

2026

Q2 MEETING

APRIL 28, 2026

Kansas City, Missouri



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Q2 2026 Full Commission Meeting Agenda**Location:** In Person**Date:** April 28, 2026 2PM CT**Venue:** InterContinental Kansas City at the Plaza, 401 Ward Pkwy, Kansas City, MO 64112**Virtual Option:** Join: <https://teams.microsoft.com/join/22387486651739?p=EVNs1ZHoLcl6nsKaM6>

Meeting ID: 223 874 866 517 39 Passcode: hX9UX68J Phone: +1 323-694-9789,,623177296#

Note, this is a primary off-site in-person meeting. This meeting may not be optimized for an optimum hybrid or virtual attendance experience. This meeting is hosted in conjunction with the National Association of State EMS Officials (NASEMSO) Annual Meeting. Individuals attending the ICEMSPP Commission Meeting are not required to attend or register for NASEMSO. For additional NASEMSO details: <https://nasemso.org/2026-annual-meeting>

- I. Call to Order & Welcome - *Commissioner Kinney (IN), Chair*
- II. Commissioner Roll Call - *Commissioner Herrera (UT), Secretary*
 - a. Declare Quorum Present - *Kinney*
- III. Introduce New Commissioners (Seated since Q1 meeting) - *Kinney*
 - a. Missouri, Commissioner Sam Vance
 - b. Wyoming, Commissioner Susan Neugebauer
- IV. Adopt Business Agenda - *Kinney*
- V. Public Comments Regarding Matters Not on the Agenda - *Kinney*
- VI. Reports
 - a. Chair's Report - *Kinney*
 - b. Treasurer's Report - *Commissioner Brad Vande Lunde (IA)*
 - c. Executive Director Report - *Woodyard*
 - d. Committee Reports
 - i. Stakeholder Advisory Committee Report- *Woodyard*
 - ii. Criminal History and Fitness to Practice Evaluation Committee - *Commissioner Jon Jones (SC)*
 - iii. Rules & Bylaws Committee - *Commissioner Joe Schmider (TX)*
 - iv. Compliance Committee - *Commissioner Joe House (KS)*
 - e. Database Administrator Report
 - f. Federal Reports
 - i. U.S. DOT NHTSA Office of EMS
- VII. Old Business
 - a. Action: Approve Q1 2026 Meeting Minutes - *Herrera*
- VIII. New Business
 - a. EMS Week Resolution
 - b. EMS For Children Day Resolution
 - c. Discussion on Rural Health Transformation Grant, EMS Representation
 - d. Discussion on National Disaster Preparedness and Interstate Mobility of EMS Personnel
- IX. NGO / Stakeholder Partner Updates
- X. Adjourn Meeting

Executive Session to Immediately Follow Meeting

Pursuant to Section 10.B.6 of the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (hereinafter referred to as the "Compact"), I hereby certify as legal counsel for the Commission that the Executive Committee may convene in closed session at its next meeting to discuss matters set forth in Sections 10.B.5(a) of the Model Compact.

2026 Commission Meetings

Executive Committee	Stakeholder Advisory Committee	Bylaws & Rules Committee	Full Commission
April 8, 2026	April 15, 20026		April 29, 2026 (Kansas City, MO)
May 13, 2026			
June 10, 2026	June 17, 2026		
July 8, 2026			
August 12, 2026	August 18, 2026		August 19, 2026
September 9, 2026			
October 14, 2026	October 21, 2026		
November 4, 2026			November 18, 2026 (Elections)
December 9, 2026	December 16, 2026		

The EMS Compact is law in these states: Alabama, Arkansas, Colorado, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, & Wyoming.

Meeting Norms:

The Interstate Commission for EMS Personnel Practice is a governmental body established in law. Public and stakeholder attendance is encouraged. Public comment sections are included on the agenda, and the chair may open any agenda item for public comment. To allow for equal participation by all attendees during the meeting, please note the following guidelines for all attendees:

- Commissioners are requested to attend in person when possible.
- Public Attendees:
 - Public attendance is encouraged.
 - Public attendees are welcome to observe the meeting in person.
 - Please sign in at the registration table upon arrival.
 - Members of the public may request to speak during public comment periods by raising their hand. The Chair will recognize speakers in order.
 - Public attendees should announce their name and organization before speaking.
 - Public comments are limited to two minutes or less.
 - In the case of disruptive behavior or comments exceeding two minutes, the Chair may ask the speaker to yield.

*All times are approximate. The chair may modify the agenda during the meeting at their discretion.

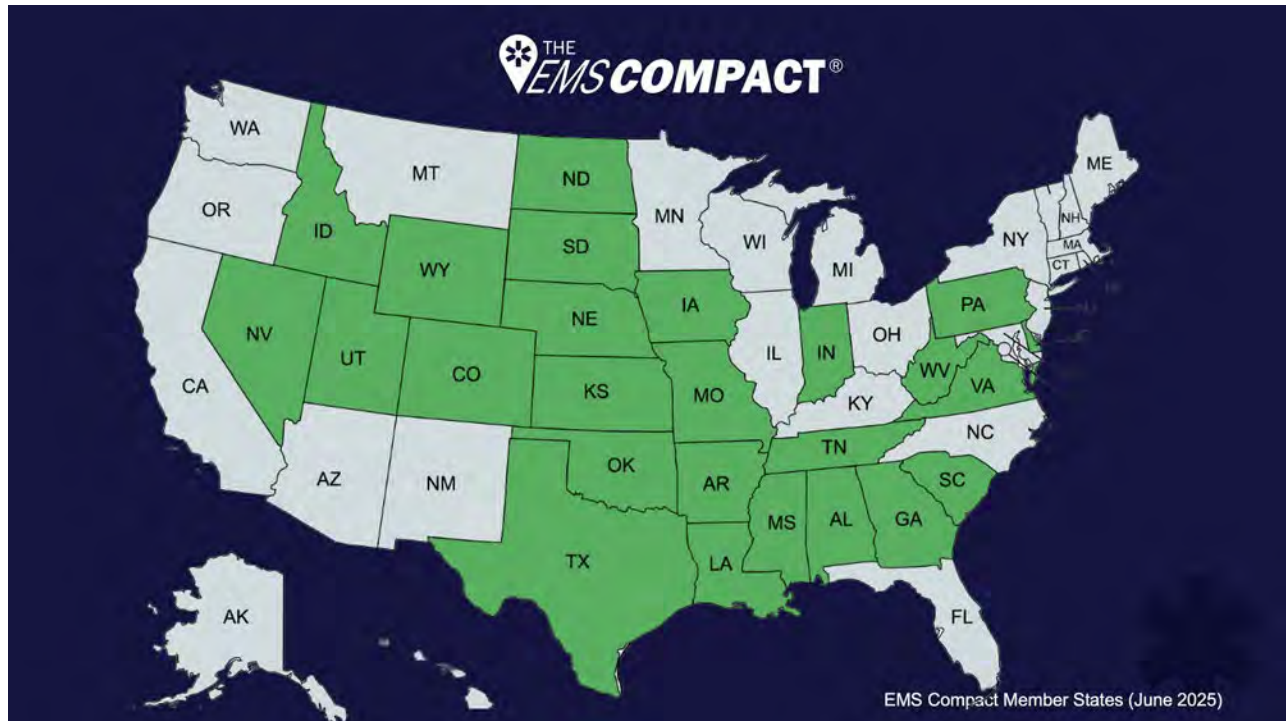
Commissioner Roll Call — April 28, 2026

State	Commissioner	Elected Role	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Alabama	Jamie Gray		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Arkansas	Christy Kresse		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Colorado	Michael Bateman		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Delaware	Britany Huss		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Georgia	Michael Johnson	Commissioner-At-Large	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Idaho	Wayne Denny	Vice Chairperson	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Indiana	Kraig Kinney	Chairperson	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Iowa	Brad Vande Lune	Treasurer	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Kansas	Joe House		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Louisiana	Susan Bailey		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Mississippi	Teresa Windham		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Missouri	Sam Vance		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Nebraska	Tim Wilson		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Nevada	Bobbie Sullivan		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
North Dakota	Christopher Price		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Oklahoma	Lewis Robinson		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Pennsylvania	Anthony Martin		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
South Carolina	Jonathan Jones		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
South Dakota	Margaret B. Hansen		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Tennessee	Brandon Ward		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Texas	Joseph Schmider	Immediate Past Chair	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Utah	Mark Herrera	Secretary	<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Virginia	Maria Beermann-Foat		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
West Virginia	David Jamie Weller		<input type="checkbox"/> Present	<input type="checkbox"/> Absent
Wyoming	Susan Neugebauer		<input type="checkbox"/> Present	<input type="checkbox"/> Absent

Ex-Officio & Staff

Role	Name	Present Absent
Executive Director	Donnie R. Woodyard, Jr., MAML, NRP, WP-C	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Counsel	Doug Wolfberg, JD / Christie Mellott, JD — Page, Wolfberg & Wirth	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Database Administrator	Ray Mollers — National Registry of EMTs	<input type="checkbox"/> Present <input type="checkbox"/> Absent

MAP: 2026 EMS Compact Member States



EMS Compact Member States (April 2026)

The EMS Compact is law in 25 states: Alabama, Arkansas, Colorado, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wyoming.

**Interstate Commission for EMS Personnel Practice
Official Meeting Minutes
Q1 2026 Full Commission Meeting****Date:** February 11, 2026**Time:** 3:00 PM Eastern**Location:** Virtual Attendance Only (Microsoft Teams)**I. Call to Order & Welcome****Chairperson:** Commissioner Kraig Kinney (IN)

The Q1 2026 Full Commission Meeting of the Interstate Commission for EMS Personnel Practice was called to order on February 11, 2026, at 3:00 p.m. Eastern Time via Microsoft Teams. Chairperson Kinney presided over the meeting, welcomed all attendees, and reviewed the participation guidelines and meeting protocols for Commissioners and public attendees.

Roll Call - Secretary: Commissioner Mark Herrera (UT)

Secretary Herrera conducted the roll call (as noted). Vice Chairperson Wayne Denny (ID) was excused due to illness. Commissioner Weller (WV) and Commissioner Ward (TN) joined after the initial roll call and were noted as present by Executive Director Woodyard. With 3 absent members, Chairman Kinney declared a quorum present.

Present (22): Arkansas (Kresse), Colorado (Bateman), Georgia (Johnson), Indiana (Kinney), Iowa (Vande Lune), Kansas (House), Louisiana (Bailey), Mississippi (Windham), Missouri (Vance), Nebraska (Wilson), Nevada (Sullivan), North Dakota (Price), Oklahoma (Robinson), Pennsylvania (Martin), South Carolina (Jones), South Dakota (Hansen), Tennessee (Ward), Texas (Schmider), Utah (Herrera), Virginia (Beermann-Foat), West Virginia (Weller), Wyoming (Neugebauer)**Absent (2):** Alabama (Gray), Delaware (Huss)**Excused (1):** Idaho (Denny)**Introduction of New Commissioners - Chairman Kinney (IN)**

Introduced and welcomed Commissioner Sam Vance of Missouri. Commissioner Vance noted he previously served in this role from 2019 to 2021 and expressed his enthusiasm for returning to serve the Commission.

Introduced and welcomed Commissioner Susan Neugebauer of Wyoming. Commissioner Neugebauer shared her background as a paramedic with nearly 15 years at Denver Health and her current role as EMS program supervisor, having promoted into the Commissioner role following the departure of former Commissioner Koehler.

Adoption of Business Agenda - Chairman Kinney (IN)

Commissioner Michael Bateman (CO) motioned to adopt the business agenda. Commissioner Jonathan Jones (SC) seconded. Executive Director Woodyard noted that Commissioner Weller (WV) and Commissioner Ward (TN) had joined and should be recorded as present. The business agenda was adopted without opposition.

II. Public Comments Regarding Matters Not on the Agenda**Chairperson:** Commissioner Kinney (IN)

Chairman Kinney noted public comments were deferred to after the reports section. No public comments were received when the floor was opened.

III. Reports**Chairperson's Report:** Commissioner Kinney (IN)

Chairman Kinney outlined the Commission's priorities for 2026, including streamlining operations, continued growth through state outreach and legislative engagement, and ensuring Commissioner relevance and engagement. He noted the Commission currently has 25 member states with several additional states actively pursuing legislation. He publicly commended Executive Director Woodyard for his dedication in advancing the mission of the Compact, including fiscal responsibility during travel. He noted the Executive Committee recognized the Executive Director with a performance bonus at year-end. Chairman Kinney highlighted the successful adoption of administrative rules in 2025 and the strong work of all committees.

Treasurer's Report: Commissioner Brad Vande Lune (IA)

Treasurer Vande Lune reported the Q4 2025 financial standing: previous balance of \$97,913.90, debits of \$50,751.18, credits of \$47,500.00, with a closing balance of \$94,662.72 as of January 2, 2026. No questions were raised. Report accepted as provided.

Executive Director's Report: Executive Director Donnie Woodyard

Executive Director Woodyard provided a comprehensive report. Highlights included:

- **Federal Recognition:** The Rural Health Transformation Grant (\$50 billion over five years) specifically names the EMS Compact in the application scoring criteria. States that are members of the EMS Compact receive baseline points; states that are not members lose points, directly impacting funding amounts. Individual state grants range from approximately \$166 million to \$250 million per state for Year 1.
- **Department of Defense Integration:** The Department of War and Department of the Air Force have specifically included the EMS Compact on Military Base Assessment scorecards. Military bases in compact member states receive preferential points in base rankings, representing a significant shift from the Compact being a priority to a federal mandate for health, safety, and welfare.

State Legislative Update:

- Florida: EMS Compact bill passed the House as part of an omnibus bill, headed to the Senate.
- Ohio: Governor committed to the EMS Compact as part of Rural Health Transformation Funding, targeting enactment by next year.
- Massachusetts: Bill currently in study; anticipated motion next year.
- New Jersey: EMS Compact bill filed.
- New Mexico: Bill passed out of the House, headed to the Senate.
- Arizona: EMS Compact bill anticipated to be reheard in committee the following week.
- Montana: Pre-filing stage with an identified sponsor; bill number anticipated soon.
- Oregon: Governor's office committed to joining the Compact; anticipated next legislative session.
- Alaska: Governor committed to joining; sponsor identified with bill number anticipated imminently.
- Department of Defense state liaison officers have been testifying in support of the EMS Compact in multiple states.

Rural Health Transformation Grant Analysis:

Executive Director Woodyard reported that his office analyzed all 50 state grant applications. Approximately 10 of 50 states did not explicitly reference EMS in their submissions, which he characterized as extremely troubling. He is developing a policy and intergovernmental recommendation to ensure a minimum allocation of Rural Health Transformation Grant funding is designated to EMS nationally. He specifically commended Wyoming, whose application allocated approximately 48% of total submitted funding (approximately \$100 million in Year 1) directly to EMS, compared to some states with zero EMS allocation. Commissioner Schmider (TX) noted that in some states, the EMS office advocated for inclusion but external agencies controlled grant priorities. Chairman Kinney indicated he would likely designate a committee to conduct a deeper review of the proposal and invited Commissioner interest.

Additional Items:

- Continued work with federal partners on upgrades to the National EMS Coordinated Database (NEMSCD); project remains active.
- Added a Medical Director Q&A resource to the EMS Compact website to address commonly received questions from medical directors.
- Upcoming webinar sponsored by CoAEMSP targeting educational institutions and program directors on the EMS Compact.
- Noted that EMS Compact educational session proposals have been declined by EMS World Expo for the 10th consecutive year, despite the Compact covering over 450,000 EMS clinicians. Continuing to seek alternative mechanisms for education delivery.

Committee Reports

Stakeholder Advisory Committee - Executive Director Woodyard

Executive Director Woodyard reported the committee has a meeting scheduled for the following week but noted a vacancy in the committee chair position following Commissioner Koehler's departure from Wyoming. Chairman Kinney invited interested Commissioners to reach out to serve as the new chair. Chairman Kinney noted he would sit in on the next meeting and committed to ensuring continuity of the committee's work.

Criminal History and Fitness to Practice Evaluation Committee - Commissioner Jonathan Jones (SC)

Commissioner Jones deferred the detailed report to the new business agenda item on Position Paper 2601. He noted the committee's draft document and proposed amendments would be reviewed during new business.

Rules & Bylaws Committee - Commissioner Joe Schmider (TX)

Commissioner Schmider reported the committee has not met since the end of 2025. Meetings will resume in March. He invited interested Commissioners to join the committee.

Compliance Committee - Commissioner Joe House (KS), Chair (Designee)

Chairman Kinney announced the formation of a new Compliance Committee, designated during a prior Executive Committee meeting, to be chaired by Commissioner House. The committee will assist the Executive Director with compliance matters related to newly adopted rules and state engagement. Commissioners interested in serving were asked to notify the Chair or Executive Director.

Database Administrator Report: Ray Mollers (NREMT)

Mr. Mollers reported on the status of state reporting to the National EMS Coordinated Database:

- Tennessee: Encountered difficulties since September; last correspondence January 21st, working through issues.
- Oklahoma: Working with ImageTrend as a statewide vendor; Commissioner Robinson reported anticipating a contract by the April meeting with an 8-9 month integration timeline including historical data migration.
- Pennsylvania: Commissioner Martin reported via chat that Pennsylvania anticipates having their vendor agreement signed within the next month.
- Delaware: Encountered an ALS issue as of November 20th; can send individual records but not batch submissions.
- Indiana: Very close to going live; added four more paramedics to QA environment today with credentials to begin loading records imminently.
- Nebraska: Experienced personnel changes; Commissioner Wilson confirmed testing expected to resume soon.

Commissioner Schmider (TX) requested that future database reports include the date of last communication with each non-reporting state to provide the Commission with better visibility into progress. Mr. Mollers agreed and also requested Commission assistance in following up with non-compliant states. Chairman Kinney indicated the new Compliance Committee would coordinate with Mr. Mollers on these matters.

IV. Old Business

Action: Approval of Q4 2025 Meeting Minutes - Commissioner Herrera (UT)

Commissioner Margaret Hansen (SD) moved to approve the Q4 2025 meeting minutes from November 5, 2025. Secretary Mark Herrera (UT) seconded the motion.

Vote: The minutes were approved without opposition or abstention.

V. New Business

a. Action: Position Paper 2601 - Criminal Convictions and Licensure of EMS Personnel

Executive Director Woodyard provided extensive background on the position paper, noting it is an advisory document representing the collective position of the EMS Compact member states, not an administrative rule or binding regulation. The paper addresses how state EMS offices should evaluate criminal history when making licensure determinations, an issue the industry has not fully standardized in over 50 years. He referenced the Hawker v. New York Supreme Court precedent establishing the legal authority for state licensing bodies to make morality-based determinations.

The four-tier framework provides guidance as follows:

- Tier 1 - Permanent Disqualifiers: Most serious offenses (life imprisonment, death sentences, capital crimes). Recommendation: automatic denial with no rehabilitation review.
- Tier 2 - Serious Felonies and Misdemeanors: Very serious offenses with significant sentences. Recommendation: 7-year look-back period from completion of sentence and debt to society; states may consider licensure with extreme caution under their local laws.
- Tier 3 - Discretionary Review: Moderate offenses requiring case-by-case evaluation. May result in denial, limitation, or approval depending on circumstances and state law.
- Tier 4 - Generally Non-Considered: Minor offenses including dismissed charges, expunged records, juvenile records, traffic infractions, and convictions for conduct no longer criminalized. Generally not a barrier, with exceptions for Tier 1-level juvenile offenses.

Amendments Incorporated:

Based on feedback from NASEMSO and the State of Nevada, the following amendments were incorporated:

- Removed specific state names under recommended best practices to avoid potential inaccuracies in categorizing individual state positions.
- Added pre-trial intervention program guidance, recognizing that individuals entering such programs would be evaluated on public risk, with compact privilege designated as provisional when the underlying conduct does not preclude EMS practice.
- Clarified that state versus Member State references reflect the advisory nature of the paper for all states, compact and non-compact alike.
- Added pattern assessment criteria, recognizing the distinction between isolated offenses and patterns of repeat conduct that may change the risk determination.
- Added additional footnotes, resources, and documentation references.

Commissioner Jones (SC) made a motion to adopt the position paper as amended. Commissioner Beermann-Foat (VA) seconded the motion. Commissioner Bateman (CO) expressed appreciation for the document, noting Colorado has been searching for this kind of guidance. Chairman Kinney clarified that as a position paper, states are not required to adopt all elements, but the document provides a reliable best-practice resource.

Vote: The position paper was adopted as amended without opposition or abstention.

VI. NGO / Stakeholder Partner Updates

NASEMSO - Dia Gainor, Executive Director

Ms. Gainor thanked the Commission for consideration of NASEMSO's comments on the criminal convictions position paper. She reminded Commissioners of the upcoming NASEMSO Annual Meeting during the week of April 26, 2026, in Kansas City, Missouri, which will include the Commission's in-person meeting. Chairman Kinney noted the Commission meeting is scheduled for Tuesday, April 28, 2026, in the afternoon and encouraged all Commissioners to attend in person.

VII. Adjournment

Having reached the end of the published agenda and with no further business before the Commission, Chairman Kinney thanked all attendees for their participation and engagement, noting only 3 Commissioners were absent, with Vice Chairperson Denny (ID) having communicated his illness in advance. The meeting was adjourned.

Adjournment Time: The meeting was adjourned at approximately 4:09 p.m. Eastern Time.

Commissioner Roll Call - FEBRUARY 11, 2026

State	Commissioner	Elected Role	Present	Absent
Alabama	Jamie Gray		Present	Absent
Arkansas	Christy Kresse		Present	Absent
Colorado	Michael Bateman		Present	Absent
Delaware	Britany Huss		Present	Absent
Georgia	Michael Johnson	At-Large	Present	Absent
Idaho	Wayne Denny	Vice Chairperson	Present	Excused
Indiana	Kraig Kinney	Chairperson	Present	Absent
Iowa	Brad Vande Lune	Treasurer	Present	Absent
Kansas	Joe House		Present	Absent
Louisiana	Susan Bailey		Present	Absent
Mississippi	Teresa Windham		Present	Absent
Missouri	Sam Vance *NEW*		Present	Absent
Nebraska	Tim Wilson		Present	Absent
Nevada	Bobbie Sullivan		Present	Absent
North Dakota	Christopher Price		Present	Absent
Oklahoma	Lewis Robinson		Present	Absent
Pennsylvania	Anthony Martin		Present	Absent
South Carolina	Jonathan Jones		Present	Absent
South Dakota	Margaret B. Hansen		Present	Absent
Tennessee	Brandon Ward		Present	Absent
Texas	Joseph Schmider	Immediate Past Chair	Present	Absent
Utah	Mark Herrera	Secretary	Present	Absent
Virginia	Maria Beermann-Foat		Present	Absent
West Virginia	David Jamie Weller		Present	Absent
Wyoming	Susan Neugebauer *NEW*		Present	Absent

Ex-Officio & Staff

Role	Name	Present	Absent
Executive Director	Donnie Woodyard, Jr	Present	Absent
Counsel	Doug Wolfberg, JD / Christie Mellott, JD - Page, Wolfberg & Wirth	Present	Absent
Database Administrator	Ray Mollers / National Registry of EMTs	Present	Absent



INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE™

Resolution 2026-01 | EMS Week 2026

To recognize the Week of May 17 - 23, 2026, as Emergency Medical Services Week

WHEREAS, emergency medical services are a vital public service; and

WHEREAS, EMS practitioners are professional medical providers who are ready to provide lifesaving care to those in need 24 hours a day, seven days a week; and

WHEREAS, access to quality emergency care dramatically improves the survival and recovery rate of those who experience sudden illness or injury; and

WHEREAS, emergency medical services have grown to fill a gap by providing essential, out-of-hospital care, including preventative medicine, follow-up care, and access to telemedicine; and

WHEREAS, the emergency medical services system consists of first responders, emergency medical technicians, paramedics, emergency medical dispatchers, firefighters, police officers, educators, administrators, pre-hospital nurses, emergency nurses, emergency physicians, trained members of the public, and other out-of-hospital medical care providers; and

WHEREAS, the members of emergency medical services teams, whether career or volunteer, engage in thousands of hours of specialized training and continuing education to enhance their lifesaving skills; and

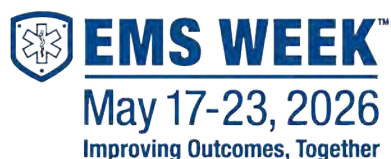
WHEREAS, the Interstate Commission for EMS Personnel Practice also recognizes State EMS Offices, which serve as the lead state executive branch offices responsible for ensuring a coordinated, systems approach to emergency medical services, overseeing the licensure of EMS personnel, administering the EMS system, and upholding public protection, thereby ensuring effective and responsive healthcare delivery; and

WHEREAS, it is appropriate to recognize the value and the accomplishments of emergency medical services providers by designating the Emergency Medical Services Week;

THEREFORE, BE IT RESOLVED that the Interstate Commission for EMS Personnel Practice, in recognition of this event, does hereby adopt and recognize the week of May 17 - 23, 2026, as EMERGENCY MEDICAL SERVICES WEEK, commemorating the 52nd Anniversary of EMS Week.

BE IT FURTHER RESOLVED that the Commission encourages the community to observe this week with appropriate programs, ceremonies, and activities.

ADOPTED by the Interstate Commission for EMS Personnel Practice on this ___ day of May, 2026.





INTERSTATE COMMISSION FOR
EMS PERSONNEL PRACTICE

Certificate of Recognition

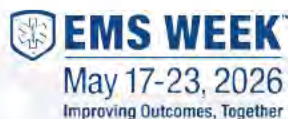
HONORING EMS WEEK 2026 AND YOUR DEDICATION TO EMERGENCY MEDICAL SERVICES

On behalf of the United States EMS Compact,
this certificate of appreciation is presented to

Sarah M. Thompson

Licensed Paramedic • Colorado

As an EMS clinician licensed in a state participating in the United States EMS Compact, your commitment to excellence, patient care, accountability, and interstate cooperation in emergency medical services is greatly appreciated and valued. Thank you for your dedication to the profession and the patients and communities you serve.



EMS WEEK™

May 17-23, 2026

Improving Outcomes, Together

Donnie R. Woodyard, Jr., MAML
Executive Director

National EMS ID: 123456789012
www.EMSCompact.gov

Kraig Kinney, JD
Chair



INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE™

Resolution 2026-02 | EMS for Children Day 2026

To recognize May 20, 2026, as Emergency Medical Services for Children (EMSC) Day

WHEREAS, 35 million children receive emergency medical care each year due to illness or injury; and

WHEREAS, the needs of children are different than the needs of adults in medical emergencies; and

WHEREAS, the goal of Emergency Medical Services for Children is to help states and communities prepare for an emergency involving a child by helping emergency medical services agencies and emergency departments become Pediatric Ready; and

WHEREAS, the Emergency Medical Services for Children Program supports research and improvement science to drive transformation of emergency care systems, including the prehospital setting; and

WHEREAS, Emergency Medical Services for Children relies on its established partnership within the EMS community, as well as multidisciplinary teams of providers across the emergency care continuum, to help states and communities reduce child and youth disability and death due to severe illness or injury; and

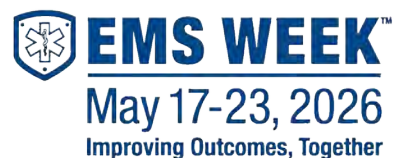
WHEREAS, Emergency Medical Services for Children, the hundreds of thousands of prehospital and hospital-based clinicians it serves, the professional organizations and federal agencies with which it partners, and the patients and families it engages, are committed to collaborating to ensure high-quality emergency care for children; and

WHEREAS, it is proper and timely to recognize the value and accomplishments of Emergency Medical Services for Children and the dedicated personnel who work tirelessly to improve pediatric care delivery across emergency care systems ...

THEREFORE, BE IT RESOLVED that the Interstate Commission for EMS Personnel Practice, in recognition of this event, does hereby adopt and recognize May 20, 2026, as EMERGENCY MEDICAL SERVICES FOR CHILDREN.

BE IT FURTHER RESOLVED that the Commission encourages the community to observe this day with appropriate programs, ceremonies, and activities.

ADOPTED by the Interstate Commission for EMS Personnel Practice on this ___ day of May, 2026.



Briefing: Rural Health Transformation Grant and EMS Representation

Q2 2026 Full Commission Meeting — New Business, Item VIII(c)

Prepared for: Commissioners, Interstate Commission for EMS Personnel Practice

Prepared by: Office of the Executive Director

Date: April 22, 2026

Status: Informational briefing for discussion

Purpose

This briefing provides Commissioners with background on the federal Rural Health Transformation (RHT) Program, summarizes the Commission's recent policy work on EMS representation within state RHT plans, and presents the Executive Director's updated recommendation for Commission engagement with the Centers for Medicare & Medicaid Services (CMS). It is intended to inform the New Business discussion.

Background: The Rural Health Transformation Program

The Rural Health Transformation Program is a five-year, \$50 billion federal initiative established under Public Law 119-21 and administered by CMS. The program distributes \$10 billion annually across states through a two-part allocation:

- **Baseline funding** — a flat per-state allocation.
- **Workload funding** — a performance-based allocation calculated from each state's application score on the technical factors published in the Notice of Funding Opportunity (CMS-RHT-26-001).

Two factors in the NOFO bear directly on EMS Compact participation and EMS representation:

- **Factor C.2 — EMS.** An initiative-based factor scoring the degree to which a state's RHT application includes EMS-focused activities, investments, or reforms.
- **Factor D.2 — Licensure Compacts.** A state policy-actions factor awarding points for state participation in interstate occupational licensure compacts, including the EMS Compact.

Because these factors are scored and weighted into the workload allocation, a state's participation in the EMS Compact and its inclusion of EMS initiatives in its transformation plan both directly influence how much federal RHT funding the state receives. Member states of the EMS Compact hold an inherent scoring advantage on Factor D.2.

What the Data Shows: State RHT Plans and EMS Representation

A joint analysis of all 50 state Year 1 RHTP applications, conducted on behalf of the national EMS community and incorporated into the Commission's policy work with NASEMSO, identified the following patterns in how states represented EMS:

- **Broad but uneven inclusion.** Forty-three states (86%) included EMS-related activities in their Year 1 RHTP plans. Fifteen states created dedicated, named EMS initiatives.
- **Wide range of allocation levels.** Among states that quantified their EMS investment, allocations ranged from approximately 2% to 48% of total state awards, with a median exceeding 6%.
- **States with no clear EMS integration.** A review of publicly available state plans indicates that multiple states submitted RHTP applications without clear EMS integration, forgoing available points under Factor C.2 and leaving EMS workforce and access gaps unaddressed within their transformation strategies.
- **Diverse EMS activity types.** State plans include community paramedicine and mobile integrated health programs (approximately 28 states), treat-in-place models (20), EMS workforce training initiatives (18), telehealth-EMS integration (17), fleet and equipment modernization (13), and regional EMS coordination hubs (12).

State-by-state data and source citations are contained in the Legislative Tracker (For Reference section) and in the joint Policy Paper, which is available as a separate Commission work product.

Commission Policy Work to Date

In February 2026, the Commission's Executive Director developed a policy paper, *Stabilizing Rural and Frontier Emergency Medical Services: A Strategic Refinement of the Rural Health Transformation Program*, addressing the gap between the RHT Program's statutory authorization of EMS as a permissible use and the actual allocation of funding to EMS in Year 1 state plans.

The policy paper was subsequently developed as a joint effort with the **National Association of State EMS Officials (NASEMSO)** through a March 5, 2026 collaboration letter from the Executive Director to NASEMSO's Executive Committee, establishing the paper as a joint product of both organizations.

As originally drafted, the policy paper proposed two specific legislative asks:

- A Congressional directive (via report language, Dear Colleague letter, or appropriations guidance) establishing a **5% floor** on each state's RHT award for rural and frontier EMS stabilization.
- A **\$12 million** investment in national EMS data infrastructure, funded through RHT reversion recapture, to establish a national ambulance registry and expand workforce visibility.

The full policy paper is a separate Commission work product. The NASEMSO collaboration letter establishing joint authorship is included in the For Reference section of this meeting book.

Executive Director's Updated Recommendation

Following continued engagement with stakeholders and reflection on the appropriate Commission posture, the Executive Director's current recommendation is to **shift the Commission's engagement from a Congressional mandate framework to a collaboration framework with CMS**, focused on improving the NOFO guidance and supporting tools available to state applicants.

The rationale for this shift is threefold:

- **Preservation of state discretion.** A floor on state allocations, even a modest one, constrains a state's sovereign judgment on how to use RHT funds. Many member states have established processes for stakeholder input on transformation plans, and a federal allocation mandate could

disrupt those processes. CMS guidance and tooling, by contrast, strengthens state decision-making without dictating outcomes.

- **Collaborative posture with CMS.** CMS has established infrastructure for state support, including the 50 State Spotlights publication and technical assistance channels. The Commission is positioned to offer CMS substantive technical input on EMS integration without entering the Congressional appropriations process.
- **Scoring already exists; guidance is what's missing.** Factor C.2 and Factor D.2 in the current NOFO already reward EMS representation and compact participation. The evidence from Year 1 plans suggests that variation in state outcomes is driven less by scoring weight and more by the absence of accessible benchmarks, peer examples, and comparative framing for state application drafters.

