



Emergency Medical Services (EMS) Systems Inactive Request

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

Applicant Name _____

Address _____ Apt. Number _____

City/State _____ ZIP Code _____

Phone Number _____ E-mail Address _____

Level of License: EMT-B EMT-I EMT-P ECRN TNS PHRN LI

Illinois license enclosed. License Number _____

I have attached my written request to the EMS medical director for inactive status. I understand that during my inactive period I will not function as an EMS provider at any level in Illinois.

Signature of Applicant

Date

EMS SYSTEM/REMISC:

Inactive re-licensure requirements are:

- Current
- Not current (please attach explanation)
- License attached

EMS Medical Director / REMISC Signature

Date

System Number

CENTRAL OFFICE:

Inactive request processed on: ____/____/____

Make a copy of all materials for your records prior to submitting the information to:

Illinois Department of Public Health
Division of Emergency Medical Systems and Highway Safety
422 South Fifth Street, Third Floor
Springfield, Illinois 62701

