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To: South Dakota Emergency Medical Services Interim Committee
From: Kelsie George and Aneesa Turbovsky, NCSL
Topic: EMS Workforce

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Dear members of the South Dakota Emergency Medical Services Interim Committee,

Thank you for reaching out to NCSL with your request on state actions relating to EMS workforce. The document below includes background information, state examples and additional resources on each topic.

Please note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.

Sincerely,

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EMS WORKFORCE

EMS workforce shortages are prevalent across the country. Turnover rates remain high for the occupation, with the [American Ambulance Association estimating 2024 turnover rates](#) to range between 22% and 40% annually. To address EMS workforce shortages, state legislatures are considering various policy options, including adjusting licensure and certification requirements, expanding recruitment and retention efforts, and addressing burnout and safety concerns. A [2024 Prehospital Emergency Care survey](#) found approximately 7.1% of EMTs and 7.9% of paramedics renewing their certifications intended to leave the occupation in the next 12 months.

LICENSURE AND CERTIFICATION

The EMS workforce includes: emergency medical responders (EMR), emergency medical technicians (EMT), advanced emergency medical technicians (AEMT), paramedics and other EMS clinicians, including nurses and physicians. The table below outlines several EMS occupations. The licensure requirements outlined in the sections below highlight on three occupations: EMTs, AEMTs and Paramedics.

Paramedic	Community Paramedic	Advanced Emergency Medical Technician (AEMT)	Emergency Medical Technician (EMT)	Emergency Medical Responder (EMR)	Emergency Medical Services Instructor (EMS Instructor)
Provides advanced emergency medical care and transportation for critical and emergent patients.	Provide primary health care and preventative services without necessarily transporting patients to an emergency department.	Provides basic and limited advanced emergency medical care and transportation for critical and emergent patients.	Provides basic emergency medical care and transportation for critical and emergent patients.	Initiates immediate lifesaving care to critical patients while awaiting additional EMS response and to assist higher-level personnel at the scene and during transport.	Develops and implement EMS clinician training programs at varying levels in compliance with national certification and state licensure standards.

Emergency Medical Technicians: As of 2022, at least 23 states and the District of Columbia required EMTs to complete a state approved EMT training program but did not specify the number of hours they must complete. Hawaii had the highest number of training hours required at 315, and Maine had the lowest number of training hours required at 44. Between 2022-2024, approximately 25 pieces of legislation related to the licensure of emergency medical professionals has been enacted across 17 different states. These reforms span from reciprocity agreements to training reimbursements, to changes in licensing board authority.

Age requirements for EMTs vary by state. Previously, NREMT required applicants for EMT certification to be at least 18 years of age, though this requirement changed in June 2020. The NREMT Board of Directors approved 19-Resolution-01 in June 2020, which eliminated age requirements (previously 18 years old) for all certification. This means that the National Registry defers to state age requirements set in statute and administrative rules. Stateline reported that at least six states have lowered minimum age requirements for EMT training in February 2023. Examples are included in the bulleted list below. This list is not exhaustive.

- **Connecticut** (Conn. Gen. Stat. §19a-179d) requires EMT applicants to be at least 16 years old and minors must submit a parental consent form.
- **Idaho** (Idaho Admin. Code §16.01.07) requires applicants for EMR and EMT licensure to be at least 16 years old. Applicants for AEMT and paramedic licensure must be 18 years or older.
- **New Jersey** (N.J. Admin Code §8:40A-5.5) allows minors aged 16 and 17 to enroll in an EMT-Basic program, but requires them to produce signed parental consent to participate. Minors who pass the NREMT assessment examination are granted a provisional EMT-Basic status.
- **New Mexico** (N.M. Stat. Ann §7.27.2.9) requires EMR applicants to be at least 16 years old and EMT-Basic applicants to be at least 17 years old.
- **New York** (N.Y. Admin. Code tit. 10 §800.6) requires applicants to be at least 17 years of age prior to the last day of the month in which he/she is scheduled to take the written certification examination for the course in which they are enrolled, except that an applicant for a certified first responder must be at least 16 years of age prior to the last day of the month in which he/she is scheduled to take the written certification examination.
- **Pennsylvania** (EMS Education Policy and Procedures) requires EMR and EMT students to be at least 16 years old to be eligible for certification.
- **Virginia** (Va. Admin. Code §12-5-31-1453) requires EMR and EMT students to be at least 16 years old by the first day of the certification course. Minors must provide the course coordinator with a completed parental or guardian permission form to enroll in the course.
- **Wisconsin** (Wis. Admin Code Ch. DHS §110.15) requires all EMT-B students to be at least 16 years old at the start of the course and requires EMT applicants to be at least 17 years old and complete 46 hours of the initial EMT training or have certification as an EMR before serving as a part of the required minimum ambulance staff.

