EVER BEEN LIMITED, DENIED, SURRENDERED, REPRIMANDED, SUSPENDED OR REVOKED?

Yes (if yes, please attach certified copies of any actions)     
  No

HAS THE APPLICANT EVER BEEN CONVICTED OF A FELONY?

Yes (if yes, please explain): \_\_\_\_\_  
 No       Unknown

**DO YOU KNOW OF ANY REASON WHY CERTIFICATION IN OHIO SHOULD BE DENIED?**

- Yes (if yes, please explain): \_\_\_\_\_  
 No

**IF APPLYING FOR FIRST RESPONDER, DID THE APPLICANT'S TRAINING INCLUDE THE FOLLOWING** (Check the appropriate box(s):

- Automated External Defibrillation (AED)                       Oxygen Administration                       Epinephrine Administration (Epi-pen)

**IF APPLYING FOR EMT-BASIC, DID THE APPLICANT'S TRAINING INCLUDE THE FOLLOWING** (Check the appropriate box(s):

- Automated External Defibrillation (AED)                       Epinephrine Administration (Epi-pen)                       Dual Lumen Airway  
 Endotracheal Intubation – Adult                       Endotracheal Intubation – Pediatric                       Nasal Gastric Tube Insertion

**IF APPLYING FOR EMT-INTERMEDIATE, DID THE APPLICANT'S TRAINING INCLUDE THE FOLLOWING** (Check the appropriate box(s):

- Automated External Defibrillation (AED)                       Endotracheal Intubation - Adult                       Peripheral IV's  
 Manual Defibrillation                       Endotracheal Intubation – Pediatric                       Intraosseous Infusion  
 Epinephrine Administration (Epi Pen)                       Dual Lumen Airway                       Medication administration other than  
 Epinephrine Administration (Subcutaneous)                       Nasal Gastric Tube Insertion                      O<sub>2</sub> and epinephrine

NAME (PRINT) OF STATE/MILITARY OFFICIAL COMPLETING THIS FORM	TITLE OF OFFICIAL
SIGNATURE OF ABOVE OFFICIAL <b>X</b>	TELEPHONE NUMBER OF ABOVE OFFICIAL (         )

**PLEASE RETURN TO:**

Ohio Division of Emergency Medical Services  
1970 West Broad Street, PO Box 182073  
Columbus, Ohio 43218-2073  
Phone (800) 233-0785      Fax (614) 995-7012