

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

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

=====

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 request 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