NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Memorandum

To: All AAREMS Basic Life Support First Response agencies
From: Daniel J. Clayton, HPA 1 (EMC)
Date: August 16, 2011
Re: EMS Training Reimbursement State Funding

Dear Chief Operations Officer/Chief Executive Officer,

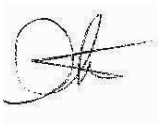
In an attempt to update records, the New York State Department of Health Bureau of Emergency Medical Services (BEMS) is requiring Basic Life Support First Response (BLSFR) agencies to review and complete the enclosed BLSFR information packet and return it to this office promptly.

If your agency intends to include public access defibrillation (PAD) and/or epinephrine auto injectors in its level of service, then a copy of your notices of intent and collaborative agreements will be required. Additionally, if your agency intends to provide albuterol and/or blood glucometry, please provide this office with written approval from the Regional Emergency Medical Advisory Committee (REMAC) and an updated Medical Director Verification form (included with this packet). Please also note that Microsoft word templates of the required EMS Participation Agreement (referenced on page two of this packet) and the required letter granting EMS response authority to your agency by a municipality (i.e. town supervisor, village or city mayor, board of fire commissioners, etc also referenced on page two of this packet) are available by requesting them from BEMS.

Until the required documentation is received by BEMS, your agency is not eligible for EMS training reimbursement funding. If the completed and signed packet is not received by October 11, 2011, then BEMS will assume that your agency is not participating in 911 EMS response in your community and your four digit Department issued agency code will be deactivated.

Thank you for your immediate attention to this matter. If you need further information, please feel free to contact me or Ms. Lisa DeLong of my staff at 518-402-0996 ext 2.

Sincerely,



Daniel J. Clayton
HPA 1 (EMC)
Bureau of Emergency Medical Services
433 River St 6th Floor
Troy NY 12180

(518) 402-0996
(518) 402-0985 FAX
E-mail – djc08@health.state.ny.us

Cc : NYS DOH BEMS Regional Office
REMSCO/Program Agency

BLSFR SERVICE UPDATE CHECKLIST

If Your Agency is Currently Providing EMS and Wishes to Retain its BEMS issued Agency Code Number, then Your Agency will be Required to complete, sign, and submit all of the following:

- ☐ The BLS Agency Information Update Form – Leave the boxed area at the bottom blank.
- ☐ A letter on official letterhead from the chief elected executive of your municipality (i.e. mayor, town supervisor, chair of board of fire commissioners, etc) granting your agency authority to respond to EMS related 911 calls within the municipality's jurisdiction. Note that a sample/template agreement in Microsoft word format is available from BEMS upon request.
- ☐ A copy of the " EMS Participation Agreement" (EMS-PA) which your agency currently holds with the ambulance service(s) that transport the patients you treat. If your agency does not currently have an executed EMS-PA, then one will be required to be executed. Note that a sample/template EMS-PA in Microsoft word format is available from BEMS upon request.
- ☐ The EMS System Information Sheet included with this packet. Provide responses to each of the items listed, or attach separate document providing explanation if needed.
- ☐ A Personnel Roster (DOH-2828) and list all your members with EMS training. Check boxes in the right hand columns to indicate employees/volunteers with First Aid, CPR or Defibrillation levels of training. Note that CFR and EMT-B level personnel have fields for a BEMS issued certification number and expiration date. Note that an agency may elect to submit their own version of a personnel roster provided that it contains all of the same data elements as the DOH-2828 form.
- ☐ **If** your agency provides epinephrine auto injector and/or public access defibrillation as adjunct levels of care **and** your agency physician medical director/EHCP has changed since the original/initial Notice of Intent (NOI) and collaborative agreement were filed, then your agency must submit a **new** NOI and collaborative agreement to your REMSCO with a copy to BEMS as part of this agency update. Otherwise, please submit a copy of your original NOI to BEMS as part of this agency update as evidence of your original/initial filing.
- ☐ A Medical Director Verification form (DOH-4362) if your agency has been granted authority by your off line physician medical director to provide adjunct levels of care such as PAD, epinephrine auto injector, albuterol, and/or blood glucometry (if applicable).
- ☐ A letter from your Regional Emergency Medical Advisory Committee (REMAC) authorizing your agency to provide adjunct levels of care including albuterol and/or blood glucometry (if applicable).

