DIVISION OF EMERGENCY MEDICAL SERVICES & HIGHWAY SAFETY
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" BLOW

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 NUMBERS	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 vehicles response area, square miles, population, location of Resource/Associate Hospital, vehicle locations.)

[ ] MODIFY ACCESS AND DISPATCH PROCEDURES AND MECHANISMS: (describe and attach.)

[ ] ADD AUTOMATIC DEFIBRILLATOR 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 INLEVEL OF CARE ABOVE THE BASIC LEVEL. ATTACH COPIES OF APPROVED EQUIPMENT LIST BY ITEM. DESCRIPTION AND QUANTITY CARRIED ON EACH CEHICLE FOR THE LEVEL OF CARE REQUESTED.

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EMS SYSTEM APPROVAL:

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

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EMS MEDICAL DIRECTOR/EMS SYSTEM COORDINATOR SIGNATURE DATE

REMSC REVIEW: [ ] Recommended [ ] Not recommended [ ] Discuss

REMSC Signature/Date:_____

CENTRAL OFFICE REVIEW: [ ] Approved [ ] Not approved (see notes) [ ] Provider license(s) issued

NOTES: