State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems Extension Request Application

(This Request Must Be Approved Prior to Lapse/Expiration Date)

Applicant Name _____

Address _____ Apt. Number _____

City _____ State _____ ZIP Code _____

Phone Number _____ E-mail Address _____

Level of License: ❑ FRD ❑ EMT-B ❑ EMT-I ❑ EMT-P ❑ ECRN ❑ TNS ❑ PHRN ❑ LI

License Number _____ Social Security Number _____

Lapse/Expiration Date of Current License: _____

❑ Copy of most recent CPR (cardiopulmonary resuscitation) card attached.

Previous Extension Date _____

_____ _____
Signature of Applicant **Date**

EMS SYSTEM/REMSC:

❑ I verify that the above named applicant is in full compliance of the regulation at issue, a hardship is or would be caused without this waiver, and that the applicant has received no more than one extension since his or her last renewal.

The extension must not exceed a total of six months. I am recommending an extension of _____ months. The new expiration date for the above applicant is _____/_____/_____.

_____ _____ _____
EMS Medical Director / REMSC Signature **Date** **System Number**

CENTRAL OFFICE:

❑ Extension processed on: _____/_____/_____

Make a copy of all materials for your records prior to submitting the information to:

Illinois Department of Public Health
Division of Emergency Medical Systems and Highway Safety
422 South Fifth Street, Third Floor
Springfield, Illinois 62701