KALAMAZOO COUNTY MEDICALCONTROL AUTHORITY PROVIDER REGISTRATION

TO BE COMPLETED BY EMPLOYEE

Name:____
Last First Middle

Home Address: ____
Street City State Zip

Agency:_____________________________Email: ______________________________

Cell Phone: (__)______________________Hire Date: ______________________

Michigan State License #:_____________Driver's License #:_________________State:____

PHTLS/ATLS Expiration________________PALS/PEPP/EPC Expiration:______________

Have you ever had formal Medical Control Authority action against you? ☐ Yes ☐ No
If yes, please explain:____

Have you worked as an EMS provider at a different agency? ☐ Yes ☐ No
If yes, please explain:____

Authorization for Release of Employment/Education Information

I have made application for Provider of Emergency Medical Services with the Kalamazoo County Medical Control Authority and desire that they be fully informed as to my previous employment, professional status and/or academic records. I hereby authorize any former or current employer, Medical Control Authority and school official to release any information contained in my employment, professional status and/or school records upon request. I specifically waive prior or subsequent written notice of disclosure of record information including disciplinary reports, letters of reprimand or other disciplinary action. I also release my former employers, Medical Control Authorities and schools from all claimed liability arising out of such response and disclosure.

________________________________ ____________________________
Print Applicant Signature

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Date