Advanced Emergency Medical Technicians: At least 10 states do not define AEMTs in statute or set specific training or licensure requirements. Among states that license AEMTs, most defer to national training standards for licensure. At least 15 states set hour requirements for licensure, including: Arizona, Illinois, Ohio, Oklahoma, Oregon, South Carolina,

South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. In lieu of hour-based requirements, Nebraska defines the competencies AEMTs must prove for state licensure.

Paramedics: In addition to meeting national training standards, every state requires paramedics to complete and provide proof of AHA-approved [Cardio-Pulmonary Resuscitation \(CPR\)](#) training for health care providers and [Advanced Cardiac Life Support \(ACLS\)](#) training.

At least 13 states set hour-specific training requirements for paramedics, including: Arizona, California, Hawaii, Illinois, Maryland, Missouri, New Jersey, Ohio, Oklahoma, Oregon, South Carolina, South Dakota and West Virginia. The majority of states defer to National EMS Education Standards. Some states set specific training requirements, such as Alaska's requirement of two hours of education in pain management and opioid use and addiction.

Some states allow certain EMS clinicians to administer immunizations and dispense medication with additional training. Nevada requires AEMTs and paramedics to complete an approved course in intravenous therapy and the management of a passage for air to the lungs annually to administer or dispense immunizations and medications.

SCOPE OF PRACTICE

The National Highway Traffic Safety Administration's Office of EMS maintains the [National EMS Scope of Practice Model](#) that "reflects the latest evidence and best practices in EMS care and helps improve EMS personnel licensure level consistency." The current edition includes 2021 changes related to vaccine administration and specimen collection for testing. All states and territories maintain this model as the foundation for EMS clinician licensure and scope of practice, while some states may set further education, training, licensure or certification requirements beyond this model.

States may refer to the national EMS scope of practice in statute ([Kansas](#), [Missouri](#), [Nevada](#), [New Mexico](#), [South Dakota](#)), or they delegate the authority to establish EMS clinician scope of practice to the medical director ([Colorado](#), [Minnesota](#)) or the state agency responsible for EMS administration ([Alabama](#)). Several states provide more specific guidelines on the unique activities EMS clinicians may provide beyond the national EMS scope of practice, depending on their level of education, training and licensure. Examples of statute-define scope of practice for EMS clinicians are included below.

- [Illinois](#)
- [Iowa](#)
- [Indiana](#)
- [Kentucky](#)
- [Louisiana](#)
- [Maine](#)
- [Michigan](#)
- [New York](#)
- [North Dakota](#)
- [Ohio](#)
- [Washington](#)
- [Wisconsin](#)

RECRUITMENT AND RETENTION

To address EMS workforce shortages, states are turning to recruitment and retention strategies.

Career Pathways

The [Committee on Accreditation of Educational Programs for the EMS Professions](#) estimated that 21% of paramedic students did not complete their education and another 11% did not pass the Registry examination, which is required for licensure, in 2019. This resulted in approximately 5,400 potential paramedics lost in one year. States are establishing career pathways, or sequenced programs of classroom and hands-on instruction that guide toward a certain occupation, to encourage individuals to enter and stay in the EMS profession.

- [Kentucky HB 484](#) (2024) establishes an Emergency Medical Services Education Grant Program to increase the number of persons seeking paramedic initial certification. The program consists of three components: student tuition support, agency support and emergency medical services training or educational institution support.
 - [Maine SB 110](#) (2023) directs Maine Emergency Medical Services to convene a stakeholder group to explore emergency medical services career pathways and educational opportunities in the State.
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- **West Virginia HB 5347** (2024) establishes a program for EMTs to become certified paramedics and provides program funding.