Proposed Commission Position for Discussion

For Commissioner consideration, the Executive Director offers the following for discussion and, if acceptable, refinement into a formal Commission action:

The Interstate Commission for EMS Personnel Practice respectfully requests that the Centers for Medicare & Medicaid Services collaborate with the Commission and the National Association of State EMS Officials on additional guidance, benchmarks, and scoring tools that support state applicants in considering meaningful EMS allocations within their Rural Health Transformation plans. The Commission does not seek a federal mandate on state allocation percentages; state discretion over transformation plan design remains appropriate and is preserved. The Commission's interest is in ensuring state applicants have sufficient information and comparative examples to make informed decisions about the role of EMS in rural health transformation, and that the scoring framework's existing emphasis on EMS (Factor C.2) and Licensure Compacts (Factor D.2) is accessible and understood by state application teams.

Discussion Prompts for Commissioners

1. Does the Commission concur that variation in state EMS representation within RHT plans warrants Commission engagement?
2. Is the collaborative-with-CMS posture (not a Congressional mandate) the appropriate Commission direction?
3. Should the Commission formally engage CMS through a joint Commission-NAEMSO communication, a letter from the Chair, or another mechanism?
4. How should the Commission handle the joint policy paper previously developed with NAEMSO, given the updated engagement direction?
5. Are there member state experiences with the RHT application process that should inform Commission engagement?

Source Materials

- Public Law 119-21 (Rural Health Transformation Program authorizing statute)
- CMS Notice of Funding Opportunity CMS-RHT-26-001
- CMS Announcement of \$50 Billion in Awards to Strengthen Rural Health in All 50 States (December 29, 2025)
- *Stabilizing Rural and Frontier Emergency Medical Services: A Strategic Refinement of the Rural Health Transformation Program* — Joint Commission / NAEMSO Policy Paper (v6)

- NASEMSO Collaboration Letter (March 5, 2026)

Briefing: National Disaster Preparedness and Interstate Mobility of EMS Personnel

Q2 2026 Full Commission Meeting — New Business, Item VIII(d)

Prepared by: Office of the Executive Director

Status: Informational — Executive Committee action previously taken; Commissioner discussion invited

Purpose

This briefing invites Commissioner discussion on the Commission's ongoing engagement with the Federal Emergency Management Agency (FEMA) regarding the National Medical Transport Service (NMTS) and the incorporation of EMS Compact provisions into future revisions of the National Ambulance Contract.

Background and Executive Committee Action

The Commission's Executive Committee has previously considered the matters addressed in the attached FEMA/NMTS Policy Brief and has taken action in the form of formal correspondence to FEMA leadership requesting consideration of EMS Compact provisions in future National Ambulance Contract cycles. The letter has been transmitted. Conversations with FEMA, NASEMSO, and contract stakeholders are ongoing.

The attached Policy Brief (prepared March 21, 2026) provides the substantive analysis that informed the Executive Committee's decision and the Commission's continuing engagement. It is included here for Commissioner awareness and to support Commission-level discussion on the path forward.

Why This Matters for the Commission

- **Scale of federal deployment.** The National Ambulance Contract is the primary federal mechanism for large-scale EMS deployment in response to declared disasters. Current contract provisions do not fully reflect the interstate licensure framework established by the Compact.
- **Compact operational readiness.** The Compact's Privilege to Practice mechanism and the NEMSCD together provide the infrastructure to support real-time federal deployment decisions. Incorporating Compact provisions into future contract revisions strengthens both the contract and the Compact's operational role in national disaster response.
- **Preservation of non-Compact state interests.** The Commission's engagement does not seek to alter deployment mechanisms or contract terms applicable to non-Compact states. The ask is limited to ensuring that Compact state personnel and infrastructure are properly recognized and leveraged within existing contract frameworks.

What Commissioners Will Find in the Attached Brief

The attached Policy Brief documents the legal and operational basis for EMS Compact integration into the National Ambulance Contract, the specific contract provisions relevant to interstate EMS practice, and the Executive Committee's formal request. Commissioners should review the brief in full to inform the discussion.

Discussion Prompts for Commissioners

1. Are there additional federal contracts, policies, or deployment mechanisms that warrant similar Commission engagement?
2. How should the Commission communicate progress on the FEMA engagement to member states and stakeholders?
3. What member state experiences with federal disaster deployment should inform the Commission's continued engagement?

The Policy Brief follows this page.

For Reference

Supplemental materials and reference documents

2026 Commission Meeting Schedule

Executive Committee	Stakeholder Advisory Committee	Bylaws & Rules Committee	Full Commission
April 8, 2026	April 15, 2026		April 28, 2026 (Kansas City, MO)
May 13, 2026			
June 10, 2026	June 17, 2026		
July 8, 2026			
August 12, 2026	August 18, 2026		August 19, 2026
September 9, 2026			
October 14, 2026	October 21, 2026		
November 4, 2026			November 18, 2026 (Elections)
December 9, 2026	December 16, 2026		

All committee meetings are held virtually via Microsoft Teams unless otherwise noted. Full Commission meetings are open to the public; committee meetings may be open or closed session as determined by the Commission chair.

Timeline & Key Dates

Date	Event
June 2014	REPLICA Model Legislation released for state consideration
October 7, 2017	EMS Compact effective (10th state enacted); Commission established
March 10, 2020	NEMSCD activated to support national COVID-19 response
March 15, 2020	EMS Compact fully activated
Feb 11, 2026	Position Paper 2026-01 unanimously adopted at Q1 meeting
Feb 15, 2026	Indiana completes full NEMSCD integration
Feb 17, 2026	Vector Solutions' Acadis certified as NEMSCD-compliant vendor
April 28, 2026	Q2 2026 Full Commission Meeting (Kansas City, MO)
May 17-23, 2026	EMS Week 2026 — “Improving Outcomes, Together”
May 20, 2026	EMS for Children Day
August 19, 2026	Q3 2026 Full Commission Meeting
November 18, 2026	Q4 2026 Full Commission Meeting & Officer Elections

EMS Compact Legislative Tracker

& Federal Funding Analysis

Status Update: April 2026

Current National Picture

The EMS Compact is enacted law in **25 member states**: Alabama, Arkansas, Colorado, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wyoming.

Arizona is currently poised as a potential 26th member state pending legislative action. Alaska and Connecticut remain active with positive momentum and a high probability of enactment in the current legislative session. In Florida and New Mexico, EMS Compact legislation passed the House but was not voted on in the Senate before the legislative session ended; re-introduction is anticipated in the next session.

Active States (April 2026)

State	Bill / Vehicle	Status	Momentum
Alaska	Legislation anticipated	In preparation	Strong gubernatorial support; virtual stakeholder Q&A planned
Arizona	Active	In-play	Poised as potential 26th member state
Connecticut	SB 93 (2026)	In committee	REPLICA language embedded; addressing UPFFA opposition
Florida	House-passed (2026)	Senate — ran out of time	Re-introduction anticipated next session
New Mexico	House-passed (2026)	Senate — ran out of time	Re-introduction anticipated next session

Federal Funding Nexus — Rural Health Transformation Program

The federal Rural Health Transformation Program (Public Law 119-21, administered by the Centers for Medicare & Medicaid Services via NOFO CMS-RHT-26-001) is a \$50 billion, five-year initiative distributing \$10 billion annually across states. The program's scoring framework explicitly rewards EMS representation and interstate compact participation:

- **Factor C.2 — EMS.** Scores the inclusion of EMS-focused activities, investments, or reforms in a state's transformation plan.

- **Factor D.2 — Licensure Compacts.** Awards points for state participation in interstate occupational licensure compacts, including the EMS Compact.

Both factors directly influence the workload funding allocation, which is the performance-based half of each state's annual distribution.

Year 1 State RHTP Plans — EMS Representation Findings

A joint analysis of all 50 state Year 1 RHTP applications, incorporated into the Commission's joint policy paper with NASEMSO, identified the following patterns:

- **43 states (86%)** included EMS-related activities in their Year 1 plans.
- **15 states** created dedicated, named EMS initiatives.
- **Allocation range: 2% to 48%** among states that quantified EMS investment. Median allocation exceeds 6%.
- **Multiple states** submitted RHTP applications without clear EMS integration, forgoing available points under Factor C.2.

Prevalent state EMS activity types (Year 1 plans): community paramedicine and mobile integrated health (≈28 states), treat-in-place models (20), EMS workforce training (18), telehealth-EMS integration (17), fleet and equipment modernization (13), and regional EMS coordination hubs (12). Additional state innovations include EMS reimbursement reform pilots, alternate destination transport models, perinatal and neonatal EMS programs, 911 dispatch clinical triage, pre-hospital whole blood programs, paramedic-initiated medication-assisted treatment, and centralized EMS billing infrastructure.

Commission Engagement

The Commission, in collaboration with NASEMSO, developed a joint policy paper (v6, March 2026) addressing EMS representation in state RHTP plans. As documented in the RHT Briefing (New Business item VIII(c) of this meeting), the Executive Director's current recommendation is to engage CMS in collaboration on additional guidance, benchmarks, and scoring tools for state applicants — preserving state discretion while supporting informed application development.

Sources

- Public Law 119-21; CMS Notice of Funding Opportunity CMS-RHT-26-001
- CMS Announcement of \$50 Billion in Awards to Strengthen Rural Health in All 50 States (December 29, 2025)
- Joint Commission / NASEMSO Policy Paper v6 (March 2026) — available as separate Commission work product
- Connecticut SB 93 (2026); legiscan.com bill text repository

Recent Press Releases

The following press releases have been issued by the Interstate Commission for EMS Personnel Practice since the Q1 2026 Full Commission Meeting:

1. **January 14, 2026** — Commissioner Michael Johnson (GA) Appointed to Executive Committee
2. **February 6, 2026** — Wyoming and Missouri Appoint New Commissioners (Neugebauer & Vance)
3. **February 15, 2026** — Indiana Completes Full Integration Into the National EMS Coordinated Database
4. **February 17, 2026** — EMS Compact Commission Unanimously Adopts Historic Position Paper 2026-01 on Criminal Convictions and EMS Licensure
5. **February 24, 2026** — Vector Solutions' Acadis System Achieves Compliance with the United States EMS Compact

Full press releases follow this page.



United States EMS Compact

The Interstate Commission for EMS Personnel Practice

5010 E. Trindle Road, Suite 202

Mechanicsburg, PA 17050

(717) 888-4147

PRESS RELEASE

Interstate Commission for EMS Personnel Practice Appoints Commissioner Michael Johnson (GA) to Executive Committee

14 JAN 2026 Washington, DC — The Interstate Commission for EMS Personnel Practice, the governmental commission responsible for the implementation and operation of the United States EMS Compact, announced the appointment of Michael Johnson, MS, NRP, Commissioner for the State of Georgia, to the Commission's Executive Committee.



Commissioner Michael Johnson

Commissioner Johnson was appointed to fill the Executive Committee position recently vacated by Aaron Koehler of Wyoming. The appointment fills the remainder of the current term in accordance with the Compact's governing bylaws and ensures continuity of leadership for the Commission's day-to-day operations.

Michael Johnson serves as Director of the Georgia Office of EMS and Trauma at the Georgia Department of Public Health. He is an active member of the National Association of State EMS Officials and has served as Georgia's appointed Commissioner to the Interstate Commission for EMS Personnel Practice. Previously, Commissioner Johnson served as Deputy Director for Systems of Care and Director of the Office of Cardiac Care, where he led the designation of Georgia's first 41 Emergency Cardiac Care Centers and helped establish a sustainable statewide cardiac care system.

Prior to his service with the Georgia Department of Public Health, Commissioner Johnson taught EMS and emergency management at the university and college levels and served as Program Director for EMS education programs in both Alabama and Georgia. He also spent seven years as a CBRNE subject matter expert consultant supporting FEMA and the Department of Homeland Security. Beginning his EMS career in 1995, he has maintained a longstanding commitment to improving EMS system performance and expanding access to care in rural and underserved communities.

The Executive Committee is responsible for managing the Interstate Commission's affairs between full Commission meetings, providing operational oversight, strategic direction, and continuity of governance. Under the Compact statute, each member state's governor appoints a commissioner to represent the state on the Interstate Commission.

Commission Chair Kraig Kinney of Indiana stated, "Commissioner Johnson brings deep operational, regulatory, and systems-of-care experience to the Executive Committee. His background in statewide system development and emergency preparedness will strengthen the Commission's ability to support a safe, mobile, and resilient EMS workforce."

Executive Director Donnie Woodyard, MAML, NRP, added, "Leadership continuity matters for a national regulatory body operating across state lines. Commissioner Johnson's appointment ensures experienced oversight during a critical period of growth for the United States EMS Compact and reinforces our commitment to public protection, accountability, and interstate collaboration."

Today, 25 states participate in the United States EMS Compact, enabling more than 450,000 EMS clinicians to practice across Compact member states using their active, unrestricted home-state license. This interstate licensure model strengthens emergency preparedness, supports workforce mobility, and enhances patient access to timely emergency medical care nationwide.

For more information about the Interstate Commission for EMS Personnel Practice and the United States EMS Compact, visit the Commission's official website.

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About the Interstate Commission for EMS Personnel Practice

The Interstate Commission for EMS Personnel Practice is the lead governmental authority in the United States responsible for regulating and overseeing the interstate practice of Emergency Medical Services (EMS). Established by the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA), the Commission is composed of appointed Commissioners from each Compact Member State and is vested with the authority to enforce compliance, administer national operations, resolve multistate regulatory and disciplinary issues, operate the National EMS Coordinated Database, and facilitate immediate license recognition and the Privilege to Practice across state lines. Operational 24/7, the EMS Compact enables more than 400,000 EMS clinicians in 25 member states to deliver care wherever and whenever needed—supporting routine operations, surge staffing, disaster response, recruitment and retention, and the demands of a modern, mobile workforce. The Commission safeguards public protection, enhances national preparedness, and stands as the definitive model for multistate licensure in healthcare.

The EMS Compact is law in the following states:

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5010 E. Trindle Road, Suite 202

Mechanicsburg, PA 17050

(202) 888-4142

PRESS RELEASE

Wyoming and Missouri Appoint New Commissioners to the Interstate Commission for EMS Personnel Practice

6 FEB 2026 Washington, DC — The Interstate Commission for EMS Personnel Practice today announced the appointments of Susan Neugebauer as Wyoming’s Commissioner and Sam Vance as Missouri’s Commissioner to the United States EMS Compact.

Commissioner Neugebauer was also recently appointed as Wyoming’s EMS Unit Manager and State EMS Director, bringing more than 25 years of experience in emergency medical services. Her career spans clinical practice as a paramedic, field training, and leadership of a paramedic education program, with a sustained focus on clinical quality, workforce development, and EMS system improvement.

In addition to her EMS leadership, Commissioner Neugebauer holds a Master of Education degree and brings extensive experience in general and early childhood special education, having supported children from birth through age five. This distinctive combination of clinical and educational expertise positions her to strengthen pediatric emergency care initiatives and EMS education across Wyoming and the Compact.



Commissioner
Susan Neugebauer
Wyoming



Commissioner
Sam Vance
Missouri

Missouri’s newly appointed Commissioner, Sam Vance, brings a strong background in EMS system leadership and healthcare administration, with a focus on operational excellence, regulatory integrity, and workforce sustainability. He holds a Master of Healthcare Administration from A.T. Still University, equipping him with advanced expertise in healthcare systems management, policy implementation, and organizational performance. His combined clinical and administrative experience positions him to support Missouri’s continued leadership within the EMS Compact, particularly in advancing interstate practice, system modernization, and resilient workforce development.

“We are pleased to welcome both Commissioner Neugebauer and Commissioner Vance to the United States EMS Compact Commission,” said Kraig Kinney, JD, NRP, Chair of the Interstate Commission for EMS Personnel Practice. “Their combined experience in clinical care, education, system leadership, and regulation strengthens the Compact’s mission to protect the public while enabling a modern, mobile EMS workforce nationwide.”

Both Commissioners emphasized the importance of strong regulatory frameworks that support patient safety while expanding workforce mobility through interstate collaboration.

Wyoming joined the EMS Compact in 2016 through enactment of the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA) law, authorizing interstate EMS practice and Privilege to Practice across Compact member states.

In Missouri, the REPLICA legislation was signed into law on July 9, 2018, making Missouri the sixteenth state to enact the EMS Compact and further strengthening national workforce mobility, disaster response coordination, and multistate regulatory collaboration.

For more information about the EMS Compact, member states, or to validate an EMS clinician’s Privilege to Practice, please visit www.emscompact.gov.

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About the Interstate Commission for EMS Personnel Practice

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(202) 888-4142
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PRESS RELEASE | FOR IMMEDIATE RELEASE

Indiana Completes Full Integration Into the National EMS Coordinated Database

Nearly 20,000 Indiana EMS Clinicians Now Connected to the Nation's Only De-Duplicated, Real-Time EMS Workforce Database—Strengthening Interstate Mobility, Public Protection, and National Readiness

WASHINGTON (15 FEB 2026)— The Interstate Commission for EMS Personnel Practice today announced that the State of Indiana has completed full integration of its EMS licensure data into the National EMS Coordinated Database (NEMSCD). With this milestone, nearly 20,000 Indiana EMS clinicians—including Emergency Medical Technicians, Advanced EMTs, and Paramedics—are now connected to the nation's only de-duplicated, real-time EMS workforce verification system, operated by the governmental body of the EMS Compact.

Indiana's integration means that every EMS clinician holding a valid Indiana license now holds a state-authorized privilege to practice across all 25 EMS Compact member states—a privilege created by Indiana's own legislature through its enactment of the Compact. That privilege can be electronically validated in real time through the EMS Compact's website (www.emscompact.gov)—ensuring that when an Indiana paramedic, EMT, or Advanced EMT crosses a state line to respond to an emergency, provide mutual aid, or support a large-scale event, their credentials are instantly verifiable by any participating state, employer, or deploying authority.

This achievement represents years of dedicated effort by the Indiana Department of Homeland Security, the Indiana EMS Commission, and the Indiana State EMS Office to align state licensure systems with the Compact's national data infrastructure. Indiana's commitment to this process reflects the state's leadership in strengthening both workforce mobility and public protection.

"Indiana's EMS clinicians deserve a system that works as hard as they do," said Kraig Kinney, Indiana State EMS Director and Chair of the Executive Committee of the Interstate Commission for EMS Personnel Practice. "By fully integrating our licensure data into the National EMS Coordinated Database, we've given our nearly 20,000 EMTs, Advanced EMTs, and Paramedics the ability to practice seamlessly across 25 states—while ensuring that every state they enter has real-time access to verified licensure and regulatory information. This is what modern EMS workforce management looks like, and I'm proud that Indiana is leading the way."

"Indiana's full integration into the NEMSCD is a landmark moment—not just for Indiana, but for the entire national EMS system," said Donnie Woodyard, Executive Director of the Interstate Commission for EMS Personnel Practice. "Every state that completes this process adds depth and accuracy to the only national system capable of providing a de-duplicated, real-time view of America's EMS workforce. With Indiana now fully connected, the NEMSCD contains verified licensure data for more than 400,000 EMS clinicians across 25 states—data that is essential for public protection, disaster response planning, and national medical surge readiness. I congratulate Director Kinney and the entire Indiana team for their perseverance and vision in completing this critical milestone."

A Stronger National System

The National EMS Coordinated Database is the only system in the United States that de-duplicates EMS licensure records across state lines, providing an accurate, real-time count of the nation's EMS workforce. Because EMS clinicians frequently hold licenses in multiple states—sometimes 20 or more—traditional counting methods based on state-reported license totals significantly overestimate the true size of the workforce. The NEMSCD resolves this by linking all of a clinician's state licenses to a single, authoritative national record tied to their National EMS ID.

This capability is indispensable for national planning and emergency preparedness. Federal, state, and regional planners rely on accurate workforce data to model medical surge capacity, coordinate interstate deployments, and ensure that the right clinicians with the right credentials are available when and where they are needed most. Each new state integration—like Indiana's—strengthens the national picture and brings the country closer to complete EMS workforce visibility across all 50 states, Washington, D.C., and U.S. territories. As more state legislatures recognize the value of the EMS Compact for their clinicians and their communities, each new member state that joins and integrates its data further closes the gaps that currently limit the nation's ability to plan for and respond to large-scale emergencies.

The EMS Compact is law in the following states:

Alabama • Arkansas • Colorado • Delaware • Georgia • Idaho • Indiana • Iowa • Kansas • Louisiana • Mississippi • Missouri • Nebraska • Nevada • North Dakota • Oklahoma • Pennsylvania • South Carolina • South Dakota • Tennessee • Texas • Utah • Virginia • West Virginia • Wyoming

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5010 E. Trindle Road, Suite 202
Mechanicsburg, PA 17050
(202) 888-4142
<http://www.emscompact.gov/>

Strengthening Public Protection Across 25 States

Indiana's integration also significantly strengthens public protection for Hoosier patients. Through the NEMSCD, Indiana now has full, real-time visibility into the licensure status of EMS clinicians across all 25 member states. If an EMS clinician's license is suspended, revoked, or restricted in all EMS Compact states, that information is immediately visible to Indiana's regulators—ensuring that the state can act swiftly to protect the public. This coordinated data sharing is a core function of the EMS Compact and a direct fulfillment of the Commission's legislative mandate to facilitate "the exchange of licensure, investigative, and disciplinary information between member states."

With Indiana's data now fully integrated, the NEMSCD operates as a continuously updated, government-operated national data system—providing state EMS officials, employers, and deploying authorities with a single, trusted source for verifying the licensure and regulatory status of EMS clinicians across jurisdictional boundaries.

A Proven, Scalable National Infrastructure

The NEMSCD has been operational since March 10, 2020, when it was activated to support the national COVID-19 response. Since then, it has served as the backbone of the EMS Compact's interstate license verification system, supporting routine cross-border operations, disaster deployments, medical surge events, and workforce mobility. The system is built on a secure, government-authorized data architecture and operates under the legal authority established by each member state's enactment of the EMS Compact. In Indiana, this authority is codified in the Indiana Code, creating a legislatively shared framework for interstate cooperation that preserves Indiana's sovereign control over its licensure decisions while enabling seamless coordination across all participating states. At zero cost to individual EMS clinicians, the NEMSCD provides real-time license verification and credential validation to protect patients, support employers, and empower clinicians.

The Commission gratefully acknowledges the National Registry of Emergency Medical Technicians, which serves as the EMS Compact's technology partner. The NREMT's expertise in the design, development, and ongoing maintenance of the National EMS Coordinated Database has been instrumental in building a system that is secure, scalable, and trusted by state EMS officials nationwide.

About the EMS Compact

The Interstate Commission for EMS Personnel Practice is a governmental body established by the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA). The EMS Compact facilitates the interstate practice of EMS personnel while strengthening public protection through coordinated data sharing, real-time notification of disciplinary actions, and cooperative investigations. The Compact currently includes 25 member states, whose legislatures enacted the legislation with overwhelming bipartisan support—3,250 total "YES" votes against 61 "NO" votes, representing 98% legislative approval. For more information, visit www.EMSCompact.gov.

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The EMS Compact is law in the following states:

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PRESS RELEASE | FOR IMMEDIATE RELEASE

EMS Compact Commission Unanimously Adopts Historic Position Paper on Criminal Convictions and EMS Licensure

First-of-its-Kind Framework in 50 Years of Modern EMS Establishes National Best Practices for Evaluating Criminal History in Licensure Decisions

WASHINGTON (February 17, 2026) — The Interstate Commission for EMS Personnel Practice, representing 25 member states, today announced the unanimous adoption of *Position Paper 2026-01: Criminal Convictions and Licensure of EMS Personnel* at the Commission's Q1 2026 meeting. The position paper is the first document of its kind in the 50-year history of modern Emergency Medical Services, providing a comprehensive, evidence-based framework for how states evaluate criminal history when making EMS licensure decisions.

The position paper was developed through a rigorous process that included public comment, a survey of all member state practices, and careful consideration of established legal precedents, criminological research on recidivism and rehabilitation, and the constitutional sovereignty of each state. The result is a monumental achievement—a balanced framework that protects the public while recognizing the potential for individual rehabilitation, and that provides powerful guidance for state EMS officials across the country.

"When someone calls 911, they place their life in the hands of a stranger," said Donnie Woodyard, Executive Director of the Interstate Commission for EMS Personnel Practice. "This position paper ensures that every state has access to a clear, research-based, and legally defensible guide for evaluating criminal history—balancing the public's expectation of safety with fairness for individuals who have demonstrated genuine rehabilitation. This will be a powerful guide for state EMS officials as they review criminal history information and make determinations related to EMS licensure."

Position Paper 2026-01 builds on the Commission's prior *Position Paper 2023-01: Biometric Criminal History Checks for EMS Personnel*, which called on all states to perform an FBI-compliant biometric criminal history check on all EMS personnel prior to licensure. That requirement reflects the minimum expectation of the public and is now required by law in all 25 EMS Compact member states. With the foundation of universal background checks in place, this new position paper provides the essential next step: a comprehensive framework for how states should evaluate the criminal history information those checks reveal.

Transparency was key to the development of both position papers. The Commission invited and considered public comment throughout the process, ensuring that the perspectives of state officials, EMS professionals, and the public informed the final product. This open, collaborative approach directly fulfills one of the seven legislative mandates of the EMS Compact: to "encourage the cooperation of member states in the areas of EMS personnel licensure and regulation."

A Landmark for Public Protection

The position paper establishes a four-tier framework that categorizes criminal convictions based on their severity and relationship to patient safety. The framework provides state EMS licensing officials with clear, actionable guidance for making determinations related to EMS licensure—from permanent disqualifiers for the most serious offenses to discretionary review pathways that recognize rehabilitation. It includes detailed example scenarios, procedural safeguards, applicant rights, and recommendations for public accountability and reporting.

Critically, the framework carefully recognizes the individual sovereignty of each state. While it establishes a best-practice standard for public protection, it preserves every state's independent constitutional authority to determine who may hold an EMS license within its jurisdiction. States may voluntarily adopt, adapt, or exceed the recommendations based on their own statutory frameworks and policy priorities.

Respecting State Sovereignty While Strengthening National Standards

Achieving unanimous adoption across 25 states with diverse legal traditions, political landscapes, and regulatory approaches required extraordinary collaboration and compromise. The Commission navigated the complex task of establishing meaningful national best practices without infringing on the authority that each state retains under the Tenth Amendment to the U.S. Constitution. The position paper reinforces that licensure is created and governed by state law, and that Compact participation is a voluntary contract between sovereign states.

The EMS Compact is law in the following states:

Alabama • Arkansas • Colorado • Delaware • Georgia • Idaho • Indiana • Iowa • Kansas • Louisiana • Mississippi • Missouri • Nebraska • Nevada • North Dakota • Oklahoma • Pennsylvania • South Carolina • South Dakota • Tennessee • Texas • Utah • Virginia • West Virginia • Wyoming



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50 Years in the Making

Since the advent of modern EMS in the 1970s, no national body has produced a comprehensive, consensus-driven framework for evaluating criminal history in EMS licensure. States have operated with widely varying standards—some with detailed statutory disqualifiers, others with broad discretionary authority, and many with limited or no formal guidance. The Commission's survey of member states revealed significant disparities: only 52% had mandatory disqualifiers, look-back periods ranged from 5 years to lifetime, and just 35% used continuous criminal record monitoring.

This position paper addresses those gaps by providing a model that balances public protection with public expectation—ensuring that EMS patients can trust that the clinician who responds to their emergency has been thoroughly evaluated, properly licensed, and held accountable to transparent standards.

About the Position Paper

Position papers produced by the Interstate Commission for EMS Personnel Practice document the official positions of the Commission. While position papers are not binding administrative rules or regulations, they represent the official consensus position of the Commission and its 25 member states. They are intended to guide and inform state policymakers, licensing officials, EMS professionals, and the public on matters of policy and best practice.

About the EMS Compact

The Interstate Commission for EMS Personnel Practice is a governmental body established by the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA). The EMS Compact facilitates the interstate practice of EMS personnel while strengthening public protection through coordinated data sharing, real-time notification of disciplinary actions, and cooperative investigations. The Compact currently includes 25 member states, whose legislatures enacted the legislation with overwhelming bipartisan support—3,250 total "YES" votes against 61 "NO" votes, representing 98% legislative approval. For more information, visit www.EMSCompact.gov.

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The EMS Compact is law in the following states:

Alabama • Arkansas • Colorado • Delaware • Georgia • Idaho • Indiana • Iowa • Kansas • Louisiana • Mississippi • Missouri • Nebraska • Nevada • New York • North Dakota • Oklahoma • Pennsylvania • South Carolina • South Dakota • Tennessee • Texas • Utah • Virginia • West Virginia • Wyoming

Interstate Commission for EMS Personnel Practice

www.EMSCompact.gov

PRESS RELEASE

FOR IMMEDIATE RELEASE

February 24, 2026

Contact: Interstate Commission for EMS Personnel Practice

Vector Solutions' Acadis System Achieves Compliance with the United States EMS Compact

*Second Commercial Vendor Certified for National EMS Coordinated Database
Integration—Indiana Goes Live with Over 20,000 Licensure Records*

WASHINGTON (17 FEB 2026)— The Interstate Commission for EMS Personnel Practice today announced that Vector Solutions' Acadis Readiness Suite, a unified training and license management platform, has been certified as compliant with the requirements of the United States EMS Compact for integration with the National EMS Coordinated Database (NEMSCD). Acadis is the second commercial software product to achieve this certification, joining ImageTrend License Management as certified commercial vendors.

Under Compact law and administrative rules, state EMS licensure systems are required to integrate and exchange data with the NEMSCD—the nation's only de-duplicated, real-time EMS workforce verification system. Vendor certification ensures that licensure data flows accurately, securely, and in compliance with the standards established by the Commission.

The Acadis integration went live in Indiana on February 15, 2026, synchronizing over 20,000 EMT, Advanced EMT, and Paramedic licensure records to the NEMSCD. With this milestone, every qualified Indiana EMS clinician now holds a verified privilege to practice across all 25 EMS Compact member states, with credentials instantly verifiable at www.EMSCompact.gov.

“We appreciate the work of the Vector Solutions Acadis certifications platform team that partnered with the Commission to achieve integration,” said Kraig Kinney, Director of the Indiana Department of Homeland Security and Indiana's EMS Compact Commissioner. “Their investment into NEMSCD integration demonstrates their commitment to the state EMS systems they serve.”

“It has been a pleasure working with Vector Solutions on this integration,” said Donnie Woodyard, Executive Director of the Interstate Commission for EMS Personnel Practice. “The Acadis platform serves state EMS offices across the country, and their certification means that additional member states now have a clear, proven path to NEMSCD compliance. Every state that connects to the database strengthens public protection and workforce mobility for the entire Compact.”

“Vector is proud to support the EMS market and practitioners by integrating our proven unified training and license management solution, the Acadis Readiness Suite, with the EMS Compact,” said Josh Grossman, General Manager, Public Sector at Vector Solutions. “Indiana’s go-live with the Acadis-EMS Compact integration, syncing more than 20,000 licensure records, demonstrates the importance of EMS license standardization and centralization to strengthen real-time credential verification, improve workforce mobility, and advance public protection across Compact states.”

Compliant Software Vendors and Systems

The following vendors and systems have demonstrated compliance with NEMSCD integration requirements:

- ImageTrend License Management
- **Vector Solutions’ Acadis Training and License Management**
- DB Sysgraph
- Texas Department of State Health Services License Management System
- Virginia Department of Health License Management System

About the EMS Compact

The Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) is enacted law in 25 states, enabling licensed EMTs, Advanced EMTs, and Paramedics to practice across state lines through a privilege to practice. The Compact was enacted with overwhelming bipartisan support—3,250 total “YES” votes against 61 “NO” votes across all member state legislatures, representing 98% legislative approval.

The National EMS Coordinated Database is the nation’s only de-duplicated, real-time EMS workforce verification system, containing verified licensure data for more than 400,000 EMS clinicians. The NEMSCD enables real-time credential verification, interstate adverse action reporting, and coordinated public protection across all member states.

For more information, visit www.EMSCompact.gov.

About Vector Solutions for Fire & EMS

Vector Solutions for Fire & EMS is the leading Unified Agency Readiness Platform helping fire and EMS agencies save time, streamline operations, improve performance, and achieve measurable outcomes. Our solutions help agencies improve their readiness goals through industry-leading training management systems, license management and compliance, online training courses, live skill evaluations, policy management, truck checks and PPE/asset management, shift scheduling, critical incident and exposure tracking, academy automation, and auto-reporting to state standards and training systems. Trusted by more than 10,000 public safety agencies and 2 million first responders, Vector helps departments achieve operational excellence. Learn more at www.vectorsolutions.com/solutions/acadis/ems-training-licensure-management.

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Policy Awareness Briefing — Summary

Electric Aviation and Advanced Air Mobility: Implications for EMS Systems and Interstate Personnel Practice

Original Briefing: February 14, 2026 | Prepared by: Donnie R. Woodyard, Jr., NRP, WP-C, MAML, Executive Director

Summary Prepared For: Q2 2026 Full Commission Meeting Book — For Reference

Status: Informational. No action requested.

Purpose

This summary distills the 100-page Policy Awareness Briefing issued to Commissioners on February 14, 2026, describing developments in electric aviation and advanced air mobility (AAM) that have near-term relevance to EMS systems and interstate personnel practice. The full briefing, with complete citations to Congressional records, FAA regulatory artifacts, SEC filings, and federal policy documents, is available separately from the Commission.

What Is Happening

Multiple electric aviation companies are developing aircraft and operational partnerships specifically targeting medical transport, organ delivery, emergency logistics, and air medical operations. These are not conceptual programs. They are supported by Congressional testimony, federal contracts, operator commitments backed by financial deposits, and a federal regulatory framework designed to enable pre-certification demonstration flights beginning in 2026.

Key federal and industry markers include:

- The U.S. Department of Transportation's **Advanced Air Mobility National Strategy** (December 2025) envisions initial AAM flights in 2027 and expanded operations by 2030.
- **Congressional action** has appropriated \$12.5 billion for air traffic control modernization and \$50 million for the Center for Advanced Aviation Technologies.
- The **FAA Powered-Lift Integration Final Rule** establishes pilot certification and operational requirements for this new class of aircraft.
- **Manufacturer commitments** include BETA Technologies' stated focus on "cargo, medical, logistics" as the initial mission set, with named medical partners including Metro Aviation for interfacility patient transport and United Therapeutics for organ delivery.
- **State interest** is already evident — NASAO testified before Congress that states are "very interested in the use of AAM for aeromedical activities," specifically citing a state-owned helicopter air medical program preparing for eVTOL fleet transition.

Why It Matters for EMS Systems

State EMS offices retain clinical and personnel governance authority over air medical services — medical direction, licensure, protocols, quality assurance, and crew standards — regardless of airframe. The existing regulatory architecture will still apply to eVTOL operations in medical roles, but it was built around the fixed-wing and rotorwing platforms that have defined air medical service for decades. eVTOL introduces:

- **A community-based air medical model.** Lower acquisition, operating, and infrastructure costs than helicopters could distribute air medical resources more broadly, including to rural hospitals, regional health centers, and clinics.
- **Expanded interfacility transport capacity.** The economics favor the highest-volume segment of air medical operations — interfacility hospital transfers — particularly for time-sensitive transfers between rural facilities and tertiary care centers.

- **Access to care in underserved areas.** eVTOL offers a potential new layer of capability in ambulance deserts and frontier communities where ground transport times of two to three hours are common and existing air medical options are impractical.
- **Increased interstate clinical volume.** As eVTOL expands the operational reach of air medical services, interstate medical missions — and the Compact’s role in facilitating them — will grow. The Compact’s existing framework accommodates this growth; volume is the change, not mechanics.
- **Parallel drone developments.** UAS programs raise many of the same questions on a compressed timeline and are already deploying under existing FAA authorities. The pending Part 108 BVLOS rule will expand scale and geographic reach once finalized.

Anticipated Timeline

Timeframe	Expected Activity	EMS System Impact
2026	Demonstration flights begin; medical cargo demos in select states; drone medical delivery programs expand	Awareness phase; state EMS offices may receive inquiries
2027–2028	First FAA type certifications (fixed-wing); initial commercial cargo ops; medical cargo corridors may begin operating	Medical logistics begin shifting; Compact may receive personnel practice questions
2028–2030	VTOL type certifications; air medical operator fleet integration; eVTOL interfacility patient transfers may commence	Direct EMS system impact: medical direction, clinical protocols, dispatch integration, and interstate personnel practice questions become operational
2030+	Scaled operations per DOT National Strategy; potential autonomous medical logistics	Full integration required across Compact processes, state EMS regulations, and medical oversight frameworks

All dates are subject to FAA certification timelines, which have historically experienced delays across the eVTOL sector.

Recommended Posture

No action is requested at this time. The full briefing recommends that the Commission:

- **Monitor** — the Executive Director will continue tracking AAM developments with direct relevance to EMS systems and interstate personnel practice and provide periodic updates as warranted.
- **Connect** — State EMS Officials are encouraged to verify whether their state’s EMS office is aware of and connected to any AAM planning activities occurring through their state’s aviation or transportation agency.
- **Anticipate** — the Commission should anticipate that air medical operators, state EMS offices, and federal partners will begin raising questions about how EMS system governance — including Compact-facilitated interstate practice — applies to eVTOL medical operations within the next two to three years.
- **Engage when appropriate** — as the federal AAM planning process matures, the Commission should evaluate whether formal engagement with the FAA, DOT, or HHS is warranted to ensure EMS system governance considerations are represented in national AAM policy development.

Full briefing available on request. Complete citations to Congressional transcripts, FAA regulatory artifacts, SEC filings, and federal policy documents are contained in the original February 14, 2026 briefing.

National Trauma and Emergency Preparedness System (NTEPS)

Relevance to the EMS Compact and Commission Operations

Overview

In February 2025, the American College of Surgeons (ACS) Board of Regents approved NTEPS V. 2.0, a blueprint requesting Congress establish a **National Trauma and Emergency Preparedness System**. The proposal builds on Regional Medical Operations Coordinating Centers (RMOCCs) to connect daily injury care with mass casualty readiness across the United States. The Commission is in ongoing collaborative conversations with ACS Committee on Trauma leadership and other national partners regarding the RMOCC framework and its intersection with interstate EMS workforce mobility.

Why This Matters for the EMS Compact

NTEPS identifies EMS as a core stakeholder and calls for EMS to be established as an essential service at all levels. Several NTEPS objectives directly depend on capabilities the EMS Compact already provides:

- **Workforce Mobility Without Emergency Declarations.** NTEPS envisions daily coordination of patient movement and transport resources, scalable for mass casualty events. The EMS Compact's Privilege to Practice operates 24/7 without requiring a governor's disaster declaration—filling the gap NTEPS identifies between daily operations and EMAC activation.
- **Military-Civilian Readiness Integration.** NTEPS calls for civilian healthcare facilities to absorb combat casualty surges and for military-civilian coordination. Section 7 of REPLICA and the Compact's military family provisions directly support this objective.
- **Real-Time Data and Situational Awareness.** NTEPS requires comprehensive, real-time data on EMS resources and personnel. The National EMS Coordinated Database (NEMSCD) already provides the licensure data layer—covering 25 member states with validated credential and disciplinary information—that complements the resource and capacity data NTEPS envisions.
- **Interstate Investigation and Public Protection.** NTEPS emphasizes coordinated response across jurisdictions. The Compact's adverse action reporting (within two business days), cross-state investigative cooperation, and the NEMSCD's public validation tools provide an existing interstate accountability framework.

Commission Positioning

The EMS Compact and its Commission represent **existing, operational infrastructure** that supports NTEPS objectives without requiring new federal legislation for workforce mobility. As Congress considers the NTEPS proposal, the Commission is positioned as a proven model of interstate coordination—established by state law, governed by appointed commissioners, and operating a national coordinated database—that aligns with the collaborative, multi-stakeholder framework NTEPS envisions.

The Commission's ongoing engagement with ACS COT and other national partners ensures that the EMS Compact's capabilities are represented in these conversations. Commissioners should be aware of NTEPS as a developing federal initiative and the Commission's active role in shaping how interstate EMS workforce considerations are addressed within it.

For questions or additional information, contact the Commission office.

2026 Annual Threat Assessment — EMS Implications

Policy Summary for EMS Compact Commissioners

Overview

In March 2026, the Office of the Director of National Intelligence published the *Annual Threat Assessment of the U.S. Intelligence Community*, the IC's official evaluation of threats to U.S. citizens, the Homeland, and U.S. interests worldwide. This summary extracts the findings most relevant to EMS operations, emergency preparedness, disaster response, and the Commission's strategic positioning.

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Commission Positioning

The EMS Compact and its Commission represent **existing, operational infrastructure** that directly supports multiple national security objectives identified in the 2026 ATA. Unlike proposals that require new federal legislation or appropriations, the Compact already provides interstate workforce mobility, real-time credential verification, and cross-jurisdictional accountability. These are the capabilities the threat environment increasingly demands.

As the Commission engages with Congress, federal agencies, and national partners on initiatives such as NTEPS, the Rural Health Transformation Program, and federal sustainment funding, the 2026 ATA provides [REDACTED] workforce development goals but also homeland security and national defense objectives.

Recommended Commissioner Actions

1. **Legislative Awareness** [REDACTED]
2. **Tabletop Exercise.** [REDACTED]
3. **Cybersecurity Assessment.** [REDACTED]
4. **Fentanyl Intelligence Sharing.** [REDACTED]
5. **Federal Funding.** [REDACTED]

Source: Office of the Director of National Intelligence, 2026 Annual Threat Assessment of the U.S. Intelligence Community (Unclassified), March 2026. Information available as of 14 March 2026 was used in preparation of the source assessment.

For questions or additional information, contact the Commission office.

Commissioner Appointment Memo Template

*** TEMPLATE ***

To: Donnie R. Woodyard, Jr., Executive Director
Interstate Commission for EMS Personnel Practice
5010 E. Trindle Rd, Suite 202
Mechanicsburg, PA 17050

From: <<Governor, Cabinet Secretary, or Governor Delegate>>

Subject: Notification of Commissioner Appointment Memo

In accordance with Section 10.B.1 of the Recognition of EMS Personnel Interstate Compact ("REPLICA") model legislation, as enacted in [STATE] Code § [XXX], the State of [STATE] hereby designates [NAME] as the delegate ("Commissioner") to the Interstate Commission of EMS Personnel Practice.

[STATE] Code § [XXXXX] outlines the guidelines for the appointment of the delegate as follows:

"Each member state shall have and be limited to one (1) delegate. The responsible official of the state EMS authority or his designee shall be the delegate to this compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office, or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the governor of the state will determine which entity will be responsible for assigning the delegate."

Commissioner Duties and Responsibilities

The role of the Commissioner is recognized as a vital part of the official duties and responsibilities of the state employee. Commissioners play a critical role in the governance and operations of the Interstate Commission.

Key responsibilities include:

- **Mandatory Attendance:** Commissioners are required to attend all Commission meetings, which typically include three virtual meetings and one in-person meeting annually.
- **Non-Delegable Vote:** The Commissioner's vote is a unique and critical function that cannot be delegated in their absence.
- **Compliance Oversight:** The Commissioner shall ensure that [STATE] remains in compliance with the requirements of the EMS Compact, as defined in [STATE] Code § [XXXXX], and actively engage in actions necessary to uphold this compliance.

This level of engagement ensures [STATE]'s active participation and representation in matters that influence interstate EMS personnel practice.

Appointment Effective Date



This appointment is effective [Effective Date]. Please update your records accordingly to reflect this designation.

If you need additional information regarding this appointment, please contact [Contact Name] in my office at [Contact Phone Number] or [Contact Email Address].

We appreciate your attention to this matter and look forward to Commissioner [NAME]'s active participation in the Interstate Commission for EMS Personnel Practice.

Executive Committee Service Dates

Chairperson

Name	State	Term
Kraig Kinney	Indiana	July 1, 2023 – Present
Donnie R. Woodyard, Jr.	Colorado	Oct 22, 2022 – June 30, 2023
Joseph Schmider	Texas	Oct 7, 2017 – Oct 22, 2022
Doug Wolfberg, JD	Inaugural Chair	Oct 7, 2017

Vice Chairperson

Name	State	Term
Wayne Denny	Idaho	July 1, 2023 – Present (re-elected Nov 2025)
Kraig Kinney	Indiana	Nov 2, 2022 – June 30, 2023
Donnie R. Woodyard, Jr.	Colorado	Sept 18, 2020 – Oct 22, 2022
Jeanne Marie Bakehouse	Colorado	Oct 7, 2017 – Sept 18, 2020

Treasurer

Name	State	Term
Brad Vande Lune	Iowa	July 1, 2023 – Present
Wayne Denny	Idaho	Nov 6, 2020 – July 2023
Stephen Wilson	Alabama	Oct 7, 2017 – October 2020

Secretary

Name	State	Term
Mark Herrera	Utah	November 2025 – Present
Joseph House	Kansas	April 3, 2020 – November 2025
Andy Gienapp	Wyoming	Oct 7, 2017 – April 2020

Commissioner-At-Large

Name	State	Term
Michael Johnson	Georgia	January 14, 2026 – Present
Aaron Koehler	Wyoming	June 2023 – January 2026
Aaron Rhone	Pennsylvania	Dec 12, 2022 – June 2023
Gary Brown	Virginia	Sept 23, 2021 – Dec 2022
Justin Romanello	New Hampshire	June 16, 2020 – Sept 2021
Donna G. Tidwell	Tennessee	Oct 7, 2017 – June 2020

Immediate Past Chair

Name	State	Term
Joseph Schmider	Texas	Oct 22, 2022 – Present

Model Legislation

As Enacted In:

State	Reference	Effective Date
Alabama	AL Code § 22-18-50 (2022)	May 17, 2017
Arkansas	Ark. Code Ann. § 20-13-1901 et seq.	March 20, 2025
Colorado	CO Rev Stat § 24-60-3502 (2017)	May 8, 2015
Delaware	16 DE Code § 98A-100 (2017)	September 15, 2017
Georgia	O.C.G.A. Title 38, Ch. 3, Art. 4	May 8, 2017
Idaho	ID Code § 56-1013B (2018)	March 16, 2016
Indiana	IN Code § 16-31.5 (2021)	March 11, 2020
Iowa	IA Code § 147D.1 (2020)	March 11, 2020
Kansas	KS Stat § 65-6158 (2021)	March 31, 2016
Louisiana	LA Rev Stat § 40:1141 (2020)	July 1, 2021
Mississippi	MS Code § 41-59-101 (2018)	March 20, 2017
Missouri	MO Rev Stat § 190.900 (2019)	July 9, 2018
Nebraska	NE Code § 38-3801 (2018)	March 20, 2017
Nevada	Nev. Rev. Stat. § 450B	October 1, 2023
North Dakota	ND Century Code § 23-27.1 (2018)	April 1, 2019
Oklahoma	OK Title 63 Section 1-2205	November 1, 2023
Pennsylvania	Pa. Act 35 of 2022	July 7, 2022
South Carolina	SC Code § 44-61-710 (2018)	May 18, 2018
South Dakota	SD Codified L § 34-11C-1 (2022)	March 25, 2021
Tennessee	TN Code § 68-140-602 (2019)	April 19, 2016
Texas	TX Health & Safety Code § 778A.001 (2021)	September 1, 2015
Utah	Utah Code § 53-2e-101 (2017, rev. 2024)	March 21, 2016
Virginia	VA Code § 32.1-371 (2020)	March 1, 2016
West Virginia	WV Code § 16-60-1 (2020)	March 5, 2020
Wyoming	WY Stat § 33-36-201 (2022)	March 21, 2016

Position Papers

Official positions of the Commission



INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

Biometric Criminal History Checks for EMS Personnel

POSITION PAPER 2023-01 | APPROVED 6 DEC 2023

Introduction

EMS Practitioners, including Emergency Medical Technicians (EMTs), Advanced EMTs, and Paramedics, are integral to the health and safety of the American public and visitors. The practice of EMS requires frequent unscheduled interactions with patients in a variety of settings, and frequently the encounters may require individual, one-on-one care of vulnerable populations. As such, a high level of trust is placed in every EMS professional. This position paper reinforces the need for all states, territories, and jurisdictions to urgently implement uniform Federal Bureau of Investigation (FBI) compliant biometric criminal history records checks for all individuals seeking licensure as an EMS Practitioner in the United States.

The Imperative for Uniform Standards

Multiple Supreme Court decisions clearly established that states have the authority and responsibility to protect the public, and this is – in part – accomplished through the formal issuance of licenses to medical professionals, including EMS practitioners. The Supreme Court has affirmed that a state’s licensing responsibility not only includes evaluating an individual’s knowledge, skills, and abilities but also their character attributes. Today, meeting this standard and public expectation requires state officials to review primary source criminal history information via a biometric FBI compliant criminal history check. Reliance on self-disclosure for criminal background is both ineffective and unreliable.

In 2014, national EMS leadership organizations collaborated to write the Model Legislation for the Recognition of EMS Personnel Practice Interstate Compact (REPLICA) – the EMS Compact. This legislation requires all Compact Member States to perform an FBI compliant biometric criminal history check, as a prerequisite for state licensure. As of November 2023, 24 states have adopted this Model Legislation. While the majority of Compact Member States have already implemented this requirement, the remainder of Member States have until March 2025 to achieve compliance with this requirement. While some non-Compact states have voluntarily implemented this requirement, there is currently no uniform requirement for non-Compact states. The EMS Compact urges all states, territories, and jurisdictions to urgently implement uniform FBI-compliant biometric criminal history checks for all individuals seeking licensure as an EMS Practitioner in the United States.

Core Justifications

- Commitment to Public Health, Safety, and Welfare
 - The foremost priority of the collective profession is to protect the public. A uniform background check ensures that state/territory personnel have reliable, primary-source information available when making licensure decisions.
- Upholding Professional Standards and Ethics
 - EMS personnel are expected to adhere to a professional standard. Uniform background checks enhance the credibility and trustworthiness of the profession.
- Necessity of Public Trust
 - Emergency medical services operate on the premise of public trust. Standardized criminal history checks are vital for maintaining this trust and enabling informed decisions by state licensing officials.

- Unique Challenges of EMS Service Delivery
 - Unlike other professions, EMS personnel often serve patients in unscheduled, urgent situations where individuals are extremely vulnerable and cannot pre-research or choose their EMS providers.

Recommendations

- **Uniform Standard:** A biometric, FBI-compliant criminal history check should be universally required as a prerequisite prior to issuing new licenses (including state-issued certifications) for EMS Personnel in all states and territories.
- **Primary Source Data:** States should make licensing decisions based on primary source data that is securely transferred directly from the primary source (FBI) to the state licensing office. The primary source data evaluated by the state/territory licensing official should include, at minimum, the results of an FBI compliant criminal history records check.
- **Continual Feedback:** State and territory licensing offices should, when possible, enroll in the FBI Rap-Back service so that the licensing official is notified if the applicant engages in criminal activity where fingerprints are taken and reported to the national system. Rap-Back reduces the need to re-fingerprint EMS personnel and saves time and money.
- **State Sovereignty:** The mere presence of a criminal conviction should not serve as an automatic disqualification. States should have the ability to make informed decisions based on their laws, regulations, adopted policies and practices.

Call For Action

Representing the EMS Compact Member States, we urge every state and territory across the United States to adopt mandatory policies that require FBI-compliant biometric criminal history screenings for EMS licensure. This action is crucial for public health and safety and reflects the rigorous standards of medical professional credentialing. By uniting under this practice, we reinforce our collective commitment to earn and maintain the public's trust, an essential foundation of our profession.

We implore state legislatures to promptly update their laws, ensuring biometric, FBI-compliant checks are fundamental to EMS licensure, thus upholding the highest safety and trust standards. Join us in affirming this commitment.

Historically, the U.S. legal system, supported by Supreme Court rulings, has recognized that medical licensure must consider more than just professional knowledge—it must integrate a comprehensive assessment of factors critical to the public's well-being. In emergency medical services, where situations are unpredictable and time-sensitive, the public's unwavering trust is imperative.

As many states have already incorporated this requirement, we call upon all states and territories to unify these efforts into a national standard to guarantee consistency, trust, public protection, and professional accountability in our national EMS system.

Disclaimer: The position papers produced by the Interstate Commission for EMS Personnel Practice are designed to document the official positions of the Commission. It is important to note that these position papers are not administrative rules and do not possess any enforceable authority. Instead, they are intended to provide perspectives and insights on various matters of policy. These documents are meant to guide and inform but should not be mistaken for legally binding regulations or mandates.

Clarifications & Discussions on Restricting the Privilege to Practice

Position Paper 2024-01

Adopted by the Commission on 14 May 2024

This position paper provides a comprehensive overview and guidance for Commissioners concerning a scenario that has implications for the Privilege to Practice under the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA). It includes background information, a detailed discussion, foundational insights, and specific recommendations from the Executive Director. The central goal of this document is to foster a consistent and unified interpretation and application of key terms and provisions across all member states. Such consistency is crucial for preserving the integrity of multistate collaboration and ensuring effective regulation within the EMS framework. By harmonizing these interpretations, the memorandum equips Commissioners with the necessary insights to apply these provisions judiciously and uniformly, thereby enhancing public health and safety through the regulated practice of EMS professionals across member states. Additionally, this memo may prompt the Commission to consider whether further Administrative Rules, policy adjustments, or the development of position papers on this topic are necessary.

Scenario at Question

The Executive Committee recently reviewed a situation concerning an EMS Practitioner licensed in two Member States, Kansas and Missouri. The practitioner voluntarily requested an inactive license status in Kansas. According to guidance from the Kansas EMS Authority, EMS practitioners with such status are prohibited from identifying as or working as an EMS practitioner in Kansas. Consequently, Kansas designated the practitioner's Privilege to Practice status as "No Privilege to Practice." Meanwhile, the practitioner maintained an active, unrestricted license in Missouri, which was in good standing and had a Privilege to Practice status listed as "Yes/Active." The National EMS Coordinated Database confirmed that no discipline was reported against the Missouri license, thus the overall Privilege to Practice status was considered "Active." Despite the inactive status in Kansas, the practitioner wished to utilize the EMS Compact's Privilege to Practice, by virtue of their active Missouri license, to continue working in Kansas. Additionally, this case prompted further consideration of Section 8.B.2 of the model legislation, which addresses the restoration of an individual's Privilege to Practice under specific conditions.

This scenario highlighted four important areas for clarification:

1. Can an EMS Practitioner utilize a Privilege to Practice, granted by a second Home State, to practice in a Home State where their license status is inactive?
2. Is a voluntary change of license status to inactive in a Home State, which restricts or limits practice in that Home State, considered an Adverse Action?
3. Should this voluntary, non-disciplinary related action globally restrict a Privilege to Practice status in the same manner as disciplinary-related Adverse Actions?
4. Can an individual with a restricted license in a Home State, practice in a Remote State?

Definitions

Key definitions in the Model Legislation pertinent to this discussion include:

- **Adverse Action (Section 2[B]):** is defined as “any administrative, civil, equitable or criminal action permitted by a state’s laws which may be imposed against licensed EMS personnel by a state EMS authority or state court, including, but not limited to, actions against an individual’s license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual’s practice, letters of reprimand or admonition, fines, criminal convictions and state court judgments enforcing adverse actions by the state EMS authority.”
- **Home State (Section 2[G]):** is defined as “a member state where an individual is licensed to practice emergency medical services.”
- **Remote State (Section 2[M]):** is defined as “a member state in which an individual is not licensed.”
- **Restricted (Section 2[N]):** is defined as “the outcome of an adverse action that limits a license or the Privilege to Practice.”

Model Legislation

The pertinent sections of REPLICA that provide a framework for understanding and managing the Privilege to Practice include:

- **Section 4.A** mandates Member States *shall* recognize the Privilege to Practice of individuals licensed in another Member State. However, this recognition is subject to certain conditions and limitations aimed at safeguarding public health and safety.
- **Section 4.E** clarifies that a Home State license which is “restricted or suspended” renders the individual ineligible to practice in remote states under the Privilege to Practice until the Home State license is restored.
- **Section 8.B** outlines the procedures for addressing Adverse Actions and limitations imposed by a Home State on an individual’s license, providing a mechanism for the exercise of the Privilege to Practice, subject to authorization by both the Home State and Remote State authorities.

Question 1:

Can an EMS Practitioner utilize a Privilege to Practice, granted by a second Home State, to practice in a Home State where their license status is inactive?

To address this question, it is crucial to understand the definitions of a Home State and a Remote State as outlined in the Model Legislation. The EMS Compact provides a qualified EMS practitioner with a Privilege to Practice in Remote States. Remote States are defined as “Member States in which the individual is *not licensed...*”

In this scenario, although the EMS practitioner holds an inactive license from Kansas, the state is still considered a Home State, since the individual holds a license there, rather than a Remote State. The EMS Compact uniquely allows an individual to have multiple Home States, which are not defined by residency or workplace affiliations.

Consequently, the Privilege to Practice is only authorized in Remote States, provided the EMS Practitioner meets the provisions outlined by the EMS Compact. As Kansas is not a Remote State for this practitioner, the Privilege to Practice does not apply here.

Question 2:

Is a voluntary license restriction (like a status change to inactive, which restricts or limits practice) considered an Adverse Action?

Adverse Actions, as defined in the Compact and imposed by Member States, can significantly impact an EMS practitioner’s Privilege to Practice in Remote States under REPLICA. It is mandatory for any limitations that affect the Privilege to Practice status to be communicated across all Member States via the National EMS Coordinated Database, ensuring integrity in national EMS practice.

Voluntary vs. Imposed Restrictions

The scenario detailed in this memo raised concerns in which an EMS practitioner’s license is limited due to voluntary reclassification of that license by the practitioner to inactive status, which is an option expressly afforded to EMS practitioners in that state through duly-enacted regulations.¹ For instance, an EMS practitioner electing an ‘inactive’ license status in a jurisdiction that prohibits practice under this status prompts the question: Does such a voluntary, non-disciplinary action qualify as a “restricted” license under the EMS Compact, and consequently, should this impact the Privilege to Practice in Remote States?

Definition of Adverse Action

The determination of whether a license restriction qualifies as an Adverse Action under the Model Legislation is a critical issue for Member States. Adverse Actions are described as “any administrative, civil, equitable, or criminal action permitted by a state’s laws which may be imposed against licensed EMS personnel...” The phrase “*imposed against*” implies that Adverse Actions are compulsory, distinguishing them from voluntary decisions by the EMS practitioner, such as self-selecting an inactive license status when that option is afforded the practitioner under state law or regulations. While Adverse Actions include disciplinary license restrictions and may extend to negotiated license statuses following an inquiry (e.g., consent agreements), voluntary changes to license status by the practitioner are generally not considered “imposed” and, therefore, should not be categorized as Adverse Actions under the EMS Compact.

¹ Kan. Admin. Regs. §109-6-4 provide as follows: “[b]efore expiration of an active certificate, any emergency medical service provider may apply for an inactive certificate on a form provided by the board. The application shall be accompanied by the inactive certificate fee...”

Consideration of Section 4.E.

Section 4.E of the Model Legislation clearly states,

"If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored."

While this provision might initially suggest that any form of restriction, such as the inactive status of the Kansas license, would disqualify an individual from practicing in a remote state, it is essential to consider the specific definition of 'restricted' within the context of the EMS Compact legislation. 'Restricted' is precisely defined as "the outcome of an adverse action that limits a license or the Privilege to Practice." Since the restriction in this scenario was not the outcome of an Adverse Action, Section 4.E does not apply.

Adverse Action Consequences & Reporting Requirements

State EMS Authorities must ascertain whether an Adverse Action affects the Privilege to Practice and report this to the Commission per Section 8.B.1 of the Model Legislation. This section mandates that "All Home State Adverse Action orders *shall* include a statement that the individual's compact privileges are inactive. The order may allow the individual to practice in remote states with prior written authorization from both the home state and remote state's EMS authority." This underscores the responsibility of Home State EMS Authorities to determine the impact of Adverse Actions and emphasizes the necessity for clear and consistent communication. All Adverse Actions and limitations on the Privilege to Practice must be documented in writing to the affected EMS Practitioner *and* reported to the Commission via the National EMS Coordinated Database.

Question 3

Should this voluntary, non-disciplinary related action globally restrict a Privilege to Practice status in the same manner as disciplinary-related Adverse Actions?

Determination of an Adverse Action

The responsibility for determining whether licensure statuses and actions by the State EMS Authority qualify as Adverse Actions, as defined in the REPLICA model legislation and enacted in state regulations, rests with the State EMS Authority itself. While the Commission may offer guidance to promote consistency across states, the ultimate discretion to make and communicate these determinations lies with the State EMS Authority. This approach is communicated to both the EMS practitioner involved and the Commission, affirming the autonomy of State EMS Authorities in these critical regulatory decisions.

While the determination of a reportable "Adverse Action" is, by necessity, the responsibility of each Member State, the definition of "Adverse Action" is a Compact term. Accordingly, it benefits the administration of the Compact for the Commission to offer guidance so that each state can apply consistent criteria regarding a practitioner's voluntary election of "inactive" license status in a state where that is permitted.

While each state's process for voluntary reclassification of license status must be reviewed individually to determine whether the result is a "restriction" as defined in the Compact and thus constituting a basis for an "Adverse Action," it is the Commission's position that laws and regulations such as the Kansas provision cited above do *not* constitute Adverse Actions for purposes of the Compact. No practitioner who voluntarily elects transfer to inactive status would reasonably anticipate or expect that they would also be voluntarily causing the state to use the Compact to report a disciplinary type "Adverse Action" to a national database that could have significant implications for that practitioner in the future, if they apply for other

professional licenses, security clearances, etc.

Note that, in the specific scenario presented to the Commission at its May 1, 2024 Executive Committee meeting, the practitioner in question possessed a Home State license in another state (Missouri), which maintains the practitioner's eligibility for a Privilege to Practice (since the voluntary transfer to inactive status in Kansas did not constitute an Adverse Action). However, if the practitioner held only one Home State license, and voluntarily elected transfer of that license to inactive status, the practitioner would be ineligible for a Privilege to Practice in *any* Remote State.

Rights of EMS Practitioners

It is important to note that EMS practitioners generally have the right to appeal the State's determination or implementation of what constitutes an Adverse Action, as allowed under applicable state law. This ensures that EMS practitioners can seek recourse in situations where they disagree with the state's decisions.

Role of the EMS Compact Commission

The Commission does not adjudicate or evaluate the correctness of decisions made by state EMS authorities regarding the imposition of license restrictions or the associated Privileges to Practice. Rather, the Commission's role is to report on, and implement the license status and privilege to practice as communicated by the state authorities.

Question 4

Can an individual with a restricted license in a Home State, practice in a Remote State?

In the specific scenario discussed earlier, involving a practitioner with licenses in Kansas and Missouri, this question does not directly apply, as the inactive status of the Kansas license was not classified as an Adverse Action. However, this issue was brought up tangentially during the Executive Committee discussion, leading to a broader examination of the related legal provisions and their implications.

Section 8.B.2 of the Model Legislation introduces a significant relief mechanism that is distinct within the framework of the EMS Compact. This provision allows for a Home State, which took an Adverse Action against the license and also restricted the associated Privilege to Practice, to authorize the practitioner to exercise an authorization to Practice in a Remote State, if the Remote State also authorizes the exercise of the privilege. The purpose of this dual-authorization process is to *potentially restore* the Privilege to Practice specifically in a Remote State, under defined circumstances.

According to Section 8.B.2, "An individual currently subject to adverse action in the Home State shall not practice in any Remote State without prior written authorization from both the Home State and Remote State's EMS authority." This clause sets up a controlled and regulated process where both the Home and Remote States must provide written authorization before a practitioner can practice in a Remote State, despite restrictions in their Home State.

It is crucial to understand that this provision neither compels nor requires Member States to utilize this mechanism. The core principle underlying the EMS Compact is the respect for State sovereignty in making licensure decisions. This respect is preserved, as the mechanism does not force any state to engage in this practice but rather offers it as an optional tool. Moreover, this provision does not prevent an individual from seeking licensure directly in any Remote State, nor does it stop a Remote State from requiring an individual—who does not have a Privilege to Practice due to restrictions in their Home State—to make a

formal application for licensure should they wish to practice in that state.

This unique provision may serve as a beneficial tool for State EMS Authorities under specific, non-standard circumstances. For instance, it may be applicable in cases where an individual is subject to mandatory administrative actions or other non-criminal or non-public threat situations that necessitate a Home State to restrict a license. By facilitating such a process, the provision underscores the importance of mutual actions among states, which are crucial for maintaining inter-state operational harmony among EMS personnel.

By way of example, this mechanism could be employed in a scenario where an EMS practitioner's license is temporarily restricted in their Home State due to administrative oversights or minor non-criminal infractions that do not necessarily compromise public safety. For example, a state licensing authority may be compelled by their state's law to restrict a license because a licensee is delinquent on child support or student loan obligations. These underlying actions have no bearing on the practitioner's ability to practice safely and in a manner which protects the public. In such cases, if the individual seeks to practice in a Remote State, both states can choose to authorize the individual to practice in the Remote State under specific conditions, thereby ensuring continuity of service and adherence to professional standards.

Section 8.B.2 represents a thoughtful inclusion in REPLICA, providing flexibility and respect for state decisions while upholding the overall integrity of EMS practice across state lines. This provision, while optional, exemplifies the compact's commitment to adaptability and cooperative federalism in the regulation of EMS personnel.

Conclusion

This position paper has outlined the critical aspects of the Privilege to Practice within the framework of the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA), focusing specifically on the nuances of "Adverse Actions" and licensing "Restrictions." Uniformity in interpreting and applying these concepts across all Member States is essential to maintain the integrity and foundational trust that are central to such compacts.

A unique provision of the EMS Compact is Section 8.B.2, which introduces a significant mechanism for restoring a Privilege to Practice authorization under specific conditions, thereby reinforcing respect for state sovereignty and promoting robust interstate cooperation. It is vital for each state to meticulously evaluate whether certain actions constitute Adverse Actions and to assess their impact on the Privilege to Practice. All such evaluations must be promptly and clearly communicated to the affected EMS practitioners and reported to the National EMS Coordinated Database to enhance transparency and consistency across states.

To further ensure uniformity, the Executive Director recommends the adoption of standardized language concerning the Compact and Privilege to Practice statuses in all State EMS Authority Adverse Action orders. This step is crucial for safeguarding public health and safety by effectively regulating EMS practices.

Privilege to Practice Code of Conduct

Position Paper 2024-02

Adopted By the Commission on 16 October 2024

Medical professions adopt codes of conduct to reinforce expectations, establish, and maintain professional standards of behavior and ethical conduct. These codes serve as guidelines that outline the expected conduct, responsibilities, and ethical principles that healthcare professionals should adhere to in their practice. The Hippocratic Oath, which is one of the oldest and most well-known codes of conduct in healthcare, has been a guiding principle for physicians for centuries. Its emphasis on ethical principles such as confidentiality, honesty, and respect for patients has influenced the development of modern codes of conduct for healthcare professionals.

The EMS Compact is comprised of individually licensed EMS practitioners with a Privilege to Practice in multiple Member States, creating a need for a unified Code of Conduct that is adopted and implemented by all states and jurisdictions licensing EMS personnel. Codes of conduct help in ensuring high standards of behavior and ethical conduct in the field and they serve as a critical tool in maintaining public trust in the profession. Therefore, the EMS Compact has officially adopted this document as the official Code of Conduct for EMS Clinicians utilizing a Privilege to Practice, and the Commission is calling upon all State EMS Licensing authorities to adopt a similar companion Code of Conduct linked to State EMS Licensure.

The following Uniform EMS Code of Conduct was adopted by the Commission on 16 October 2024:

Uniform Code of Conduct

As a professional EMS Practitioner, I commit to upholding the following code of conduct:

- Promote professionalism and provide competent emergency medical care to all people.
- Use my professional knowledge and skills to promote health, alleviate suffering, and do no harm.
- Treat all patients with respect, compassion, and dignity regardless of nationality, race, creed, color, age, gender, disability, religion, or socioeconomic status.
- Assume responsibility to uphold professional standards and education, striving to provide competent medical care to every patient that I encounter.
- Advocate for patients that lack medical decision-making capacity and ensure equal access to medical services.
- Act responsibly, ethically, and lawfully within my training, knowledge, and scope of practice to enhance the reputation of the profession.
- Work cooperatively with other healthcare professionals in the best interests of our patients, and act in a responsible and professional manner that does not discredit or dishonor other health care practitioners.

- Act with honesty by being objective, truthful, and complete. I will include all relevant information in data collection and reporting, statements, applications, and testimony, and acknowledge errors and will not distort or alter facts.
- Respect every person’s right to privacy by maintaining confidentiality of my patient’s condition and history to those only in the medical field with an immediate need-to-know.
- Exercise a level of care and judgment consistent with my level of licensure, certification, and training.
- Abide by all applicable state and federal laws, rules, regulations, and permits.

Furthermore, I understand that as an EMS Practitioner licensed in a Member State or utilizing a Privilege to Practice:

- It is my professional responsibility and obligation to read, understand, and comply with all state statutes and regulations related to the provision of Emergency Medical Services in the relevant jurisdiction(s).
- I can only function as an EMS Practitioner if my license is current, and I have authorization from an EMS Agency Medical Director.
- Maintaining my license, tracking my expiration date, and continuing my education is my individual responsibility.

As an EMS Practitioner, I acknowledge and understand that:

- The State may review and request further information for consideration about any violation of any state or federal law, rules, regulations including but not limited to violations that have been dismissed, deferred, or sealed when determining my fitness to practice as an EMS Practitioner.
- Failure to follow this code of conduct provides just cause for disciplinary action by the Department.
- Sanctions or discipline imposed on my license will be a public record and final dispositions will be reported to the National Practitioner Data Bank, the Interstate Commission for EMS Personnel Practice, and the National Registry of Emergency Medical Technicians.

Disclaimer: Position papers produced by the Interstate Commission for EMS Personnel Practice are designed to document the official positions of the Commission. It is important to note that these position papers are not administrative rules. Instead, they are intended to provide perspectives and insights on various matters of policy. These documents are meant to guide and inform but should not be mistaken for legally binding regulations or mandates.



INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

Position Paper 2025-01

EMS Workforce Privacy Protection

Adopted by the Commission on February 19, 2025

Introduction

The Interstate Commission for EMS Personnel Practice ("Commission") is committed to the bold protection of all EMS Clinician data. This position paper outlines the critical need to safeguard Personally Identifiable Information (PII) and bulk licensure data of EMS Clinicians, reinforcing the foundational principles of the EMS Compact while calling for consistent standards and practices across all states and State EMS Offices. This effort aligns with federal laws, best practices, and the growing necessity to mitigate risks posed by nefarious actors.

Background

EMS Clinicians play a vital role in protecting public health and safety. The EMS Compact facilitates the cooperation of member states in licensure and regulation, enabling the seamless exchange of information regarding EMS personnel licensure, adverse actions, and significant investigatory details. However, the increasing digitalization of data and the proliferation of cyber threats expose EMS Clinicians to risks such as identity theft, doxxing, and coordinated attacks by malicious actors.

The Commission also recognizes that thousands of EMS Clinicians have primary employment roles beyond EMS, including positions as military personnel, law enforcement officers (local, state, federal), and other federal employees. These dual roles highlight the diverse responsibilities EMS Clinicians undertake, with their licensure being an essential component of their duties. These additional roles are integral to national security preparedness and response efforts. Licensure records for these individuals are often co-located with those of non-military EMS Clinicians. Federal laws, such as the Privacy Act of 1974 and Department of Defense regulations, mandate additional protections for these records, which must be upheld while balancing the need for transparency and public access to essential licensure information.

We recognize the public needs the ability to confirm licensure status of EMS clinicians, this is paramount to consumer protection and transparency. This, however, must be carefully balanced with the need to protect the EMS workforce and emerging national security threats.

The Case for Protecting EMS Clinician Data

The federal government defines PII as protected information. The Commission aligns with this federal definition and considers the following EMS Clinician data as PII, which should be strongly protected, and generally not released, as part of public records requests:

- Social Security number (SSN), passport number, driver's license number, taxpayer identification number.
- Personal address, personal email addresses, and personal phone number.

- Biometric records such as photographic images (especially of face or other distinguishing characteristics), fingerprints, retina scans, voice signatures, and facial geometry.
- Bulk information that, when combined with other request details, can easily identify specific EMS Clinicians. Examples may include: date of birth, place of birth, race, religion, geographical indicators, employment information, or education information.

Misuse of PII can lead to:

- Financial loss, identity theft, and harassment for individuals.
- Reputational damage, legal liability, and administrative burdens for organizations.

In the context of EMS Clinicians, excessive release of bulk data, including detailed PII, exposes them to heightened risks such as doxxing and coordinated large-scale attacks by terrorists or adversaries. Such scenarios are unacceptable and underscore the need for robust data protection measures.

Recommendations

To address these challenges, the Commission calls upon all State EMS Offices, including EMS Compact Member States and non-member states, to adopt the following measures:

1. Vigilance Against Nefarious Intent:
 - Be vigilant when responding to requests for bulk data to identify potential malicious intents.
 - Seek assistance from the Department of Justice (DOJ) and FBI to vet any foreign actors or their agents requesting bulk data.
2. Protection of PII:
 - Ensure PII is not disclosed improperly.
 - Prevent the unauthorized release of military or federal agency affiliation for EMS Clinicians with such affiliations. All bulk data must adhere to federal privacy protection requirements.
3. Standardization of Public Portals:
 - Create consistent public portal standards to validate EMS Clinician licensure and EMS Compact Privilege to Practice (PTP) status.
 - Allow searches by:
 - First and last name.
 - State issued EMS license number.
 - National EMS ID number.
 - Prohibit Boolean wildcard searches (e.g., First Name: A*, Last Name: S*) and bulk data disclosures.
 - Restrict the public display of information to the following:
 1. First and last legal name on record.

2. State/jurisdiction of licensure.
3. License level.
4. License expiration date.
5. License status (e.g., active, expired, restricted, revoked).
6. Final agency action information, if applicable, available and authorized.

4. Alignment with Federal Standards:

- Recognize the federal definition of PII as protected information and adhere to its associated safeguards.
- Implement privacy protections aligned with the Privacy Act of 1974, ensuring data is collected, maintained, and disclosed responsibly.

Position

Therefore, it is the position of the Commission that all states should take action to protect EMS Clinicians' data while ensuring the public's ability to validate licensure and authorization to practice.

- States must thoroughly validate that all data requests are not originating from foreign sources, or agents of foreign sources.
- States should ensure robust procedures are in place to confirm the legitimacy of data requestors.
- States must prohibit the release of Personally Identifiable Information (PII) as part of public records requests.
- States should ensure all military and federal employee EMS licensure data are handled in compliance with federal laws and regulations.
- States must establish standard protections and review processes for all bulk data requests, ensuring alignment with federal guidelines and best practices.
- States should review state laws to ensure EMS Clinicians have the same data privacy protection afforded to law enforcement, public health, and elected officials.

By implementing these recommendations, states can maintain a critical balance between transparency and security, safeguarding the personal and professional well-being of EMS Clinicians. This approach not only fulfills the purposes of the EMS Compact but also addresses the evolving challenges of data security in a digital age.

Position Paper: Criminal Convictions and Licensure of EMS Personnel

Position Paper 2026-01

A position paper is a formal document that outlines an organization's stance on a specific issue, supported by research and analysis, with the goal of influencing decision-making or advocating for policy changes. It serves to clarify and communicate the organization's viewpoint to stakeholders, policymakers, and the public, while often calling for specific actions or solutions to address the issue. Position papers are essential tools for driving discussions, informing stakeholders, and promoting thoughtful, data-driven decisions.

Executive Summary

The Public Trust in Emergency Medical Services

When someone calls 911, they place their life —and often the lives of their loved ones —in the hands of strangers. Unlike scheduled medical care, where patients may research and select their physician, or personal services where families choose childcare providers, emergency medical care is unscheduled, urgent, and delivered by whoever arrives first. There is no choice, no interview, no background check by the patient. In moments of crisis—a cardiac arrest, a serious injury, a medical emergency—the public grants EMS clinicians nearly universal trust: to enter homes, treat vulnerable individuals, make rapid life-altering decisions, and act with both authority and compassion.

That level of public trust must be earned and protected. It depends on knowing that every licensed¹ Emergency Medical Technician and Paramedic² has been thoroughly vetted and meets consistent ethical, professional, and moral character standards. Yet today, each state applies different rules when evaluating criminal convictions during licensure, creating inconsistencies in how the public is protected across state lines and confusion for both applicants and licensing officials.

A Framework for Protection and Fairness

This position paper presents a consensus-driven framework for Criminal Convictions and Licensure —a data-driven, evidence-based, and constitutionally grounded approach for states to evaluate applicants with criminal histories. Drawing on survey data from Compact member states, established legal precedents, and criminological research on recidivism and rehabilitation. This framework achieves three critical goals:

First, it protects the public by clearly identifying offenses that permanently disqualify individuals from licensure or interstate practice, applying time-tested standards to serious felonies, and requiring thorough background checks and ongoing monitoring.

¹ In this paper, the term “licensed” is used universally to denote a state-granted legal authorization to practice. Some states use alternate terminology, such as “certification” or “state EMS certification,” when referring to the same legal authority to engage in the practice of emergency medical services.

² For the purposes of this paper, references to “EMS Clinician” or “EMTs and Paramedics” include all levels of licensed emergency medical services personnel, including but not limited to Emergency Medical Technicians (EMTs), Advanced Emergency Medical Technicians (Advanced-EMTs), Paramedics, and any levels of licensure between EMT and Paramedic.

Second, it promotes fairness and recognizes rehabilitation by allowing individuals who have demonstrated genuine change to re-enter the profession, establishing clear pathways based on evidence rather than arbitrary barriers, and ensuring due-process protections for all applicants.

Third, it preserves state sovereignty by providing model guidance that states may voluntarily adopt while maintaining each state's independent constitutional authority to determine who may hold an EMS license within its jurisdiction.

The Provisional Privilege Mechanism

The framework also provides clear guidance on the Provisional Privilege to Practice mechanism established in the Commission's Administrative Rules. This innovative approach allows states to maintain full licensing authority while ensuring enhanced scrutiny for interstate practice when an individual's criminal history raises legitimate public safety concerns. Under this system:

- **Home states retain exclusive authority** to license EMS personnel based on their own standards.
- **Individuals with potentially serious criminal histories** who are licensed as an EMS Clinician by one or more states receive "Provisional" rather than automatic interstate recognition.
- **Remote states individually evaluate** whether to grant interstate practice privileges.
- **Public safety is enhanced** through transparency and state-by-state review
- **Rehabilitation pathways remain open** for those who demonstrate sustained positive conduct

This mechanism respects the reality that states may reach different conclusions about an individual's fitness for practice while ensuring that no state is required to automatically recognize a license that does not meet its own public protection standards.

A Call for Consistency Without Uniformity

The United States EMS Compact exists to facilitate workforce mobility and strengthen public protection through state cooperation; not to federalize EMS regulation or override state sovereignty. This framework embraces that principle. It does not mandate that all states adopt identical standards. Instead, it provides a research-based, legally defensible model that states can adapt to their own constitutional structures, statutory frameworks, and policy priorities.

What the framework does require, because the state's Compact legislation mandates it, is compliance with certain baseline protections: FBI fingerprint-based background checks for initial licensure, timely reporting to the National EMS Coordinated Database, and fair evaluation procedures for interstate practice privileges. These are not recommendations. They are legal obligations that all member states accepted when they enacted the Compact into law.

The Bottom Line

Together, these standards ensure that no matter where a 911 call originates, the patient can trust that the EMS clinician who responds has been thoroughly evaluated, properly licensed, and held accountable to transparent standards. They ensure that individuals with criminal histories are neither automatically excluded from public service nor granted the privilege of patient care without demonstrating genuine rehabilitation. And they ensure that states can cooperate effectively across borders while maintaining the independence guaranteed by the Tenth Amendment.

The framework presented in this position paper represents a commitment by the Interstate Commission and all Compact member states to protect the sacred trust that the public places in EMS personnel every time they call for help. It recognizes that trust must be earned through rigorous standards, maintained through continuous accountability, and renewed through evidence that every licensed clinician is worthy of the responsibility they carry.

When someone's life hangs in the balance, they deserve nothing less.

Document Purpose and Use

This position paper is intended to:

- **Inform state policymakers** about constitutional authority, legal precedents, and evidence-based practices
- **Guide state licensing officials** in developing or refining criminal history evaluation procedures
- **Clarify Compact obligations** regarding background checks, data reporting, and privilege recognition
- **Provide transparency** to applicants, employers, and the public about how criminal convictions affect licensure
- **Establish accountability** through recommended reporting standards and continuous improvement mechanisms

States retain complete discretion to adopt, modify, or exceed these recommendations while fulfilling their mandatory obligations under REPLICA and Commission Administrative Rules.

1. Purpose

The United States EMS Compact exists to strengthen public protection and workforce mobility through lawful cooperation among states. As stated in Section 1 of the *Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA)*, the Compact is designed to "facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties" while ensuring "states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel."

This model policy helps states:

- **Protect the public** by identifying offenses that disqualify applicants from EMS licensure or interstate practice.
- **Promote fairness** by recognizing legitimate rehabilitation and due process.
- **Ensure consistency** across states while preserving each state's independent licensing authority.
- **Provide clear guidance** to state EMS officials, policymakers, and the public.
- **Implement Compact requirements** regarding criminal background checks as mandated in Section 3.C.4 of REPLICA.

2. Legal and Ethical Foundation

State Authority to License Health Professionals

The authority to license and regulate health professionals—including physicians, nurses, Emergency Medical Technicians, and Paramedics—belongs solely to the states. This authority arises from the Tenth Amendment to the United States Constitution, which reserves to the states the power to make and enforce laws protecting the health, safety, and welfare of their citizens. This concept, often referred to as a state's "police power," forms the constitutional basis for professional licensure and public health regulation.

Unlike federal powers such as defense or foreign affairs, the licensing of healthcare personnel has always been a state responsibility. Each state legislature creates statutes defining qualifications for licensure, establishes licensing boards, and enforces disciplinary standards. There is no federal medical or EMS license. States determine who may legally practice within their borders.

Emergency Medical Technicians and Paramedics fall under this same authority. Their education, examination/verification of knowledge, licensure, scope of practice, and moral character requirements are governed by state law. The United States EMS Compact functions within this framework. It does not replace or federalize state control; instead, it allows states to mutually recognize each other's licenses for cross-border practice while retaining full sovereignty over licensure decisions.

This cooperative model is authorized by the Compact Clause of the U.S. Constitution (Article I, Section 10, Clause 3), which allows states to enter into agreements with one another, provided their legislatures approve them. Through the Compact, states agree to shared procedures for interstate practice, but each state continues to determine who is licensed, who is disciplined, and under what conditions.

In summary:

- Licensure is created and governed by state law.
- Compact participation is a voluntary contract between states.
- Interstate privilege exists only while the home-state license remains valid.

This structure preserves state sovereignty and ensures that the Compact strengthens, rather than limits, each state's independence.

Judicial Precedents Supporting State Authority

Two landmark U.S. Supreme Court cases still define how states exercise this authority when considering criminal history:

1. ***Dent v. West Virginia (1889)*** – The Court affirmed that a state may require training, examination, and good moral character as conditions of medical licensure. Licensing is a legitimate use of state police power to protect public health and safety.
2. ***Hawker v. New York (1898)*** – The Court upheld a law denying medical licensure to a convicted felon, holding that a past conviction can demonstrate unfitness for practice when the offense relates to moral character or patient trust.

These rulings remain the foundation for all healthcare licensing. They establish that:

- States have exclusive authority to determine professional qualifications.
- Licensing standards must have a rational connection to public protection.
- Consideration of criminal history is lawful when directly related to the duties of the profession.

Balancing Public Protection and Rehabilitation

Modern administrative law extends these principles by requiring due process—notice of any proposed denial, an opportunity to respond, and a written explanation of the decision. Fairness and transparency ensure that decisions are protective rather than punitive.

The Compact's model framework embodies this balance. It permanently excludes individuals from an automatic multi-state Privilege to Practice whose crimes make them unfit for patient care, while allowing those who demonstrate sustained rehabilitation to re-enter the profession under careful review.

By reaffirming that licensing is a state power, this framework protects state sovereignty and public confidence. The Compact merely provides a lawful mechanism for cooperation among states exercising that power.

Compact Requirements for Criminal Background Checks

Section 3.C.4 of REPLICA mandates that member states require criminal background checks for initial licensure:

"No later than five years after activation of the Compact, [member states must require] a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation..."

The Compact was activated on March 15, 2020. Therefore, all member states must require FBI fingerprint-based background checks for initial licensure by March 15, 2025. This requirement is now incorporated into state licensure law through Compact enactment.

Definitions

For purposes of this policy:

- **"Conviction"** as defined in Section 2.5 of the Commission's Administrative Rules, means "a finding by a court of competent jurisdiction that an individual is guilty of a criminal offense through adjudication, or the entry of a plea of guilty or nolo contendere (no contest). Conviction also includes a finding of guilt for a Serious Offense under the Uniform Code of Military Justice (UCMJ)."
- **"Conviction Requiring Review"** as defined in Section 2.6 of the Administrative Rules, means "any criminal conviction that may impact an individual's fitness to practice as an EMS Clinician and requires evaluation by a State EMS Authority prior to the issuance or recognition of a license. This includes but is not limited to any Felony conviction; any Serious Misdemeanor conviction; or any conviction involving Moral Turpitude."
- **"Felony"** as defined in Section 2.12 of the Administrative Rules, means "a serious criminal offense that is graded, codified or classified as a felony under the laws of the state in which the defendant was convicted."
- **"Serious Misdemeanor"** as defined in Section 2.26 of the Administrative Rules, means "a criminal offense, classified as a misdemeanor under applicable state law, that involves conduct of a serious nature—such as violence, theft, or other acts that could reasonably be considered to pose a threat to public safety or trust if committed by an EMS clinician."
- **"Moral Turpitude"** as defined in Section 2.16 of the Administrative Rules, means "an act involving baseness, vileness, or depravity in private or social duties that one owes to others or to society, contrary to accepted moral standards, regardless of whether it directly involves EMS practice."
- **"Sentence Completion"** means release from all incarceration, probation, parole, and payment of all restitution and fines.
- **"Clear and Convincing Evidence"** means proof that the fact is highly probable; a standard between "preponderance of evidence" and "beyond reasonable doubt."
- **"Direct Relationship"** means the criminal conduct bears a substantial connection to the duties and responsibilities of EMS practice.
- **"Vulnerable Person"** includes children under 18, adults over 65, individuals with disabilities, and any person receiving medical care.
- **"Privilege to Practice"** as defined in Section 2 of REPLICA, means "an individual's authority to deliver emergency medical services in remote states as authorized under this compact."
- **"Provisional Privilege to Practice"** as defined in Section 2.22 of the Administrative Rules, means "a temporary form of Compact recognition granted to an EMS Clinician who holds a license that meets all but one or more of the criteria for a Qualified License under Rule 4.7(B). Provisional Privilege to Practice is not automatically recognized by Remote States and requires individual state-level review and approval."

3. Findings from Compact State Survey

In 2025, the Commission surveyed all Member States to analyze how each handles criminal convictions in EMS licensure.

Key Disparities Revealed:

- **Mandatory Disqualifiers:** 52% have statutory "shall not license" provisions; 48% have no mandatory disqualifiers
- **Discretionary Review:** 65% use discretionary review with rehabilitation criteria
- **Look-Back Periods:** Range from 5 years to lifetime, with no consensus
- **Interstate Treatment:** 91% treat out-of-state convictions the same as in-state convictions
- **Continuous Monitoring:** Just 35% use Rap-Back³ for ongoing criminal record monitoring
- **Result:** Inconsistent protection across state lines and confusion for interstate practitioners

State Practice Examples:

- **States with Structured Frameworks:** Some member states have established clear statutory disqualifiers, discretionary provisions with rehabilitation criteria, and defined look-back periods (typically 5–7 years).
- **States with Broad Discretion:** Other member states rely primarily on broad discretionary authority with fewer specific statutory criteria for evaluating criminal history.
- **States with Comprehensive Disqualifier Frameworks:** Still other member states maintain comprehensive mandatory disqualifier lists and provide limited opportunities for rehabilitation review for certain criminal offenses.

The survey showed a shared commitment to safety but a wide variation in the methods used. The model policy builds on this data to create a clear, balanced framework that respects diverse state approaches while establishing common ground for public protection and compliance with Compact requirements.

³ Rap Back is a continuous criminal history monitoring service operated by the Federal Bureau of Investigation (FBI) through its Next Generation Identification (NGI) System. Once an individual's fingerprints are enrolled, Rap Back automatically notifies authorized agencies if that individual is later arrested, charged, or has new criminal information added to their FBI record. This allows licensing and regulatory bodies to receive timely updates about criminal activity without requiring periodic re-fingerprinting or relying on self-disclosure by the individual.

4. Guiding Principles

The United States EMS Compact Model Policy on Criminal Convictions and Licensure is built on foundational principles that balance public protection, fairness, and state sovereignty. These principles recognize that when the public calls 911, they rely on state governments to ensure that only qualified, trustworthy individuals are authorized to respond.



Each state retains its constitutional authority to license EMS clinicians, yet through the Compact, states agree to uphold shared standards that protect the public and promote transparency across jurisdictions. The following guiding principles articulate the values and legal framework that inform this model policy and ensure that decisions about licensure and interstate practice remain consistent, equitable, and firmly grounded in law.



1. **Public Safety First** – The public's right to safety and trust takes precedence over any individual's interest in licensure.
2. **Fairness and Rehabilitation** – People can change; policies must allow proof of rehabilitation.
3. **Consistency Across States** – Common language and criteria reduce confusion and strengthen the Compact.
4. **State Sovereignty** – Each state retains full authority to issue, deny, or revoke its own licenses. Membership in the Compact is intended to preserve, not limit, this authority. The Compact does not supplant any state's determination of moral character or qualification for licensure but rather provides a framework for mutual recognition once a state has made its own independent determination.
5. **Transparency and Due Process** – Applicants must know the rules, receive notice, and have the opportunity to appeal.
6. **Compact Compliance** – Member states must fulfill obligations under REPLICA and the Commission's Administrative Rules while exercising their independent licensing authority. Transparency in licensure decisions and Compact data sharing ensures accountability while safeguarding each state's sovereign right to determine who may practice within its jurisdiction.

5. Model Framework for State Adoption

This framework organizes criminal convictions into four distinct tiers based on their relationship to patient safety, the seriousness of the offense, and the potential for rehabilitation. Each tier guides how states should evaluate convictions while preserving state sovereignty in final licensing decisions.

The four-tier structure balances two critical objectives: protecting the public from individuals whose criminal conduct demonstrates permanent unfitness for patient care, while recognizing that many people with criminal histories can successfully rehabilitate and serve their communities as trusted EMS professionals.

Tier	Description
1	<p> Permanent Disqualifiers</p> <p>These are the most serious offenses that demonstrate an irreparable breach of patient trust or permanent risk to public safety. They include sexual crimes (especially against vulnerable persons), abuse of patients, lifetime sex offender registration requirements, and other violent crimes that are generally punishable by life imprisonment or death.</p> <p>Recommended Action: Automatic denial with no rehabilitation review. These convictions warrant permanent exclusion from EMS licensure due to their direct relationship to the core duties and trust inherent in emergency medical care.</p> <p>Compact Status: State licensure is not recommended, but any licenses issued despite Tier 1 convictions automatically trigger Provisional Privilege to Practice, requiring individual remote state approval. Most states should revoke interstate recognition.</p>
2	<p> Time-Limited Disqualifiers (7-Year Look-Back)</p> <p>These are serious felonies and misdemeanors—including drug trafficking, felony assault, major fraud, and felony domestic violence—that warrant automatic denial during a defined look-back period but <i>may</i> permit rehabilitation review after sufficient time has passed.</p> <p>Recommended Action: Automatic denial if within seven years of sentence completion. After the seven-year period, discretionary review is permitted based on clear and convincing evidence of rehabilitation.</p> <p>Rationale: The seven-year standard is supported by criminological research showing significant decline in recidivism after this period. This evidence-based approach acknowledges that sustained offense-free conduct demonstrates genuine behavioral change while maintaining rigorous protection during the highest-risk period.</p> <p>Compact Status: All Tier 2 convictions trigger Provisional Privilege to Practice status, requiring individual remote state evaluation for interstate practice.</p>

Tier	Description
3	<p> Discretionary Review</p> <p>These are lesser felonies and misdemeanors that require individualized assessment based on multiple factors: time since offense, nature and context of the crime, evidence of rehabilitation, and relationship to EMS duties.</p> <p>Recommended Action: Approve, conditionally approve, or deny based on evaluation of specific rehabilitation factors and clear and convincing evidence standard. Written decisions must document findings on each factor considered.</p> <p>Examples: Misdemeanor drug possession (after 5 years), misdemeanor assault (after 5 years), misdemeanor domestic violence (after 7 years), DUI/DWI offenses evaluated case-by-case, and old felonies not listed in Tiers 1 or 2 (after 7 years).</p> <p>Compact Status: Offenses classified as "Serious Misdemeanors" or involving "Moral Turpitude" trigger Provisional Privilege status. Minor offenses that do not meet these definitions may qualify for standard Compact privileges.</p>
4	<p> Non-Considerable Records</p> <p>These are records that generally should not affect licensure decisions: arrests without conviction, dismissed charges, expunged records, most juvenile adjudications, traffic infractions, and convictions for conduct no longer criminalized.</p> <p>Recommended Action: Do not consider in licensing decisions unless state law specifically requires disclosure or unless pending charges suggest ongoing public safety concerns.</p> <p>!! Exception: If an individual has been arrested and charged with a serious offense that has not yet been adjudicated, the state EMS office may—in accordance with state law—temporarily delay licensure action or suspend an existing license until the criminal matter is resolved. This ensures that licensing decisions are based on verified judicial outcomes rather than pending allegations, maintaining fairness to the applicant while prioritizing public safety and protection.</p> <p>!! Exception: Juvenile offenses in Tier 1 categories may be considered if permitted by state law and directly related to patient safety.</p>

How to Use This Framework

For State Licensing Officials:

Each tier includes detailed guidance on recommended actions, required assessment factors (for discretionary tiers), and specific examples illustrating how the framework applies to real-world scenarios. These examples demonstrate both denials and approvals, showing how rehabilitation evidence is evaluated and when conditional licensure may be appropriate.

For Applicants:

This framework provides transparency about how criminal history will be evaluated. Understanding which tier applies to your conviction helps you know whether you're eligible now, must wait a specific period, or should focus on building rehabilitation evidence for discretionary review.

For the Public:

The tier structure ensures that the most serious offenses—those directly threatening patient safety—result in permanent exclusion, while allowing states to recognize genuine rehabilitation for less serious convictions.

Sovereignty and Flexibility

This framework is *advisory, not mandatory*. States retain full constitutional authority to adopt more restrictive standards, establish different look-back periods, or apply different criteria for rehabilitation assessment. What is compulsory under the Compact is:

- FBI background checks for initial licensure (by March 15, 2025)
- Reporting to the National EMS Coordinated Database
- Recognition of Qualified Licenses from other states
- Individual evaluation of Provisional Privilege applications
- Verification against the U.S. Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) for all initial and renewal applications (strongly recommended)

The tier classifications and specific timelines recommended here represent best practices based on survey data from Compact states, established legal precedents, and evidence on recidivism and rehabilitation. States are encouraged to adopt this framework to promote consistency and clarity, but the ultimate licensing decision remains with each sovereign state.

Understanding The Four Tiers

● Tier 1 - Permanent Disqualifiers

These are the most serious offenses that demonstrate an irreparable breach of patient trust or permanent risk to public safety. They include sexual crimes (especially against vulnerable persons), abuse of patients, lifetime sex offender registration requirements, and other violent crimes that are generally punishable by life imprisonment or death.

Crimes that show permanent risk to patient safety or an irreparable breach of trust:

Category A: Crimes Against Vulnerable Persons

- Sexual assault, rape, or sexual misconduct (any degree)
- Sexual crimes against children (including exploitation, pornography, enticement)
- Physical abuse of children, the elderly, or vulnerable adults
- Neglect or abandonment of persons entrusted to care
- Financial exploitation of vulnerable persons or patients

Category B: Violent Crimes with Life/Death Sentences

- Murder or capital murder
- Attempted murder
- Voluntary manslaughter
- Kidnapping or aggravated kidnapping
- Crimes punishable by life imprisonment or death

Category C: Crimes Demonstrating Fundamental Unfitness

- Lifetime sex-offender registration requirement in any jurisdiction
- Permanent revocation of a healthcare license by another state EMS office or recognized healthcare licensing body
- Active listing on the U.S. Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), indicating federal exclusion from participation in federally funded healthcare programs

Recommended Best Practice for State EMS Licensing Officials

- **Action:** *Automatic denial*; no rehabilitation review permitted.

Rationale: These crimes directly relate to the core duties of EMS personnel—patient care, access to vulnerable populations, physical contact, and emergency authority. They demonstrate a fundamental breach of the trust essential to healthcare practice and constitute "Convictions Requiring Review" under Administrative Rule 2.6, warranting permanent disqualification.

Compact Consideration: Under Administrative Rule 4.7(B)(1)(iii), individuals with these convictions would be issued a Provisional Privilege to Practice at best, requiring individual state approval for interstate practice. Given the permanent nature of these disqualifications, most states should deny Provisional Privilege for Tier 1 offenses.

Example Scenario: Tier 1 Permanent Disqualification

Facts: Applicant was convicted in 2018 of felony sexual assault of a patient while working as a nursing assistant. Completed sentence in 2021. Seeking an EMT license in 2025.

Analysis: Crime involves sexual misconduct against a person in care—Tier 1 Category A offense showing irreparable breach of patient trust. This is a Felony conviction involving Moral Turpitude that constitutes a "Conviction Requiring Review" under Administrative Rule 2.6.

Decision: Application **denied**—no rehabilitation review permitted under any circumstances. If the home state were to license this individual, they would hold Provisional Privilege to Practice status requiring approval from each remote state under Administrative Rule 4.7(B), which remote states should deny.

Tier 2 - Time-Limited Disqualifiers (7-Year Look-Back)


These are serious felonies and misdemeanors—including drug trafficking, felony assault, major fraud, and felony domestic violence—that warrant automatic denial during a defined look-back period but *may* permit rehabilitation review after sufficient time has passed.

Examples of serious crimes that *may* permit later review after a defined period:

Disqualifying Offenses (7-Year Period from Sentence Completion):

- Felony drug trafficking, dealing, or manufacturing
- Felony assault or battery
- Felony domestic violence
- Arson
- Robbery
- Major fraud, embezzlement, or identity theft
- Felony DUI causing death or serious injury
- Stalking
- Vehicular manslaughter
- Any felony involving controlled substances

Recommended Best Practice for State EMS Licensing Officials

 **Action:** *Deny* if within seven years of sentence completion (including release from all incarceration, probation, and parole). After seven years, allow *discretionary review* upon clear and convincing evidence of rehabilitation.

Rationale: The seven-year standard is supported by criminological research showing a significant decline in recidivism after this period and represents a middle ground between the five-year periods used by some member states and the ten-year periods used by others. This evidence-based approach balances rehabilitation research with the serious nature of the offenses involved. Research demonstrates that individuals who remain offense-free for seven years post-sentence rarely reoffend, providing a rational basis for permitting rehabilitation review. States may also consider aligning their look-back periods with the timelines under which specific offenses become eligible for expungement under their own state law, as an additional factor in adapting this framework to their statutory structure. However, because expungement eligibility varies significantly across jurisdictions, this framework recommends the seven-year evidence-based standard as the baseline to promote interstate consistency.

