



New Hampshire  
 Emergency Medical Services  
 Region 1



EMS PROVIDER CONTACT INFORMATION FORM

NAME: \_\_\_\_\_  
LAST FIRST MI

ADDRESS: \_\_\_\_\_  
STREET / PO BOX  
 \_\_\_\_\_  
CITY / TOWN STATE ZIP

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ WORK (\_\_\_\_) \_\_\_\_\_ HOME  
 (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_ PAGER

E-MAIL: \_\_\_\_\_ (This is how you will contacted)

N.R.E.M.T. NUMBER: \_\_\_\_\_ N.H. PROVIDER LICENSE #: \_\_\_\_\_

DEPT. AFFILIATION: \_\_\_\_\_

DEPT. TRAINING OFFICER: \_\_\_\_\_

PEETE EVALUATOR?  YES  NO

I AM INTERESTED IN HELPING OUT IN THE EXAM PROJECT. I CAN CONTRIBUTE TO THIS EFFORT BY: \_\_\_\_\_

This information will not be shared without permission. By signing and returning this form, I hereby give permission to the Region 1 Council to use this information in their Provider Contact Information Database for the Region 1 Exam Process.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**PLEASE RETURN THE COMPLETED FORM TO:**  
 Dartmouth Lake Sunapee Region 1 EMS  
 PO Box 195  
 Georges Mills, NH 03751-0195