Certain military medic roles must maintain NREMT certification as an EMR or EMT, and other occupations may provide a more direct pathway into NREMT paramedic certification. Some studies have compared civilian EMS training, education and scope of practice requirements with that of military medic occupations. For example, [a 2024 study examining army combat medical specialist and civilian EMS clinician levels](#) found “The data demonstrate a clear alignment of the 2019 Scope of Practice Model for civilian EMTs and AEMTs with the SOP of Army 68W. Army 68W training covers the entirety of the civilian EMT 2019 Scope of Practice Model.”

Several states have implemented military to civilian bridge programs in EMS careers. Examples are included below; please note, this list is not exhaustive.

- **Arizona HB 2589** (2023) establishes certification of EMTs who have completed training and testing by the U.S. Armed Forces as a level comparable to the national standards for EMTs.
- **Georgia SB 449** (2023) requires the department of health and department of veterans service to establish a program through which military medical personnel may provisionally operate within their scope of practice and training for a period of 12 months.
- **New Jersey AB 4107** (2022) directs the commissioner of health to license a candidate as a mobile intensive care paramedic who has equivalent military training or experience in any branch of the active duty or reserve component of the Armed Forces of the United States or the National Guard of any state if they meet or exceed licensure standards.
- **Wyoming SB 119** (2025) provides temporary practice permits for military service members with relevant education, training and experience received by the applicant as a member of the U.S. Armed Forces or Reserves.

Financial Incentives

The [two primary reasons](#) cited for leaving the EMS field are a desire for a career change and dissatisfaction with pay and benefits. [Research suggests](#) that increasing career and promotion opportunities and pay rates may improve retention among EMS clinicians. States may leverage financial incentives—such as tax credits, scholarships, agency reimbursement for training costs and financial awards—as well as benefits, like workers compensation, death benefits, retirement benefits and health insurance—to bolster the EMS workforce.

Tax Incentives: Several states have implemented tax incentives aimed at supporting and retaining volunteer emergency medical services (EMS) personnel and firefighters. These incentives are often structured as income tax credits or property tax reductions and are designed to recognize the service of active volunteers and encourage ongoing participation.

- **Iowa (Iowa Code §422.12)** created a volunteer fire fighter and volunteer EMS personnel member tax credit equal to \$250 to compensate for services provided during the tax year. Volunteer fire fighters and EMS personnel are required a written statement from the fire chief or other appropriate supervisor verifying their volunteer service.
 - **Maine HP 194** (2025) expands municipal volunteer program eligibility requirements to include volunteer emergency medical services personnel. Allows volunteer EMS personnel to earn benefits up to \$1,000 per year or 100 times the state minimum hourly wage, whichever is greater, by volunteering to provide services to a municipality.
 - **Maryland HB 947** (2023) authorizes the governing body of Charles County to grant a tax credit against the property tax imposed on the owner-occupied residence of certain emergency responders and their surviving spouses if the federal adjusted gross income of the emergency responder or the unmarried surviving spouse.
 - **Oklahoma SB 747** (2023) establishes an income tax credit for volunteer firefighters.
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Scholarships: States are exploring scholarships, tuition assistance and other financial aid to support EMS clinicians and trainees as they complete the required education and training for new roles, or progression throughout the EMS licensure levels.

- **Kentucky HB 200** (2023) establishes the Kentucky Healthcare Workforce Investment Fund to be administered by the Council on Postsecondary Education to fund public and private partnerships to provide healthcare training scholarships to Kentucky residents seeking high-demand eligible healthcare credentials, including as EMS clinicians.
- **Maryland SB 691** (2024) expands the Charles W. Riley Firefighter and Ambulance and Rescue Squad Member Scholarship to be applicable to all courses at institutions of higher education in the state and alters the maximum award amount available.
- **Missouri SB 71** (2025) establishes tuition awards for dependents of public safety personnel with at least 10 years of service. The dependent must provide proof of residency in Missouri for five years following the use of a tuition award, and the tuition award shall be treated as a loan.

Other Financial Awards: States may also offer other types of financial incentives, like length of service awards or training pay bonus supplement payments, to encourage individuals to enter and stay in the EMS profession.

