



## 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

**Chief Operations Officer** \* Required

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

**Agency Portal Super User**

**Infection Control Officer**\* Required

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

**Vaccine Administrator**

**Training Officer**\* Required

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

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

Print Name & Title: \_\_\_\_\_