



**EMERGENCY MEDICAL SERVICES-  
PRIMARY INSTRUCTOR CONTINUING  
EDUCATION & ACTIVITY REPORT**

State Form 54507 (R / 7-13)

**INDIANA DEPARTMENT OF HOMELAND SECURITY  
EMS CERTIFICATION, Room E-239  
Indiana Government Center South  
302 West Washington Street  
Indianapolis, IN 46204  
1-800-666-7784**



PLEASE TYPE OR PRINT CLEARLY

| PRIMARY INSTRUCTOR INFORMATION  |                      |  |                |
|---|----------------------|--|----------------|
| Public Safety Identification number   |                      | Reporting date (month, day, year)  |                |
| Last name   |                      | First name   | Middle initial |
| Address 1 (number and street)   |                      |  |                |
| Address 2 (number and street)   |                      |  |                |
| City  |                      | State  | Zip code       |
| Driver's License number   |                      | E-mail address   |                |
| Home telephone number<br>( ) -  | Cell number<br>( ) - | Work number<br>( ) -   |                |
| VIOLATION STATEMENT   |                      |  |                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |                      | Have you ever been arrested for or convicted of a crime that has not been expunged by a court?<br>(Excluding minor traffic violations) |                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |                      | Have you previously reported this conviction to the Indiana Department of Homeland Security?   |                |
| EMERGENCY MEDICAL SERVICES REGISTRANT SIGNATURE   |                      |  |                |
| I, the undersigned Primary Instructor, hereby affirm, under the penalty of perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates and other required documents for verification. I understand that false statements or documents maybe sufficient cause for revocation by the Indiana Department of Homeland Security and the Emergency Medical Services Commission. I also understand that the audit of the recertification activities listed at any time. |                      |  |                |
| Signature of Primary Instructor   |                      | Date (month, day, year)  |                |
| Printed name of Training Institution Official   |                      | Name of Affiliated Training Institution  |                |
| Signature of approval (Training Institution Official)   |                      | Date (month, day, year)  |                |
| Have you been trained in NIMS/ICS? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                      |  |                |
| Level of NIMS/ICS training. <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 700 <input type="checkbox"/> 800 <input type="checkbox"/> Other _____  |                      |  |                |
| Would you be willing to assist in a disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                      |  |                |

