

**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  
1200 Maple Road  
Joliet, IL 60432

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: \_\_\_\_\_

Home Phone # :(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ County of Residence: \_\_\_\_\_

Date-of-Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Drivers License #: \_\_\_\_\_

This individual is requesting their Primary System be: \_\_\_\_\_

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

Region VII SMO Exam Date: \_\_\_/\_\_\_/\_\_\_ and Score: \_\_\_\_\_%

\_\_\_\_\_  
EMS Coordinator's Signature and Date

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