



South Cook County Emergency Medical Service System  
Ingalls Memorial Hospital  
One Ingalls Drive, Harvey, Illinois 60426  
Phone: 708-915-6900 Fax: 708-915-2743

## SYSTEM ENTRANCE REQUIREMENTS

Dear Applicant:

You will be required to submit the following requirements for System Entrance:

1. Letter of good standing from current EMS System to include documentation of current continuing education hours.
2. Letter of employer verification.
3. Current EMT-Paramedic license.
4. Current AHA or Red Cross CPR course card.
5. Current Illinois Driver's license.
6. Completion of Personal/Professional Data Sheet.
7. Verification of minimum score of 80% on most recent Region VII SMO Update exam. Successful completion (80%) of a Medical Math and EKG exam. \*
8. Entrance fee of \$25.00.

\*If unable to provide proof of items from #8, you will be tested on those three topics during your scheduled appointment.

**Please call the EMS office at 708-915-6900 to schedule a testing day/time when you have the above requirements.**

The EMS office is located in the Oak Forest College Center of South Suburban College, 16333 Kilbourn, Oak Forest, Illinois.

One retake will be allowed on each examination. These retakes must be taken within three months of the original examination. Should a failure occur on the second attempt, an interview evaluation will be scheduled with the Medical Director. The Medical Director will determine if additional testing will be required.

It is the responsibility of each individual to become familiar with and have an understanding of the South Cook County EMS Policies and Procedures.

**The above listed items can be emailed to:**  
**Dawn McDermott at [Dawn.McDermott@UChicagomedicine.org](mailto:Dawn.McDermott@UChicagomedicine.org)**



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## SYSTEM ENTRANCE PERSONAL/PROFESSIONAL DATA SHEET

NAME \_\_\_\_\_ DATE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

DOB \_\_\_\_\_ Email ADDRESS: \_\_\_\_\_

IDPH LICENSE # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

DEPARTMENT AFFILIATION (PRIMARY) \_\_\_\_\_

DEPARTMENT AFFILIATION (SECONDARY) \_\_\_\_\_

RESOURCE HOSPITAL (PRIMARY SYSTEM) \_\_\_\_\_

NAME OF PARAMEDIC  
TRAINING PROGRAM: \_\_\_\_\_

MONTH & YEAR OF GRADUATION \_\_\_\_\_

DATE OF LICENSING EXAM \_\_\_\_\_

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

\_\_\_\_\_

Completed Data Sheets can be emailed to: [Dawn.McDermott@UChicagomedicine.org](mailto:Dawn.McDermott@UChicagomedicine.org)

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