1609 Northbrook Dr. Ste. 8 Normal, IL 61761
Phone: 309)827-4348 Fax: (309)808-4235
www.mcleancountyems.org

# EMS PROVIDER SYSTEM ENTRY PACKET

## Directions to all candidates:

**PLEASE FILL OUT IN ENTIRETY AND SIGN THE FOLLOWING:**

- **SYSTEM ENTRANCE APPLICATION**

**AFTER YOU HAVE COMPLETED THE SYSTEM ENTRANCE APPLICATION, PLEASE RETURN IT TO THE EMS OFFICE ALONG WITH A COPY OF THE FOLLOWING**

- **CURRENT STATE OF ILLINOIS FIRST RESPONDER/EMT-B / EMT-I / EMT-P LICENSE/PHRN/ECRN**
- **DRIVER'S LICENSE AND/OR STATE-ISSUED PHOTO ID**
- **LETTER OF AGENCY AFFILIATION**
- **LETTER OF GOOD STANDING FROM PREVIOUS SYSTEM (IF APPLICABLE)**
- **CURRENT HEALTHCARE PROVIDER CPR CERTIFICATION (OR EQUIVALENT)**
- **CURRENT ACLS CERTIFICATION (ILS/ALS/ECRN/PHRN ONLY)**
- **CURRENT ITLS OR PHTLS CERTIFICATION (ILS/ALS ONLY) OR TNS/TNCC (ECRN/PHRN)**
- **CURRENT PALS OR PEPP CERTIFICATION (ILS/ALS ONLY) OR ENPC (ECRN/PHRN)**

## MEMORANDUM OF UNDERSTANDING

**I, _____ do hereby understand and agree to the MCAMES system entry policy as outlined in the system policy manual. I have been given the opportunity to ask any questions I have regarding the policy and expectations of me within the system to a system representative. I understand that privileges to function within the McLean County Area EMS System are completely at the professional discretion of the EMS Medical Director and/or designee. I also understand that my current status in the system entry process will be shared freely with the administration of my sponsoring agency.**

_____ _____

**Signature** **Date**

MCLEAN COUNTY AREA EMS SYSTEM

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## SYSTEM ENTRANCE APPLICATION

*Please PRINT legibly*

Date of Application: _____

Name: _____ Date of Birth: _____
Last First Middle MM/DD/YYYY

Address: _____

City _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sponsor Agency: _____

Previous EMS System: _____

Driver's License #: _____ SSN: _____

IDPH EMS License Number: _____

Application Level: **FR** **EMT-B** **EMT-I** **EMT-P** **PHRN** **ECRN**

| | | |
|---|---|---|
| Have you ever been suspended from an EMS system? | Yes | No |
| Are you currently suspended from an EMS system? | Yes | No |
| Are you currently or have you ever worked in another EMS system? | Yes | No |
| Have you ever been convicted of a felony? | Yes | No |
| Are you currently charged with a felony or have pending felony charges? | Yes | No |
| Are you currently the subject of any pending investigations by IDPH or a former system? | Yes | No |

**I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing system entry, or for removal from the system should I be accepted into the system. I authorize any person, organization or company listed on this application to furnish you any and all information concerning my previous employment, education and qualifications for system entry. I also authorize you to request and receive such information.**

_____ _____ _____
Name, Printed Signature Date

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**Application**

- ❑ **System Entrance Application**
- ❑ **Authorization and Release**
- ❑ **Memorandum of Understanding**

**Supporting Documents**

- ❑ **Letter of Agency Affiliation**
- ❑ **Letter of Good Standing from previous system**
- ❑ **Driver's License/ID**

**Certifications**

- ❑ **Current State of Illinois EMS License** **EXP: _____**
- ❑ **Current CPR Card** **EXP: _____**
- ❑ **Current ACLS Card (ILS/ALS/RN only)** **EXP: _____**
- ❑ **Current Trauma Certification (ILS/ALS/RN only)** **EXP: _____**
- ❑ **Current Pediatric Life Support (ILS/ALS/RN only)** **EXP: _____**

**Competency Form**

- ❑ **Skill Sheet, signed by agency training officer (FR/BLS only)**

**Written Exam**

**First Attempt**
Date_____
Version _____ **Complete**_____
Score_____

**Second Attempt**
Date_____
Version _____ _____ **Complete**_____
Score_____

**Third Attempt**
Date_____
Version_____ **Complete**_____
Score_____

**Practical Exam**

| **First Attempt- Date -_____** | **Second Attempt-Date_____** | **Third Attempt Date-_____** | |
|---|---|---|---|
| Medical_____ | Medical_____ | Medical_____ | **Complete**_____ |
| Trauma_____ | Trauma_____ | Trauma_____ | |

***Final Verification and Approval***

**I have verified that all the above materials are present in the candidate's folder and hereby approve the above-named applicant to function within the McLean County Area EMS System.**

_____ _____
**EMS System Coordinator, Printed** **Date**

_____
**EMS System Coordinator, Signed**

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**Instructions:** The agency training officer or designee complete the entire form once the applicant has successfully demonstrated competency in each section. Only complete the sections that are required for the applicants level of care.

Applicant Name _____ Date _____

| EMR/BLS Medications | | | | | | |
|---|---|---|---|---|---|---|
| **Medication** | **EMR** | **BLS** | **Indication** | **Contra** | **Dose** | **Administration** |
| Albuterol | | X | ☐ | ☐ | ☐ | ☐ |
| Aspirin | X | X | ☐ | ☐ | ☐ | ☐ |
| Atrovent | | X | ☐ | ☐ | ☐ | ☐ |
| Diphenhydramine | | X | ☐ | ☐ | ☐ | ☐ |
| Epinephrine(IM/Auto-Injector) | | X | ☐ | ☐ | ☐ | ☐ |
| Glucagon | | X | ☐ | ☐ | ☐ | ☐ |
| Ibuprofen | | X | ☐ | ☐ | ☐ | ☐ |
| Narcan | X | X | ☐ | ☐ | ☐ | ☐ |
| Nitroglycerin | | X | ☐ | ☐ | ☐ | ☐ |
| Oral Glucose | X | X | ☐ | ☐ | ☐ | ☐ |
| Ondasetron | | X | ☐ | ☐ | ☐ | ☐ |

| EMR/BLS Skills | | | | | |
|---|---|---|---|---|---|
| **Skill** | **EMR** | **BLS** | **Indication** | **Contra.** | **Administration** |
| BIAD | X | X | ☐ | ☐ | ☐ |
| CPAP | | X | ☐ | ☐ | ☐ |
| Defibrillator | X | X | ☐ | ☐ | ☐ |
| Quikclot | X | X | ☐ | ☐ | ☐ |
| Glucometer | X | X | ☐ | ☐ | ☐ |
| 12-Lead* | | X | ☐ | ☐ | ☐ |
| Wound Packing | X | X | ☐ | ☐ | ☐ |

* For agencies equiped with 12-lead capabilities

Training Officer Name Printed _____ Training Officer Signature _____