WREMAC Provider Privileges Application

Provider:	Agency: ume First Name Maiden Name or Alias							
	Paramedic	Criti	cal Care	AEMT	ЕМТ	Γ- I	EMT-B	CFR
NYS Certification # (6 digits): Expiration Date:								
Date of agency orientation: (new providers with agency only)								
Date skills verification complete:								
Date of WREMAC protocol exam:								
CPR Course Name: Expiration Date:								
Trauma Life Support Course:								
Expiration Date:								
Pediatric Life Support Course:								
Expiration Date: Cardiac Life Support Course:								
Expiration Date								
List <u>all</u> EMS agencies with which you	u have <u>ever bee</u>	n affilia	ated as a c	ertified provid	der (use b	ack of fo	orm if neces	ssary)
Name of Service	Dates with Service		Service Medical Director		rector	Telephone Number		
If you answer "Yes" to any question b	pelow, provide	a full de	escription	on a separate	sheet of r	oaper.		
J 1	71		1	1	1	•		
1. Has your medical command aut	horization ever	r been 1	estricted	? No	Yes ((explain))	
2. Has your medical command authors from an EMS agency to avoid an				· ·	•	ou ever	voluntaril	y resigned
3. Has any disciplinary sanction be disposition of an appeal), or is an		•	, ,		_			- C
By signing below, I attest that all information I give permission to the WREMAC, the EMS eligibility for privileges. I understand that any at any time for violation of just cause. I agree understand that failure to do so will result in s my privileges in all agencies with which I hav Agency, the Medical Director, and all affiliate permission to the WREMAC, the EMS Progra if my privileges are suspended or revoked for	Program Agency, decision is final at to meet the continuuspension or revoce an affiliation, reges for any loss incum Agency, the Mo	or any af nd that pr uing educ cation of r gardless i rred relat	filiates to verivileges are ration requiremy privileges f volunteer of the tolunteer of the tolunteer of tolu	rify all informati not rights, they a ements of the Wh es. I understand the pr paid. I agree to gibility for privil	ion which mare privilege REMAC an hat a loss of the hold harmleges as a pr	nay be rele es which m nd this agen f privileges less the W re-hospital	evant in determ may be revoked ney's medical s in any agence (REMAC, the care provider	nining my d (all or in part) director and y will affect EMS Program . I grant
Provider's Signature	Date	:	Agen	cy Officer Sig	gnature		Б	Pate
Date reviewed by medical director: _								

WREMAC Provider Privileges Application Continuation

Name of Service	Dates with Service	Service Medical Director	Telephone Number