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Monroe Livingston Region Program Agency

Division of Prehospital Medicine, University of Rochester
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ADVANCED LIFE SUPPORT

PROVIDER AFFILIATION CHANGE

Agency: _____ **Date:** _____

Provider Name	EMT #	Level	Add	Remove
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐
		EMT-I	☐	☐

As ALS Chief, I affirm the accuracy of the change in provider affiliations as indicated above.

ALS Chief Name: _____ **Date:** _____

ALS Chief E-Mail Address: _____

Provider affiliation forms must be forwarded to the Program Agency within two business days of the status change.