



Emergency Medical Services (EMS) Systems Equipment Waiver Request

DO NOT USE FOR STAFFING WAIVERS

Request to waive: Equipment Requirements Vehicle Requirements Other

Provider Name _____

Address _____ City _____ State _____ ZIP _____

Contact Person _____ Phone _____ E-Mail _____

Vehicle license(s) with last four (4) Vehicle Identification Numbers _____

Section 515.150 b) 1) - 5) Waiver Provisions

- List the section of the act for which the waiver is being sought.
- Explain why complying with this section of the act is a hardship including a description of how you have attempted to comply with this section

- Explain how the waiver will NOT reduce the quality of medical care established by the act.

Requested length of time for the waiver (maximum 12 months) _____ months

Provider Signature Date

Submit completed request to your EMS System Hospital for Signature

EMS System ONLY

EMS System Hospital Name _____ System Number _____

Address _____ City _____ State _____ ZIP _____

The above request Complies Does NOT comply with our EMS System Plan.

EMS Medical Director Signature Date

Submit completed request to your Regional EMS Coordinator for Signature

Regional EMS Coordinator ONLY

I recommend the waiver be Processed Denied Refer to attached Waiver Explanation Form. _____

Initial and Date

Central Office ONLY Waiver: Processed Denied _____ Copies mailed

Initial and Date

