

SYSTEM AGENCY AFFILIATION VERIFICATION
for System Entrance Applicant

(place this form letter on your Agency letterhead)

Date: ___/___/___

David J. Mikolajczak, DO, FACOEP
Will/Grundy 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 Will/Grundy 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 Will/Grundy 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.