EMS AGENCY STATUS REPORT

Submit electronically to your EMS Program Representative

EMS Agency Name: Agency Number:

Please complete the following:

EMS Agency Officers

Chief Administrative Officer * Required

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

Chief Operations Officer * Required

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

Agency Portal Super User

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

Infection Control Officer* Required

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

Vaccine Administrator

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

Training Officer* Required

Name:	
Address:	
Home Phone:	Work Phone:
Email:	

I certify that the above information is true and correct: _____ Date: _____

Print Name & Title: