State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems
Non-transport Provider Application

Use this form only to add NON-TRANSPORT service to a currently approved transport provider.

EMS System Name _____ EMS System Number _____

EMS System Address _____ City _____ State ____ ZIP Code _____

EMS Medical Director Name _____ EMS System Coordinator Name _____

Provider Name _____

Provider Address _____ City _____ State ____ ZIP Code _____

Provider Contact _____ Phone Number _____ E-mail Address _____

1. Non-transport Level of Care (check) ❑ ALS ❑ ILS ❑ B/D ❑ BLS ❑ FRD ❑ CCT
2. List Vehicle Description

   Type _____ Local ID Number _____ VIN _____ Level of Care _____
3. Describe the role of each vehicle in the provision of EMS. Include vehicle coverage area.

   _____

   _____
4. Describe your patient transport procedure(s). Attach copies of transport agreement(s), if applicable.

   _____

   _____
5. Describe how the vehicle(s) will communicate with the resource hospital to receive medical direction.

   _____

   _____
6. *"The provider agrees to follow all EMS system policies and procedures."*

Provider Signature **Title** **Date**

System ONLY:
We have reviewed the above request and verify that this provider meets the vehicle, equipment and staffing requirements of the Illinois Department of Public Health rules and regulations and our EMS system plan and, therefore, recommend approval of this application.

EMS Medical Director Signature **Date**

EMS System Coordinator Signature **Date**

Regional EMS Coordinator ONLY: ❑ **Recommended** ❑ **Not Recommended** ❑ **Discuss**

REMSC Signature **Date**

CENTRAL OFFICE: ❑ **Recommended** ❑ **Denied (see comments)** ❑ **Provider License(s) Issued**

Comments _____

_____

EMS Division Chief Signature **Date**