Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

EMS AGENCY STATUS REPORT

Submit electronically to your EMS Program Representative or fax to: (804) 371-3409

EMS Agency Name: _____ **EMS Agency Number:** _____

Please Complete the following:

EMS Agency Officers

Chief Administrative Officer

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

Chief Operations Officer

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

VPHIB Officer

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

Infection Control Officer

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

Vaccine Admin

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

Training Officer

Name:	Term of Office Expires:
Address:	
Home Telephone:	Work Telephone:
Email:	

I certify that the above information is true and correct. _____ Date: _____
(Signature)

Printed Name & Title: _____