

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS & HIGHWAY SAFETY

EQUIPMENT/VEHICLE WAIVER REQUEST FORM

Request to waive the (check): Equipment requirements
(Not for staffing waivers) Vehicle requirements

Provider name: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact person: _____ Phone: _____ E-mail: _____

EMS System Name: _____ System #: _____

*Describe the exact nature of the waiver. Explain in detail why the waiver is necessary.
Describe how you will meet this requirement in the absence of the equipment.
Describe how you will accomplish obtaining and carrying this equipment in the future.*

Request to waive equipment requirements [Section 515.830 a) 3) A-D), b), c), d), e), f)] for the following ambulance(s):
list below each vehicle's license plate, local ID # and last 4 #s of the VIN

We request that this vehicle be recognized as an Unstocked/Mechanical Reserve Ambulance that will only be placed into service when a front-line ambulance is taken out of service (OOS) for maintenance or other short term circumstances. This ambulance will be placed into service after receiving all of the transferred equipment and supplies from the OOS vehicle in order to meet compliance with the Rules. Our EMSS Office will be notified of replacement vehicle activation within one business day. A replacement ambulance in service for more than 10 days will be inspected by the System. If the front-line ambulance is OOS greater than 10 days, it will be inspected by the System or the IDPH/Division of EMS & Highway Safety Regional EMS Coordinator at the discretion of the same per Section 515.830 i) when the ambulance returns to service. Use of this replacement vehicle will preserve our commitment to our communities as defined by our provider agency plan and enable us to continue uninterrupted 24/7 operations.

Indicate length of time requested for waiver (12 month *maximum*): _____ months

Provider Signature: _____ Date: _____

SUBMIT COMPLETED REQUEST TO YOUR EMS SYSTEM RESOURCE HOSPITAL

*******EMS SYSTEM ONLY*******

Resource Hospital Name: _____ EMS System #: _____

EMS Medical Director Name: _____

Address: _____ City: _____ State: _____ Zip: _____

The above request complies does not comply with my EMS System Plan Requirements.

EMS Medical Director's signature _____

Date _____

SUBMIT SIGNED WAIVER REQUEST TO THE REGIONAL EMS COORDINATOR.

*******REGIONAL EMS OFFICE USE ONLY*******

I recommend the waiver be: processed denied discuss with me

See attached waiver explanation/processing form _____

REMSC - Initial/Date: _____

*******CENTRAL OFFICE USE ONLY*******

Waiver: processed denied Initials/Date