



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Emergency Medical Systems and Highway Services

Emergency Medical Systems Extension Application

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

Applicant Name _____

Address _____ Apt. # _____

City/State _____ ZIP Code _____

Phone Number: () _____ Address change

Level of license: F.R.-D EMT-B EMT-I EMT-P ECRN TNS PHRN EMD L. Instructor

License ID# _____

Lapse/Expiration date of current license: ____/____/____

Copy of most recent CPR (cardio pulmonary resuscitation) card attached

Previous extension date: ____/____/____

Signature of Applicant _____ Date _____

EMS SYSTEM/REMSC PORTION:

I verify the above to be accurate and recommend an extension of _____ months. The new expiration date for the above applicant is: ____/____/____.

EMS Medical Director/REMSC Signature _____ Date _____ System # _____

CENTRAL OFFICE:

Extension processed ____/____/____

Make a copy of all materials for your records prior to submitting the information to the Illinois Department of Public Health.

500 E. Monroe St., 8th Floor, Springfield, IL 62701