

PROCTOR HOSPITAL EMS SYSTEM
EMS System Agency Application
PERSONAL INFORMATION FORM

(Each member of your squad or agency must complete a form. Attach a copy of all IDPH licenses and certifications.)

PLEASE PRINT

Proctor Hospital 5409 N. Knoxville Ave Peoria, IL (309) 691-1000

Personal Information

Last Name: _____ First Name: _____ Middle Name: _____
(Indicate Jr., Sr., I, II as applicable.) (Enter Legal name, as it appears on license)

Date of Birth: _____ Nickname: _____
(if applicable) (Use this space to indicate if you wish to be called Bill instead of William, or commonly use your middle name, etc.)

Home Address Line 1: _____

Home Address Line 2: _____

City: _____ State: IL Nine Digit Zip Code: _____

County of Residence _____ Home Phone Number : _____
(include area code)

Cell Phone Number : _____ E-Mail Address: _____

Height: _____ Hair Color: _____ Eye Color: _____ Gender: Male Female
(Circle One)

Primary IDPH EMS License or Recognition Information: (i.e. First Responder, First Responder/Defib, EMT-Basic, EMT-Intermediate, EMT-Paramedic)
(Attach a copy of each current IDPH license to the form.)

Level of License: _____ License ID Number: _____ License Expiration Date: _____

Other IDPH EMS Licenses or Recognitions : (i.e. EMS Lead Instructor, ECRN, EMD)
(Attach a copy of each current IDPH license to the form.)

Level of License: _____ License ID Number: _____ License Expiration Date: _____

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Level of License: _____ License ID Number: _____ License Expiration Date: _____

CPR Card Issuing Agency: _____ CPR Certification Expiration Date: _____
(Indicate ARC or AHA) (Indicate Healthcare Provider, Professional Rescuer, etc.)

Illinois Drivers License Information: (If no Illinois Drivers License held, enter applicable State Drivers License or None.)

Drivers License State: IL Drivers License Number: _____ Drivers License Expiration Date: _____

Social Security Number Information: (The Illinois Department of Public Health requires submission of the Social Security Number when applying for license renewal.)

Social Security Number: _____

The Proctor Hospital EMS System requests your Social Security Number to expedite the issuance of licenses or renewal of licenses by the Illinois Department of Public Health. You may elect to not disclose your Social Security number at this time. The Social Security Number may be requested by IDPH on the Child Support Statement required at the time of licensure or re-licensure. If provided, the Proctor Hospital EMS System will only release the Social Security Number as required by IDPH for license renewal or the issuance of a new license.



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PERSONAL INFORMATION FORM CONTINUED

PLEASE PRINT

Last Name: _____ First Name: _____ Middle Name: _____

Agency Affiliation Information:

Primary EMS Agency Name: _____ Agency ID for Individual: _____
(if applicable)

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Other EMS Agency Name: _____ Agency ID for Individual: _____
(if applicable)

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Other EMS Agency Name: _____ Agency ID for Individual: _____
(if applicable)
(Use back of form to list other agencies if active with more than three EMS agencies.)

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Employment Information:

Primary Employer: _____
(Workplace information is optional if primary employer is not an EMS agency.)

Work Address Line 1: _____

Work Address Line 2: _____

City: _____ State: IL Zip Code: _____

Workplace Title: _____ Work Phone Number : _____
(include area code)

Certification Information: (Enter certifications earned such as ACLS, PHTLS, ITLS, PEPP, PALS, Technical Rescue, etc. Use back of sheet for more space if needed.)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Mark Those that apply: (Contact the Proctor EMS Office to change these elections.)

The Proctor EMS System may release my name and mailing address to other parties for EMS related mailings including educational opportunities, job opportunities and/or EMS products.

The Proctor EMS System may release my e-mail address to other parties for EMS related mailings including educational opportunities, job opportunities and/or EMS products.

The Proctor EMS System may release my name and mailing address to other parties for EMS related mailings regarding educational opportunities only.

The Proctor EMS System may release my e-mail address to other parties for EMS related mailings regarding educational opportunities only.

The Proctor EMS System may not release my name and mailing address to other parties except IDPH.

The Proctor EMS System may not release my e-mail address to other parties except IDPH.

I attest that I have completed this form and all of the information on this Personal Information Form is true and accurate as of the date completed.

Signature: _____ Date Completed: _____