UnityPoint Health
EMS System

UnityPoint Health EMS System

PERSONAL INFORMATION FORM

(Each member of your squad or agency must complete a form. Attach a copy of all IDPH licenses and certifications.)

PLEASE PRINT Proctor Hospital 5409 N. Knoxville Ave Peoria, IL (309) 683-6189

Personal Information

Last Name: _____ (Indicate Jr., Sr., I, II as applicable.)

First Name: _____ (Enter Legal name, as it appears on license)

Middle Name: _____

Date of Birth: _____

Nickname: (if applicable) _____ (Use this space to indicate if you wish to be called Bill instead of William, or commonly use your middle name, etc.)

Home Address Line 1: _____

Home Address Line 2: _____

City: _____ State: IL Nine Digit Zip Code: _____

County of Residence _____ Home Phone Number : (include area code) _____

Cell Phone Number : _____ E-Mail Address: _____

Height: _____ Hair Color: _____ Eye Color: _____ Gender: Male Female (Circle One)

Primary IDPH EMS License or Recognition Information: (i.e. First Responder, First Responder/Defib, EMT-Basic, EMT-Intermediate, EMT-Paramedic)
(Attach a copy of each current IDPH license to the form.)

Level of License: _____ License ID Number: _____ License Expiration Date: _____

Other IDPH EMS Licenses or Recognitions : (i.e. EMS Lead Instructor, ECRN, EMD)
(Attach a copy of each current IDPH license to the form.)

Level of License: _____ License ID Number: _____ License Expiration Date: _____

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Level of License: _____ License ID Number: _____ License Expiration Date: _____

CPR Card Issuing Agency: _____ (Indicate ARC or AHA)

CPR Certification Held: _____ (Indicate Healthcare Provider, Professional Rescuer, etc.)

CPR Certification Expiration Date: _____

Illinois Drivers License Information: (If no Illinois Drivers License held, enter applicable State Drivers License or None.)

Drivers License State: IL Drivers License Number: _____ Drivers License Expiration Date: _____

Social Security Number Information: (The Illinois Department of Public Health requires submission of the Social Security Number when applying for license renewal.)

Social Security Number: _____

Your Social Security Number is requested by IDPH on the Child Support Statement required at the time of licensure or re-licensure.

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PLEASE PRINT

Last Name: _____ First Name: _____ Middle Name: _____

Agency Affiliation Information:

Primary EMS Agency Name: _____ Agency ID for Individual: (if applicable) _____

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Other EMS Agency Name: _____ Agency ID for Individual: (if applicable) _____

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Other EMS Agency Name: _____ Agency ID for Individual: (if applicable) _____
(Use back of form to list other agencies if active with more than three EMS agencies.)

Agency's Current EMS System: _____ Level of function with this agency: _____
(Indicate if you function as a First Responder, EMT-Basic, Paramedic, etc.)

Employment Information:

Primary Employer: _____
(Workplace information is optional if primary employer is not an EMS agency.)

Work Address Line 1: _____

Work Address Line 2: _____

City: _____ State: IL Zip Code: _____

Workplace Title: _____ Work Phone Number : (include area code) _____

Certification Information: (Enter certifications earned such as ACLS, PHTLS, ITLS, PEPP, PALS, Technical Rescue, etc. Use back of sheet for more space if needed.)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Certification Held: _____ Expiration Date: _____
(Attach copy of certification to form)

Mark Those that apply: (Contact the EMS Office to change these elections.)

☐ The EMS System may release my name and mailing address to other parties for EMS related mailings including educational opportunities, job opportunities and/or EMS products.

☐ The EMS System may release my name and mailing address to other parties for EMS related mailings regarding educational opportunities only.

☐ The EMS System may not release my name and mailing address to other parties except IDPH.

☐ The EMS System may release my e-mail address to other parties for EMS related mailings including educational opportunities, job opportunities and/or EMS products.

☐ The EMS System may release my e-mail address to other parties for EMS related mailings regarding educational opportunities only.

☐ The EMS System may not release my e-mail address to other parties except IDPH.

I attest that I have completed this form and all of the information on this Personal Information Form is true and accurate as of the date completed.

Signature: _____ Date Completed: _____