

**EMS VARIANCE/EXEMPTION APPLICATION FOR PROVIDERS**  
**VIRGINIA DEPARTMENT OF HEALTH**  
**OFFICE OF EMERGENCY MEDICAL SERVICES**  
**(Please print or type all information)**

**VARIANCE**     **EXEMPTION**

Date:

Name of Applicant:

SSN:

Address:

Primary Phone:

Secondary Phone:

Email Address:

EMS Agency Affiliation (Name and number):

Section(s) of the applicable Rules & Regulations:

Reason for the Request, including any extenuating circumstances (be specific):

Submit written documentation for any matters related to medical situations (including proof of medical treatment from a physician) or military mobilizations.

If variance, period of time needed to complete requirements:

Name of Individual Completing form:

\_\_\_\_\_  
Signature

OMD Approval:

\_\_\_\_\_  
Signature

Chief Officer:

\_\_\_\_\_  
Signature

Health Department Use Only:

Date Received: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

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**Form Completion Check Sheet**

1. Form completed in its entirety and signed:  Yes  No
2. Signature of EMS agency Operational Medical Director - Required if EMS provider is affiliated with an EMS agency:  Yes  No
3. Signature of Chief Officer of EMS agency – required if EMS provider is affiliated with an EMS agency:  Yes  No
4. Supporting documentation (medical documentation, military orders, etc):  Yes  No

*Code of Virginia § 32.1-111.9 Applications for variance or exemptions*

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+32.1-111.9>

**IMPORTANT**

- A. Form must be completed in its entirety, submitted and received by OEMS prior to the expiration of the EMS certification, license or testing eligibility.
- B. Failure to complete this form in its entirety will delay the processing of the request.

Health Department Use Only:

Date Received: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

EMS 6036 Revised: 06/2011