Compact Consideration: Under Administrative Rule 4.7(B)(1)(iii), individuals with Tier 2 convictions hold Provisional Privilege to Practice status. Even if the home state licenses an individual within the look-back period or shortly thereafter, remote states retain discretion under Rule 4.7(B)(3) to require individual approval before recognizing interstate practice authority.

Example Scenario: Tier 2 Within Look-Back Period

Facts: Female applicant, age 28, applying for Paramedic license. Criminal history shows a 2019 conviction for felony drug trafficking (heroin) at age 22. Applicant served 2 years in prison, released in 2021, and completed 2 years supervised probation ending in 2023. Sentence completion date: 2023. Current application: 2025 (2

years post-sentence completion). No subsequent arrests.

Applicant's Argument: Applicant was young at the time of the offense and involved with an abusive partner who coerced participation in drug trafficking. Has completed intensive substance abuse treatment, earned EMT certification while on probation, volunteered with community outreach programs, maintained sobriety for 4 years (verified by probation officer), and received strong letters of support from probation officer, substance abuse counselor, and community service supervisor. Applicant argues that rehabilitation is complete and seeks the opportunity to serve the community as a paramedic.

Analysis: Felony drug trafficking falls under Tier 2 time-limited disqualifiers and constitutes a "Conviction Requiring Review" as a Felony under Administrative Rule 2.6. The seven-year look-back period runs from the date of sentence completion (2023), making the applicant eligible for discretionary review in 2030. The current application in 2025 is only 2 years post-sentence completion, well within the mandatory exclusion period.

While the applicant presents compelling evidence of rehabilitation efforts, Tier 2 offenses require a minimum of 7 years of demonstrated stability before discretionary review is available. This time period is evidence-based and necessary to ensure sustained behavioral change. Two years, while positive, is insufficient to establish long-term rehabilitation for felony drug trafficking.

Decision: Application **denied** under Tier 2 time-limited disqualifier. Applicant may reapply after 2030 (seven years post-sentence completion) with evidence of sustained rehabilitation. Applicant is encouraged to maintain sobriety, continue community involvement, and consider working as an EMT in states where a prior conviction does not bar licensure, as this experience will strengthen future applications.

Compact Implications: If the applicant's home state were to license despite the conviction within the look-back period, the license would trigger Provisional Privilege to Practice status under Administrative Rule 4.7(B)(1)(iii). Remote states would not be required to recognize interstate practice authority and would evaluate the application individually under Rule 4.7(B)(3).

Advisory: If the applicant maintains a clean record and continues rehabilitation efforts, discretionary review after 2030 will give substantial weight to the extended period of stability and professional experience gained.

Example Scenario: Tier 2 Beyond Look-Back with Strong Rehabilitation

Facts: Applicant, age 37, applying for Paramedic license in 2025. Criminal history shows a 2010 conviction for felony drug trafficking (cocaine) at age 22. Applicant served 3 years in prison, released in 2013, and completed 2 years of probation ending in 2015. Sentence completion: 2015. Current application: 2025 (10 years post-sentence completion). No subsequent arrests or criminal activity.

Rehabilitation Evidence:

- Completed court-ordered substance abuse treatment (2013-2014)
- Continued voluntary counseling through 2018
- Earned an associate degree in emergency medical services (2016-2018)
- Obtained EMT license in neighboring non-Compact state (2018)
- Employed as an EMT for 7 years (2018-2025) with exemplary performance reviews
- Promoted to shift supervisor (2022)
- Completed additional certifications (ACLS, PALS, critical care transport)
- Letters from the medical director, the fire chief, and three senior paramedics describing the applicant as "outstanding provider," "completely trustworthy," and "mentor to newer staff"
- Active volunteer work with youth drug prevention programs (5 years)
- Married, homeowner, stable family life
- No disciplinary actions, patient complaints, or workplace issues
- Random drug tests throughout employment (all negative)

Analysis: Sentence completion occurred in 2015; ten years have elapsed (exceeding the 7-year look-back). This is a Felony "Conviction Requiring Review" under Administrative Rule 2.6. The applicant is eligible for a discretionary Tier 2 review and must demonstrate rehabilitation by clear and convincing evidence.

Assessment of Rehabilitation Factors:

Time Factors: Ten years post-sentence with no reoffense or legal issues. This extended period significantly exceeds the seven-year threshold and demonstrates sustained behavioral change.

Nature and Context: Offense occurred at age 22 during active addiction. While serious, drug trafficking at a young age during addiction differs from predatory or violent crime. The applicant has aged out of the highest-risk period for recidivism.

Evidence of Rehabilitation: Exceptionally strong. The applicant has not only completed the required treatment but also voluntarily continued counseling. Educational achievement (associate's degree in EMS), seven years of successful EMT practice with progressive responsibility, professional certifications, and outstanding employer references demonstrate commitment to the profession and public service. Volunteer work in drug prevention shows insight into past conduct and a desire to prevent others from following a similar path.

Risk Assessment: Risk of reoffense appears very low. An extended period without incident, stable employment in the healthcare field (with access to controlled substances without any diversion issues), strong family support, ongoing accountability through random drug testing, and demonstrated professional competence all indicate minimal current risk. The medical director's strong endorsement is particularly significant given the applicant's access to medications in the current role.

Concerns: Felony drug trafficking remains a serious offense with relevance to paramedic practice (access to controlled substances, judgment, trustworthiness). However, ten years of exemplary conduct, including seven years of successful EMT work with medication access and zero diversion or integrity issues, provides clear and convincing evidence that the applicant has fundamentally changed.

Decision: State Paramedic License approved with provisional status for 2 years, Compact Privilege to Practice is Provisional, indefinitely.

Conditions:

1. Quarterly compliance reports from the medical director
2. Random drug/alcohol testing (minimum quarterly, may be more frequent at discretion)
3. Enhanced medical director oversight with monthly check-ins in the first year
4. Immediate reporting requirement for any legal issues or disciplinary matters
5. Annual review of provisional status
6. The applicant bears all testing and reporting costs

After successful completion of a 2-year provisional period with no violations or concerns, the license will convert to a full unrestricted status.

Compact Implications: Upon initial licensure with this Felony conviction, the applicant's license would trigger Provisional Privilege to Practice status under Administrative Rule 4.7(B)(1)(iii). Remote states would not be required to recognize interstate practice authority and would evaluate the application individually under Rule 4.7(B)(3).

Rationale: The strength of rehabilitation evidence meets a clear and convincing standard, but provisional conditions provide additional public safety safeguards given the serious nature of the original offense and paramedic-level access to controlled substances. This approach balances recognition of demonstrated rehabilitation with prudent ongoing monitoring.

Tier 3 - Discretionary Review

These are lesser felonies and misdemeanors that require individualized assessment based on multiple factors: time since offense, nature and context of the crime, evidence of rehabilitation, and relationship to EMS duties.

Examples of Tier 3 crimes and convictions.

Offenses Subject to Discretionary Review:

- Misdemeanor drug possession (after 5 years from sentence completion)
- Misdemeanor assault/battery (after 5 years)
- Misdemeanor domestic violence (after 7 years)
- Property crimes – misdemeanor level (after 5 years)
- DUI/DWI offenses (case-by-case, considering patterns and circumstances)
- Misdemeanor fraud or deception
- Other felonies not listed in Tiers 1-2 (after 7 years from sentence completion)

Required Assessment Factors:

Time Factors:

- Time elapsed since offense and sentence completion
- Time elapsed since release from all custody/supervision
- Pattern of conduct (single incident vs. repeated offenses)
- Compliance with probation, parole, and all court orders

Nature and Context:

- Seriousness of the offense
- Direct relationship to EMS duties and responsibilities
- Age and maturity level at time of offense
- Circumstances and context (aggravating/mitigating factors)
- Whether violence, deception, or breach of trust was involved


Evidence of Rehabilitation:

- Completion of court-ordered programs (substance abuse treatment, anger management, etc.)
- Voluntary rehabilitation efforts beyond court requirements
- Educational achievements since the offense
- Employment history and stability, particularly in healthcare or public service
- Community involvement and service
- Letters of recommendation from employers, educators, supervisors, or community leaders
- Successful completion of probation/parole without violations
- Demonstrated changed behavior and life circumstances
- Testimonials regarding character and fitness

Risk Assessment:

- Likelihood of reoffense based on established risk factors
- Current risk to public safety
- Ability to perform EMS duties responsibly and safely
- Evidence of sustained behavioral change

Recommended Best Practice for State EMS Licensing Officials

 **Action:** Approve, conditionally approve, or deny based on clear and convincing evidence. A written decision must explain the specific findings for each factor considered.

Compact Consideration: Tier 3 offenses that meet the definition of "Serious Misdemeanor" under Administrative Rule 2.26 or involve Moral Turpitude constitute "Convictions Requiring Review" under Rule 2.6. If the home state licenses an individual with such convictions, the license triggers Provisional Privilege to Practice status under Administrative Rule 4.7(B)(1)(iii), requiring remote state approval for interstate practice under Rule 4.7(B)(3).

If the offense does *not* meet these definitions, the individual may be licensed and granted an unrestricted Privilege to Practice under the Compact.

Example Scenario: Tier 3 Discretionary Denial - Pattern of Conduct

Facts: Male applicant, age 31, applying for EMT license. Criminal history shows:

- 2019: Misdemeanor DUI (age 25)
- 2021: Misdemeanor DUI (age 27)
- 2023: Misdemeanor DUI (age 29), most recent 24 months ago
- 2024: Arrested for DUI (age 30), charges currently pending

All offenses occurred alone (no passengers) with a BAC of 0.10-0.14. No accidents or injuries. Currently on probation for a 2023 conviction.

Applicant's Argument: Each DUI was an isolated incident occurring during a personal crisis (job loss, relationship breakup, family death). The applicant has attended AA meetings and completed court-ordered alcohol education after each conviction. Charges are misdemeanors, not felonies. Applicant needs an EMT license for employment opportunity as an industrial plant medic (non-driving role). Argues that mistakes should not prevent career opportunities, especially for a position that does not involve operating vehicles.

Analysis: While individual DUI offenses may fall under Tier 3 discretionary review, the pattern reveals an ongoing alcohol problem and poor judgment despite repeated intervention. Multiple DUI convictions could be classified as "Serious Misdemeanors" under Administrative Rule 2.26 as "conduct of a serious nature" that "could reasonably be considered to pose a threat to public safety."

Assessment Factors:

Pattern of Conduct: Three convictions over 4 years, plus a fourth pending charge, demonstrate a persistent problem rather than an isolated mistake. Each sentence was followed by the required programming that failed to prevent the subsequent offense. The pattern shows escalation (increasing frequency) rather than resolution.

Relationship to EMS Duties: Even in a non-transport role, EMTs make critical medical decisions, administer medications, assess patient stability, and determine the need for emergency transport. Alcohol dependence raises serious questions about judgment, reliability, and ability to respond to emergencies. EMTs often work alone or with minimal supervision; impairment could be undetected until patient harm occurs.

Time Factors: Most recent conviction only 24 months ago, with pending charges. No sustained period of sobriety or stability demonstrated. Still on probation, indicating sentence not yet complete.

Evidence of Rehabilitation: Minimal. Court-ordered programming was completed after each conviction, but it repeatedly failed to prevent reoffense. AA attendance appears compliance-based rather than committed recovery—no voluntary treatment beyond court requirements. No sobriety support system is evident. Pending charges suggest the problem continues.

Risk Assessment: High risk of continued alcohol-related issues. The pattern suggests untreated alcohol use disorder. Applicant minimizes seriousness (blames external circumstances rather than accepting accountability). The industrial plant medic role still requires sound judgment, medication administration, and emergency decision-making—all compromised by an active alcohol problem.

Decision: Application denied under Tier 3 discretionary review.

Path to Future Eligibility: Applicant may reapply after demonstrating:

1. Resolution of pending charges
2. Successful completion of current probation
3. Completion of an intensive substance abuse treatment program (not just alcohol education)
4. Participation in recovery support (AA/SMART Recovery) for a minimum of 2 years
5. Minimum 3 years with a completely clean record post-probation
6. Evidence of stable employment and lifestyle changes
7. Letters from the treatment provider and recovery sponsor
8. Evaluation from a substance abuse professional documenting sustained recovery

Timeline: Realistically, 4-5 years before eligibility for reconsideration, given the current probation status and pending charges.

Compact Implications: Given the pattern of Serious Misdemeanors under Administrative Rule 2.26, if any Home State were to license this individual, the license would trigger Provisional Privilege to Practice status under Administrative Rule 4.7(B)(1)(iii). Remote states evaluating the application under Rule 4.7(B)(3) would likely deny, given the ongoing pattern, pending charges, and lack of rehabilitation evidence.

Rationale: Public safety requires assurance that EMS providers have sound judgment and reliability, particularly regarding substance use. Pattern of repeated DUI convictions despite interventions indicates an untreated disorder that poses unacceptable risk to patients. Denial protects the public while providing a clear pathway for the applicant to demonstrate genuine recovery and rehabilitation.

Example Scenario: Tier 3 Discretionary Approval - Isolated Incident

Facts: Female applicant, age 26, applying for AEMT license. Criminal history shows a single misdemeanor drug possession (marijuana, small amount) from 2017 when the applicant was age 19 (college sophomore)—completed court-ordered community service and drug education program—no other arrests or legal issues.

Current Circumstances: Applicant graduated with a bachelor's degree in business management (2020), has worked as an EMT for 4 years with excellent performance reviews, completed an AEMT education program, holds current certifications, and received letters from the medical director and operations supervisor describing the applicant as "reliable, compassionate, and highly skilled provider." The applicant is also a member of a volunteer fire department and a youth mentor.

Analysis: Single misdemeanor drug possession at age 19, now 9 years past, falls under Tier 3 discretionary review. While this is technically a "Conviction Requiring Review" under Administrative Rule 2.6, simple possession of a small amount of marijuana at a college age represents a common youthful mistake rather than serious criminal behavior or pattern. This offense likely does not meet the definition of "Serious Misdemeanor" under Rule 2.26.

Assessment Factors:

Time Factors: Nine years since offense with no subsequent legal issues. The applicant was a teenager at the time; now a mature adult with an established career.

Nature and Context: Minor offense (small amount, personal use). Many jurisdictions have since decriminalized marijuana possession. Offense does not involve violence, deception, theft, or vulnerable persons.

Evidence of Rehabilitation: Exceptional. Applicant completed court requirements, earned a degree, established a successful EMS career spanning 4 years, advanced education to AEMT level, and actively contributes to the community through volunteer fire service and youth mentoring. The applicant has presented strong professional references from supervisors with direct knowledge of the applicant's work performance and character.

Relationship to EMS Duties: Limited direct relationship. Simple marijuana possession at age 19 does not predict medication diversion, impaired judgment in emergency care, or untrustworthiness with controlled substances. Four years of EMT practice with no medication-handling issues, disciplinary matters, or patient complaints demonstrate fitness for practice.

Risk Assessment: Minimal risk. Single youthful offense followed by nearly a decade of responsible conduct, professional achievement, and community service. No indicators of substance abuse or concerning behavior patterns.

Decision: License **approved** without conditions.

Compact Implications: This isolated, minor misdemeanor conviction from 9 years ago likely *does not* trigger Provisional Privilege to Practice status, as it does not constitute a "Serious Misdemeanor" under Administrative Rule 2.26 and may not be considered a "Conviction Requiring Review" given its age, minor nature, and subsequent exemplary record. A home state license should qualify for standard Privilege to Practice under Administrative Rule 4.7(A) and be automatically recognized by remote states under Rule 4.0.

Rationale: Clear and convincing evidence demonstrates that a single minor drug offense at age 19 does not indicate current unfitness for AEMT practice. An extended time period, professional track record, educational achievement, and strong employer endorsements establish that the applicant is qualified, competent, and trustworthy. Imposing conditions or denial would be disproportionate to the offense and would fail to recognize obvious rehabilitation and professional development.

This case illustrates the framework's flexibility in distinguishing between youthful mistakes followed by responsible conduct and patterns of serious criminal behavior, consistent with the Compact's purpose of protecting public safety while facilitating workforce mobility.

Tier 4 - Non-Considerable Records

These are records that *generally* should not affect licensure decisions: arrests without conviction, dismissed charges, expunged records, most juvenile adjudications, traffic infractions, and convictions for conduct no longer criminalized.

The following should generally not affect licensure decisions unless state law requires explicit disclosure:

- Arrests without conviction
- Charges dismissed or acquitted
- Expunged or sealed records (unless conviction occurred after sealing and state law requires disclosure)
- Juvenile adjudications (generally, unless exceptionally serious and recent)
- Traffic violations (non-criminal infractions)
- Convictions for conduct no longer criminalized in the applicant's jurisdiction.

!! Exception: If an individual has been arrested and charged with a serious offense that has not yet been adjudicated, the state EMS office may—in accordance with state law—temporarily delay licensure action or suspend an existing license until the criminal matter is resolved. This ensures that licensing decisions are based on verified judicial outcomes rather than pending allegations, maintaining fairness to the applicant while prioritizing public safety and protection.

In cases where the arrest involves an alleged Tier 1 offense, the general interest of public safety and protection should guide decision-making. New licenses should not be granted until the case has been fully adjudicated. For existing license holders, states should consider summary suspension or temporary restriction of practice, if permitted under their local statutes or administrative procedures, until the criminal matter is resolved.

Arrests may also be considered if criminal charges are currently pending or if a pattern suggests ongoing investigation into serious criminal activity. Juvenile offenses that fall within the Tier 1 category should be considered if permitted under state law, particularly when the conduct demonstrates behavior directly related to patient safety or moral fitness for EMS practice.

Pre-Trial Intervention (PTI) Programs

All states maintain some form of Pre-Trial Intervention (PTI) or pretrial diversion program, which allows individuals charged with criminal offenses to participate in supervised programs as an alternative to traditional prosecution. Because PTI participants have generally not been convicted, their status falls within Tier 4's general principle that non-conviction records should not affect licensure decisions. However, the nature of the charges and the individual's plea status warrant specific guidance:

Currently licensed individuals entering PTI with a non-guilty plea, where the underlying conduct does not directly preclude EMS practice: The individual's Compact Privilege to Practice should be converted to Provisional status until the PTI program is successfully concluded. Upon successful completion, with no resulting conviction, the Provisional designation may be removed and full Privilege restored.

Currently licensed individuals who have entered a guilty plea or whose underlying conduct directly precludes EMS practice: The individual's licensure should be suspended, in accordance with state law, until the charge has been fully adjudicated. The state EMS office should evaluate the outcome under the applicable tier of this framework once the matter is resolved.

Unlicensed applicants currently participating in a PTI program: The individual falls under Tier 4's first exception, which permits the state EMS office to temporarily delay licensure action until the criminal matter is resolved. Licensure should not be granted until the PTI program is successfully completed and the charges are resolved.

Successful completion of a PTI program that results in dismissal of charges should be treated as a dismissed charge under Tier 4 and generally should not affect subsequent licensure decisions. If the individual fails to complete the PTI program and the case proceeds to adjudication, the resulting conviction should be evaluated under the applicable tier of this framework.

Compact Compliance Note: Administrative Rule 11.3(H) requires member states to report "acts of misconduct or criminal convictions that a Member State becomes aware of, from sources other than the FBI background check that may result in action against an EMS Clinician's License or Privilege to Practice." This reporting obligation to the Coordinated Database does not require member states to consider non-convictions in initial licensing decisions, but ensures transparency when such information suggests ongoing public safety concerns. Member states should fulfill this reporting obligation in accordance with their own administrative procedures and applicable state law. The obligation is triggered by information that may result in action against a license or privilege, not by unverified allegations alone. States are encouraged to establish internal protocols that balance timely reporting with procedural safeguards to ensure that reports to the Coordinated Database reflect substantiated or actionable information rather than preliminary, unconfirmed allegations.

6. Procedural Safeguards and Applicant Rights

Background Checks

All Member States must comply with REPLICA Section 3.C.4, which requires:

- **FBI fingerprint-based criminal history check** (mandatory for all initial applications as of March 15, 2025)
- **State criminal record repository search** (mandatory)
- **National EMS Coordinated Database (NEMSCD) verification** (mandatory to check discipline history in all states per Section 11 of REPLICA)
- **Interstate Compact database check** (mandatory for privilege applicants per Administrative Rule 4.0)
- **Rap-Back continuous monitoring enrollment** (strongly recommended for all licensed personnel)

Notice and Appeal Rights

Every applicant has the right to:

- **Clear Notice:** Written explanation of specific conviction(s) under consideration, the applicable tier classification, and potential grounds for denial
- **Opportunity to Respond:** Minimum 30 days to submit evidence of rehabilitation, mitigating circumstances, documentary proof, or factual corrections
- **Hearing:** Upon request, opportunity to appear before the review board, hearing officer, or licensing authority to present evidence and testimony
- **Representation:** Right to be represented by counsel or an advocate during proceedings
- **Written Decision:** Detailed findings explaining approval, denial, or conditions imposed, including specific factors considered and weight given to each
- **Appeal:** Right to appeal an adverse decision to an independent body with authority to overturn or modify the licensing agency's determination
- **Timeline Protection:** Final decision issued within 60-90 days of complete application submission

Burden of Proof

The burden of proof varies by tier:

- **For Tier 1 offenses:** State must prove conviction occurred and falls within Tier 1 categories; no rehabilitation review permitted
- **For Tier 2 offenses within the look-back period:** State demonstrates conviction; automatic denial applies; no rehabilitation review until the look-back period expires.
- **For Tier 2 offenses beyond the look-back period,** the applicant must demonstrate rehabilitation by clear and convincing evidence; the state must show a direct relationship to EMS duties.
- **For Tier 3 offenses:** State must demonstrate conviction has a direct relationship to EMS duties; applicant must demonstrate rehabilitation by clear and convincing evidence.

Conditional Licensure Options

States may grant conditional or provisional licensure when rehabilitation is demonstrated, but additional safeguards are warranted:

Possible Conditions:

- Required supervision by a designated medical director or senior provider
- Random drug/alcohol testing at the applicant's expense
- Regular reporting requirements (monthly or quarterly)
- Prohibition from specific practice settings (e.g., solo response, home health, critical care transport)
- Mandatory counseling or continuing treatment
- Limited initial license term (1-2 years), with successful completion required for full licensure
- Geographic or agency restrictions
- Enhanced medical director oversight with written protocols

Duration: Typically, 1-2 years with demonstration of compliance and stability required before conditions are lifted or full licensure granted.

Modification or Revocation: Conditions may be modified based on compliance; serious violations may result in immediate license suspension or revocation.

7. Balancing Public Safety and Rehabilitation

Research shows that individuals who remain offense-free for seven years after completing their sentence rarely reoffend.⁴ Adopting this evidence-based period acknowledges the potential for rehabilitation while safeguarding patients. Permanent exclusions apply only to crimes demonstrating irreversible unfitness for patient contact or public trust.

The Evidence Base

Studies of criminal recidivism consistently demonstrate that the risk of reoffense decreases significantly over time, particularly after 7-10 years of remaining offense-free. The seven-year standard:

- Reflects mainstream criminological research
- Balances rehabilitation potential with public safety
- Provides sufficient time to observe sustained behavioral change
- Aligns with the look-back periods used by multiple Compact states
- Exceeds the 5-year standard some states use for less serious offenses
- Remains shorter than the lifetime consideration some states apply

Rehabilitation Indicators

Effective rehabilitation is evidenced by:

- **Time:** Extended period without reoffense
- **Treatment:** Completion of substance abuse, mental health, or behavioral programs
- **Stability:** Consistent employment, housing, and family relationships
- **Accountability:** Full compliance with all sentence requirements
- **Growth:** Educational advancement and professional development
- **Service:** Community involvement and contributions
- **Support:** Strong references from employers and community leaders
- **Insight:** Demonstrated understanding of past conduct and its impact

- **Pattern Assessment:** Evaluation of overall criminal behavior history, including the breadth and diversity of offenses, and assessment of repetitive criminal behavior patterns that may indicate persistent risk factors or unresolved underlying issues

⁴ National Institute of Justice. (2016). *Violent offending among juveniles: A 7-year longitudinal study of recidivism*. U.S. Department of Justice. <https://nij.ojp.gov/library/publications/violent-offending-among-juveniles-7-year-longitudinal-study-recidivism>

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Public Safety Considerations

Even with strong rehabilitation evidence, public safety requires:

- **Direct Nexus:** Conviction must be evaluated for relationship to EMS duties consistent with *Hawker v. New York*
- **Pattern Analysis:** Single incident vs. repeated behavior matters
- **Risk Assessment:** Ongoing evaluation of risk factors
- **Monitoring:** Enhanced oversight during provisional or conditional periods
- **Transparency:** Public access to licensing information through NEMSCD per Rule 11.2(C)
- **Accountability:** Swift action for any subsequent violations

Compact Framework Integration

The Provisional Privilege mechanism in Administrative Rules 4.7(B) and 4.2 operationalizes this balance:

- **Respects Rehabilitation:** Allows home states to license individuals who demonstrate rehabilitation
- **Ensures Safety:** Requires remote state review before interstate practice
- **Promotes Transparency:** NEMSCD reporting per Rule 11.3 ensures all states have complete information
- **Facilitates Improvement:** Time-limited provisional status with pathway to full privilege
- **Maintains Flexibility:** Remote states retain authority to deny or impose conditions per Section 4.D of REPLICA

8. Public Accountability and Reporting

Transparency reinforces trust. Transparency in how states evaluate and license individuals with criminal convictions ensures that this trust is earned and maintained. When licensing authorities clearly communicate their standards, decision-making processes, and outcomes—while protecting individual privacy—they demonstrate that public safety is the guiding priority. Openness also discourages arbitrary or inconsistent decision-making, strengthens accountability, and allows the public to see that rehabilitation is recognized only when it aligns with clear evidence of changed behavior and low risk to patients.

By publishing aggregate data and adhering to transparent reporting standards, states affirm their integrity and consistency. Transparency protects not only patients, but also the reputation of the EMS profession, ensuring that every clinician who wears the uniform has met standards that are both fair and worthy of public confidence.

Each state should publish annual, de-identified statistics on:

- Applications received by license level
- Applications denied due to criminal history, by tier category
- Conditional or provisional licenses granted and their conditions
- Conditional license completion rates (successful vs. revoked)
- Average processing time for applications with a criminal history
- Appeal outcomes (upheld vs. overturned)
- Recidivism rates for license holders with criminal histories
- Disciplinary actions taken against license holders for subsequent criminal conduct
- Provisional Privilege applications received, approved, denied, and conditions imposed

Benefits of Public Reporting

- **Accountability:** Demonstrates responsible stewardship of licensing authority
- **Transparency:** Builds public confidence in the licensing process
- **Data-Driven Policy:** Enables evidence-based refinement of the framework
- **Interstate Learning:** Allows states to learn from each other's experiences
- **Continuous Improvement:** Identifies areas needing adjustment or additional resources

Commission Coordination

Per Administrative Rule 11.4(E), the Interstate Commission should:

- Establish standard reporting metrics for consistency across states
- Compile aggregate data from NEMSCD annually
- Publish Commission-wide statistics on framework implementation
- Facilitate information sharing through Commissioner forums
- Conduct periodic framework review based on outcomes data
- Adjust recommendations as evidence and experience warrant

Administrative Rule 11.2(C) provides public access to the Coordinated Database, displaying:

- Legal name
- National EMS ID Number
- Privilege to Practice Status
- State Licensure Status
- License levels and expiration dates
- Jurisdiction(s) issuing licenses

This public portal enhances transparency while protecting sensitive information in accordance with Rule 11.4(A) and (C).

Shared reporting allows evidence-based improvements and public confidence in the system's fairness and rigor.

9. Frequently Asked Questions

Q: Does this policy require states to change their laws?

A: No. This is a model policy for *voluntary* adoption regarding evaluation criteria and tier classifications. States may adopt it through legislation, administrative rules, or policy guidance, depending on their legal structure and existing authority.

However, all member states must comply with mandatory REPLICA requirements:

- FBI fingerprint-based background checks for initial licensure (Section 3.C.4 - by March 15, 2025)
- NEMSCD Uniform Data Set submission (Section 11 of REPLICA and Rule 11.3)
- Adverse action reporting within two business days (Rule 8.1)
- Provisional Privilege evaluation for license holders with Convictions Requiring Review (Rule 4.7(B))

Q: What if my state has more restrictive standards than this framework?

A: States retain full authority to maintain higher standards for public protection under their police powers. However, states should consider how more restrictive approaches interact with the Provisional Privilege mechanism in Administrative Rules.

If a state denies licensure for offenses that other states approve, those individuals won't hold licenses, and the Compact privilege question doesn't arise. If a state licenses individuals with serious convictions that would be disqualified elsewhere, those licenses trigger Provisional Privilege status under Rule 4.7(B), and remote states evaluate individually under Rule 4.2.

Q: Can someone with a criminal record ever get full Compact privileges?

A: In most cases, no for Tier 1 or Tier 2 convictions. An individual with a Tier 1 or Tier 2 conviction will not be eligible for full, automatically recognized Compact Privilege. If licensed by a home state, that license will carry Provisional Privilege to Practice that requires each remote state's approval and does not convert to full Privilege later.

!! Exception: *In rare circumstances where the Tier 1 or Tier 2 conviction is pardoned or expunged under applicable law, and the home state subsequently issues or reissues a license that meets all Qualified License criteria, the individual may be eligible for full Privilege. States retain discretion to evaluate the legal effect of a pardon or expungement.*

For Tier 3 (and Tier 4) matters, outcomes are discretionary. Some Tier 3 convictions (e.g., those meeting the definitions of Serious Misdemeanor or Moral Turpitude) will trigger Provisional status. Other Tier 3 or Tier 4 situations may not trigger Provisional status at all, allowing a Qualified License and full, automatic Privilege if all other criteria are met.

Q: How does this affect current license holders?

A:

- Compact reporting obligations apply to all licensees per Rule 11.3.
- New criminal convictions trigger reporting and potential discipline per Rule 8.1.
- Renewal applications may be subject to each state's policies and administrative rules.
- The FBI background check requirement (Section 3.C.4) applies to initial licenses issued after March 15, 2025.
- Upon discovery by a state EMS office that a current licensee has a Tier 1 or Tier 2 conviction, whether newly identified or previously undisclosed, the individual's Compact Privilege to Practice (PTP) should be converted to Provisional status in accordance with Administrative Rule 4.7(B)(1)(iii), pending review and remote state approval for continued interstate practice under Rule 4.7(B)(3).

Q: What about marijuana convictions in states where it's now legal?

A: States should consider the current legal status and the time since the offense. The framework's tier system allows flexibility:

Simple possession misdemeanor from years ago: May not constitute "Serious Misdemeanor" under Rule 2.26 or "Conviction Requiring Review" under Rule 2.6, especially if jurisdiction has decriminalized or legalized marijuana. Would not trigger Provisional Privilege.

Recent possession or trafficking convictions: May still warrant consideration under Tier 2 or 3 depending on circumstances, even if conduct now legal in some jurisdictions. Felony trafficking convictions trigger Provisional Privilege per Rule 4.7(B)(1)(iii) regardless of current legal status.

States should document their approach to evolving marijuana laws to ensure consistency.

Q: How long does provisional Compact privilege status last?

A: In most situations, a Provisional status is permanent once triggered under Administrative Rule 4.7(B). It does not expire or convert to full Privilege at a later date. *A Provisional Privilege to Practice designation may be triggered for multiple reasons and is not limited to criminal convictions.*

The individual may continue to practice under their home state license, but interstate practice remains subject to remote state approval as required by Rule 4.7(B)(3). This permanent designation ensures transparency across all Compact member states and preserves each state's sovereign authority to decide who may practice within its jurisdiction.

!! Exception: In limited circumstances, Provisional status may later be removed. For example, if a state has not yet implemented an FBI fingerprint-based criminal history check as required by Section 3.C.4 of the Compact, all licenses issued by that state are designated as Provisional until compliance is achieved. Once the state implements the FBI background check requirement *and* the individual is subsequently licensed under that compliant process, the reason for the Provisional status is removed, and the license may then be recognized with full Compact Privilege.

Q: Can a state refuse to recognize another state's license, and the individual's Privilege to Practice, due to criminal history?

A: It depends on the type of license and privilege:

Qualified Licenses (Rule 4.7(A)): Remote states must recognize per Section 4.A of REPLICA: "Member states shall recognize the privilege to practice of an individual licensed in another member state that is in conformance with Section 3."

Provisional Privilege (Rule 4.7(B)): Per Rule 4.7(B)(3), these are "not automatically recognized by Remote States" and require "individual state-level review and approval." Remote states may deny based on criminal history evaluation.

Post-Recognition: Even after recognition, Section 4.D of REPLICA provides: "A remote state may, in accordance with due process and that state's laws, restrict, suspend, or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens."

Q: What happens if someone is arrested, or convicted of a crime, while holding Compact privileges?

A: Multiple reporting obligations trigger:

1. **Individual's Duty:** Must report arrest to home state per state law
2. **Home State Duty:** Per Rule 11.3(H), must report to NEMSCD within 2 business days: "acts of misconduct or criminal convictions...that may result in action against an EMS Clinician's License or Privilege to Practice"
3. **Home State Investigation:** Investigates and determines appropriate action
4. **If Adverse Action Taken:** Per Rule 8.1(B), home state reports to Commission within 2 business days and notifies individual that Remote State Privileges are revoked
5. **Automatic Suspension:** Per Section 8.B of REPLICA, all Compact privileges become inactive
6. **Remote State Options:** May independently investigate and take action per Section 8.E of REPLICA

Q: Who decides what constitutes "clear and convincing evidence" of rehabilitation?

