

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? Yes 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 |
|------------------------|------------------|

Initial Certification

| | | | |
|---|---------------|------------|-----------------|
| Training Institution where course was taken | Course Number | Start Date | Completion Date |
|---|---------------|------------|-----------------|

Certification Provided Through Reciprocity/Waiver

| | | | | |
|--|--------------------------|-----------------|--------------|-----------------|
| State/organization where training was obtained | National Registry Cert # | Expiration Date | State Cert # | Expiration Date |
|--|--------------------------|-----------------|--------------|-----------------|

Advanced Life Support Organization Information

| | |
|---|--|
| Name of Indiana State Certified EMS Provider Organization | EMS Provider Organization Certification Number |
|---|--|

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 |
|--|------|-------------------------------|------------------|------|