Personnel Action Form

Kitsap County Emergency Medical Services & Trauma Care Council

Medical Officer Name: _____

Agency Name: _____

Please fill out the form below when your department either adds or deducts a provider. Once completed, please send this form back to the EMS Office at info@kitsapcountyems.org.

Add/Remove	Provider Name	Effective Date:	EMT or PM:		Career or Volunteer:	
			☐ EMT	☐ PM	☐ Career	☐ Volunteer
			☐ EMT	☐ PM	☐ Career	☐ Volunteer
			☐ EMT	☐ PM	☐ Career	☐ Volunteer
			☐ EMT	☐ PM	☐ Career	☐ Volunteer
			☐ EMT	☐ PM	☐ Career	☐ Volunteer
			☐ EMT	☐ PM	☐ Career	☐ Volunteer