A: The state licensing authority makes this determination based on the totality of evidence presented, applying the legal standard that the evidence shows the fact is highly probable—more than "preponderance of evidence" (more likely than not) but less than "beyond reasonable doubt" (criminal standard).

Factors to consider are enumerated in Tier 3 of this framework. Applicants may appeal adverse determinations through state administrative procedures and ultimately to courts of competent jurisdiction per state law.

Interstate consistency: NEMSCD reporting per Rule 11.3 ensures all states can review the same evidence and home state determination when evaluating Provisional Privilege applications.

Q: What if my state hasn't implemented FBI background checks by the March 15, 2025 deadline?

A: This creates a serious compliance issue. Section 3.C.4 of REPLICA is mandatory: "No later than five years after activation of the Compact, [states must require] a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation..."

Consequences of non-compliance:

Per Administrative Rule 4.7(A)(5), licenses issued after March 15, 2025 without FBI background check review **do not qualify** as Qualified Licenses. They trigger Provisional Privilege status per Rule 4.7(B)(1)(ii).

Per Section 13 of REPLICA and Rule 13.1, failure to comply constitutes grounds for default, which may result in:

- Remedial education and technical assistance
- Suspension of membership
- Suspension of Privilege to Practice for all licensees from that state per Rule 13.1(F)(4)
- Termination of membership

States must:

1. Enact separate statutory authority for FBI checks (REPLICA doesn't grant this authority)
2. Establish operational processes for conducting checks
3. Train staff on procedures
4. Budget for costs
5. Integrate with NEMSCD reporting

Contact the Commission immediately if implementation challenges exist. The Commission provides technical assistance but cannot extend the statutory deadline.

Q: How do I access the NEMSCD to check someone's privilege status?

A: Access depends on your role:

Public Access (Rule 11.2(C)): Visit the Commission's public portal at www.emscompact.gov and search by National EMS ID number. Public can view:

- Name and ID number
- Privilege to Practice status
- State licensure status and expiration
- License levels
- Issuing jurisdictions

Employer Access (Rule 11.2(D)): [FUTURE FUNCTIONALITY] Registered employers can conduct individual or bulk searches with a validated user account.

Government/Member State Access (Rule 11.2(A) and (B)): [FUTURE FUNCTIONALITY] Commissioners and authorized delegates can access the full database, including:

- Complete conviction and discipline history
- Basis for Provisional Privilege status
- Conditions and restrictions
- Adverse actions across all states
- Significant investigatory information

Contact the Commission to establish authorized user accounts for government access.

State Implementation and Compact Compliance

This document provides model guidance for state evaluation of criminal convictions in EMS licensure decisions. Member states retain full sovereignty over licensure decisions and may adopt, adapt, or decline these recommendations based on their constitutional structure, statutory framework, and policy priorities.

However, all member states must comply with mandatory requirements under the *Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA)* and the Commission's Administrative Rules, including FBI background checks, NEMSCD reporting, and privilege recognition procedures. Failure to comply with these mandatory requirements may result in default proceedings under Section 13 of REPLICA.

Governing Documents

REPLICA, Administrative Rules, and Bylaws

1
2
3 NOTES: Thank you for your interest in the EMS Compact! Before introducing the
4 EMS Compact legislation in your state, please carefully review the following:

5 **1. Uniformity Is Required**

6 This Model Legislation must not be modified. It serves as state law and a
7 contractual agreement among all Compact Member States. All states must
8 enact the same language to ensure legal consistency.

9
10 ► Please consult the EMS Compact Commission before proposing any edits
11 or amendments.

12
13 **2. FBI Background Check Becomes a State Licensure Requirement**

14
15 The legislation requires that biometric criminal history record checks—
16 compliant with FBI standards—become a prerequisite for all newly issued
17 state EMS licenses.

18
19 However, this legislation does not grant your state the legal authority
20 required by the FBI to conduct such checks.

21
22 Your state must already have—or must separately enact—a statute
23 authorizing FBI-compliant, fingerprint-based background checks for EMS
24 personnel.

25
26 ► *Ensure your state's EMS statutes provide this authority and that*
27 *operational processes are in place to conduct and process these checks.*

28
29 Although this requirement is activated by participation in the Compact,
30 it becomes part of your state's EMS licensure process, not an ongoing
31 Compact-level mandate.

32
33
34 **3. Licensure Data Sharing Is Required**

35 Member States must share EMS personnel licensure data with the National
36 EMS Coordinated Database.

- 37
38 • There is no charge from the Commission for data submission.
39 • Many states already comply. If your state software system does not,
40 confirm that your licensure system can transmit data—or ensure
41 resources are available to upgrade or implement a compatible
42 system.

43
44 For technical or legal consultation, please contact the EMS Compact Commission
45 office.

48 **MODEL LEGISLATION**

49
50
51 **RECOGNITION OF EMERGENCY MEDICAL SERVICES PERSONNEL LICENSURE INTERSTATE**
52 **COMPACT ("REPLICA")**
53

54 **SECTION 1. PURPOSE**
55

56 In order to protect the public through verification of competency and ensure
57 accountability for patient care related activities all states license
58 emergency medical services (EMS) personnel, such as emergency medical
59 technicians (EMTs), advanced EMTs and paramedics. This Compact is intended to
60 facilitate the day-to-day movement of EMS personnel across state boundaries in
61 the performance of their EMS duties as assigned by an appropriate authority
62 and authorize state EMS offices to afford immediate legal recognition to EMS
63 personnel licensed in a member state.
64

65 This Compact recognizes that states have a vested interest in protecting the
66 public's health and safety through their licensing and regulation of EMS
67 personnel and that such state regulation shared among the member states will
68 best protect public health and safety. This Compact is designed to achieve the
69 following purposes and objectives:
70

- 71 1. Increase public access to EMS personnel;
- 72
73 2. Enhance the states' ability to protect the public's health and
74 safety, especially patient safety;
- 75
76 3. Encourage the cooperation of member states in the areas of EMS
77 personnel licensure and regulation;
- 78
79 4. Support licensing of military members who are separating from an
80 active-duty tour and their spouses;
- 81
82 5. Facilitate the exchange of information between member states
83 regarding EMS personnel licensure, adverse action and significant
84 investigatory information;
- 85
86 6. Promote compliance with the laws governing EMS personnel practice in
87 each member state; and
- 88
89 7. Invest all member states with the authority to hold EMS personnel
90 accountable through the mutual recognition of member state licenses.
91

92 **SECTION 2. DEFINITIONS**
93

94 In this compact:
95

96 A. "Advanced Emergency Medical Technician (AEMT)" means: an individual
97 licensed with cognitive knowledge and a scope of practice that corresponds to
98 that level in the National EMS Education Standards and National EMS Scope of

99 Practice Model.

00
01 B. "Adverse Action" means: any administrative, civil, equitable or criminal
02 action permitted by a state's laws which may be imposed against licensed EMS
03 personnel by a state EMS authority or state court, including, but not limited
04 to, actions against an individual's license such as revocation, suspension,
05 probation, consent agreement, monitoring or other limitation or encumbrance on
06 the individual's practice, letters of reprimand or admonition, fines, criminal
07 convictions and state court judgments enforcing adverse actions by the state
08 EMS authority.

09
10 C. "Alternative program" means: a voluntary, non-disciplinary substance abuse
11 recovery program approved by a state EMS authority.

12 D. "Certification" means: the successful verification of entry-level cognitive
13 and psychomotor competency using a reliable, validated, and legally defensible
14 examination.

15
16 E. "Commission" means: the national administrative body of which all states
17 that have enacted the compact are members.

18
19 F. "Emergency Medical Technician (EMT)" means: an individual licensed with
20 cognitive knowledge and a scope of practice that corresponds to that level in
21 the National EMS Education Standards and National EMS Scope of Practice Model.

22
23 G. "Home State" means: a member state where an individual is licensed to
24 practice emergency medical services.

25
26 H. "License" means: the authorization by a state for an individual to practice
27 as an EMT, AEMT, paramedic, or a level in between EMT and paramedic.

28
29 I. "Medical Director" means: a physician licensed in a member state who is
30 accountable for the care delivered by EMS personnel.

31
32 J. "Member State" means: a state that has enacted this compact.

33
34 K. "Privilege to Practice" means: an individual's authority to deliver
35 emergency medical services in remote states as authorized under this compact.

36
37 L. "Paramedic" means: an individual licensed with cognitive knowledge and a
38 scope of practice that corresponds to that level in the National EMS Education
39 Standards and National EMS Scope of Practice Model.

40
41 M. "Remote State" means: a member state in which an individual is not
42 licensed.

43
44 N. "Restricted" means: the outcome of an adverse action that limits a license
45 or the privilege to practice.

46
47 O. "Rule" means: a written statement by the interstate Commission promulgated
48 pursuant to Section 12 of this compact that is of general applicability;
49 implements, interprets, or prescribes a policy or provision of the compact; or

50 is an organizational, procedural, or practice requirement of the Commission
51 and has the force and effect of statutory law in a member state and includes
52 the amendment, repeal, or suspension of an existing rule.

53
54 P. "Scope of Practice" means: defined parameters of various duties or services
55 that may be provided by an individual with specific credentials. Whether
56 regulated by rule, statute, or court decision, it tends to represent the
57 limits of services an individual may perform.

58
59 Q. "Significant Investigatory Information" means:

60
61 1. investigative information that a state EMS authority, after a
62 preliminary inquiry that includes notification and an opportunity to
63 respond if required by state law, has reason to believe, if proved true,
64 would result in the imposition of an adverse action on a license or
65 privilege to practice; or

66
67 2. investigative information that indicates that the individual
68 represents an immediate threat to public health and safety regardless of
69 whether the individual has been notified and had an opportunity to
70 respond.

71
72 R. "State" means: means any state, commonwealth, district, or territory of
73 the United States.

74
75 S. "State EMS Authority" means: the board, office, or other agency with the
76 legislative mandate to license EMS personnel.

77
78 **SECTION 3. HOME STATE LICENSURE**

79
80 A. Any member state in which an individual holds a current license shall be
81 deemed a home state for purposes of this compact.

82
83 B. Any member state may require an individual to obtain and retain a license
84 to be authorized to practice in the member state under circumstances not
85 authorized by the privilege to practice under the terms of this compact.

86
87 C. A home state's license authorizes an individual to practice in a remote
88 state under the privilege to practice only if the home state:

89
90 1. Currently requires the use of the National Registry of Emergency
91 Medical Technicians (NREMT) examination as a condition of issuing initial
92 licenses at the EMT and paramedic levels;

93
94 2. Has a mechanism in place for receiving and investigating complaints
95 about individuals;

96
97 3. Notifies the Commission, in compliance with the terms herein, of any
98 adverse action or significant investigatory information regarding an
99 individual;

- 01 4. No later than five years after activation of the Compact, requires a
02 criminal background check of all applicants for initial licensure,
03 including the use of the results of fingerprint or other biometric data
04 checks compliant with the requirements of the Federal Bureau of
05 Investigation with the exception of federal employees who have
06 suitability determination in accordance with US CFR §731.202 and submit
07 documentation of such as promulgated in the rules of the Commission;and
08
09 5. Complies with the rules of the Commission.

10
11 **SECTION 4. COMPACT PRIVILEGE TO PRACTICE**

- 12
13 A. Member states shall recognize the privilege to practice of an individual
14 licensed in another member state that is in conformance with Section 3.
15
16 B. To exercise the privilege to practice under the terms and provisions of
17 this compact, an individual must:
18
19 1. Be at least 18 years of age;
20
21 2. Possess a current unrestricted license in a member state as an EMT,
22 AEMT, paramedic, or state recognized and licensed level with a scope of
23 practice and authority between EMT and paramedic; and
24
25 3. Practice under the supervision of a medical director.
26
27 C. An individual providing patient care in a remote state under the privilege
28 to practice shall function within the scope of practice authorized by the home
29 state unless and until modified by an appropriate authority in the remote
30 state as may be defined in the rules of the commission.
31
32 D. Except as provided in Section 4 subsection C, an individual practicing in a
33 remote state will be subject to the remote state's authority and laws. A
34 remote state may, in accordance with due process and that state's laws,
35 restrict, suspend, or revoke an individual's privilege to practice in the
36 remote state and may take any other necessary actions to protect the health
37 and safety of its citizens. If a remote state takes action it shall promptly
38 notify the home state and the Commission.
39
40 E. If an individual's license in any home state is restricted or suspended,
41 the individual shall not be eligible to practice in a remote state under the
42 privilege to practice until the individual's home state license is restored.
43
44 F. If an individual's privilege to practice in any remote state is restricted,
45 suspended, or revoked the individual shall not be eligible to practice in any
46 remote state until the individual's privilege to practice is restored.
47

48 **SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE**

49
50 An individual may practice in a remote state under a privilege to practice
51 only in the performance of the individual's EMS duties as assigned by an

52 appropriate authority, as defined in the rules of the Commission, and under
53 the following circumstances:
54

- 55 7. The individual originates a patient transport in a home state and
56 transports the patient to a remote state;
57
- 58 2. The individual originates in the home state and enters a remote state
59 to pick up a patient and provide care and transport of the patient to the
60 home state;
61
- 62 3. The individual enters a remote state to provide patient care and/or
63 transport within that remote state;
64
- 65 4. The individual enters a remote state to pick up a patient and provide
66 care and transport to a third member state;
67
- 68 5. Other conditions as determined by rules promulgated by the
69 commission.
70

71 **SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT**

72

73 Upon a member state's governor's declaration of a state of emergency or
74 disaster that activates the Emergency Management Assistance Compact (EMAC),
75 all relevant terms and provisions of EMAC shall apply and to the extent any
76 terms or provisions of this Compact conflicts with EMAC, the terms of EMAC
77 shall prevail with respect to any individual practicing in the remote state in
78 response to such declaration.
79

80 **SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING FROM ACTIVE-DUTY MILITARY, AND** 81 **THEIR SPOUSES**

82

83 A. Member states shall consider a veteran, active military service member, and
84 member of the National Guard and Reserves separating from an active-duty tour,
85 and a spouse thereof, who holds a current valid and unrestricted NREMT
86 certification at or above the level of the state license being sought as
87 satisfying the minimum training and examination requirements for such
88 licensure.

89 B. Member states shall expedite the processing of licensure applications
90 submitted by veterans, active military service members, and members of the
91 National Guard and Reserves separating from an active-duty tour, and their
92 spouses.
93

94 C. All individuals functioning with a privilege to practice under this Section
95 remain subject to the Adverse Actions provisions of Section 8.
96

97 **SECTION 8. ADVERSE ACTIONS**

98

99 A. A home state shall have exclusive power to impose adverse action against an
00 individual's license issued by the home state.
01

02 B. If an individual's license in any home state is restricted or suspended,

03 the individual shall not be eligible to practice in a remote state under the
04 privilege to practice until the individual's home state license is restored.
05

06 1. All home state adverse action orders shall include a statement that
07 the individual's compact privileges are inactive. The order may allow the
08 individual to practice in remote states with prior written authorization
09 from both the home state and remote state's EMS authority.
10

11 2. An individual currently subject to adverse action in the home state
12 shall not practice in any remote state without prior written
13 authorization from both the home state and remote state's EMS authority.
14

15 C. A member state shall report adverse actions and any occurrences that the
16 individual's compact privileges are restricted, suspended, or revoked to the
17 Commission in accordance with the rules of the Commission.
18

19 D. A remote state may take adverse action on an individual's privilege to
20 practice within that state.
21

22 E. Any member state may take adverse action against an individual's privilege
23 to practice in that state based on the factual findings of another member
24 state, so long as each state follows its own procedures for imposing such
25 adverse action.
26

27 F. A home state's EMS authority shall investigate and take appropriate action
28 with respect to reported conduct in a remote state as it would if such conduct
29 had occurred within the home state. In such cases, the home state's law shall
30 control in determining the appropriate adverse action.
31

32 G. Nothing in this Compact shall override a member state's decision that
33 participation in an alternative program may be used in lieu of adverse action
34 and that such participation shall remain non-public if required by the member
35 state's laws. Member states must require individuals who enter any alternative
36 programs to agree not to practice in any other member state during the term of
37 the alternative program without prior authorization from such other member
38 state.
39

40 **SECTION 9. ADDITIONAL POWERS INVESTED IN A MEMBER STATE'S EMS AUTHORITY**

41
42 A member state's EMS authority, in addition to any other powers granted under
43 state law, is authorized under this compact to:
44

45 1. Issue subpoenas for both hearings and investigations that require the
46 attendance and testimony of witnesses and the production of evidence.
47 Subpoenas issued by a member state's EMS authority for the attendance and
48 testimony of witnesses, and/or the production of evidence from another
49 member state, shall be enforced in the remote state by any court of
50 competent jurisdiction, according to that court's practice and procedure
51 in considering subpoenas issued in its own proceedings. The issuing state
52 EMS authority shall pay any witness fees, travel expenses, mileage, and
53 other fees required by the service statutes of the state where the

witnesses and/or evidence are located; and

2. Issue cease and desist orders to restrict, suspend, or revoke an individual's privilege to practice in the state.

SECTION 10. ESTABLISHMENT OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

A. The Compact states hereby create and establish a joint public agency known as the Interstate Commission for EMS Personnel Practice.

1. The Commission is a body politic and an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate. The responsible official of the state EMS authority or his designee shall be the delegate to this Compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office, or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the Governor of the state will determine which entity will be responsible for assigning the delegate.

2. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section XII.

05
06 5. The Commission may convene in a closed, non-public meeting if the
07 Commission must discuss:

08
09 a. Non-compliance of a member state with its obligations under
10 the Compact;

11
12 b. The employment, compensation, discipline or other personnel
13 matters, practices or procedures related to specific employees or
14 other matters related to the Commission's internal personnel
15 practices and procedures;

16
17 c. Current, threatened, or reasonably anticipated litigation;

18
19 d. Negotiation of contracts for the purchase or sale of goods,
20 services, or real estate;

21
22 e. Accusing any person of a crime or formally censuring any
23 person;

24
25 f. Disclosure of trade secrets or commercial or financial
26 information that is privileged or confidential;

27
28 g. Disclosure of information of a personal nature where
29 disclosure would constitute a clearly unwarranted invasion of
30 personal privacy;

31
32 h. Disclosure of investigatory records compiled for law
33 enforcement purposes;

34
35 i. Disclosure of information related to any investigatory reports
36 prepared by or on behalf of or for use of the Commission or other
37 committee charged with responsibility of investigation or
38 determination of compliance issues pursuant to the compact; or

39
40 j. Matters specifically exempted from disclosure by federal or
41 member state statute.

42
43 6. If a meeting, or portion of a meeting, is closed pursuant to this
44 provision, the Commission's legal counsel or designee shall certify that
45 the meeting may be closed and shall reference each relevant exempting
46 provision. The Commission shall keep minutes that fully and clearly
47 describe all matters discussed in a meeting and shall provide a full and
48 accurate summary of actions taken, and the reasons therefore, including a
49 description of the views expressed. All documents considered in
50 connection with an action shall be identified in such minutes. All
51 minutes and documents of a closed meeting shall remain under seal,
52 subject to release by a majority vote of the Commission or order of a
53 court of competent jurisdiction.

54
55 C. The Commission shall, by a majority vote of the delegates, prescribe

56 bylaws and/or rules to govern its conduct as may be necessary or appropriate
57 to carry out the purposes and exercise the powers of the compact, including
58 but not limited to:

- 59 1. Establishing the fiscal year of the Commission;
- 60 2. Providing reasonable standards and procedures:
 - 61 a. for the establishment and meetings of other committees; and
 - 62 b. governing any general or specific delegation of any authority
 - 63 or function of the Commission;
- 64 3. Providing reasonable procedures for calling and conducting meetings
65 of the Commission, ensuring reasonable advance notice of all meetings,
66 and providing an opportunity for attendance of such meetings by
67 interested parties, with enumerated exceptions designed to protect the
68 public's interest, the privacy of individuals, and proprietary
69 information, including trade secrets. The Commission may meet in closed
70 session only after a majority of the membership votes to close a meeting
71 in whole or in part. As soon as practicable, the Commission must make
72 public a copy of the vote to close the meeting revealing the vote of each
73 member with no proxy votes allowed;
- 74 4. Establishing the titles, duties and authority, and reasonable
75 procedures for the election of the officers of the Commission;
- 76 5. Providing reasonable standards and procedures for the establishment
77 of the personnel policies and programs of the Commission. Notwithstanding
78 any civil service or other similar laws of any member state, the bylaws
79 shall exclusively govern the personnel policies and programs of the
80 Commission;
- 81 6. Promulgating a code of ethics to address permissible and prohibited
82 activities of Commission members and employees;
- 83 7. Providing a mechanism for winding up the operations of the
84 Commission and the equitable disposition of any surplus funds that may
85 exist after the termination of the Compact after the payment and/or
86 reserving of all of its debts and obligations;
- 87 8. The Commission shall publish its bylaws and file a copy thereof,
88 and a copy of any amendment thereto, with the appropriate agency or
89 officer in each of the member states, if any.
- 90 9. The Commission shall maintain its financial records in accordance
91 with the bylaws.
- 92 10. The Commission shall meet and take such actions as are consistent
93 with the provisions of this Compact and the bylaws.

07 D. The Commission shall have the following powers:
08

09 1. The authority to promulgate uniform rules to facilitate and
10 coordinate implementation and administration of this Compact. The rules
11 shall have the force and effect of law and shall be binding in all member
12 states;

13
14 2. To bring and prosecute legal proceedings or actions in the name of
15 the Commission, provided that the standing of any state EMS authority or
16 other regulatory body responsible for EMS personnel licensure to sue or
17 be sued under applicable law shall not be affected;

18
19 3. To purchase and maintain insurance and bonds;

20
21 4. To borrow, accept, or contract for services of personnel,
22 including, but not limited to, employees of a member state;

23
24 5. To hire employees, elect or appoint officers, fix compensation,
25 define duties, grant such individuals appropriate authority to carry out
26 the purposes of the compact, and to establish the Commission's personnel
27 policies and programs relating to conflicts of interest, qualifications
28 of personnel, and other related personnel matters;

29
30 6. To accept any and all appropriate donations and grants of money,
31 equipment, supplies, materials and services, and to receive, utilize and
32 dispose of the same; provided that at all times the Commission shall
33 strive to avoid any appearance of impropriety and/or conflict of
34 interest;

35
36 7. To lease, purchase, accept appropriate gifts or donations of, or
37 otherwise to own, hold, improve or use, any property, real, personal or
38 mixed; provided that at all times the Commission shall strive to avoid
39 any appearance of impropriety;

40
41 8. To sell convey, mortgage, pledge, lease, exchange, abandon, or
42 otherwise dispose of any property real, personal, or mixed;

43
44 9. To establish a budget and make expenditures;

45
46 10. To borrow money;

47
48 11. To appoint committees, including advisory committees comprised of
49 members, state regulators, state legislators or their representatives,
50 and consumer representatives, and such other interested persons as may be
51 designated in this compact and the bylaws;

52
53 12. To provide and receive information from, and to cooperate with, law
54 enforcement agencies;

55
56 13. To adopt and use an official seal; and
57

58 14. To perform such other functions as may be necessary or appropriate
59 to achieve the purposes of this Compact consistent with the state
60 regulation of EMS personnel licensure and practice.
61

62 E. Financing of the Commission
63

64 1. The Commission shall pay, or provide for the payment of, the
65 reasonable expenses of its establishment, organization, and ongoing
66 activities.
67

68 2. The Commission may accept any and all appropriate revenue sources,
69 donations, and grants of money, equipment, supplies, materials, and
70 services.
71

72 3. The Commission may levy on and collect an annual assessment from
73 each member state or impose fees on other parties to cover the cost of
74 the operations and activities of the Commission and its staff, which must
75 be in a total amount sufficient to cover its annual budget as approved
76 each year for which revenue is not provided by other sources. The
77 aggregate annual assessment amount shall be allocated based upon a
78 formula to be determined by the Commission, which shall promulgate a rule
79 binding upon all member states.
80

81 4. The Commission shall not incur obligations of any kind prior to
82 securing the funds adequate to meet the same; nor shall the Commission
83 pledge the credit of any of the member states, except by and with the
84 authority of the member state.
85

86 5. The Commission shall keep accurate accounts of all receipts and
87 disbursements. The receipts and disbursements of the Commission shall be
88 subject to the audit and accounting procedures established under its
89 bylaws. However, all receipts and disbursements of funds handled by the
90 Commission shall be audited yearly by a certified or licensed public
91 accountant, and the report of the audit shall be included in and become
92 part of the annual report of the Commission.
93

94 F. Qualified Immunity, Defense, and Indemnification
95

96 1. The members, officers, executive director, employees and
97 representatives of the Commission shall be immune from suit and
98 liability, either personally or in their official capacity, for any claim
99 for damage to or loss of property or personal injury or other civil
00 liability caused by or arising out of any actual or alleged act, error or
01 omission that occurred, or that the person against whom the claim is made
02 had a reasonable basis for believing occurred within the scope of
03 Commission employment, duties or responsibilities; provided that nothing
04 in this paragraph shall be construed to protect any such person from suit
05 and/or liability for any damage, loss, injury, or liability caused by the
06 intentional or willful or wanton misconduct of that person.
07

08 2. The Commission shall defend any member, officer, executive

09 director, employee or representative of the Commission in any civil
10 action seeking to impose liability arising out of any actual or alleged
11 act, error, or omission that occurred within the scope of Commission
12 employment, duties, or responsibilities, or that the person against whom
13 the claim is made had a reasonable basis for believing occurred within
14 the scope of Commission employment, duties, or responsibilities; provided
15 that nothing herein shall be construed to prohibit that person from
16 retaining his or her own counsel; and provided further, that the actual
17 or alleged act, error, or omission did not result from that person's
18 intentional or willful or wanton misconduct.

19
20 3. The Commission shall indemnify and hold harmless any member,
21 officer, executive director, employee, or representative of the
22 Commission for the amount of any settlement or judgment obtained against
23 that person arising out of any actual or alleged act, error or omission
24 that occurred within the scope of Commission employment, duties, or
25 responsibilities, or that such person had a reasonable basis for
26 believing occurred within the scope of Commission employment, duties, or
27 responsibilities, provided that the actual or alleged act, error, or
28 omission did not result from the intentional or willful or wanton
29 misconduct of that person.

30 **SECTION 11. COORDINATED DATABASE**

31
32
33 A. The Commission shall provide for the development and maintenance of a
34 coordinated database and reporting system containing licensure, adverse
35 action, and significant investigatory information on all licensed individuals
36 in member states.

37
38 B. Notwithstanding any other provision of state law to the contrary, a
39 member state shall submit a uniform data set to the coordinated database on
40 all individuals to whom this compact is applicable as required by the rules of
41 the Commission, including:

- 42
43 1. Identifying information;
- 44
45 2. Licensure data;
- 46
47 3. Significant investigatory information;
- 48
49 4. Adverse actions against an individual's license;
- 50
51 5. An indicator that an individual's privilege to practice is
52 restricted, suspended or revoked;
- 53
54 6. Non-confidential information related to alternative program
55 participation;
- 56
57 7. Any denial of application for licensure, and the reason(s) for such
58 denial; and
59

60 8. Other information that may facilitate the administration of this
61 Compact, as determined by the rules of the Commission.
62

63 C. The coordinated database administrator shall promptly notify all member
64 states of any adverse action taken against, or significant investigative
65 information on, any individual in a member state.
66

67 D. Member states contributing information to the coordinated database may
68 designate information that may not be shared with the public without the
69 express permission of the contributing state.
70

71 E. Any information submitted to the coordinated database that is
72 subsequently required to be expunged by the laws of the member state
73 contributing the information shall be removed from the coordinated database.
74

75 **SECTION 12. RULEMAKING**

76
77 A. The Commission shall exercise its rulemaking powers pursuant to the
78 criteria set forth in this Section and the rules adopted thereunder. Rules and
79 amendments shall become binding as of the date specified in each rule or
80 amendment.
81

82 B. If a majority of the legislatures of the member states rejects a rule, by
83 enactment of a statute or resolution in the same manner used to adopt the
84 Compact, then such rule shall have no further force and effect in any member
85 state.
86

87 C. Rules or amendments to the rules shall be adopted at a regular or special
88 meeting of the Commission.
89

90 D. Prior to promulgation and adoption of a final rule or rules by the
91 Commission, and at least sixty (60) days in advance of the meeting at which
92 the rule will be considered and voted upon, the Commission shall file a Notice
93 of Proposed Rulemaking:
94

95 1. On the website of the Commission; and

96
97 2. On the website of each member state EMS authority or the
98 publication in which each state would otherwise publish proposed rules.
99

00 E. The Notice of Proposed Rulemaking shall include:

01
02 1. The proposed time, date, and location of the meeting in which the
03 rule will be considered and voted upon;

04
05 2. The text of the proposed rule or amendment and the reason for the
06 proposed rule;
07

08 3. A request for comments on the proposed rule from any interested
09 person; and
10

11 4. The manner in which interested persons may submit notice to the
12 Commission of their intention to attend the public hearing and any
13 written comments.

14
15 F. Prior to adoption of a proposed rule, the Commission shall allow persons
16 to submit written data, facts, opinions, and arguments, which shall be made
17 available to the public.

18
19 G. The Commission shall grant an opportunity for a public hearing before it
20 adopts a rule or amendment if a hearing is requested by:

- 21 1. At least twenty-five (25) persons;
- 22 2. A governmental subdivision or agency; or
- 23 3. An association having at least twenty-five (25) members.

24
25
26
27
28 H. If a hearing is held on the proposed rule or amendment, the Commission
29 shall publish the place, time, and date of the scheduled public hearing.

30
31 1. All persons wishing to be heard at the hearing shall notify the
32 executive director of the Commission or other designated member in
33 writing of their desire to appear and testify at the hearing not less
34 than five (5) business days before the scheduled date of the hearing.

35
36 2. Hearings shall be conducted in a manner providing each person who
37 wishes to comment a fair and reasonable opportunity to comment orally or
38 in writing.

39
40 3. No transcript of the hearing is required, unless a written request
41 for a transcript is made, in which case the person requesting the
42 transcript shall bear the cost of producing the transcript. A recording
43 may be made in lieu of a transcript under the same terms and conditions
44 as a transcript. This subsection shall not preclude the Commission from
45 making a transcript or recording of the hearing if it so chooses.

46
47 4. Nothing in this section shall be construed as requiring a separate
48 hearing on each rule. Rules may be grouped for the convenience of the
49 Commission at hearings required by this section.

50
51 I. Following the scheduled hearing date, or by the close of business on the
52 scheduled hearing date if the hearing was not held, the Commission shall
53 consider all written and oral comments received.

54
55 J. The Commission shall, by majority vote of all members, take final action
56 on the proposed rule and shall determine the effective date of the rule, if
57 any, based on the rulemaking record and the full text of the rule.

58
59 K. If no written notice of intent to attend the public hearing by interested
60 parties is received, the Commission may proceed with promulgation of the
61 proposed rule without a public hearing.

62
63 L. Upon determination that an emergency exists, the Commission may consider
64 and adopt an emergency rule without prior notice, opportunity for comment, or
65 hearing, provided that the usual rulemaking procedures provided in the Compact
66 and in this section shall be retroactively applied to the rule as soon as
67 reasonably possible, in no event later than ninety (90) days after the
68 effective date of the rule. For the purposes of this provision, an emergency
69 rule is one that must be adopted immediately in order to:
70

- 71 1. Meet an imminent threat to public health, safety, or welfare;
- 72 2. Prevent a loss of Commission or member state funds;
- 73 3. Meet a deadline for the promulgation of an administrative rule that
74 is established by federal law or rule; or
- 75 4. Protect public health and safety.

76
77
78
79 M. The Commission or an authorized committee of the Commission may direct
80 revisions to a previously adopted rule or amendment for purposes of correcting
81 typographical errors, errors in format, errors in consistency, or grammatical
82 errors. Public notice of any revisions shall be posted on the website of the
83 Commission. The revision shall be subject to challenge by any person for a
84 period of thirty (30) days after posting. The revision may be challenged only
85 on grounds that the revision results in a material change to a rule. A
86 challenge shall be made in writing, and delivered to the chair of the
87 Commission prior to the end of the notice period. If no challenge is made, the
88 revision will take effect without further action. If the revision is
89 challenged, the revision may not take effect without the approval of the
90 Commission.
91

92 **SECTION 13. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT**

93 **A. Oversight**

- 94 1. The executive, legislative, and judicial branches of state
95 government in each member state shall enforce this compact and take all
96 actions necessary and appropriate to effectuate the compact's purposes
97 and intent. The provisions of this compact and the rules promulgated
98 hereunder shall have standing as statutory law.
- 99 2. All courts shall take judicial notice of the compact and the rules
00 in any judicial or administrative proceeding in a member state pertaining
01 to the subject matter of this compact which may affect the powers,
02 responsibilities or actions of the Commission.
- 03 3. The Commission shall be entitled to receive service of process in
04 any such proceeding, and shall have standing to intervene in such a
05 proceeding for all purposes. Failure to provide service of process to the
06 Commission shall render a judgment or order void as to the Commission,
07 this Compact, or promulgated rules.

