



**Request for Verification of Certification/Licensure from Another State/Jurisdiction  
"Attachment A"**

State of Nebraska  
 Department of Health and Human Services  
 Division of Public Health – Licensure Unit  
 PO Box 94986 – Lincoln, Nebraska 68509-4986

**SECTION A – To Be Completed By The Applicant If Licensed In Another State Or Jurisdiction.**

Name: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SECTION B – To Be Completed By The Issuing Agency.**

Our records certify that the aforementioned individual was granted License/Certificate Number \_\_\_\_\_  
 in the State/Jurisdiction of \_\_\_\_\_ to practice as a/an:  
 Emergency Medical Responder     Advanced Emergency Medical Technician  
 Emergency Medical Technician     Paramedic     Other \_\_\_\_\_  
 Issuance Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

This licensure/certification was issued based on:  
 Reciprocity with \_\_\_\_\_  
 Completion of a United States Department of Transportation, National Highway Traffic Safety Administration, National Standard Curriculum.  
 Name of Curriculum: \_\_\_\_\_  
 Other Training – please specify: \_\_\_\_\_

Did the aforementioned individual pass an examination?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

**IF YES**, provide the following information:  
 Name of the Examination: \_\_\_\_\_

Scores the individual received:	Written	Practical

Has this individual's certification/license ever been:			
Suspended:	Yes	No	IF YES, explain:
	<input type="checkbox"/>	<input type="checkbox"/>	
Revoked:	Yes	No	IF YES, explain:
	<input type="checkbox"/>	<input type="checkbox"/>	
Other disciplinary action:	Yes	No	IF YES, explain:
	<input type="checkbox"/>	<input type="checkbox"/>	

Name and Title: \_\_\_\_\_  
 Licensing Agency: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_