ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

TRAINING PROGRAM APPLICATION FOR AMENDMENT

☐ **Name Change** ☐ **Address Change**

I. IDENTIFICATION

OLD INFORMATION

Legal Business or Corporate Name: ______________________________

Mailing Address: ______________________________

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Physical Address if Different: ______________________________

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Telephone Number: ______________ Facsimile Number: ______________

NEW INFORMATION

Legal Business or Corporate Name: ______________________________

Mailing Address: ______________________________

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Physical Address if Different: ______________________________

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Telephone Number: ______________ Facsimile Number: ______________

Effective Date of Change(s): ______________________________

II. ATTESTATIONS

I attest that the insurance required in R9-25-301 (F) is valid for the new name or new address.

I attest that the applicant will comply with all requirements in A.R.S. Title 36, Chapter 21.1 and Title 9 A.A.C. Chapter 25, and that all information required as part of the application has been submitted and is true and accurate.

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Signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative

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Date of signature or electronic signature

A COPY OF A.A.C. TITLE 9, CHAPTER 25, ARTICLE 3 HAS BEEN FORWARDED TO THE APPLICANT WITH THIS APPLICATION.

Form #25-303A