

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES AND HIGHWAY SAFETY
525 WEST JEFFERSON – SPRINGFIELD, IL 62761
217-785-2080/217-524-0966 FAX

EMS EXTENSION APPLICATION

All areas must be appropriately completed or the application will be returned unapproved.

APPLICANT NAME: _____

ADDRESS: _____ APT#: _____

CITY/STATE: _____ ZIP CODE: _____

Address change

Level of license: EMT-B EMT-I EMT-P ECRN TNS PHRN

License I.D.# _____

Copy of most recent CPR card attached

Expiration date of current license: ____/____/20____

Previous extension date: ____/____/20____

Signature of Applicant Date

EMS SYSTEM/REMSC PORTION:

I verify the above to be accurate and recommend an extension of _____ months (not to exceed six months). The new expiration date for the above applicant is:
_____/_____/20____

EMS Medical Director/REMSC Signature Date System #

CENTRAL OFFICE:

Extension processed ____/____/20____