

**ADVOCATE CHRIST MEDICAL CENTER
EMERGENCY MEDICAL SERVICES SYSTEM**

LETTER OF GOOD STANDING REQUEST FORM

**A \$10.00 Fee is required for all Letters of Verification.
Please allow 5 business days for completion.**

Please print the following information (or attach copy of request).

I _____ am requesting a Letter of Verification. I understand it is my responsibility to notify **in writing**, the ACMC EMS System of the official date of my change in status. Please send the information to:

EMS Coordinator: _____

EMS System: _____

Resource Hospital: _____

Address: _____

Fax number: _____

I will:

- Maintain my primary status with ACMC EMS System.
- Change to secondary status.
- My primary status will be with the _____ EMS System.
- Transfer to the _____ EMS System and leave ACMC completely. I am aware my file will be purged.

Signature

Date

For office use only 5/1/16 df

- | | |
|--|--|
| <input type="checkbox"/> \$10.00 fee collected | <input type="checkbox"/> EMS database updated (demographic & con-ed) |
| <input type="checkbox"/> Con ed and CPR up to date | <input type="checkbox"/> File updated |
| <input type="checkbox"/> Letter & con ed print out faxed | <input type="checkbox"/> File purged |