



# CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM

25 N. WINFIELD ROAD  
WINFIELD, IL 60190

PHONE: 630.933.6910  
EMAIL: CDHEMS@NM.ORG

WEB: WWW.CDHEMS.COM

## PERSONNEL INFORMATION FORM

TYPE OF REQUEST:            **NEW / ADDITION**                    **UPDATE**                    **REMOVAL**            DATE OF REQUEST:    \_\_\_/\_\_\_/\_\_\_

FOR NEW SYSTEM APPLICANTS, INCLUDE COPIES:                    **ILLINOIS EMS LICENSE**                    **ILLINOIS DRIVER'S LICENSE**                    **CPR CARD**

### PERSONAL INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

SOCIAL SECURITY NUMBER:    \_\_\_ - \_\_\_ - \_\_\_\_\_ DATE OF BIRTH:    \_\_\_/\_\_\_/\_\_\_

ILLINOIS DRIVER'S LICENSE NUMBER:    \_\_\_\_\_ DRIVER'S LICENSE EXPIRATION DATE:    \_\_\_/\_\_\_/\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

PRIMARY PHONE:    \_\_\_ - \_\_\_ - \_\_\_\_\_ TYPE:                    **MOBILE**                    **HOME**                    **WORK**

OTHER PHONE:    \_\_\_ - \_\_\_ - \_\_\_\_\_ TYPE:                    **MOBILE**                    **HOME**                    **WORK**

EMAIL: \_\_\_\_\_ TYPE:                    **PERSONAL**                    **WORK**

### EMS SYSTEM INFORMATION:

IDPH LICENSE NUMBER:    \_\_\_\_\_ EXPIRATION DATE:    \_\_\_/\_\_\_/\_\_\_

LICENSE TYPE:                    **CRITICAL CARE**                    **EMT-BASIC**                    **EMT-PARAMEDIC**  
   **ECRN**                                    **PHRN**                                    **EMERGENCY MEDICAL DISPATCHER**

CDHEMS SYSTEM AGENCY:    \_\_\_\_\_ START DATE:    \_\_\_/\_\_\_/\_\_\_

PRIMARY EMS SYSTEM:    \_\_\_\_\_ SECONDARY EMS SYSTEM:    \_\_\_\_\_

### BACKGROUND SCREENING QUESTIONS:

HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN AGAINST YOU IN ANY EMS SYSTEM YOU HAVE WORKED IN?                    YES                    NO

HAS YOUR EMS LICENSE OR CERTIFICATION EVER BEEN SUSPENDED, REMOVED, OR REVOKED?                    YES                    NO

HAVE YOU EVER BEEN CONVICTED OF A DISQUALIFYING OFFENSE AS LISTED IN THE ILLINOIS JOINT COMMITTEE ON ADMINISTRATIVE RULES, DEPARTMENT OF PUBLIC HEALTH CARE WORKERS BACKGROUND CHECK CODE, SECTION 955.160?                    YES                    NO

REFERENCE: [HTTP://ILGA.GOV/COMMISSION/ICAR/ADMINCODE/077/077009550001600R.HTML](http://ilga.gov/commission/icar/admincode/077/077009550001600R.HTML)

HAVE YOU EVER FUNCTIONED AS A LICENSED OR CERTIFIED FIRST RESPONDER, EMT-BASIC, OR EMT-PARAMEDIC IN ANY OTHER STATE? IF YES, LIST STATE(S): \_\_\_\_\_ YES                    NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW, PROVIDING DATES, DETAILS, AND DISPOSITIONS. ATTACH ADDITIONAL DOCUMENTATION AS NECESSARY.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSONNEL INFORMATION FORM



# CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM

25 NORTH WINFIELD ROAD  
WINFIELD, IL 60190

PHONE: 630.933.6910  
WEBSITE: www.CDHEMS.COM

## PERSONNEL INFORMATION FORM

### EMS EDUCATION INFORMATION:

EMS PROGRAM: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

GRADUATION OR COMPLETION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

LEVEL OF TRAINING:	CRITICAL CARE	EMT-BASIC	EMT-PARAMEDIC
	ECRN	PHRN	EMERGENCY MEDICAL DISPATCHER
LEAD INSTRUCTOR	YES	NATIONAL REGISTRY:	YES
	No		REGISTRY NUMBER _____
			No

### CERTIFICATION STATEMENT:

BY SIGNING BELOW, I CERTIFY THAT ALL INFORMATION LISTED IN THIS DOCUMENT IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT WILLING FALSIFICATION, OMISSION, OR MISREPRESENTATION OF INFORMATION CONTAINED WITHIN WILL BE GROUNDS FOR DISCIPLINARY ACTION, UP TO AND INCLUDING DISMISSAL FROM THE CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

### RELEASE OF INFORMATION:

MY SIGNATURE BELOW SHALL SERVE AS AUTHORIZATION FOR THE CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM TO RELEASE INFORMATION REGARDING MY SYSTEM STATUS, TEST SCORES, CONTINUING EDUCATION RECORDS, AND LICENSURE TO MY CDHEMSS EMPLOYER.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*STOP\*\* EMS PERSONNEL DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY!**

PROCESSED BY: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_/\_\_\_\_/\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_