**State of Illinois**
Illinois Department of Public Health

# 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**

1. List the section of the act for which the waiver is being sought.
2. 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

_____

_____

_____

3. 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**