



INLAND COUNTIES EMERGENCY MEDICAL AGENCY

Serving San Bernardino, Inyo and Mono Counties

1425 South "D" Street

SAN BERNARDINO, CA 92415-0060

909-388-5823 FAX: 909-388-5825

QUARTERLY DECLARATION

1. Quarterly Reporting Period: 1/1 to 3/31 4/1 to 6/30 7/1 to 9/30 10/1 to 12/31
Due Apr 15th Due Jul 15th Due Oct 15th Due Jan 15th

2. Personal Information to be completed each quarter:

Certification or License No. _____ Name: _____ Cell Phone: _____

Address/City/State/Zip: _____

Change of address: Yes No E-mail Address: _____

3. Employment Information to be completed each quarter:

Name: _____ Telephone: _____

Address/City/State/Zip: _____

Name: _____ Telephone: _____

Address/City/State/Zip: _____

4. Attach verification/reports for any of the following that apply to you:

Coursework/CE Ethics Course Stress/Anger Mgmt. Medical Treatment
 Psychotherapy AA Attendance Drug Detox/Diversion Other _____

5. Since the last Quarterly Declaration have you been arrested, charged, or convicted of any Federal or State offense or any county or city laws rules or regulations? (Exclude parking tickets)

Yes No (If "Yes" explain answer on a separate sheet and attach to this form)

6. During this reporting period have you complied with each and every term and condition of probation?

Yes No (If "No" explain answer on a separate sheet and attach to this form)

7. If you did not practice all or part of the period covered by this report, include dated you ceased practice _____ and date you resumed practice _____.

Executed on _____, at San Bernardino, San Bernardino, California.
(Date)

By signing here, I acknowledge that the above is true and correct.

Probationer Signature