

**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

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Provider name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Contact person: _____ Phone: _____
Vehicle license #: _____ EMS System name: WILL/GRUNDY System #: 0710

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: SILVER CROSS HOSPITAL EMS System #: 0710
Address: 1200 MAPLE RD. City: JOLIET State: IL ZIP: 60432

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