Illinois Department of
Public Health

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525-535 West Jefferson Street • Springfield, Illinois 62761-0001

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Emergency Medical Services & Highway Safety
AMBULANCE STAFFING WAIVER REQUEST FORM

(PRINT OR TYPE)

IMPORTANT INSTRUCTIONS

Regulation (535.150(g)(2) requires that a provider shall operate its ambulance service 24 hours a day, every day of the year. Each individual vehicle within the ambulance service shall not be required to be operated 24 hours a day, but at least one vehicle for each licensed level of care covered by the license is in operation at all times. Personnel may be on site or call. ALS vehicles may provide coverage at an ALS or BLS level.

COMPLETE AND SUBMIT THE FOLLOWING FOR *EACH VEHICLE* REQUESTING STAFFING WAIVER:

Date: _____ License # _____ Last 4 VIN # _____
Provider Name: _____
Contact Person: _____
Address: _____
City: _____ State:____ ZIP:_____
Business Phone: ( )_____
EMS System Participant: ( )YES ( )NO
Resource Hospital Name:_____
Our Licensed EMTs are: ( )Volunteer ( )Paid ( )Paid on call
List the dates of previous staffing waivers and describe nature of waiver:_____
_____
_____

Length of waiver requested (12 months maximum): _____ months.

Current Level of Care: ( )BAS ( )BLS ( )B/D ( )ILS ( )I/D ( )ALS
Hours above level of care will be provided: From _____PM/AM to _____AM/PM
_____days a week and/or describe: _____
_____
_____

What level of care will be provided with this vehicle at times other than indicated above:
( )BAS ( )BLS ( )B/D ( )ILS ( )I/D ( )ALS
from _____AM/PM to _____AM/PM _____days a week and/or describe: _____
_____
_____
_____

On what date will this vehicle provide its licensed level of care, 24 hours/365 days:_____. Attach details of your plan to accomplish this. If additional personnel are to be trained list their names, training site, date training begins, date training concludes and estimated date of licensure.

How will the community be advised of the change in service:_____
_____ Attach a copy of the announcement.

(CONTINUES OVER)

AMBULANCE STAFFING WAIVER REQUEST FORM (continued)

**********EMS SYSTEM ONLY**********

I have reviewed the attached action plan proposed for this ambulance vehicle and find that it complies with Section 535.150(g)(2) (see "instructions", over). This request for a vehicle staffing waiver:

( )COMPLIES ( ) DOES NOT COMPLY with our EMS System staffing requirements.

PMD Signature:_____Date:_____

**********REGIONAL EMS OFFICE ONLY**********

I recommend the waiver request be: ( )APPROVED ( )DENIED ( )DISCUSSED WITH ME

REMSC Signature: _____Date:_____

**********EMS CENTRAL OFFICE USE ONLY**********

Final Determination: ( )APPROVED ( )DENIED

Comments:_____

_____

Signature:_____Date:_____

NOTES/COMMENTS/ATTACHMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT NOTICE: This state agency is requesting disclosure of information necessary to accomplish the statutory purpose as outlines in Public Act 81-1518. Disclosure of this information is mandatory. The form IL #482-0805 has been approved by the Forms Management Center.

WVR1/95