- **Maine HB 1345** (2022) establishes the Length of Service Award Program to provide length of service awards to eligible volunteer firefighters and emergency medical services personnel.
- **Tennessee HB 155** (2023) requires an annual training pay bonus supplement for eligible emergency medical services personnel in the amount of \$800.

States may also look at certain benefits and services—such as workers compensation protections, death benefits, retirement benefits and health insurance—to bolster the EMS clinician workforce and provide additional financial incentives to enter and stay in the EMS workforce.

Workers Compensation: Within workers compensation protections, states may expand the presumption of workplace post-traumatic stress disorder or expand eligibility for certain first responders to purchase hazardous duty time.

- **Alabama HB 71** (2024) allows EMS personnel to purchase hazardous duty time in the Employees Retirement System in the same manner as certain firefighter, law enforcement officers and correctional officers.
- **Maine HP 46** (2025) amends the workers compensation law by extending the presumption applying to law enforcement officers, e911 dispatchers, firefighters and EMS clinicians diagnoses with posttraumatic stress disorder.
- **Pennsylvania SB 365** (2024) provides that a claim for a post-traumatic stress injury suffered by a first responder shall establish that the injury was the result of the individual undergoing a qualifying traumatic event and was sustained in the course and scope of the individuals employment, based on diagnosis by a licensed psychologist or psychiatrist.

Death Benefits: States may also provide line of duty death benefits to first responders, including EMS clinicians.

- **Arizona SCR 1006** (2023) establishes a death benefit for first responders.
- **Delaware SB 202** (2024) includes volunteer ambulance and rescue company members and paramedics under the individuals who may submit claims for line of duty death benefits.

Retirement Benefits: Several states are looking at including volunteer and career EMS clinicians who work for certain ambulance providers in state-run retirement systems.

- **North Dakota HB 1419** (2025) provides that a political subdivision may extend the benefits of the public employees retirement system to include peace officers, firefighters, dispatchers, emergency medical services personnel and correctional officers.
 - **South Dakota HB 1007** (2023) adds emergency medical services personnel to Class B public safety membership of the South Dakota Retirement System.
 - **West Virginia SB 439** (2024) authorizes certain 911 personnel to be members of Emergency Medical Services Retirement System under certain circumstances.
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Health Insurance: Approximately 13% of EMS clinicians are volunteers, [according to a study by NREMT](#), and many work part-time for one or many EMS agencies. Unless they have other full-time employment, they may not have access to health insurance themselves. [The National Highway Transportation Safety Authority estimates](#) that 17.5% of EMS clinicians (24.5% of EMTs and 9.6% of paramedics) do not have health insurance, and even more lack dental, optical, prescription, long-term care, disability or life insurance benefits. States may include volunteer EMS clinicians under their [state employee health plans](#), in some circumstances, to ensure they have access to health insurance.

- **Utah HB 289** (2022) creates health insurance coverage for volunteer EMS personnel under the state’s Public Employees’ Benefit and Insurance program, and **HB 298** (2025) allows additional municipalities to participate in the Volunteer Emergency Medical Service Personnel Insurance Program.
- **Wyoming SF 8** (2024) authorizes volunteer firefighters, volunteer emergency medical technicians and volunteer search and rescue persons to participate in the State Employees and Officials Group Insurance Plan.

BURNOUT AND SAFETY

EMS professionals face tough situations every day, including dealing with death, grief, and serious injuries. This occupational stress can lead to burnout, or a state of physical, mental or emotional exhaustion, for EMS clinicians. [A 2024 study in the International Journal of Medical Science](#) found that of the surveyed EMS clinicians, over 57% were likely to experience burnout. Burnout not only affects workers' mental and physical health but also impacts job performance, retention, and patient care quality. States may mitigate several factors of burnout by addressing workplace violence, establishing peer support programs and providing mental and physical wellbeing supports for EMS clinicians.

Violence Against EMS Clinicians

[Between 57% and 93% of all EMS clinician report experiencing workplace violence](#) at least once in their career. While physical assaults are the most reported form of workplace violence for EMS clinicians, [research shows that verbal violence is the most prevalent type](#) experienced on the job, with patients being the most prevalent assailant. Several states have increased penalties for assault or violence against health care workers, including EMS clinicians, and bolstered reporting requirements for employers and facilities for incidents of workplace violence.

