SYSTEM AGENCY AFFILIATION VERIFICATION

for System Entrance Applicant

RESET FORM

Date: _____

Silver Cross EMS System
1900 Silver Cross Blvd
New Lenox, IL 60451

I verify that the below named EMS person has been hired to work with the following Silver Cross EMS System agency (FD/Amb Service name) _____.
I will notify the System immediately upon the time that this person is no longer employed. Please forward a Silver Cross EMS System Number authorizing this person to work in SCEMSS.

License Level: (check one) ☐ **EMT or** ☐ **EMR**

This individual was initially licensed at this current level in what year: _____

Entry applicant full legal name: _____

Mailing address: _____

City: _____State:_____Zip:_____

Cell Phone #: _____

Date-of-Birth: _____ Social Security #: _____

EMAIL:_____

Primary System: _____ Secondary System: _____

2016 Region VII SMO Exam Date: _____ and Score: _____%

Attachment: * ALL ON 1 PAGE * EMR/EMT License, Current BLS/CPR Card, Driver's License
All copies must be clear and easily readable or the request will not be processed.

I

_____
EMS Coordinator's Name and Date