SYSTEM AGENCY AFFILIATION VERIFICATION

for System Entrance Applicant

(Place this form letter on your Agency letterhead)

Date: ___/___/___

David J. Mikolajczak, DO, FACOEP
Silver Cross EMS System
1900 Silver Cross Blvd
New Lenox, IL 60451

Dr. Mikolajczak,

I verify that (entry applicant name) _____is an actively functioning

EMT-B with this IDPH approved provider agency with the Silver Cross EMS System. The aforementioned individual will operate and be affiliated with this agency. Should the applicant cease affiliation with this agency, the System EMS Office will be notified. Please forward a Silver Cross EMS System Number.

Entry Applicant Address: _____

City: _____State:_____Zip:_____

Cell Phone # :(_____) _____-_____ County of Residence: _____

Date-of-Birth: _____/_____/_____ Social Security #: _____-_____-_____

EMAIL:_____

Primary System: _____ Secondary System: _____

This individual was initially licensed at his current level in _____ (year).

2016 Region VII SMO Exam Date: ____/____/____ and Score: _____%

Attachment: * ALL ON 1 PAGE ***** EMT License / Current CPR Card / Drivers License
All copies must be clear and easily readable or the request will not be processed.

_____
EMS Coordinator's Signature and Date