EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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EMS PERSONNEL
INFORMATION/SPONSORSHIP UPDATE FORM

Complete and return by mail or email to:

LAC EMS Agency/Cert Sect
10100 Pioneer Blvd Ste 200
Santa Fe Springs CA 90670

PMandMICNinfo@dhs.lacounty.gov

Any changes of name, contact information, or employer must be submitted to the EMS Agency on this form within 30 days.

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: FROM: _____
(ATTACH UPDATED STATE LICENSE) 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:_____

Paramedic or MICN - Sponsorship Notification by Approved Los Angeles County ALS Providers

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

Effective Date of Change: (Month/Date/Year) 5-5-2026

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

Sponsoring Agency or Base Hospital: _____

Date: _____

****** EMS AGENCY USE ONLY ******

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