Western Regional
Emergency Medical Advisory Committee
462 Grider Street
Buffalo, New York 14215

Application for Change in Medical Director

NYS Agency Code: _____

Agency Name: _____

Address: _____ State: New York Zip: _____

Contact Name: _____ Contact Title: _____

Contact E-Mail: _____ Contact Phone: _____

Current Medical Director: _____ Intended Medical Driector: _____

Reason for change request: _____

Completed applications must include:

- ☐ This WREMAC Application Form
- ☐ Medical Director/EMS Agency Agreement (sample provided)
- ☐ Revised Medical Director Verification Form (DOH-4362)
- ☐ Agency Information Page
- ☐ Roster of NYS Certified Providers on "active" status with agency
- ☐ Copy of current NYSDOH Operating Certificate (ambulance services & ALSFR only)

Send all items above to your EMS Program Agency (see list by county)

- END OF APPLICATION -

THIS SECTION IS FOR THE EMS PROGRAM AGENCY TO COMPLETE:

1. Date received by Program Agency (complete): _____

   Note to Program Agencies: Verify that each active provider on roster has a completed *Provider Privilege Application* on file with the agency before the application is presented to WREMAC.

2. Date acted upon by WREMAC: _____

3. OUTCOME (circle): Approved Denied (if denied provide reason below):

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems

Medical Director Verification

Please identify the physician providing Quality Assurance oversight to your individual agency. If your agency provides Defibrillation, Epi-Pen, Blood Glucometry, Albuterol or Advance Life Support (ALS), you must have specific approval from your Regional EMS Council's Medical Advisory Committee (REMAC) and oversight by a NY state licensed physician. If you change your level of care to a higher ALS level, you must provide the NYS DOH Bureau of EMS a copy of your REMAC's written approval notice.

If your service wishes to change to a lower level of care, provide written notice of the change and the level of care to be provided, and the effective date of implementation, to your REMAC with a copy to the NYS DOH Bureau of EMS.

If your agency has more than one Medical Director, please use copies of this verification and indicate which of your operations or REMAC approvals apply to the oversight provided by each physician. Please send this form to your DOH EMS Central Office for filing with your service records.

☐ **Defibrillation / PAD** ☐ **Epi Autoinject** ☐ **Albuterol** ☐ **Blood Glucometry** ☐ **Naloxone**

☐ **CPAP** ☐ **Check and Inject** ☐ **12 Lead** ☐ **Ambulance Transfusion Service (ATS)**

☐ **EMT** Level of Care ☐ **AEMT** Level of Care ☐ **Critical Care** Level of Care ☐ **Paramedic** Level of Care ☐ **Controlled Substances** (BNE License on File)

Agency Name _____

Agency Code Number _____ **Agency Type:** ☐ **Ambulance** ☐ **ALSFR** ☐ **BLSFR**

Agency CEO _____
Name

Medical Director _____
Name

_____
NYS Physician's License Number

Ambulance/ALSFR Agency Controlled Substance License # if Applicable: 03C – _____

Ambulance/ALSFR Agency Controlled Substance License Expiration Date: _____

I affirm that I am the Physician Medical Director for the above listed EMS Agency. I am responsible for oversight of the pre-hospital Quality Assurance/Quality Improvement program for this agency. This includes medical oversight on a regular and on-going basis, in-service training and review of Agency policies that are directly related to medical care.

I am familiar with applicable State and Regional Emergency Medical Advisory Committee treatment protocols, policies and applicable state regulations concerning the level of care provided by this Agency.

If the service I provide oversight to is not certified EMS agency and provides AED level care, the service has filed a Notice of Intent to Provide Public Access Defibrillation (DOH-4135) and a completed Collaborative Agreement with its Regional EMS Council.

Medical Director _____
Signature

_____
Date of Signature

WREMAC

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Medical Director/EMS Agency Agreement

This agreement dated _____by and between _____herein referred to as the **EMS Agency**, and _____, Physician, herein referred to as the **Medical Director**.

The purpose of this agreement is to identify a Medical Director of record for the EMS Agency and establish minimum guidelines for medical oversight of the EMS Agency by the Medical Director. The Medical Director may have a "designee" who represents the interests or opinions of the Medical Director. Such designee shall be identified to the EMS Agency by the Medical Director.

This relationship may be terminated by written notice served upon the Medical Director at least 5 business days prior to the effective date of said termination. The Medical Director may suspend or terminate the relationship at will for cause, as defined hereinafter, or upon five business days' notice without cause.

The EMS Agency Agrees to:

1. Be responsible for the transmission of all communications from the Medical Director (or his/her designee) to all Agency providers
2. Take necessary steps to ensure participation by its providers in all programs and courses required by the Medical Director including but not limited to Protocol requirements, Continuing Medical Education and Quality Improvement.
3. Monitor the activities of each provider and keep accurate records, which shall be made available to the Medical Director (or his/her designee) upon request. An officer shall be appointed to maintain such records.
4. Forward immediately to the Medical Director (or his/her designee) any and all complaints, notification, summonses, subpoenas, letters and communication of any nature received which in any way bears on the quality of service rendered, is suggestive of any possible lawsuit or legal proceeding or in any way bears on the competence of any agency provider.
5. Abide by and strictly adhere to all standards and protocols and other requirements by the Medical Director and agrees to suspend provider privileges for failure to comply with this provision.

Signed:

_____ _____
Medical Director **Date**

_____ _____
Agency Chief / CEO **Date**

Agency Information

Date: _____

Agency/Department Name: _____ Agency Number: _____

Level of Care: _____ Election Month: _____

Physical Address: _____ Mailing Address: _____

_____ _____

Phone Number: _____ Fax: _____

Website address: _____

EMS Captain: _____

Phone: _____ Email: _____

Address: _____

Agency Chief: _____

Phone: _____ Email: _____

Address: _____

Agency Contact: ***All communications from Program Agency will be directed to this person.***

☐ EMS Captain ☐ Agency Chief ☐ Other (Please provide contact information below)

Name: _____

Phone: _____ Email: _____

Address: _____

Medical Director: _____

Comments/Questions/Concerns: _____

_____

_____

Personnel Roster

Name	Certification Level	NYS EMT #	Expiration Date