- **Iowa HB 310** (2025) addresses penalties for assaults on persons engaged in certain occupations including EMS clinicians.
- **Missouri HB 225** (2025) creates the offense of interference with a first responder, which includes impeding or interfering with their ability to perform their legal duty; threatening a first responder with physical harm or engaging in conduct toward a first responder that serves no legitimate purpose. Interfering with a first responder shall be a Class B misdemeanor for a first offense and a Class A misdemeanor for a second or subsequent offense.
- **Virginia SB 1260** (2025) requires hospitals in the Commonwealth to report any threat or battery perpetrated against a health care provider while on the premises and engaged in the performance of his duties to the Department of Health, including EMS clinicians employed by a hospital-based EMS agency.

Peer Support

Peer support programs for first responders allow colleagues to provide support, through reflective listening, emotional support and help with response after a critical incident, to their peers. [According to SAMHSA](#), “peer support can help responders cope, lower stigma, and build team cohesion.” States may establish peer support programs, or ensure confidentiality of information shared between first responders and the peer support specialists who are supporting them.

- **Alaska SB 103** (2024) peers support counseling programs for law enforcement, EMS and corrections professionals.
 - **Arkansas SB 103** (2024) allows a law enforcement agency, emergency service provider and the department of health to establish a peer support counseling program to provide emotional and moral support to emergency service personnel who have experienced emotionally traumatic incidents in the course of employment.
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- **California AB 2859** (2024) authorizes EMS providers to establish a peer support and crisis referral program to provide a network of peer representatives to aid fellow employees on emotional or professional issues. EMS personnel have a right to refuse to disclose a confidential communication between EMS personnel and a peer support team member, crisis hotline or crisis referral service.
- **Kansas HB 2557** (2024) expands the definition of a peer support counseling session, including any peer support specialist who is contacted regarding a critical incident, traumatic event, professional, personal or social problem or difficult life event where peer support may benefit a law enforcement agency, EMS provider or State National Guard.
- **Maryland SB 527** (2023) defines peer support program as an evidence-based program provided by a fire, rescue, or emergency medical services entity or the International Association of Firefighters that provides evidence-based support from a peer support specialist to a member of a fire, rescue, or emergency medical services entity.
- **Wisconsin AB 576** (2024) provides that the Department of Justice shall establish and implement a program for the establishment of peer support teams and critical incident stress management services teams.

Mental and Physical Health Resources

EMS clinicians [tend to experience](#) high levels of acute and chronic stress, high rates of depression and substance abuse, and higher risk of suicide than the general public. To meet the mental and behavioral health needs of EMS clinicians, several states provide access to mental health resources.

- **Florida HB 5001** (2022) appropriates funds for the Post Traumatic Stress Disorder Clinic for First Responders.
- **Mississippi HB 1268** (2025) creates the State First Responder PTSD and Suicide Prevention Task Force and requires the task force to submit a report on its findings and recommendations to the legislature before the specified date.
- **Oklahoma HB 1408** (2023) creates the First Responders Job Protection Act, defines terms, requires first responders to report passive drug exposure and requires reports of passive drug exposure be provided to medical review officer, and **SB 1457** (2024) requires employers to provide medical and mental health treatment for up to a year for first responders who suffer post-traumatic stress injuries on the job.
- **Utah HB 23** (2022) established a grant program to provide mental health resources to EMTs, AEMTs, paramedics and other first responders, and **HB 67** (2024) amends eligibility for the program, expands institutions at which a recipient may use a grant under the program and amends the grant amount.
- **Washington HB 2311** (2024) establishes a first responder wellness task force to evaluate the wellbeing of first responders, make recommendations to the legislature and develop policies for peer support services.

ADDITIONAL NCSL RESOURCES

- [EMS Legislative Database, Enacted-only, 2021-Present.](#)
 - [State Policies Defining EMS as Essential](#)
 - [EMS Overdose and Prevention: Innovative Strategies to Save Lives](#)
 - [Key Trends in Emergency Medical Services Policies for 2024](#)
 - [Allied Health Professionals Series: Community Paramedics](#)
 - [Emergency Medicine in Rural America, Our American States Podcast](#)
 - [Community Paramedicine: Connecting Patients to Care and Reducing Costs](#)
 - [State Actions to Address EMS Workforce Shortages](#)
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