MISSISSIPPI STATE DEPARTMENT OF HEALTH

OUT OF STATE RECIPROCITY VERIFICATION

Applicants are to complete Section 1 of this form and email/mail to each state where he/she currently holds or has held a License/Certification.

APPLICANTS: DO NOT MAIL THIS FORM TO THE STATE OF MISSISSIPPI.

Section I: To be Completed by Applicant

Last Name	First Name	Middle I	Soc Sec Number

Street/P.O. Box	City	State	Zip Code

Area Code and Phone	Lic/Cert Level	Lic/Cert Number	Expiration Date

Section II: To be Completed by State Agency

The above applicant has applied for reciprocity in Mississippi. Please email, mail or fax this completed form to the Mississippi State Department of Health, Bureau of Emergency Medical Services.

1. Current License/Certification level of applicant: _____ Exp. Date: _____
2. Has applicant's License/Certification ever been suspended/revoked? □ No □ Yes Explain: _____

   _____
3. Has this applicant ever been convicted of a felony? □ No □ Yes □ Unknown Explain: _____

   _____
4. Was applicant issued License/Certification based on reciprocity in your state? □ No □ Yes If yes, please complete the following:

   Reciprocity State: _____ Date Lic/Cert Granted: _____
5. Do you know of any reason why this applicant should not be granted reciprocity? □ No □ Yes

   Explain: _____

Representative Printed Name	Title	Agency

Representative Signature	Date	State	Phone

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Instructions

Section I: To be Completed by Applicant

1. Applicants are required to complete 'Last Name', 'First Name', and 'Middle Initial' as it appears on both his/her National Registry License and State Driver's License.
2. Applicants are required to complete the box 'Social Security Number'. This is required for federal reporting purposes. This number will not appear on any license.
3. Applicants are required to complete 'Street/P.O. Box', 'City', 'State', and 'Zip Code' with the address he/she receives official mail regarding licenses.
4. Applicants are required to complete 'Area Code and Phone' with the best, most reliable number to reach him/her should the office have questions regarding the individual's application or license.

Section II: To be Completed by Reciprocity State Agency

1. State Agency should provide the current licensed level of the applicant requesting reciprocity and the corresponding expiration date.
2. State Agency should provide, by selecting the appropriate box, if the applicant's license has ever been suspended or revoked.
3. State Agency should provide, by selecting the appropriate box, if the applicant has ever been convicted of a felony and provide any details as appropriate.
4. State Agency should provide, by selecting the appropriate box, if the applicant was granted licensure by reciprocity in lieu of the state's formal certification process. If so, please provide Reciprocity State and Date License was granted.
5. State Agency should provide any other information pertinent to the licensure of the applying individual not covered in the previous questions.
6. State Agency should complete the following:
    a. 'Representative Printed Name' of person completing the request.
    b. 'Representative Title' of person completing the request.
    c. Name of 'Agency' completing the request.
    d. 'Representative Signature' of person completing the request.
    e. 'Date' of Representative Signature.
    f. Agency's 'State'.
    g. Agency's 'Phone' number to include area code.

The complete form should be mailed to:
Bureau of EMS
MS State Dept. of Health
ATTN: Certification
P.O. Box 1700
Jackson, MS 39215

Or emailed to:
Scottie.martin@msdh.ms.gov
Dale.holdiness@msdh.ms.gov

Or faxed to 601-576-7270**.**

Questions? Contact 601-576-7377.