

EMERGENCY MEDICAL TECHNICIAN VERIFICATION OF LICENSURE

This form is authorized under s. 146.50, Wis. Stats., and Chapter 110, Wis. Admin. Code. Completion of this form is mandatory for licensure as an EMT by reciprocity. Personally identifiable information requested on this form will only be used for licensure purposes. Provision of your social security number is optional and is used by the Bureau of EMS and Injury Prevention only as an identifier in the licensure database.

INSTRUCTIONS: Type or print legibly. Complete Section A of this form; send a copy to all states where you have been granted a license as an EMT.

SECTION A: APPLICANT INFORMATION

Last Name		First Name		MI	Former Name(s)
Mailing Address					
City	State	Zip Code	Date of Birth	Social Security Number(Optional)	
Daytime Telephone Number			Other Telephone Number		

SECTION B: TO BE COMPLETED BY STATE LICENSING AGENCY

The above-named individual has applied for a Wisconsin EMT license based upon reciprocity from your state. Complete Section B of this form and forward to the Wisconsin Department of Health Service.

State Verifying License		License Number			
This applicant is/was certified/licensed/registered in your state as:			Issue Date	Expiration Date	
<input type="checkbox"/> First Responder					
<input type="checkbox"/> EMT-Basic					
<input type="checkbox"/> EMT-Intermediate (1985 curriculum) or <input type="checkbox"/> EMT-Intermediate (1999 curriculum)					
<input type="checkbox"/> EMT-Paramedic (1986 curriculum) or <input type="checkbox"/> EMT-Paramedic (1999 curriculum)					
<input type="checkbox"/> Other:					

Date of last DOT-approved refresher training:

Yes No Has this applicant's EMT license ever been denied, reprimanded, limited, suspended or revoked?

If yes, please provide a copy of the disciplinary action.

Yes No Is there any reason this applicant should not be licensed in Wisconsin?

If yes, please explain:

SECTION C: STATE LICENSING AGENCY CERTIFICATION

Print name of person completing this form		Title	
SIGNATURE		Date	Telephone Number

Mail or FAX completed form to:

DEPARTMENT OF HEALTH SERVICES
BUREAU OF EMS AND INJURY PREVENTION
LICENSING MANAGER
PO BOX 2659
MADISON WI 53701-2659
FAX: 608-261-6392