

DIVISION OF EMERGENCY MEDICAL SERVICES
REQUEST TO MODIFY/AMEND PREVIOUSLY APPROVED EMS SYSTEM PLAN

THIS FORM IS TO BE COMPLETED TO REQUEST AN AMENDMENT TO A CURRENTLY APPROVED EMS SYSTEM PLAN AND A CURRENTLY APPROVED PROVIDER. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE RESOURCE HOSPITAL FOR COMPLETION. INITIAL APPLICATIONS MUST BE SUBMITTED ON FORM APP1-97. SEE "INSTRUCTIONS" BELOW.

EMS/MD NAME (Print):

RESOURCE HOSPITAL NAME:

EMS SYSTEM #:

ADDRESS:

CITY:

STATE:

ZIP:

PROVIDER NAME (Print):

PROVIDER CITY/STATE:

PROVIDER (OR AGENT) SIGNATURE:

LICENSE NUMBER

LAST 4 VIN NUMBER

CURRENT LEVEL

REQUESTED LEVEL

CHECK THE APPROPRIATE ITEMS:

REQUEST TO: UPGRADE DOWNGRADE PROVIDER VEHICLE(S) LEVEL OF CARE

FROM: 1ST RESP. BLS B/D ILS ALS TO: 1ST RESP. BLS B/D ILS ALS

MODIFY RESPONSE AREA OF ABOVE PROVIDER: (List changes on separate sheet and attach. Include description of response area, map indicating each vehicle response area, square miles, population, location of Resource/Associate Hospital, vehicle locations)

MODIFY ACCESS AND DISPATCH PROCEDURES AND MECHANISMS: (Describe and attach)

ADD AUTOMATIC DEFIBRILATION PROCEDURES (Training program must be approved by the Department prior to implementation)

ADDITIONAL OR REPLACEMENT VEHICLES: (IDPH inspection required.)

INSTRUCTIONS:

1. RESOURCE HOSPITAL AND PROVIDER SHOULD COMPLETE THEIR SECTIONS ABOVE AND SIGN WHERE INDICATED;
2. FORWARD TWO COPIES, THREE-HOLE PUNCHED TO THE REGIONAL EMS COORDINATOR;
3. ONE APPLICATION PER PROVIDER;
4. FOR UPGRADES IN LEVEL OF CARE ABOVE THE BASIC LEVEL, ATTACH COPIES OF APPROVED EQUIPMENT LIST BY ITEM, DESCRIPTION, AND QUANTITY CARRIED ON EACH VEHICLE FOR THE LEVEL OF CARE REQUESTED.

EMS SYSTEM APPROVAL:

I have reviewed the above request and verify that this license meets the vehicle, equipment and staffing requirements of the Regulations and our EMS System Plan for the requested level of care and recommend approval of this application.

EMS Medical Director/EMS System Coordinator Signature

Date

REMISC REVIEW: Recommended

Not Recommended

Discuss

REMISC Signature/Date: _____

CENTRAL OFFICE REVIEW: Approved

Not Approved (See notes)

Provider license(s) issued

NOTES: