Carle Health EMS System

PERSONAL INFORMATION FORM

(Attach a copy of all IDPH licenses and certifications)

PLEASE PRINT

Personal Information:

Last Name: (Indicate Jr., Sr., I, II as applicable.)	First Name: (Enter Legal name, as it appears on license)	Middle Initial:
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:	Zip Code:
County of Residence:	Phone: (Include area code)	
Email Address:		
Height:	Hair Color:	Eye Color:
Gender: ☐ Male ☐ Female (Mark One)		

Primary IDPH EMS License or Recognition Information: (i.e., EMR, EMT-Basic, EMT-Intermediate, EMT-Paramedic, PHRN, PHPA, APRN)

Level of License:	License ID number:	License Expiration Date:
Level of License:	License ID number:	License Expiration Date:
Level of License:	License ID number:	License Expiration Date:
CPR Card Issuing Agency: (Indicate ARC or AHA)	CPR Certification Held: (Indicate Healthcare Provider, Professional Rescuer, etc.)	CPR Certification Expiration Date:

Illinois Driver's License Information:(Attach a copy) (If no Illinois Driver's License held, enter applicable State Driver's License or None.)

Driver's License State: Driver's License Number: Driver's License Expiration Date:

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

Social Security Number:

Agency Affiliation Information:

Carle Health EMS Agency Name:

Level of function with this agency:
(Indicate if you function as an EMR, EMT-Basic, Paramedic, etc.)

Agency Address Line 1:

Agency Address Line 2:

Carle Health EMS System

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City:	State:	Zip Code:
Workplace Title:	Work Phone Number: (Include area code)	
Other EMS Agency Name:		
Agency current EMS System:	Level of function with this agency: (Indicate if you function as an EMR, EMT-Basic, Paramedic, etc.)	
Other EMS Agency Name:		
Agency current EMS System:	Level of function with this agency: (Indicate if you function as an EMR, EMT-Basic, Paramedic, etc.)	

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

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

Signature:	Date: