State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems
Request to Modify / Amend Approved 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.

EMS Medical Director Name (print) _____

Resource Hospital Name _____ EMS System Number _____

Address _____

City/State _____ ZIP Code _____

Provider Name (print) _____ Provider Number _____

Provider City/State _____

License Number	VIN	Current Level	Requested Level

Check the appropriate items:

Request to: ❑ Upgrade ❑ Downgrade **Request for:** ❑ Provider ❑ Vehicle(s) ❑ Level of Care

From: ❑ First Responder ❑ BLS ❑ ILS ❑ ALS ❑ B/D **To:** ❑ First Responder ❑ BLS ❑ B/D ❑ ILS ❑ ALS ❑ CCT

❑ **Modify Response Area of Above Provider.** List changes on separate sheet and attach. Include description of response area, map indicating each vehicle response area, square miles, population, location of resource/associate hospital, and vehicle location.

❑ **Modify Access and Dispatch Procedures and Mechanisms** (Describe and attach)

❑ **Additional or Replacement Vehicles** (Illinois Department of Public Health inspection required)

❑ **Other** (Describe and attach)

Signature of Applicant **Date**

EMS System Approval

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

EMS Medical Director / EMS System Coordinator Signature **Date**

REMSC Review ❑ Recommended ❑ Not Recommended ❑ Discuss

Regional EMS Coordinator Signature **Date**

Central Office Processed on _____/_____/_____