

Date Requested: \_\_\_\_\_  
Requesting Agency: \_\_\_\_\_  
Requesting Individual: \_\_\_\_\_

**REQUEST FOR PCR – DS  
PERSONNEL CHANGE**

Type of Personnel Change (Check all that apply)			
<input type="checkbox"/> New Employee	<input type="checkbox"/> Employee Deletion	<input type="checkbox"/> Correction	<input type="checkbox"/> Password Change
<input type="checkbox"/> Agency Addition	<input type="checkbox"/> Agency Deletion	<input type="checkbox"/> Change of Name, Address, Phone #, etc.	
<input type="checkbox"/> Other (Please Specify) _____			

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

EMT-P State Licensure #: \_\_\_\_\_  
Issue Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

MICN  EMT – I  EMT – II  1<sup>ST</sup> Responder – Defib  1<sup>ST</sup> Aid - Defib  
Accreditation/Certification #: \_\_\_\_\_ EMS Agency: \_\_\_\_\_  
Issue Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Primary Agency/Employer: \_\_\_\_\_  
Secondary Agency/Employer: \_\_\_\_\_  
Other Agency/Employer: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOR EMS AGENCY USE ONLY	
Date Received: _____	Reviewed By: _____
Date Entered: _____	Entered By: _____
LOG ON # _____	
Comments: _____	
_____	
_____	

**New MICNs, Paramedics, EMT-IIIs, Recertifying EMT-Is, First Responder and First Aid:**  
Fill out an application at the EMS Agency