

Application for Advanced Life Support Certification

State Form 67 (R6 / 11-05)

- Instructions:
1. Please type or print clearly.
 2. Complete all items listed below.
 3. You will be notified by mail after the Department of Homeland Security Training Institute has reviewed your application.
 4. After completion send white copy to:

**Indiana Department of Homeland Security
302 W. Washington St., Rm E239
Indianapolis, IN 46204-2721**

For Office Use Only		
Date Received	Certification Approval	Expiration Date
<input type="checkbox"/> Initial Affiliation		<input type="checkbox"/> Additional Affiliation

Pursuant to Indiana Code 16-31, the Department of Homeland Security Training Institute requires the completion of each item on this form. Failure to complete any item will result in this form being returned. Upon submission, this form becomes a public record.
BOTH MISREPRESENTATION OF INFORMATION PROVIDED ON THIS FORM AND FAILURE TO COMPLY AND MAINTAIN COMPLIANCE WITH ANY APPLICABLE STANDARDS OR REQUIREMENTS ARE CAUSES FOR SUSPENSION OR REVOCATION OF YOUR CERTIFICATION.

Name of Applicant	Applying for: <input type="checkbox"/> Basic-Advanced EMT <input type="checkbox"/> Advanced EMT Intermediate <input type="checkbox"/> Paramedic	Indiana EMT Cert #	Date of Birth
Address (number and street, city, state, Zip Code)		County	

Have you ever been charged or convicted of a crime other than minor traffic violations? Yes No
 If yes, have you previously reported the details of this crime/crimes to the Department of Homeland Security? Yes No
 Do you have a High School Diploma or GED? Yes No

Have you ever been certified in any EMS capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what state/territory/military branch? _____
Level(s) of certification/licensure _____	Dates of Previous Certification: From _____ To _____

I hereby swear and affirm that I am the person named above and that I will comply with all state laws answering this type of certification and that the statement contained herein are true.

Signature of applicant	Telephone Number
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Initial Certification

Training Institution where course was taken	Course Number	Start Date	Completion Date
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Certification Provided Through Reciprocity/Waiver

State/organization where training was obtained	National Registry Cert #	Expiration Date	State Cert #	Expiration Date
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Advanced Life Support Organization Information

Name of Indiana State Certified EMS Provider Organization	EMS Provider Organization Certification Number
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Address (number and street, city, state, Zip Code)

We attest that this applicant is affiliated with the above named organization

Signature of Organization Medical Director	Date	Signature of Organization CEO	Telephone Number	Date
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