WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE,
GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

Medical Director Application

This form must be submitted along with a completed copy of NYS DOH-4362, Medical Director Verification Form

NYS EMS Agency Code: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Agency Director/Chief Officer: _____ Title: _____

Contact Number: _____

Intended Medical Director: _____

I affirm that the current Medical Director, Dr. _____, has:

- □ been notified he/she will no longer be our medical director
- □ has not been notified due to _____
  (Please state reason)

Agency Director Initials: _____

I affirm that as medical director, I meet the following requirements: (*Intended medical director must initial)*

_____ Licensed in the State of New York.

_____ Have knowledge and experience in the delivery of emergency medical care.

_____ Actively work in an Emergency Department.

_____ Completed a Base Station Course or equivalent as approved by the WREMAC.

I affirm that an agency/medical director agreement has been executed between _____
(Agency)

and _____ and is available on request.
(Medical Director)

Agency Director:

Signature:	Date:

Medical Director:

Name:	Signature:	Title:	Date:

WREMAC use only

Approved by WREMAC on _____ WREMAC Chairperson Signature: _____
(Date)

STEMS • One Blue Bird Square • Olean, NY 14760
Office of Prehospital Care • 462 Grider Street • Buffalo, NY 14215
Lake Plains Community Care Network • 56 Harvester Avenue, 3rd Floor, Suite 1 • Batavia, NY 14020

NEW YORK STATE DEPARTMENT OF HEALTH **EMS Agency**
Bureau of Emergency Medical Services **Medical Director Verification**

Notice to Service:

Please identify the physician providing Quality Assurance oversight to your individual service. If your service 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 service has more than one Service 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 Area Office for filing with your service records.

Check all special regional approvals and the single highest level of care applicable to your service:

☐ Defibrillation / PAD (BLS Level Services) ☐ Epi Pen ☐ Albuterol ☐ Blood Glucometry (Epi / Albuterol / Blood Glucometry per regional protocol)

☐ AEMT– Paramedic Level of Care ☐ AEMT– Critical Care Level of Care ☐ AEMT– Intermediate Level of Care ☐ Controlled Substances (BNE License on file)

Please Type or Print Legibly:

Name of EMS Service: _____

Agency Code Number: _____ Service Type: ☐ Amb ☐ ALSFR ☐ BLSFR

Name of Service CEO: _____

Name of Service Medical Director: _____

NYS Physician's License Number: _____

Ambulance/ALSFR Service Controlled Substance License # if Applicable: **03C-**_____

Ambulance/ALSFR Service Controlled Substance License Expiration Date: _____

Medical Director Affirmation of Compliance:

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

If the service I provide oversight to is not certified 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.

Signature – Service Medical Director: _____

Date of Signature: _____

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

Medical Director Verification

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☐ **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