

**LINCOLN COUNTY MAINE  
OFFICE OF EMERGENCY MANAGEMENT  
I.D. QUALIFICATION FORM  
EMS PROVIDERS**

Last Name: _____ First Name: _____ MI _____	Name of Department: _____  Title: _____
Emergency Contact Person: _____  Phone Number: _____	Allergies: _____  Medical History: _____
EMS Number: _____	Date of Birth: _____
QUALIFICATION:	DATE OF LAST CERTIFICATION:
Emergency Medical Technician (EMT):  <input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Paramedic	Date: _____

Chief or Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)