# STATEMENT OF AFFILIATION WITH SERVICE PROVIDER

This form is to be completed by an authorized supervisor of service provider. Please deliver completed forms to the Public Health Department, or they may be faxed to the Imperial County EMS Agency at (442) 265-1478.

________________________ will be ________________________ functioning as
(Full Name) (Paid, Volunteer)

________________________ for this department/agency.
(EMR, EMT-B, AEMT, EMT-P, MICN)

They will be covered by our liability insurance while performing these duties.

The will be on a ________________________ status as defined below.
(Full, Part-Time)

Date: ________________

________________________
(Signature)

________________________
(Authorized Supervisor)

________________________
(Title)

________________________
(Name of Service Provider)

Full Time:
- A. Employed full time, and primary assignment is to the ambulance, rescue squad or emergency department.

Part Time:
- A. Employed full time, and primary assignment not always to the ambulance, rescue squad or emergency department; or
- B: Employed part time.

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