PERRY MEMORIAL HOSPITAL- OSF NORTHERN ILLINOIS EMS
EMS TRAINING PROGRAM APPLICATION

Course Description	Course Date	Prerequisites - attach to application					
		DL / ID	Dipl./GED	Fee	License	CPR	Other

Applicant Information

Applicant Name: _____
Last First Middle

Applicant Address: _____
Street Address City State Zip Code County

Contact Information: _____
Home Phone Number Other Phone Number E-Mail Address

EMS Affiliation: _____ _____ No EMS Affiliation

I certify that all of the information provided in this application is accurate.

Signed: _____ Date: _____/_____/_____
EMS Applicant

Signed: _____ Date: _____/_____/_____
OSFNIEMS Representative

FOR OFFICE USE ONLY:

Complete Application:	Y	N		Verification of License:	Y	N	N/A
Verification of age:	Y	N		Verification of HCP CPR:	Y	N	N/A
Verification of graduation:	Y	N		Verification of Certification (s):	Y	N	N/A
Fees Paid:	Y	N	N/A				

Return to: Deb Wood RN, EMS Coordinator, Perry Memorial Hospital 530 Park Avenue East, Princeton, IL 61356
fax - 815-876-2400