OSF Northern Region EMS
SYSTEM CERTIFICATION APPLICATION

Name: ____

License #: _________________________ Expiration date: ___________________

Address: ____

Phone: (_____)______-________ Email: _____________________________________

Provider Affiliation(s): ____

System Requirements:	**Exp. Date:**	**Date Reviewed:**	**By:**
EMS System / Training Program Verification Letter	________	_________	_____
Copy of EMS License	________	_________	_____
Healthcare Provider CPR Certification	________	_________	_____
ACLS Provider Certification (ALS only)	________	_________	_____
PALS Provider Certification (ALS only)	________	_________	_____
PHTLS Provider Certification (ALS only)	________	_________	_____
Psychomotor Skills Assessment		_________	_____

Recommended for system certification: YES NO If no, explain reason and course of action:

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Signed: ____________________________________ Date: ______ / ______ / ______
OSF NREMS System Representative

Medical Director Advised: ______________________ Date: ______ / _____ / _______
Medical Director Approval: YES NO Date: ______ / _____ / _______