

**REQUEST FOR PROVIDER AGREEMENT/APPLICATION**

Date of Request: \_\_\_\_\_  
Name of Agency: \_\_\_\_\_  
Fire Chief/Manager: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax #: \_\_\_\_\_  
Agency e-mail Address: \_\_\_\_\_  
Base Hospital (if Applicable): \_\_\_\_\_  
Program Manager/Coordinator: \_\_\_\_\_  
Alternate Phone #: \_\_\_\_\_

Have you received a Nor-Cal EMS Policy and Procedure Manual:  Yes  No  
**\*\*ALS Providers shall be required to complete an application packet prior to receiving a Provider Agreement\*\***

**LEVEL OF SERVICE TO BE PROVIDED**

AED  BLS Ambulance  
 ALS Transport  ALS Non-Transport  ALS Tactical Weapons  
 ALS Aircraft  BLS Aircraft  Combi-Tube  Other (please contact our office prior to submitting form): \_\_\_\_\_

**ALS AND TRIAL STUDY PROVIDER ONLY**

Base Hospital Assignment \_\_\_\_\_  
(Hospital name)  
The above named hospital has agreed to be the assignment hospital for \_\_\_\_\_  
\_\_\_\_\_ (provider name). This will be effective upon approval of the provider by Nor-Cal  
EMS, and at such time, a copy of the Provider Approval/Agreement is on file with this hospital.  
\_\_\_\_\_  
Base Hospital Medical Director Signature Base Hospital Administrator Signature

**Please fax or mail this to:**

Nor-Cal EMS  
43 Hilltop Drive  
Redding, California 96003  
Fax #: (530) 229 – 3984

If you have any question please call (530) 229 - 3979

**NOR-CAL EMS USE ONLY**

Date Request Received: \_\_\_\_\_  
Date Agreement Mailed: \_\_\_\_\_  
Date Agreement Returned: \_\_\_\_\_

