EQUIPMENT/VEHICLE WAIVER REQUEST FORM WVR3.98
ILLINIOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF EMS & HS

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

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Provider name:

Address: City: State: Zip:

Contact person: Phone:

Vehicle license #: 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 this equipment.

Submit completed request to your EMS System Resource Hospital for signature.

_____
_____
_____
_____
_____
_____
_____

Length of waiver requested (12 month maximum): _____ months.

Provider Signature: _____ Date: _____

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

Resource Hospital Name: EMS System #:

Address: City: State: Zip:

The above request [ ] complies [ ] does not comply with the EMS System requirements.

Submit signed to the Regional EMS Coordinator.

_____ _____
EMS Medical Director signature Date

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

I recommend the waiver be: [ ] approved [ ] denied [ ] discuss with me Initial/Date

Describe the exact nature of waiver: _____
_____
_____
_____
_____
_____

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

Waiver: [ ] approved [ ] denied Initial/Date