13
14 B. Default, Technical Assistance, and Termination
15

16 1. If the Commission determines that a member state has defaulted in
17 the performance of its obligations or responsibilities under this compact
18 or the promulgated rules, the Commission shall:

19
20 a. Provide written notice to the defaulting state and other
21 member states of the nature of the default, the proposed means of
22 curing the default and/or any other action to be taken by the
23 Commission; and

24
25 b. Provide remedial training and specific technical assistance
26 regarding the default.

27
28 2. If a state in default fails to cure the default, the defaulting
29 state may be terminated from the Compact upon an affirmative vote of a
30 majority of the member states, and all rights, privileges and benefits
31 conferred by this compact may be terminated on the effective date of
32 termination. A cure of the default does not relieve the offending state
33 of obligations or liabilities incurred during the period of default.

34
35 3. Termination of membership in the compact shall be imposed only
36 after all other means of securing compliance have been exhausted. Notice
37 of intent to suspend or terminate shall be given by the Commission to the
38 governor, the majority and minority leaders of the defaulting state's
39 legislature, and each of the member states.

40
41 4. A state that has been terminated is responsible for all
42 assessments, obligations, and liabilities incurred through the effective
43 date of termination, including obligations that extend beyond the
44 effective date of termination.

45
46 5. The Commission shall not bear any costs related to a state that is
47 found to be in default or that has been terminated from the compact,
48 unless agreed upon in writing between the Commission and the defaulting
49 state.

50
51 6. The defaulting state may appeal the action of the Commission by
52 petitioning the U.S. District Court for the District of Columbia or the
53 federal district where the Commission has its principal offices. The
54 prevailing member shall be awarded all costs of such litigation,
55 including reasonable attorney's fees.

56
57 C. Dispute Resolution
58

59 1. Upon request by a member state, the Commission shall attempt to
60 resolve disputes related to the compact that arise among member states
61 and between member and non-member states.

62
63 2. The Commission shall promulgate a rule providing for both mediation

64 and binding dispute resolution for disputes as appropriate.

65
66 D. Enforcement

67 1. The Commission, in the reasonable exercise of its discretion, shall
68 enforce the provisions and rules of this compact.

69
70 2. By majority vote, the Commission may initiate legal action in the
71 United States District Court for the District of Columbia or the federal
72 district where the Commission has its principal offices against a member
73 state in default to enforce compliance with the provisions of the compact
74 and its promulgated rules and bylaws. The relief sought may include both
75 injunctive relief and damages. In the event judicial enforcement is
76 necessary, the prevailing member shall be awarded all costs of such
77 litigation, including reasonable attorney's fees.

78
79 3. The remedies herein shall not be the exclusive remedies of the
80 Commission. The Commission may pursue any other remedies available under
81 federal or state law.

82
83 **SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR EMS**
84 **PERSONNEL PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT**
85

86 A. The compact shall come into effect on the date on which the compact
87 statute is enacted into law in the tenth member state. The provisions, which
88 become effective at that time, shall be limited to the powers granted to the
89 Commission relating to assembly and the promulgation of rules. Thereafter,
90 the Commission shall meet and exercise rulemaking powers necessary to the
91 implementation and administration of the compact.

92
93 B. Any state that joins the compact subsequent to the Commission's initial
94 adoption of the rules shall be subject to the rules as they exist on the date
95 on which the compact becomes law in that state. Any rule that has been
96 previously adopted by the Commission shall have the full force and effect of
97 law on the day the compact becomes law in that state.

98
99 C. Any member state may withdraw from this compact by enacting a statute
00 repealing the same.

01 1. A member state's withdrawal shall not take effect until six (6)
02 months after enactment of the repealing statute.

03
04 2. Withdrawal shall not affect the continuing requirement of the
05 withdrawing state's EMS authority to comply with the investigative and
06 adverse action reporting requirements of this act prior to the effective
07 date of withdrawal.

08
09 D. Nothing contained in this compact shall be construed to invalidate or
10 prevent any EMS personnel licensure agreement or other cooperative arrangement
11 between a member state and a non-member state that does not conflict with the
12 provisions of this compact.

13
14 E. This Compact may be amended by the member states. No amendment to this

15 Compact shall become effective and binding upon any member state until it is
16 enacted into the laws of all member states.
17

18 **SECTION 15. CONSTRUCTION AND SEVERABILITY**
19

20 This Compact shall be liberally construed so as to effectuate the purposes
21 thereof. If this compact shall be held contrary to the constitution of any
22 state member thereto, the compact shall remain in full force and effect as to
23 the remaining member states. Nothing in this compact supersedes state law or
24 rules related to licensure of EMS agencies.



ADMINISTRATIVE RULES

Originally Drafted: March 2, 2023

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Effective: February 19, 2025

Authority: REPLICA Legislation, Section 10: Establishment of an Interstate Commission for EMS Personnel Practice, Section 12: Rulemaking

ADOPTED BY THE COMMISSION: NOVEMBER 5, 2025

EFFECTIVE: DECEMBER 1, 2025

SECTION 1. Purpose and Authority

These Rules are promulgated by the Interstate Commission for Emergency Medical Services Personnel Practice pursuant to the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA). These Rules shall become effective upon adoption by the Commission. Nothing in the compact or these Rules authorizes an individual to practice in a non-Member State.

SECTION 2. Definitions

For the purposes of the Rules adopted by the Interstate Commission for Emergency Medical Services Personnel Practice, the following definitions shall apply. Terms not specifically defined in these Rules shall have the definitions as set forth in the Compact.

- 2.0** “**Adverse Action**” means: any administrative, civil, equitable or criminal action permitted by a State’s laws which may be imposed against licensed EMS personnel by a State EMS Authority or State court, including, but not limited to, actions against an individual’s license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual’s practice, letters of reprimand or admonition, fines, criminal convictions and State court judgments enforcing adverse actions by the State EMS Authority.
- 2.1** “**Commission**” means: the national administrative body of which all States that have enacted the Compact are members.
- 2.2** “**Commissioner**” means: the appointed delegate from each State as described in Section 10.B.1. of the Compact.
- 2.3** “**Compact,**” hereinafter “the Compact” means: The Recognition of Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA) as enacted by a Member State.
- 2.4** “**Compact Data Participation Agreement**” means: the agreement established between the Commission and the Coordinated Database Administrator.

Administrative Rules - Interstate Commission for EMS Personnel Practice

- 40 2.5 “**Conviction**” means: a finding by a court of competent jurisdiction that an individual is
41 guilty of a criminal offense through adjudication, or the entry of a plea of guilty or nolo
42 contendere (no contest). Conviction also includes a finding of guilt for a Serious Offense
43 under the Uniform Code of Military Justice (UCMJ).
- 44 2.6 “**Conviction Requiring Review**” means: any criminal conviction that may impact an
45 individual’s fitness to practice as an EMS Clinician and requires evaluation by a State EMS
46 Authority prior to the issuance or recognition of a license. This includes, but is not limited to
47 any Felony conviction; any Serious Misdemeanor conviction; or any conviction involving
48 Moral Turpitude.
- 49 2.7 “**Conditions of Practice**” means: the circumstances under which an EMS Clinician is
50 authorized to practice in a Remote State under a privilege to practice.
- 51 2.8 “**Coordinated Database**” also referred to as the National EMS Coordinated Database
52 (NEMSCD) means: the information system and consolidated data established and maintained
53 by the Commission as set forth in the Compact. The Coordinated Database collects,
54 maintains, analyzes, reports, and shares authorized information on EMS personnel licensure,
55 certification, privilege to practice, investigations, enforcement, and disciplinary information.
- 56 2.9 “**Coordinated Database Administrator**” means: the contractor, person or employee named
57 by the Commission to provide oversight and management of the Coordinated Database.
- 58 2.10 “**EMS Agency**” means: an organization that is authorized by a State EMS Authority to
59 operate an ambulance service, or non-transport service.
- 60 2.11 “**EMS Clinician**” means: an individual Licensed by a jurisdiction in the United States as an
61 Emergency Medical Technician (EMT), Advanced-EMT (AEMT), Paramedic, or a level in
62 between EMT and Paramedic.
- 63 2.12 “**Felony**” means: a serious criminal offense that is graded, codified or classified as a felony
64 under the laws of the state in which the defendant was convicted.
- 65 2.13 “**License**” means: the authorization by a State for an individual to practice as an EMT,
66 AEMT, Paramedic, or a level in between EMT and Paramedic.
- 67 2.14 “**License Endorsement**” means an authorization by the State EMS Authority to permit the
68 EMS Clinician to perform additional skills or interventions as a supplement to the EMS
69 Clinician’s Scope of Practice.
- 70 2.15 “**Member State**” means: a State that has enacted the Compact.
- 71 2.16 “**Moral Turpitude**” means: an act involving baseness, vileness, or depravity in private or
72 social duties that one owes to others or to society, contrary to accepted moral standards,
73 regardless of whether it directly involves EMS practice.
- 74 2.17 “**National EMS ID number**” means: a randomly generated, unique 12-digit identification
75 number issued by the National Registry of EMTs.
- 76 2.18 “**Notify the Commission**” means: communication whether written, verbal or through
77 submission of information through the Coordinated Database. For the purposes of these
78 Rules, submission of information to the Coordinated Database shall be deemed to have

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79 satisfied any requirements under the Compact to a Home State or Member State. Nothing in
80 the Commission Rules shall be construed as prohibiting the sharing of information directly
81 between Member States, assuming all other requirements for submission to the Coordinated
82 Database are satisfied.

- 83 **2.19** “**Non-Member State**” means: a State, territory or jurisdiction of the United States that has
84 not enacted the Compact.
- 85 **2.20** “**Personally Identifiable Information**” (PII) means: any representation of information that
86 permits the identity of an individual to whom the information applies to be reasonably
87 inferred by either direct or indirect means. Further, PII is defined as information: (i) that
88 directly identifies an individual (e.g., legal name, address, social security number or other
89 identifying number or code, telephone number, email address, etc.) or (ii) by which an agency
90 intends to identify specific individuals in conjunction with other data elements, i.e., indirect
91 identification. (These data elements may include a combination of gender, race, birth date,
92 geographic indicator, and other descriptors). Additionally, information permitting the physical
93 or online contacting of a specific individual is the same as personally identifiable information.
94 This information can be maintained in either paper, electronic or other media.
- 95 **2.21** “**Privilege to Practice**” means: an individual’s authority to deliver emergency medical
96 services in Remote States as authorized under this compact.
- 97 **2.22** “**Provisional Privilege to Practice**” means: a temporary form of Compact recognition
98 granted to an EMS Clinician who holds a license that meets all but one or more of the criteria
99 for a Qualified License under Rule 4.7(B). Provisional Privilege to Practice is not
100 automatically recognized by Remote States and requires individual state-level review and
101 approval as outlined in Rule 4.2.
- 102 **2.23** “**Remote State Appropriate Authority**” means: the State EMS Authority, the Physician
103 EMS Medical Director, or the EMS Agency.
- 104 **2.24** “**Rule**” means: a written Statement by the Commission promulgated pursuant to Section 12 of
105 the Compact that is of general applicability; implements, interprets, or prescribes a policy or
106 provision of the Compact; or is an organizational, procedural, or practice requirement of the
107 Commission and has the force and effect of statutory law in a Member State and includes the
108 amendment, repeal, or suspension of an existing Rule.
- 109 **2.25** “**Scope of Practice**” means: defined parameters of various duties or services that may be
110 provided by an individual with specific credentials. Whether regulated by rule, statute, or
111 court decision, it tends to represent the limits of services an individual may perform.
- 112 **2.26** “**Serious Misdemeanor**” means: a criminal offense, classified as a misdemeanor under
113 applicable state law, that involves conduct of a serious nature—such as violence, theft, or
114 other acts that could reasonably be considered to pose a threat to public safety or trust if
115 committed by an EMS clinician.
- 116 **2.27** “**State**” means: any State, commonwealth, district, or territory of the United States.
- 117 **2.28** “**State EMS Authority**” means: the board, office, or other agency with the legislative
118 mandate to License EMS personnel.

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- 155 (2) Ineligible for Privilege to Practice restoration. The Home State EMS authority
156 where the action was taken does not authorize the individual to request
157 reinstatement of the Privilege to Practice in Remote States.

158 **4.2 Restoration or Recognition of Privilege to Practice.** The restoration or recognition of the
159 Privilege to Practice shall only occur when:

- 160 (A) the Home State License is restored, unrestricted, or determined to meet the
161 requirements for recognition under Rule 4.7(B);
- 162 (B) the Privilege to Practice restoration or recognition is authorized as Stated in section
163 4.1(B)(1) of these Rules and
- 164 (1) the Remote State restores the Privilege to Practice or removes the restriction of
165 the privilege to practice; and
- 166 (2) the EMS Clinician whose License or Privilege to Practice in any Member State
167 is restricted, suspended, or revoked has submitted a request to each Remote
168 State wherein the individual wishes to have a privilege to practice.

169 **4.3 EMS Clinicians Licensed in non-reporting Home States.** EMS Clinicians Licensed in a
170 Home State that does not collect and submit all elements of the Uniform Data Set are not
171 automatically eligible to practice in a Remote State under the Privilege to Practice until the
172 Home State has submitted all elements of the Uniform Data Set in the manner prescribed by
173 the Commission.

- 174 (A) **Manual Verification.** During a period when a Member State is not in compliance
175 with the Coordinated Database integration, A Remote State may, at its sole discretion,
176 manually verify an EMS Clinician's licensure status directly from the Home State. If
177 the Remote State determines that the EMS Clinician is otherwise in compliance with
178 Section 4(A)-(E), the Remote State may recognize the Privilege to Practice of the
179 EMS Clinician while the Home State works to achieve full compliance with the
180 Uniform Data Set submission requirements.

181 **4.4 Scope of Practice.** An EMS Clinician providing patient care in a Remote State under the
182 Privilege to Practice shall function within the Scope of Practice authorized by the EMS
183 Clinician's Home State unless or until modified by the Remote State Appropriate Authority.
184 When providing care in a Remote State:

- 185 (A) The EMS Clinician must practice only through an EMS Agency that is authorized to
186 operate in the Remote State.
- 187 (B) If the modified Scope of Practice differs from or exceeds that of the Home State, the
188 Remote State Appropriate Authority may:
- 189 (i) Require additional education or training; and/or
- 190 (ii) Mandate a demonstration of competency; and/or
- 191 (iii) Restrict the EMS Clinician's Scope of Practice.

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192 **4.5 EMS Clinician responsibility.** An EMS Clinician providing patient care in a Remote State
193 under the Privilege to Practice is responsible for adhering to the Scope of Practice
194 modifications or limitations for that Remote State, as may be modified by a Remote State
195 Appropriate Authority.

196 **4.6 Professional Code of Conduct.** EMS Clinicians functioning under the Privilege to Practice
197 shall adhere to the *Professional Code of Conduct* as adopted by the Commission. The
198 *Professional Code of Conduct* outlines ethical and professional behavior standards expected
199 of all EMS Clinicians operating in Member States under the Privilege to Practice.

- 200 (A) Failure to adhere to the *Professional Code of Conduct* shall be referred to both the
201 EMS Clinician's Home State and Remote State for investigation and may be grounds
202 for restriction, suspension, or revocation of the EMS Clinician's Privilege to Practice,
203 as provided by the Rules of the Commission.
- 204 (B) The Home State and Remote State shall coordinate on any disciplinary actions related
205 to violations of the *Professional Code of Conduct* that affect the EMS Clinician's
206 Privilege to Practice.
- 207 (C) The Commission shall notify all Member States of any disciplinary actions or
208 sanctions imposed in relation to violations of the *Professional Code of Conduct*
- 209 (D) The *Professional Code of Conduct* shall be reviewed and updated as necessary by the
210 Commission. The most current version of the *Professional Code of Conduct* will be
211 made available on the Commission's website.

212 **4.7 Qualified Licenses, Provisional Privileges to Practice, and Non-Qualified Licenses**

- 213 (A) **Qualified EMS Clinician License.** A Qualified EMS Clinician License is one that has
214 been issued by a Member State that also meets all the following criteria:
- 215 (1) The license is issued at the level of Emergency Medical Technician (EMT) up to
216 the level of Paramedic, including any license levels in between, including but
217 not limited to Advanced EMT or EMT-Intermediate.
- 218 (2) The license is issued to an individual who is at least 18 years old.
- 219 (3) For individuals licensed on or before the date their state joined the Compact, the
220 license is recognized as qualified, regardless of prior National Registry of
221 EMTs certification status.
- 222 (4) For initial licenses issued after the state joined the Compact, the EMS Clinician
223 shall have a valid National Registry of EMTs certification at the time of initial
224 license application.
- 225 (5) For initial licenses issued after March 15, 2025, the State EMS Authority shall
226 require a criminal background check of all applicants for initial licensure,
227 including the use of the results of fingerprint or other biometric data checks
228 compliant with the requirements of the Federal Bureau of Investigation with

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229 the exception of federal employees who have suitability determination in
230 accordance with US CFR §731.202.

231 (6) The license was not issued to an individual with a Conviction Requiring Review,
232 as defined in Section 2 of these Rules.

233 (B) Provisional Privilege to Practice.

234 (1) An EMS Clinician who meets all criteria for a Qualified License except one or
235 more of the following may be issued a Provisional Privilege to Practice:

236 (i) The EMS Clinician did not have a valid National Registry of EMTs
237 certification at the time of initial license application in a Member State that had
238 already joined the Compact;

239 (ii) The EMS Clinician's initial license was issued after March 15, 2025,
240 without review of a biometric criminal history check by the State EMS
241 Authority or its designee;

242 (iii) The EMS Clinician holds a license and has a Conviction Requiring
243 Review, as defined in Section 2.

244 (2) Determination of whether a Conviction Requiring Review disqualifies an
245 individual from a Privilege to Practice shall remain at the discretion of the
246 Member State EMS Authority, consistent with applicable State laws and
247 regulations.

248 (3) A Provisional Privilege to Practice is not automatically recognized by Remote
249 States. An EMS Clinician with this status must seek recognition under Rule 4.2
250 (Restoration or Recognition of Privilege to Practice) from each Remote State
251 where they intend to practice.

252 (C) **Definition of a Non-Qualified License.** A Non-Qualified License is any license that does
253 not meet the criteria of either a Qualified License or a Provisional Privilege to
254 Practice, including but not limited to:

255 (1) Licenses issued by any state or jurisdiction that is not a Member State.

256 (2) Licenses issued by any Member State that is not in compliance with the provisions
257 of the EMS Compact legislation or Administrative Rules and for which the
258 Member State has been sanctioned by the Commission.

259 (3) Licenses issued below the level of EMT, such as Emergency Medical Responder
260 (EMR) or First Responder.

261 (4) Licenses issued for any EMS clinician role that is not certified by the National
262 Registry of EMTs, or any license issued for a role above the Paramedic level—
263 even if the individual provides pre-hospital or EMS-related services—are not
264 considered qualifying EMS licenses. This includes, but is not limited to,
265 licenses held by nurses, physician assistants, physicians, respiratory therapists,
266 or any other healthcare or medical professional not certified at the EMT,
267 AEMT, or Paramedic level by the National Registry.

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(D) Impact on Compact Privilege to Practice.

- (1) Only individuals holding a Qualified License are may exercise the Compact Privilege to Practice in any Member State.
- (2) Individuals with a Provisional Privilege to Practice are not automatically eligible and must obtain approval under Rule 4.2 from each Remote State.
- (3) Individuals with a Non-Qualified License are ineligible for the Compact Privilege to Practice.

SECTION 5. Conditions Of Practice In A Remote State

5.0 Privilege to Practice Circumstances

- (A) As used in Section 5 of the Compact, the term “individual” shall mean an EMS Clinician who holds a current, active license issued by a Member State and who is granted a Compact Privilege to Practice under the terms of the Compact and Commission Rules.
- (B) An EMS Clinician practicing under a Privilege to Practice in a Remote State must do so only in the performance of their official EMS duties as assigned by an appropriate authority, which may include an EMS agency, authority having jurisdiction, or other legally authorized employer or supervisor, as recognized by the Remote State.
- (C) An EMS Clinician may practice in a Remote State under the Compact Privilege to Practice until the individual is no longer qualified under the Compact and Commission Rules. As specified in the Compact, there is no time limit on an EMS Clinician’s exercise of the Privilege to Practice.

SECTION 6. Not Used

SECTION 7. Not Used

SECTION 8. Adverse Actions

8.0 Investigation.

- (A) Member States shall collaborate in investigating alleged individual misconduct.
- (B) In those cases where the subject is licensed by one or more Member States and therefore has more than one Home State, the responsibility for the investigation shall fall to the Home State that Licenses, certifies, Commissions, or otherwise authorizes the agency or appropriate authority for which the subject was providing patient care when the alleged misconduct occurred.
- (C) Upon discovery that an EMS Clinician is under investigation in another Member State, the Member State may contact the investigating Member State and request investigative documents and information.
- (D) This section shall not be construed as limiting any Member State’s authority to investigate any conduct within that State, or to investigate any Licensee.

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8.1 Reporting of adverse actions.

- 304
- 305 (A) A Remote State that imposes adverse action against an EMS Clinician's privilege to
306 practice, shall notify the Commission as soon as possible, but no later than two (2)
307 business days after the imposition of the adverse action.
- 308 (B) A Home State that imposes adverse action against an EMS Clinician's License shall
309 notify the Commission as soon as possible, but no later than two (2) business days
310 after the imposition of the adverse action and notify the individual in writing that the
311 individual's Remote State Privilege to Practice is revoked.
- 312 (C) Member States are not required to report any other information regarding adverse
313 actions to the Commission other than what is available in the public record of the
314 reporting Member State though nothing herein shall prohibit a Member State from
315 sharing with another Member State, or a non-Member State, such additional
316 information as the Member State concludes is appropriate.

SECTION 9. Not Used

SECTION 10. The Commission.

10.0 (Reserved)

321 **10.1 New Member State.** The Commission shall notify all Member States within fifteen (15)
322 calendar days when a new Member State enacts the Compact.

10.2 Process for Review of New State Laws or Amendments to Compacts:

- 324 (A) Upon enactment by any State, commonwealth, district, or territory of the United
325 States, of a law intended as that jurisdiction's adoption of the Compact, the Executive
326 Committee shall review the enacted law to determine whether it contains any
327 provisions which materially conflict with the Compact Model Legislation.
- 328 (1) To the extent possible and practicable, this determination shall be made by the
329 Executive Committee after the date of enactment but before the effective date
330 of such law. If the timeframe between enactment and effective date is
331 insufficient to allow for this determination to be made by the Executive
332 Committee prior to the law's effective date, the Executive Committee shall
333 make the determination required by this paragraph as soon as practicable after
334 the law's effective date. The fact that such a review may occur subsequent to
335 the law's effective date shall not impair or prevent the application of the
336 process set forth in this Section 10.2.
- 337 (2) If the Executive Committee determines that the enacted law contains no
338 provision which materially conflicts with the Compact Model Legislation, the
339 State shall be admitted as a party to the Compact and to membership in the
340 Commission pursuant to Section 10 of the Compact Model Legislation upon
341 the effective date of the State's law and thereafter be subject to all rights,

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- 342 privileges, benefits and obligations of the Compact, these Rules and the
343 bylaws.
- 344 (3) In the event the enacted law contains one or more provisions which the
345 Executive Committee determines materially conflicts with the Compact Model
346 Legislation, the State shall be ineligible for membership in the Commission or
347 to become a party to the Compact, and the State shall be notified in writing
348 within fifteen (15) business days of the Executive Committee's decision.
- 349 (4) A State deemed ineligible for Compact membership and Commission
350 participation pursuant to this Section 10.2 shall not be entitled to any of the
351 rights, privileges or benefits of a Compact State as set forth in the Compact,
352 these Rules and/or the bylaws. Without limiting the foregoing, a State deemed
353 ineligible for membership and participation shall not be entitled to appoint a
354 Commissioner, to receive non-public data from the Coordinated Database
355 and/or to avail itself of the default and technical assistance provisions of the
356 Compact. EMS Practitioners Licensed in a State deemed ineligible for
357 membership and participation hereunder shall be ineligible for the Privilege to
358 Practice set forth in the Compact and these Rules.
- 359 (B) A State determined to be ineligible for Commission membership and Compact
360 participation pursuant to this Section 10.2 may, within thirty (30) calendar days of the
361 date of the decision, appeal in writing the Executive Committee's decision to the
362 Commission. An appeal received by the Commission shall be deemed filed on the date
363 it is sent to the Commission. If there is an appeal to the Commission, the Commission
364 shall review de novo whether the State's enacted law materially conflicts with the
365 Compact Model Legislation. The provisions of 10.2(A)(4) of these Rules shall apply
366 during the pendency of any such appeal. The decision of the Commission may be
367 appealed within thirty (30) calendar days of the date of its decision to a court of
368 competent jurisdiction subject to the venue provisions of Section 10(A)(2) of the
369 Compact. The appealing State shall bear all costs of the appeal and the Commission
370 shall not bear any costs relating to the appeal.
- 371 (C) Subsequent to the determination that a State's enacted law contains provision(s) which
372 materially conflict(s) with the Compact Model Legislation, the State may enact new
373 legislation to remove the conflict(s). The new legislation shall be reviewed as set forth
374 in this Section 10.2(A) and (B) above.
- 375 (D) In the event a Compact State, subsequent to its enactment of the Compact, enacts
376 amendment(s) to its Compact law, or enacts another law or laws which may in any
377 way alter or impact any provision or application of the State's enacted Compact law,
378 the Compact State shall so inform the Commission within fifteen (15) business days of
379 the enactment of such amendment(s) or law(s). After being so informed by the
380 Compact State, or learning of such amendment(s) or law(s) from any other source, the
381 Commission shall review the amendment(s) or law(s) to determine if such
382 amendment(s) or law(s) materially conflict with the State's enacted Compact law. In
383 the event the Commission determines such amendment(s) or law(s) materially

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384 conflict(s) with the Compact, the Commission shall determine if the amendment(s) or
385 law(s) constitute a condition of default pursuant to Section 13(B) of the Compact and,
386 if so, proceed according to the process established in Section 13 and Commission
387 Rules.

388 (E) For the purpose of determining whether a State's law intended as enactment of the
389 Compact, or any provision of any enacted law or amendment, materially conflicts with
390 the Compact Model Legislation or the State's enacted Compact, the Executive
391 Committee and the Commission shall consider the following, among other factors:

- 392 (1) Whether the provision constitutes a material alteration of the rights and
393 obligations of the enacting State or of Member States.
- 394 (2) Whether the provision enlarges the liability or compromises the immunity of
395 the Commission or any authorized agent of the Commission.
- 396 (3) Whether the provision modifies venue in proceedings involving the
397 Commission.
- 398 (4) Whether the provision restricts the privileges or authorizations to practice as
399 set forth in the Compact Model Legislation.
- 400 (5) Whether the provision would allow the State to negate or delay the
401 applicability of a duly promulgated Commission Rule in the State.
- 402 (6) Whether the provision would result in the reduction or elimination of fees,
403 levies or assessments payable by the State.
- 404 (7) Whether the provision fundamentally alters the nature of the agreement entered
405 into by Member States that have adopted the Compact.
- 406 (8) Whether there is a remedial mechanism, satisfactory to the Executive
407 Committee and/or Commission, whereby the effect of such law or amendment
408 can be mitigated to minimize or eliminate the practical effect of any material
409 conflict.
- 410 (9) Whether the provision strikes or amends Compact Model Legislation language
411 based upon a provision of the Compact Model Legislation being contrary to
412 the Constitution of that State, and the Executive Committee and/or
413 Commission determines that the remainder of the Compact can be
414 implemented effectively, and without compromising the rights of the
415 Commission and the Member States, without such provision, to the extent the
416 Executive Committee and/or Commission concur that such provision is
417 unconstitutional in the State.

418 **10.3 New Member State Implementation.** New States admitted as a party to the Compact and to
419 membership shall within three (3) calendar months from the enactment date, or as otherwise
420 specified in the enabling legislation, provide the Commission an implementation plan and
421 implementation date.

422 **10.4 Commissioner Appointment.**

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- 423 (A) Member States shall:
- 424 (1) appoint one delegate, also known as a Commissioner, to serve on the
- 425 Commission, in accordance with Section 10(B)(1) of the Compact Model
- 426 Legislation; and
- 427 (2) ensure the appointed Commissioner is the responsible official of the State EMS
- 428 Authority or his designee;
- 429 (3) ensure any Commissioner vacancy is promptly filled within thirty (30)
- 430 calendar days.
- 431 (B) In the event that more than one State entity (Committee, office, department, agency,
- 432 etc.) has the legislative authority to License EMS Practitioners, the Governor shall
- 433 determine which entity will be responsible for assigning the delegate.
- 434 (C) Appointed Commissioners shall not be represented by or vote by proxy.
- 435

436 SECTION 11. Coordinated Database

437 11.0 The Coordinated Database — General

- 438 (A) **Coordinated Database Ownership.** The Coordinated Database is owned, operated,
- 439 managed, and controlled by the Commission.
- 440 (B) **Data Ownership.**
- 441 (1) **Member State Data:** Member State data refers to any data provided by the
- 442 Member State. All data submitted by a Member State to the Coordinated
- 443 Database remains the property of the Member State. Any use of the data in the
- 444 Coordinated Database, other than that expressly allowed by the Commission, is
- 445 prohibited.
- 446 (2) **Derived Data:** Derived data refers to any data that is generated or produced by
- 447 the Commission from Member State data or other external data sources.
- 448 Derived data includes analyses, reports, and aggregated statistics created by the
- 449 Commission. Derived data is owned by the Commission.
- 450 (3) **Compact Data:** Compact data refers to any data that is generated directly by
- 451 the Compact itself, independent of Member State submissions or third-party
- 452 data. This includes internal administrative data, operational metrics, and other
- 453 information produced by the Compact's activities. Examples of Compact data
- 454 include the Privilege to Practice status and history. Compact data is owned by
- 455 the Commission.
- 456 (4) **Third-Party Data:** The Commission may incorporate additional third-party
- 457 data from government and/or non-government sources into the Coordinated
- 458 Database for the purpose of the Commission fulfilling its legislative mandates.
- 459 Third-party data remains the property of the data owner providing the data,

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460 unless otherwise specified in data use agreements. This data is under the
461 custody and control of the Commission.

462 11.1 Data Submission and Validation

- 463 (A) **Method of data submission.** Member States shall submit the Uniform Data Set
464 described in Section 11.3 of these Rules to the Coordinated Database.
- 465 (B) **Primary Source Equivalency.** Member State data records in the Coordinated
466 Database are an accurate reflection of the Member State licensure status for EMS
467 Clinicians. The Coordinated Database status is equivalent to validating an EMS
468 Clinician's status directly with the Member State.
- 469 (C) **Implementation.** A new Member State shall provide the Uniform Data Set to the
470 Coordinated Database in the form and format specified by the Commission. In the
471 event a Member State does not submit the Uniform Data Set, the Member State shall
472 be in default of the requirements of the Compact and the Commission. In situations
473 where there is a default in the submission of the Uniform Data Set by a Member State,
474 the Commission shall follow the requirements in Section 13.
- 475 (D) **Maintenance of Uniform Data Set.** The accuracy of Member State data submitted to
476 and maintained in the Coordinated Database, shall be the responsibility of Member
477 State.
- 478 (E) **Correction of records.** In the event an EMS Clinician asserts that the individual's
479 Uniform Data Set information is inaccurate, the Commission shall direct the EMS
480 Clinician to the data owner to research the claim, and, if necessary, modify the
481 disputed record(s). The Commission shall not modify Member State data or Third
482 Party Data.

483 11.2 Conditions and procedures for authorized users of the Coordinated Database

484 (A) Member State Access

- 485 (1) **Access Rights:** Member State Commissioners, and delegate user(s)
486 authorized by the Commissioner, shall have access to the Coordinated
487 Database.
- 488 (2) **Control and Authorization:** Member State delegate user(s) access shall be
489 controlled by the Member State Commissioner. The Commissioner is
490 responsible for designating state employees with a bona fide need to know
491 requirement to have access to the Coordinated Database. The Commissioner
492 shall submit requests for user accounts and access in writing to the
493 Commission. The Commissioner shall notify the Commission promptly, in
494 writing, but within 72 hours if any delegate user is no longer employed by the
495 Member State or should have access removed.

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- 496 (3) **Review Process:** Commissioners shall review the delegate accounts on at
497 least a quarterly basis.
- 498 (4) **Usage Limitation:** Access to the Coordinated Database is for official,
499 government use only.
- 500 **(B) Government Access**
- 501 (1) **Access Rights:** Government entities may request limited access to the
502 Coordinated Database. Access is restricted to governmental agencies
503 approved by the Commission.
- 504 (2) **Query Capabilities:** Authorized governmental agencies, for official
505 purposes, may query the Coordinated Database via a legal First Name and
506 legal Last Name, National EMS ID number, State License Number, National
507 Registry Number, or Social Security Number.
- 508 (3) **Data Access:** In addition to all data categorized as public information listed in
509 Section 11.2(C)2, government agencies shall have access to the following:
- 510 (a) State License status
- 511 (b) Indication if final disciplinary or adverse action has been taken, in the
512 form of a final National Practitioner Data Bank report submission.
- 513 **(C) Public Access**
- 514 (1) **Query Capabilities:** The public shall have the ability to query the
515 Coordinated Database via a secure website or webserver. The public portal
516 shall be limited to querying a single EMS Clinician at a time, and the query
517 may be initiated by entering a valid 12-digit National EMS ID number, the
518 EMS Clinician's First Name and Last Name, or a State License Number.
- 519 (2) **Displayed Information:** The Commission may display the following
520 information when a valid National EMS ID number is provided:
- 521 (a) Legal First Name
- 522 (b) Legal Last Name
- 523 (c) National EMS ID Number
- 524 (d) Privilege to Practice Status

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- 525 (e) State Licensure Status
- 526 (f) State Number/Identifier
- 527 (g) Jurisdiction(s) issuing the License
- 528 (h) License level(s)
- 529 (i) License expiration date(s)
- 530 (j) Third-party data as authorized by the Commission.

531 (D) Employer Access

- 532 (1) **Individual EMS Clinician Search:** an Employer of an ems clinician may
533 query a single EMS Clinician at a time, and the query may be initiated by
534 entering a valid 12-digit National EMS ID number, the EMS Clinician's legal
535 First Name and legal Last Name, or a State License Number.
- 536 (2) **Bulk Search Capability:** an Employer of an ems clinician may perform bulk
537 searches of ems clinicians using National EMS ID Numbers in a form and
538 format specified by the Commission.
- 539 (3) **User Account Validation:** Employers of ems clinicians must have a
540 validated user account to access the system.
- 541 (4) **Displayed Information:** Employers of ems clinicians will have access to the
542 Public Access data for each employee searched.

543 (E) General Provisions

- 544 (1) **Authorization:** All requests and designations must be made in accordance
545 with the procedures established by the Commission.
- 546 (2) **Review and Audit:** The Commission reserves the right to review and audit
547 access logs to ensure compliance with established Rules and regulations.

548 **11.32 Uniform Data Set.** Member States shall submit the following Uniform Data Set to the
549 Coordinated Database at the frequency indicated.

- 550 (A) **Identifying information.** The following information for each EMS Clinician who is
551 Licensed must be reported within ten (10) business days of completion of licensure
552 application process. Any changes must be reported within ten (10) business days of
553 the change being processed by the Member State.

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- 554 (1) Full legal name (first, middle, last); and
555 (2) suffix (if applicable); and
556 (3) date of birth (month, day, year); and
557 (4) Mailing address; and
558 (5) eMail address; and
559 (6) Phone number; and
560 (7) identification number (one or both of the following):
561 (a) Social Security Number
562 (b) National EMS ID number.
- 563 **(B) Licensure data.** The following information for each EMS Clinician who is Licensed
564 in the Member State must be reported within ten (10) business days of completion of
565 licensure process. Any changes must be reported within ten (10) business days of the
566 change being processed by the Member State.
- 567 (1) State of licensure; and
568 (2) License level; and
569 (3) effective date of License; and
570 (4) expiration date of License; and
571 (5) License number; and
572 (6) License status (if applicable, i.e. inactive, temporary, etc.)
- 573 **(C) Significant investigatory information.** In the fulfillment of public protection,
574 Member States shall submit significant investigatory information to the Coordinated
575 Database, including but not limited to:
- 576 (1) subject's identifying information as Stated in section 11.3(A) of these Rules;
577 and
578 (2) declaration of the existence of an investigation or pending adverse action
579 related to the incident or act of misconduct.
- 580 **(D) Adverse actions imposed on an individual's License.** The following information
581 must be reported as soon as possible, but no later than two (2) business days of
582 imposition of the adverse action. Any changes to the status of the adverse action must
583 be reported as soon as possible, but no later than two (2) business days of the change
584 being processed by the Member State:
- 585 (1) subject's identifying information as Stated in Section 11.32(A) of these Rules;
586 and
587 (2) summary description of the incident or act of misconduct; and

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- 588 (3) declaration of the existence of a criminal investigation or pending criminal
589 charges related to the incident or act of misconduct; and
- 590 (4) declaration of the action taken by the Member State; and
- 591 (5) effective date of the action taken; and
- 592 (6) duration of the action.
- 593 **(E) Privilege to practice status.** The information as described in section 4.1 of these
594 Rules for each EMS Clinician Licensed by the Member State must be reported within
595 one (1) month of the effective date of the Privilege to Practice status. Any changes to
596 the Privilege to Practice status must be reported as soon as possible, but no later than
597 two (2) business days of the change being processed by the Member State.
- 598 **(F) Non-confidential alternative program participation information.** To the extent
599 allowed by a Member State's laws, non-confidential information concerning an EMS
600 Clinician's participation in an alternative program will be reported.
- 601 **(G) Denial of application for licensure.** Any final denial of applications for licensure,
602 due to significant cause or public protection concerns, must be reported within two (2)
603 days of the denial. The following information shall be reported to the Coordinated
604 Database:
- 605 (1) Applicant's identifying information as Stated in Section 11. 3(A) of these
606 Rules; and
- 607 (2) Summary of the reason for denial, specifically highlighting the cause or public
608 protection concerns; and
- 609 (3) Declaration, if applicable, of the existence of a criminal investigation or
610 pending criminal charges related to the denial; and
- 611 (4) Declaration of any restrictions on future applications for licensure, or a
612 Statement indicating that there are no such restrictions.
- 613 **(H) Other acts of misconduct or criminal convictions.** Individual acts of misconduct or
614 criminal convictions that a Member State becomes aware of, from sources other than
615 the FBI background check that may result in action against an EMS Clinician's
616 License or Privilege to Practice in any Member State must be reported as soon as
617 possible, but no later than two (2) business days of discovery by the State making the
618 discovery.
- 619 **(I) Compliance with 28 C.F.R. §20.3.** Nothing in these Rules shall require or permit the
620 sharing or reporting of Criminal History Record Information as that term is defined in
621 28 C.F.R. §20.3 in a manner that is prohibited by law.
- 622 **11.4 Data Disclosure, Inspection of Records, and Requests.**
- 623 **(A) Exemption From Disclosure.** The following Commission records shall be exempt
624 from public inspection or disclosure requests:
- 625 (1) The following EMS Clinician information:

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- 626 a. personal identifying information; and
627 b. personal contact information; and
628 c. disciplinary records; and
629 d. any data elements labeled as confidential by the data owner.
- 630 (2) The following internal Commission records:
- 631 a. personnel records of Commission staff;
632 b. Commission personnel practice and procedures;
633 c. matters specifically exempted from disclosure by federal or state
634 statutes
635 d. trade secrets, commercial, or financial information that is privileged or
636 confidential;
637 e. censures and accusations of a crime;
638 f. personal information where disclosure would constitute an
639 unwarranted invasion of personal privacy;
640 g. investigative records compiled for law enforcement purposes;
641 h. information that specifically relates to a civil action or other legal
642 proceeding except by order of a court with jurisdiction;
643 i. closed session records related to any of the above topics;
644 j. records that contain legal advice or attorney-client communications or
645 attorney work product;
646 k. confidential mediation or arbitration documents.
- 647 (3) After consultation with counsel, the Commission may designate records not
648 designated exempt under sections (1) or (2) to be confidential and not available
649 to the public for inspection.
- 650 **(B) Direction of Data Requests:** The Commission shall direct all requests for data that
651 are not otherwise published or accessible by the data requestor to the designated data
652 owner.
- 653 **(C) Restriction on Release of Personally Identifiable Information and Sensitive Data:**
654 The Commission shall not release or generate public reports that contain Personally
655 Identifiable Information, information that is exempt from disclosure under these rules,
656 or sensitive data. All measures shall be taken to ensure that such information remains
657 confidential and secure.
- 658 **(D) Security and Protection:** The Commission shall take all necessary precautions to
659 protect the security and integrity of the information contained in the coordinated
660 database. This includes implementing robust security measures and protocols to
661 prevent unauthorized access, disclosure, or misuse of data.

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- 662 (E) **Generation of Public Reports:** The Commission may, at its sole discretion, generate
663 public reports that include summarized statistics and analytics on the EMS workforce.
664 These reports shall not contain Personally Identifiable Information or sensitive data
665 and will be designed to provide valuable insights and trends without compromising
666 individual privacy.

668 SECTION 12. Rulemaking

- 669 **12.0 Proposed Rules or amendments.** Proposed Rules or amendments to the Rules shall be
670 adopted by majority vote of the members of the Commission. Proposed new Rules and
671 amendments to existing Rules shall be submitted to the Commission office for referral to the
672 Rules committee as follows:
- 673 (A) Any Commissioner may submit a proposed Rule or Rule amendment for referral to the
674 Rules committee during the next scheduled Commission meeting. This proposal shall
675 be made in the form of a motion and approved by a majority vote of a quorum of the
676 Commission members present at the meeting.
- 677 (B) Standing committees of the Commission may propose Rules or Rule amendments by
678 majority vote of that Committee.
- 679 **12.1 Preparation of draft Rules.** The Rules committee shall prepare a draft of all proposed Rules
680 and provide the draft to all Commissioners for review and comments. Based on the comments
681 made by the Commissioners the Rules Committee shall prepare a final draft of the proposed
682 Rule(s) or amendments for consideration by the Commission not later than the next
683 Commission meeting.
- 684 **12.2 Publication of draft Rules.** Prior to promulgation and adoption of a final Rule (in accordance
685 with Section 12 of the Compact) the Commission shall publish the text of the proposed Rule
686 or amendment prepared by the Rules committee not later than sixty (60) days prior to the
687 meeting at which the vote is scheduled, on the official website of the Commission and in any
688 other official publication that may be designated by the Commission for the publication of its
689 Rules. All written comments received by the Rules committee on proposed Rules shall be
690 posted on the Commission's website upon receipt. In addition to the text of the proposed Rule
691 or amendment, the reason for the proposed Rule shall be provided.
- 692 **12.3 Notification.** Each administrative Rule or amendment shall State:
- 693 (A) The place, time, and date of the scheduled public hearing, if any;
- 694 (B) The manner in which interested persons may submit notice to the Commission of their
695 intention to attend the public hearing and any written comments; and
- 696 (C) The name, position, physical and electronic mail address, telephone, and telefax
697 number of the person to whom interested persons may respond with notice of their
698 attendance and written comments.

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- 699 **12.4 Public Hearings.** Every public hearing shall be conducted in a manner guaranteeing each
700 person who wishes to comment a fair and reasonable opportunity to comment. In accordance
701 with Section 12.H. of the Compact, specifically:
- 702 (A) If a hearing is held on the proposed Rule or amendment, the Commission shall publish
703 the place, time, and date of the scheduled public hearing.
- 704 (B) All persons wishing to be heard at the hearing shall notify the Chairperson of the
705 Commission or other designated member in writing of their desire to appear and
706 testify at the hearing not less than five (5) business days before the scheduled date of
707 the hearing.
- 708 (C) Hearings shall be conducted in a manner providing each person who wishes to
709 comment a fair and reasonable opportunity to comment orally or in writing.
- 710 (D) No transcript of the public hearing is required, unless a written request for a transcript
711 is made; in which case the person or entity making the request shall pay for the
712 transcript. A recording may be made in lieu of a transcript under the same terms and
713 conditions as a transcript. This subsection shall not preclude the Commission from
714 making a transcript or recording of the public hearing.
- 715 (E) Nothing in this section shall be construed as requiring a separate hearing on each Rule.
716 Rules may be grouped for the convenience of the Commission at hearings required by
717 this section.
- 718 (F) Following the scheduled hearing date, or by the close of business on the scheduled
719 hearing date if the hearing was not held, the Commission shall consider all written and
720 oral comments received.
- 721 (G) The Commission shall, by majority vote of a quorum of the Commissioners, take final
722 action on the proposed Rule and shall determine the effective date of the Rule, if any,
723 based on the Rulemaking record and the full text of the Rule.
- 724 **12.5 Status of Rules upon adoption of additional Member States.** Any State that joins the
725 Compact subsequent to the Commission's initial adoption of the Rules shall be subject to the
726 Rules as they exist on the date on which the Compact becomes law in that State. Any Rule
727 that has been previously adopted by the Commission shall have the full force and effect of
728 law on the day the Compact becomes law in that State.
- 729 **12.6 Emergency Rulemaking.** Upon determination that an emergency exists, the Commission
730 may consider and adopt an emergency Rule that shall become effective immediately upon
731 adoption, provided that the usual Rulemaking procedures provided in the Compact and in this
732 section shall be retroactively applied to the Rule as soon as reasonably possible, in no event
733 later than ninety (90) days after the effective date of the Rule. An emergency Rule is one that
734 must be made effective immediately in order to:
- 735 (A) Meet an imminent threat to public health, safety, or welfare;
- 736 (B) Prevent a loss of federal or State funds;

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- 737 (C) Meet a deadline for the promulgation of an administrative Rule that is established by
738 federal law or Rule; or
- 739 (D) Protect public health and safety.
- 740

741 SECTION 13. Compliance Issues and Dispute Resolution Process

742 13.1 Initiation of Compliance

- 743 (A) Compliance issues shall be initiated by the Executive Committee.
- 744 (B) The Executive Committee shall first seek to provide remedial education and specific
745 technical assistance for any potential default.
- 746 (C) For unresolved potential defaults, the Executive Committee shall send a written notice
747 of non-compliance to the Commissioner in the Member State with the alleged non-
748 compliance issue. The State shall respond in writing within thirty (30) calendar days.
- 749 (1) If the Member States does not have a designated Commissioner, the written
750 notice of non-compliance shall be sent to the Governor of the Member State.
- 751 (2) If the State fails to respond to the written notice, the Executive Committee,
752 through the Executive Director, shall send a written notice of non-compliance
753 to the Governor of the Member State, copied to the Commissioner, with the
754 alleged non-compliance issue.
- 755 (3) If the response, in the determination of the Executive Committee fails to
756 reasonably resolve the non-compliance issue, the Executive Committee shall
757 request a written Plan of Correction.
- 758 (D) The Executive Committee shall provide a report and make a recommendation to the
759 Commission concerning issues of non-compliance that:
- 760 (1) do not have an approved Plan of Correction, with progress; or
- 761 (2) remain unresolved for three (3) or more calendar months.
- 762 (E) Grounds for default include but are not limited to, failure of a Compact State to
763 perform obligations or responsibilities imposed by the Compact, Commission Bylaws,
764 or duly promulgated Rules.
- 765 (F) If the Commission determines that a Compact State has at any time defaulted in the
766 performance of any of its obligations or responsibilities under the Compact, Bylaws or
767 duly promulgated Rules, the Commission shall notify the Commissioner and Governor
768 of the defaulting Compact State in writing. The Commission may impose any or all of
769 the following remedies:
- 770 (1) Remedial education and technical support as directed by the Commission;
- 771 (2) Damages and/or costs in such amounts as are deemed to be reasonable as fixed
772 by the Commission;

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- 773 (3) Suspension of membership in the Compact; and
774 (4) Suspension of the Privilege to Practice for EMS Clinicians whose Home State
775 license was issued by the defaulting Member State; and/or
776 (5) Termination of membership in the Compact as provided in the Model
777 Legislation and administrative Rules.
- 778 (G) If the Commission suspends the Privilege to Practice or terminates the membership of
779 the state in the Compact, the state shall promptly notify all EMS Clinicians licensed by
780 that state of the status change and impact of the suspension or termination.
- 781 (H) If the Commission suspends the Privilege to Practice qualifications or terminates the
782 membership of a state in the Compact, all Member States shall promptly notify all
783 licensed EMS Agencies of the status change of the affected Member State and the
784 resulting impact on the Privilege to Practice status for EMS Clinicians from that state.
785 At a minimum, such notification shall be published on the official website of each
786 Member State's EMS authority or in the same manner and publication used by that
787 state for proposed rules or regulatory announcements.
- 788 (I) The Commission shall not bear any costs relating to the defaulting Compact State
789 unless otherwise mutually agreed upon between the Commission and the defaulting
790 Compact State.

791 **13.2 Dispute Resolution Process – Informal, Mediation and Arbitration.**

- 792 (A) The Commissioner from each Compact State shall enforce the Compact and take all
793 actions necessary and appropriate to carry out the Compact's purpose and intent. The
794 Commission supports efforts to resolve disputes between and among Compact States
795 and encourages communication directly between Compact States prior to employing
796 formal resolution methods.
- 797 (B) Any Compact State may submit a written request to the Executive Committee for
798 assistance in interpreting the law, Rules, and policies of the Compact. The Executive
799 Committee may seek the assistance of the Commission's legal counsel in interpreting
800 the Compact. The Executive Committee shall issue the Commission interpretation of
801 the Compact to all parties to the dispute.
- 802 (C) Before submitting a complaint to the Executive Committee, the complaining Member
803 State and responding Member State shall attempt to resolve the issues without
804 intervention by the Commission.
- 805 (D) When disputes among Member States are unresolved through informal attempts, the
806 Commission shall request assistance from the Executive Committee.
- 807 (1) It is the duty of the Executive Committee to address disputes between or
808 among the Member States concerning the Compact when informal attempts
809 between the Compact States to resolve disputes have been unsuccessful.

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- 810 (2) The Executive Committee, on behalf of the Commission, in the reasonable
811 exercise of its discretion, has the authority to assist in the resolution of disputes
812 between and among Member States concerning the Compact.

813 (E) Informal Resolution

- 814 (1) In the event of a dispute arising from the interpretation or application of the
815 Compact by a Member State, the following procedure shall be followed:
- 816 (a) The Commissioner of the disputing State shall initiate contact with the
817 Commissioner(s) of the Member State(s) involved in the dispute.
 - 818 (b) The initiating Commissioner shall provide a written Statement to the
819 Commissioner(s) of the concerned State(s). This Statement, which will
820 be copied to the Executive Committee, shall detail the nature of the
821 dispute.
 - 822 (c) Upon receipt of the dispute letter, the Commissioner(s) of the State(s)
823 involved shall:
 - 824 (i) Review the contents of the letter.
 - 825 (ii) Conduct an inquiry into the matter.
 - 826 (iii) Provide a written response addressing the issues raised.
 - 827 (d) The response must be issued, in writing copied to the Executive
828 Committee, within 30 calendar days from the receipt of the dispute
829 letter.
 - 830 (e) If interpretation of the Compact is necessary, the Commissioner(s) shall
831 contact the Executive Committee via the Executive Director to request
832 assistance in interpreting relevant provisions.
 - 833 (f) The Commissioner raising the concern shall document all attempts to
834 resolve the issues.
- 835 (2) If the issues cannot be resolved between the Member States, the dispute shall
836 be referred to the Executive Committee for further consideration.
- 837 (3) Disputes between two (2) or more Member States which cannot be resolved
838 through informal resolution or through the Executive Committee, may be
839 referred to mediation and/or an arbitration panel to resolve the issues.

840 (F) Mediation.

- 841 (1) A Compact State that is a party to a dispute may request, or the Executive
842 Committee may require, the submission of a matter in controversy to
843 mediation.
- 844 (2) Mediation shall be conducted by a mediator appointed by the Executive
845 Committee from a list of mediators approved by the National Association of
846 Certified Mediators, or a mediator otherwise agreed to by all parties to the
847 dispute and pursuant to procedures customarily used in mediation proceedings.

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- 848 (3) If all issues are resolved through mediation to the satisfaction of all Member
849 States involved, no further action is required.
- 850 (4) In the event mediation is necessary, and unless otherwise agreed in advance by
851 all parties, the prevailing party or parties may be entitled to recover the costs of
852 such medication, including reasonable attorneys' fees, to the extent permitted
853 by State law of the prevailing party State. The Commission shall not be liable
854 for any fees, costs or charges pertaining to mediation.

855 (G) Arbitration.

- 856 (1) In the event of a dispute between Member States that cannot be resolved
857 through informal means or by mediation, the Commissioner of the initiating
858 Member State(s) shall submit an Arbitration Request form to the Executive
859 Director with a copy to be sent by the initiating State to the other Member
860 State(s) involved.
- 861 (2) Each Member State party to the dispute shall submit a signed Arbitration
862 Agreement.
- 863 (3) The Executive Director shall coordinate the arbitration process.
- 864 (4) The decision of the arbitrator(s) shall be final and binding.
- 865 (5) In the event arbitration is necessary, and unless otherwise agreed by the
866 parties, at the discretion of an independent arbitration panel, the prevailing
867 party or parties may be entitled to recover the costs of such arbitration,
868 including reasonable attorneys' fees, to the extent permitted by State law of the
869 prevailing party State. The Commission shall not be liable for any fees, costs
870 or charges pertaining to arbitration.
- 871 (6) Arbitration decisions may be enforced in a court of competent jurisdiction.

872 **13.3 Costs.** The Commission shall not bear any costs relating to the defaulting Compact State
873 unless otherwise mutually agreed upon between the Commission and the defaulting Compact
874 State.

875 **13.4 Judicial Enforcement.** The Commission may by majority vote of the Commissioners, initiate
876 legal action in the United States District Court for the Middle District of Pennsylvania to
877 enforce compliance with the provisions of the Compact, its duly promulgated Rules and
878 Bylaws against any Compact State in default. If judicial enforcement is necessary, the
879 prevailing party shall be awarded all costs of such litigation including reasonable attorney's
880 fees.

881 SECTION 14. Compact Implementation and Activation Date.

882 **14.1 Implementation Date.** The Compact was implemented on October 7, 2017, following the
883 enactment of the EMS Compact legislation in ten (10) Member States.

884 **14.2 Activation Date.** The Compact was activated on March 15, 2020.

885 SECTION 15. Not Used



INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

Bylaws

Adopted: October 17, 2017

Amended: June 13, 2023, November 15, 2023

ARTICLE I.

COMMISSION PURPOSE, FUNCTION AND BYLAWS

Section 1. Purpose

Pursuant to the terms of the Recognition of Emergency Medical Services (EMS) Personnel Licensure Interstate Compact (the "Compact"), The Interstate Commission for EMS Personnel Practice (the "Commission") is established as a body politic and an instrumentality of the compact states to fulfill the objectives of the Compact through a means of joint cooperative action among the Member States: to develop a comprehensive process that complements the existing licensing and regulatory authority of the State EMS Authority and extends to EMS personnel a Privilege to Practice across state boundaries in Member States, thereby providing immediate legal recognition to EMS personnel and ensuring the safety of patients.

Section 2. Functions.

In pursuit of the fundamental objectives set forth in the Compact, the Commission shall, as necessary or required, exercise all of the powers and fulfill all of the duties as provided by the Compact. The Commission's activities shall include, but are not limited to, the following: the promulgation of binding rules and operating procedures; equitable distribution of the costs, benefits and obligations of the Compact among the Member States; enforcement of Commission Rules, Operating Procedures and Bylaws; provision of dispute resolution; sharing of licensure history of Member State EMS personnel and coordination of significant investigatory information; and the collection and dissemination of information concerning the activities of the Compact, as provided by the Compact, or as determined by the Commission to be warranted by, and consistent with, the objectives and provisions of the Compact. The provisions of the Compact shall be reasonably and liberally construed to accomplish the purposes and policies of the Compact.

Section 3. Bylaws.

As required by the Compact, these Bylaws shall govern the management and operations of the Commission. As adopted and subsequently amended, these Bylaws shall remain at all times subject to, and limited by, the terms of the Compact.

ARTICLE II.

MEMBERSHIP

The Commission Membership shall be comprised as provided by the Compact. Each Member State shall have and be limited to one appointed voting representative. The appointees shall be the Commissioners of the Member States. Each Member State shall forward the names of its Commissioners to the Commission chairperson. The Commission chairperson or their designee shall promptly advise the State EMS Authority of the Member State of the need to appoint a new Commissioner whenever a vacancy occurs.

ARTICLE III.

OFFICERS

Section 1. Election and Succession.

The officers of the Commission shall include a chairperson, vice chairperson, secretary, and treasurer. The officers shall be duly appointed Commissioners. Officers shall be elected by the Commission at the full Commission meeting held in the last quarter of each year or any special meeting as provided by the bylaws. The chairperson and treasurer shall be elected in even numbered calendar years and the vice-chairperson and secretary shall be elected in odd numbered calendar years. All terms shall be two years. Officers shall take office immediately following the close of the meeting at which they are elected. No commissioner shall serve more than two (2) full consecutive terms in a single elected office. Fulfilling an incomplete term is not considered part of the term limit. At the end of their term, officers are eligible for re-election. The elected officers shall serve without compensation or remuneration, except as provided by the Compact.

Section 2. Removal of Officers.

Any officer may be removed from office by a majority vote of the Commission.

Section 3. Duties

The officers shall perform all duties of their respective offices as provided by the Compact and these Bylaws. Such duties shall include, but are not limited to, the following:

Chairperson. The chairperson shall call and preside at all meetings of the Commission and in conjunction with the Executive Committee, the chairperson shall prepare agendas for such meetings. The chairperson shall make appointments to all committees of the Commission, and, in accordance with the Commission's directions, or subject to ratification by the Commission, shall act on the Commission's behalf during the interims between Commission meetings as delegated by the Commission.

Vice Chairperson. The vice chairperson shall, in the absence or at the direction of the chairperson, perform any or all of the duties of the chairperson. In the event of a vacancy in the office of chairperson, the vice chairperson shall serve as acting chairperson until a new chairperson is elected by the Commission.

Secretary. The secretary shall keep minutes of all Commission meetings and shall act as the custodian of all documents and records pertaining to the status of the Compact and the business of the Commission.

Treasurer. The treasurer shall act as custodian of all Commission funds and shall be responsible for monitoring the administration of all fiscal policies and procedures set forth in the Compact or adopted by the Commission. Pursuant to the Compact, the treasurer shall execute such bond as may be required by the Commission covering all officers, Commissioners and Commission personnel, as determined by the Commission, who may be responsible for the receipt, disbursement, or management of Commission funds.

Section 4. Costs and Expense Reimbursement.

Subject to the availability of budgeted funds, the officers shall be reimbursed for any actual and necessary costs and expenses incurred by the officers in the performance of their duties and responsibilities as officers of the Commission.

Section 5. Vacancies

Upon the resignation, removal, or death of an officer of the Commission before the next annual meeting of the Commission, a majority of the Executive Committee shall appoint a successor to hold office either (1) for the unexpired portion of the term of the officer whose position shall so become vacant if there is under a year left in the term or (2) until the next regular or special meeting of the Commission at which the vacancy is filled by majority vote of the Commission should greater than a year remain on the original term with said election being for the unexpired portion of the term of the vacant position.

Section 6. Resignation

An officer may resign at any time by filing a written resignation with the chairperson.

ARTICLE IV.

COMMISSION OFFICES AND PERSONNEL

Section 1. Commission Staff and Offices.

Contractual arrangements may be made with a professional management firm to act or serve as an authorized agent on behalf of the Commission. The management firm must be approved by the Commission and serves under a contract that is legal and binding under law. The Commission may contract for administrative and management functions and tasks that further the purposes and objectives of the Compact but that do not replace the powers of the Commission as delineated by these bylaws. The management firm designates one professional employee as executive director. The executive director an ex-officio member of the Commission without voting rights.

- A. Operations: The Executive Committee oversees management firm operations and, from time to time, receives reports on the administration of the organization.
- B. Obligation: The management firm must be bonded if the person or firm performs any fiduciary or financial functions on behalf of the Commission.
- C. Meeting Attendance: The executive director is required to attend the Commission meetings and present reports of activities carried out on behalf of the Commission.

ARTICLE V.

Qualified Immunity, Defense and Indemnification

The members, officers and authorized agents such as an executive director, other personnel acting on behalf of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

The Commission shall defend any member, officer and other authorized agent of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and

provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

The Commission shall indemnify and hold harmless any member, officer and other authorized agent of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE VI.

MEETINGS OF THE COMMISSION

Section 1. Meetings and Notice.

The Commission shall meet at least once each calendar year at a time and place to be determined by the Commission. Commissioners may participate in meetings by telephone or other means of virtual participation. Additional meetings may be scheduled at the discretion of the chairperson and must be called upon the request of a majority of Commissioners, as provided by the Compact. All Commissioners shall be given written notice of Commission meetings at least thirty (30) days prior rules will be considered and voted on by the Commission. Final agendas shall be provided to all Commissioners no later than ten (10) days prior to any meeting of the Commission. Thereafter, additional agenda items requiring Commission action may not be added to the final agenda. Discussion items not requiring action may be added to the agenda at any time upon a majority vote of the Commissioners. All Commission meetings shall be open to the public except as set forth in the Compact Section 10, B, 5. Public notice will be made to announce the meeting at least 30 days prior to any meeting. A meeting may enter closed session if the Commission determines by a majority vote of the Commissioners present that there exists at least one of the conditions for closing a meeting, as provided by the Compact or authorized Rules.

Section 2. Quorum.

A majority of Commissioners shall constitute a quorum for the transaction of business, except as otherwise required in these bylaws. The presence of a quorum must be established before any vote of the Commission can be taken.

Section 3. Voting.

Each Commissioner is entitled to one vote. A Commissioner shall vote on such member's own behalf and shall not delegate such vote to another Commissioner. Except as otherwise required by the Compact or these Bylaws, any question submitted to a vote of the Commission shall be determined by a simple majority.

Section 4. Procedure.

Matters of parliamentary procedure not covered by these bylaws shall be determined by the chairperson.

Section 5. Public Participation in Meetings.

With the exception as written under Section 12 of the Compact, upon prior written request to the Commission, any person who desires to present a statement on a matter that is on the agenda shall be afforded an opportunity to present an oral statement to the Commission at a time designated on the meeting's agenda.

Commission meetings will have a designated time for public comment on items not on the agenda. The chairperson may limit the time and manner of any such statements.

The chairperson may, depending on the circumstances, afford any person who desires to present a statement on a matter that is on the agenda an opportunity to be heard absent a prior written request to the Commission. The chairperson may limit the time and manner of any such statements at any open meeting and at the beginning of the meeting.

ARTICLE VII.

COMMITTEES

Section 1. Executive Committee.

The Commission may establish an Executive Committee which shall be empowered to act on behalf of the Commission during the interim between Commission meetings, except for rulemaking or amendment of the Compact or these bylaws. The Executive Committee shall be composed of all officers of the Commission, the immediate past chairperson and one member At-Large. A Commissioner-At-Large will be elected by the membership of the Commission as a whole to an initial two- year term. The At-Large position will be elected concurrent with the chairperson and Treasurer.

The immediate past chairperson is a non-voting member of the Executive Committee. The procedures, duties, budget, and tenure of such an Executive Committee shall be determined by the Commission. The power of such an Executive Committee to act on behalf of the Commission shall be subject to any limitations imposed by the Compact. Public notice of all Executive Committee meetings must be made at least three (3) days prior to the meeting date and the meeting agenda must be made public 24 hours prior to the meeting date.

Section 2. Committees.

The Commission may establish such Committees as it deems necessary to advise it concerning the fulfillment of its objectives, which may include but not be limited to a Budget-Finance Committee, Technology Committee, Bylaws and Rules Committee and Communications and Education and Training Committee. The composition, procedures, duties, budget and tenure of such committees shall be determined by the Commission. The Commission may dissolve any committee it determines is no longer needed.

ARTICLE VIII.

FINANCE

Section 1. Fiscal Year.

The Commission's fiscal year shall begin on July 1 and end on June 30.

Section 2. Budget.

The Commission shall operate on an annual budget cycle and shall, in any given year, adopt budgets for the following fiscal year or years as provided by the Compact.

Section 3. Accounting and Audit.

The Commission will arrange for an independent audit or financial review at least once a year or as required by the Compact. The results of the audit or financial review are presented as part of the Treasurer's report during the annual meeting of the Commission.

The Commission's internal accounts, any documents related to any internal audit, and any documents related to the independent audit shall be confidential; provided, that such materials shall be made available:

- i) in compliance with the order of any court of competent jurisdiction;

- ii) pursuant to such reasonable rules as the Commission shall promulgate; and
- iii) to any Commissioner of a Member State, or their duly authorized representatives.

Section 4. Debt Limitations.

The Commission shall monitor its own and its committees' affairs for compliance with all provisions of the Compact, its rules, and these bylaws governing the incursion of debt and the pledging of credit.

Section 5. Travel Reimbursements.

Subject to the availability of budgeted funds and unless otherwise provided by the Commission, Commissioners shall be reimbursed for any actual and necessary expenses incurred pursuant to their attendance at all duly convened meetings of the Commission or its committees as provided by the Compact.

ARTICLE IX

WITHDRAWAL, DEFAULT AND TERMINATION

Member States may withdraw from the Compact only as provided by the Compact. The Commission may terminate a Member State as provided by the Compact.

ARTICLE X

ADOPTION AND AMENDMENT OF BYLAWS

Any bylaw may be adopted, amended or repealed by a majority vote of Commissioners, provided that written notice and the full text of the proposed action is provided to all Commissioners at least thirty (30) days prior to the meeting at which the action is to be considered. Failing the required notice, a two-third (2/3rds) majority vote of Commissioners shall be required for such action.

ARTICLE XI

DISSOLUTION OF THE COMPACT

The Compact shall dissolve effective upon the date of the withdrawal or the termination by default of a Member State which reduces Membership in the Compact to one Member State as provided by the Compact.

Upon dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be concluded in an orderly manner and according to applicable law. Each Member State in good standing at the time of the Compact's dissolution shall receive a pro rata distribution of surplus funds based upon a ratio, the numerator of which shall be the amount of its last paid annual assessment, and the denominator of which shall be the sum of the last paid annual assessments of all Member States in good standing at the time of the Compact's dissolution. A Member State is in good standing if it has paid its assessments timely.



Interstate Commission for EMS Personnel Practice

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