EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMS PERSONNEL INFORMATION UPDATE FORM

Complete and Return to: Mail:
LAC EMS Agency/Cert Sect
10100 Pioneer Blvd Ste 200
Santa Fe Springs CA 90670

Email:
PMandMICNinfo@dhs.lacounty.gov

PRINT NAME: _____
LAST FIRST M.I.

LEVEL: ☐ PARAMEDIC ☐ MICN

LAST FOUR SSN: _____ CA STATE NO: _____ LAC ACCRED OR MICN CERT NO: _____

PERSONAL INFORMATION CHANGE – CHECK AND COMPLETE ALL THAT APPLY

☐ NAME (ATTACH UPDATED STATE LICENSE) FROM: _____
LAST FIRST M.I.

TO: _____
LAST FIRST M.I.

☐ ADDRESS: _____
NUMBER, STREET, APT OR UNIT CITY STATE ZIP

☐ PHONE: _____ ☐ EMAIL: _____

☐ EMPLOYER: _____

ADDRESS: _____

WORK PHONE: _____ EXT _____

PM or MICN SIGNATURE _____ DATE: _____

Change of name, contact information, or employer must be submitted in writing to the EMS Agency within 30 days of change.

MICN/Paramedic - Sponsorship Notification by Approved Los Angeles County ALS Providers
Please submit the changes to the EMS Agency within 30 days.

☐ Initiation of Sponsorship ☐ No Longer Sponsored ☐ Retired ☐ Deceased
☐ Primary ☐ Secondary

Effective Date of Change: (Month/Date/Year) _____

Coordinator's Name: _____ Coordinator's Signature: _____

Sponsoring Agency/Base Hospital: _____

Date: _____

*** EMS AGENCY USE ONLY ***

Date Received: _____ Input Date: _____ Initials:_____
Notes: