ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Emergency Medical Systems and Highway Services

Emergency Medical Systems Extension Application

All areas must be completed or the application will be returned unapproved.

Applicant Name _____

Address _____ Apt. # _____

City/State _____ ZIP Code _____

Phone Number: ( ) _____ ❑ Address change

Level of license: ❑ F.R.-D ❑ EMT-B ❑ EMT-I ❑ EMT-P ❑ ECRN ❑ TNS ❑ PHRN ❑ EMD ❑ L. Instructor

License ID# _____ Social Security Number: __ __ __ - __ __ - __ __ __ __

Lapse/Expiration date of current license: _____/_____/_____

❑ Copy of most recent CPR (cardio pulmonary resuscitation) card attached

Previous extension date: _____/_____/_____

_____

Signature of Applicant Date

EMS SYSTEM/REMSC PORTION:

❑ I verify the above to be accurate and recommend an extension of _____ months. The new expiration date for the above applicant is: _____/_____/_____.

_____

EMS Medical Director/REMSC Signature Date System #

CENTRAL OFFICE:

❑ Extension processed _____/_____/_____

Make a copy of all materials for your records prior to submitting the information to the Illinois Department of Public Health.

500 E. Monroe St., 8th Floor, Springfield, IL 62701

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P.O.#XXXXXX XM 5/06

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