Please review BEMS Policy Statement 06-04 entitled "BLS-FR Services Information" to refresh your understanding of the importance and responsibilities of providing EMS response (www.nyhealth.gov/nysdoh/ems/pdf/06-04.pdf). Note that all required forms are available for download and printing at www.nyhealth.gov/nysdoh/ems/emsforms.htm

If Your Agency is No Longer Providing EMS and Wishes to Surrender its BEMS Issued Agency Code Number, then:

- ☐ Mark the "No Longer Providing EMS" box at the bottom of the EMS System Information Sheet, and return it to BEMS at 433 River St, 6th Floor, Troy, NY 12180. Your Agency Code Number will be deactivated and your Regional Emergency Medical Services Council advised that you are no longer participating in your local EMS system as a Basic Life Support First Response Service.

  ***NOTE**: Your agency does not need an Agency Code Number to be authorized to provide Public Access Defibrillation (PAD). Each Public Safety service should consider PAD as a minimum level of care even if only for the protection of their own agency members / employees.*

Please be sure to sign and date the bottom of the BLS FR Agency Information Sheet after completing the requested information.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

BLSFR Agency Information Application / Update Form

Name of Service	Code # if Update:
DBA or Assumed Name if any	
Physical Location / Address	
Mailing Address	County:
City, State, Zip Code	City: State: Zip:
Describe / list your response area	☐ Check Box if Fire/Amb District
Business Phone # and FEIN Φ	Bus #: Federal Employer ID No:
Fax Phone Number & Email	Fax #: Email Address:
Emergency Phone Number	10 digit direct phone #: ☐ Also check Box if Called via 911
Chief Operations Officer & Title	Print Name: Print Title:
Chief Officer Day Phone	
Chief Officer direct home/night Phone	Cell / Pager #:
Name of dispatching Public Safety entity	☐ Check box if Self Dispatched
Dispatch communications info	Radio Frequency: FCC Callsign:
Number of Trained Providers	First Aid: PAD*: CFR: EMT: ALS**:
Number of members that are also members of another EMS Agency	First Aid: PAD*: CFR: EMT: ALS**:
Number EMS Response Vehicles	Service owned: Privately Owned:
PrimaryTransporting Ambulance Service	Agency Code #:
Additional Transporting Ambulance Service	Agency Code #:
Additional Transporting Ambulance Service	Agency Code #:
Number of EMS Calls Annually****	# EMS Calls Dispatched to: #Calls with Patient Care given:
Printed Name and Title of Person Completing this Information Form	Print Name: Print Title:
Signature and Date of Person Completing This Information Form	Signed: Date:

* NOTE: PAD trained personnel may ONLY provide defibrillation care with service that has filed notice per PHL 3000b.
** NOTE: ALS Certified personnel may ONLY provide care at BLS level when responding with BLSFR authorized service.
****NOTE: Services not yet providing EMS – Please provide estimate of call volume based on info from local EMS dispatch.
Services providing EMS – Provide call volume based on calls to which you were dispatched to provide EMS.
EMS calls: indicate all EMS dispatches. Calls w/pt care: do not include RMAs, No Pt found, standbys, cancelled calls.
Φ NOTE: **Federal Employer ID # must be provided for any service intending to apply for EMS training reimbursement from NYS DOH.**

Please complete this form with your agency Information and send it to the address to the right. If you have questions about Filling out this form, please contact the DOH Bureau of EMS, Operations Section for Assistance at 518-402-0996 extension 2.

Return Completed Form to:

Attn: BLSFR Update - OPS
NYS DOH Bureau of EMS
433 River Street Suite 303
Troy, New York 12180-2299

Do Not Write or Mark in Box Below

App Rcd:	Chk list complete:	Date Reviewed:	Code #:

EMS System Information Sheet

Responses are <u>required</u> for each item below, or attach documentation if your selection is indicated as "Other – See attached explanation". You may indicate more than one response.

If your Agency is No Longer Providing BLSFR EMS Response, **skip to the bottom of this page** and indicate "Our Agency is no longer providing EMS". No other documents are required if you check this.

Please **Circle** the Letter of each applicable response to the following and be sure to complete the <u>BLS FR Agency Information Update</u> form. – Thank You!

Service Dispatches to medical emergencies are provided by:

A. Regional, County, Local or Government 911 Public Safety Dispatch Center
B. Local Ambulance Service
C. Self Dispatched
D. Other – See attached explanation

QA/QI for patient care rendered by members of our agency is accomplished by:

A. Participation agreement with transporting ambulance(s)
B. Local or County QA/QI program
C. Regional QA/QI Program
D. A physician affiliated or contracted by our agency
E. Own Agency Members
F. QA/QI is not done for patient contacts
G. Other – See attached explanation

Types of Calls for which an EMS response is provided by our agency includes:

A. All EMS Calls within coverage area
B. All Priority / Urgent Medical Need calls as determined by Dispatch and/or EMD system
C. All EMS Calls for which assistance is requested by transporting ambulance
D. All Calls which our agency otherwise responds to at which a medical need is discovered
E. Other – See attached explanation

Authority for the EMS response provided by our agency is documented in writing by:

A. The CEO of the City, Town, or Village of the Municipality served by our agency.
B. The Executive body or supervisor of our county.
C. A board of Commissioners appointed / elected in charge of the District served
D. The CEO or Operations Officer of our service
E. Other – See attached explanation

The minimum level of medical training *required* for members to provide patient care is:

A. Emergency Medical Technician or higher Certification
B. Certified First Responder or higher certification
C. First Aid with CPR or higher certified training
D. CPR or higher certified training
E. No officially recognized medical training required
F. Other – See attached explanation

☐ Agency provides Public Access Defibrillation. EHC/Medical Director is: _____

Name of your Service or Agency: _____

Current NYS DOH Agency # Assigned to your Agency or Service: _____

Please print legibly your Full Name: _____

Please Sign and Date: _____ Date: _____

☐ Our Agency is no longer providing EMS. As an authorized representative or Chief Operations Officer I hereby surrender the EMS Agency ID number issued to my agency.

New York State Department of Health
Bureau of Emergency Medical Services

EMS Agency Personnel Roster

Agency Name	Agency Code	Date Submitted	Page ______ of ______

List all personnel alphabetically Last name, First name	Date of Birth	Certified First Responders		Emergency Medical Technicians						Check Other Levels		
	mm/dd/yy	ID Number	Expires	ID Number	Expires	B	I	CC	P	CPR	AED/PAD	First-Aid
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐

New York State Department of Health
Bureau of Emergency Medical Services

EMS Agency Personnel Roster

Agency Name	Agency Code	Date Submitted	Page ______ of ______

List all personnel alphabetically	Date of Birth	Certified First Responders		Emergency Medical Technicians						Check Other Levels		
Last name, First name	mm/dd/yy	ID Number	Expires	ID Number	Expires	B	I	CC	P	CPR	AED/PAD	First-Aid
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐

EMS Agency Participation Agreement

- **This document or an equivalent is required for all participating BLSFR agencies with DOH issued ID number –**

Purpose:

In recognition that {Ambulance Service Name} (herein after referred to as XXX) is a duly authorized Ambulance Service, Certified by the New York State Department of Health (NYSDOH), and providing ambulance service to territory established under Article 30/30A of Public Health Law (A30 PHL), which includes in whole or in part the response area of {Non-transport BLSFR Service Name} (herein after referred to as ZZZ) in the {City, Town, Hamlet or District} of, {Name of County} County.
And also in recognition that {ZZZ} is a Basic Life Support First Response (BLSFR) agency specifically authorized by its governing municipality to provide EMS and having applied to NYSDOH for an EMS agency identity code;

The following agreement is hereby entered into for the purpose of ensuring rapid effective response, appropriate patient care and the delivery of persons in need of medical care to appropriate medical facilities, through the cooperative efforts of the organizations consenting to this agreement.

This agreement shall take effect upon the date of endorsement indicated below and shall be renewed annually by the Chief Operating Officers (COOs) of each organization. Alterations or amendments to this agreement may be made at any time by written consensus and re-execution of this agreement. No portion of this agreement shall hold precedence or preempt the authority of any valid contract for EMS or ambulance services executed between either party and any local governing municipality having jurisdiction.

Terms of Agreement

{XXX} and {ZZZ} shall:

- Provide for the identification of its prehospital certified members by badge, ID card, uniform or other visible identification to insure rapid recognition of certified responders and their authorized level of provider care and authorizing agency.
- Participate in QA/QI review of all responses for which a patient contact occurred. And further to resolve any identified patient care issues through training, remediation, discipline or protocol review as appropriate to insure continued effective patient care and compliance with state and regional patient care protocols.
- Participate with any Mutual Aid Response agency, dispatched or responding in place of either {XXX} or {ZZZ} due to the unavailability of either service, holding to the same participation standard and expectations stated in this agreement.
- Adhere to applicable state and regional policies, procedures and patient care protocols.
- Resolve member participation issues through cooperative discussion between the COOs of each organization promptly upon notice of any instance or circumstance which impairs the cooperative intent of this agreement or which compromises in any way the delivery of appropriate patient care.
- Provide notification in advance of training, drills and educational opportunities sponsored by either agency, at which members may obtain, renew or refresh EMS certification or rescue/responder skills.

{XXX} shall:

- Respond whenever possible to any medical emergency, standby or other public need as determined by county 911 dispatch, and provide prehospital medical care and patient transport in fulfillment of its operating authority under Article 30/30A of Public Health Law (A30 PHL).
- Remain an active participant in the {Name of County} County Mutual Aid and MCI/Disaster Plan such that all Medical Emergencies shall be responded to either by {XXX} or another ambulance service providing Mutual Aid Response.
- Accept any patient presented for transport, to which {ZZZ} provides initial BLS care, to insure timely transport of such patient(s) to an appropriate Article 28 designated facility or hospital.
- Accept Prehospital Care Reports (PCRs) turned over to {XXX} by {ZZZ} that document the findings and care provided to patients(s) treated by {ZZZ}.
- Replenish such disposable medical items or supplies used by {ZZZ} on calls for which {XXX} was the transporting agency, the list of such replenishable items to be agreed upon in writing by the COOs of each organization.

{ZZZ} shall:

- Respond whenever possible to any medical emergency, standby or other public need as determined by county 911 dispatch, and provide prehospital medical care at the Basic Life Support (with Defibrillation or PAD) Level of care, within the {ZZZ} response area.
- Report to 911 dispatch the condition and number of patients found at any incident to facilitate the preparedness and appropriate response by {XXX} crews and responding vehicles.
- Not cease the provision of patient care and/or monitoring until such care is turned over to another qualified/certified care provider, once patient care has been initiated.
- Turn over for treatment and transport to {XXX} any patient to which {ZZZ} provides initial BLS (and/or Defib/PAD) prehospital care.
- Insure that the prehospital care provider in charge of patient care will at all times be the {ZZZ} responder with the highest level of certification on scene, until such time as {XXX} arrives at the incident and patient care is turned over to the {XXX} member responsible for the call.
- Participate in ICS / Unified Command for incidents requiring ongoing incident management.
- Adhere to NYS DOH Policies regarding BLSFR Agencies (#06-04) and Responsibilities of EMS Providers to coordinate EMS Resources (#98-05)
- Maintain a list of supplies, equipment and authorized response vehicles as identified in DOH Policy #06-04.

This Agreement is entered into this _____ Day of _____, 200__

Signed,

For {XXX}: _____ Chief Operating Officer

Printed Name: _____ Title: _____

For {ZZZ}: _____ Chief Operating Officer

Printed Name: _____ Title: _____

Witnessed: _____

Printed Name and Affiliation: _____

Copy Distribution shall be:

- 1 copy to each organization's records officer or Chief Operating Officer
- 1 copy to {Name of County} County 911 Dispatch Center
- 1 copy to {Name of County} County EMS Coordinator
- 1 copy to New York State Dept of Health,
  Attn: {ZZZ} BLSFR Service File

Note: A computer file version of this document, easily edited for your use, is available in Microsoft WORD. To request the "electronic version" of this document, please contact DOH BEMS at (518) 402-0996x2 with a valid email address to which the file may be sent.

NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services Program

EMS Agency Personnel Roster DOH-2828
General Instructions for Form Completion

The DOH-2828 form is used to individually identify and document all personnel affiliated with an EMS agency. This includes paid and volunteer members. The personnel roster is required for all agencies that have a NYS DOH issued EMS agency ID number. Certified agencies are required to complete a DOH-2828 with each biennial submission for certification renewal. Non certified (BLSFR) agencies are required to submit a completed DOH-2828 with an initial application for EMS agency ID number and with each subsequent Update filing as periodically requested by NYS DOH.

NOTE: An agency may substitute its own printed version of a DOH-2828 roster provided that all data fields contained on the DOH form are present and clearly legible on the agency's version of the form, and the printout is in alphabetical order.

DOH-2828 field	Information required to complete
Agency Name	Legal name of agency and DBA if any
Agency Code	NYS DOH EMS Agency ID number issued to agency. If purpose of completing personnel roster is for an initial filing and no ID number has been issued to applicant by NYS DOH, leave this field blank.
Date Submitted	Date form was completed. Submitted data on form is presumed to be accurate as of this date.
Page ____of _____	Indicate page number of current page and total number of roster pages being submitted.
Personnel name field	Insert Last name then first name of all active personnel in alphabetical order. Include all personnel that have any operational roll in emergency medical responses by your agency. Include all individuals with any level of medical training, even if not NYS certified (eg: First Aid trained, CPR trained, PAD trained). Also include all authorized drivers of emergency response vehicles. Do not include members / employees that are not "active status" or that only provide administration to your agency, even if they are NYS certified. (eg: social / inactive members, corporate officers or administrative officers, unless such members / employees also routinely participate in response and have active EMS operational duties or assignments.)
Date of Birth	In Month, Day, Year format (mm/dd/yy) provide member / employee date of birth
Certified First Responders	For each individual identified that is a Certified First Responder give six (6) digit DOH ID number and expiration date as listed on NYS DOH issued certification card. Individuals with ID numbers and no corresponding expiration date will be presumed to not be currently certified.

Emergency Medical Technicians

For each individual identified that is a Certified Emergency Medical Technician give the six (6) digit DOH ID number and expiration date as listed on NYS DOH issued certification card. Individuals with ID numbers and no corresponding expiration date will be presumed to not be certified. In next set of boxes to the right check the single box that indicates the highest level of individual's certification.
B = Basic EMT, I = Intermediate, CC = Critical Care, P = Paramedic
Do not check more than one box.

Check Other Levels

For non-certified members only, indicate all additional levels of training. More than one box may be checked to indicate multiple levels of medical training.
CPR = Cardio Pulmonary Resuscitation, AED/PAD = Automatic External Defibrillation / Public Access Defibrillation,
First-Aid = Training program in emergency first aid completed.
For each indicated level, individual must have completed a nationally recognized training course (eg: American Heart Association or American Red Cross) and hold a valid recognition card issued to the individual.

NOTES: For certified agencies, the total number of medically trained providers identified by level must match the number of providers reported on Department form DOH-206 in section 27.

For non-certified agencies (BLSFR), the total number of medically trained providers identified by level must match the number of providers reported on Department form BLSFR EMS Agency Update / Application line 15.

Certified agencies that obtain staffing, paid or non-paid, from other agencies or personnel staffing companies, must provide a personnel roster that includes all individuals authorized to provide medical care or operate NYS DOH recognized emergency vehicles (eg: Driver only status personnel). Such additional personnel may be listed on a totally separate roster if desired, but must be included in the totals listed on form DOH-206 section 27.

NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services Program

Medical Director Verification DOH-4362
General Instructions for Form Completion

The DOH-4362 form is used to document the physician medical director providing individual EMS agency medical direction in accordance with DOH Policy #03-07. The form also documents the specific level of patient care and/or adjunct BLS protocols authorized by a Regional Emergency Medical Advisory Committee (REMAC) per DOH Policy #95-01.

A CFR/EMT/AEMT, as well as the EMS agency of which an individual is a member or employee, is in violation of Article 30 of Public Health Law (A30PHL) if rendering medical care that is subject to REMAC approval and medical direction without <u>first</u> receiving such approval and providing care under such medical direction.

To Complete the DOH-4362 Medical Director Verification form:

Read the Notice to Service statement. Pay particular attention to the fact that an EMS service's level of care approval, or approval of a NYS licensed physician to provide medical direction to an EMS agency, must be received in writing from the REMAC having jurisdiction in the region in which an agency provides EMS. *The DOH-4362 form is not valid unless completed after first receiving a valid written REMAC approval and endorsement of the identified service medical director. The written approval does not need to be submitted with the form but must be produced upon request by NYS DOH.*

DOH-4362 field	Information required to complete
Defib /PAD	Check this box if any personnel are authorized to provide defibrillation level care. Certified services may not use Public Access Defibrillation (PAD) to fulfill regulatory requirements. REMAC written approval is required to enable DEFIB level care for BLS members of ALS services. PAD filing by NOI (DOH-4135 Notice of Intent) is applicable for all non-certified agencies (BLSFR) providing defibrillation.
Epi Pen	Check this box if any personnel are authorized by the REMAC to provide Epinephrine by Auto Injector. A filing by NOI (DOH-4188 Notice of Intent to Possess and Use Epinephrine Auto Injector) is required by all certified and non-certified (BLSFR) services approving BLS providers. *This approval does not apply to ALS personnel.*
Albuterol	Check this box if any certified providers are authorized by the REMAC to provide Nebulized Albuterol. This level of care is subject to regional approvals and protocol for any BLS provider. *This approval does not apply to ALS personnel.*

Continued Page 2

Blood Glucometry	Check this box if any BLS certified providers are authorized by the REMAC to conduct blood glucose level testing. EMS agency compliance with DOH Clinical Laboratory Limited Service Laboratory Registration (DOH-4081) process and DOH Policy #05-04 is mandatory for this approval. *This approval does not apply to ALS personnel.*
ALS Levels of Care	Check SINGLE highest level of care authorized by the REMAC if approved to provide Advanced Life Support. (Lower levels are automatically approved within guidelines or restrictions imposed by individual REMACs)
Controlled Substances	Check this box if service holds a valid and currently unexpired license to possess and administer controlled substances issued by NYS DOH Bureau of Narcotic Enforcement. *Federally issued DEA CS Licenses do not apply to EMS agencies.*
Name of EMS Service	Full legal name of EMS agency. If agency is DOH certified name should be same as listed on DOH-3414 or DOH-4005 certificate.
Agency Code Number	Enter NYS DOH issued EMS agency 4 digit code number. If number unknown, please contact NYS DOH Bureau of EMS for further instructions.
Service Type	Check only ONE box to indicate service type: Ambulance, Advanced Life Support First Response (ALSFR) or non-certified Basic Life Support First Response (BLSFR).
Name of Service CEO	Name of agency chief executive officer or chief of operations.
Service Medical Director	Name of NYS licensed physician approved by the REMAC to provide service level medical direction per DOH Policy #03-07.
NYS Physician's License	NYS Department of Education Physician's license number issued to service medical director. *License must be valid and not expired.*
CS License Number	NYS DOH Bureau of Narcotics Enforcement (BNE) issued controlled substances license number. Give last 4 digits of number that begins with 03c. *Federally issued DEA licenses do not apply to NYS EMS controlled substances licenses. Do not enter DEA ID #.*
CS License Expiration	Expiration date of current BNE issued CS license. (mm/dd/yyyy)

Service medical director must read the affirmation at the bottom of the form and sign the statement of compliance. Signature of the medical director means that the physician assumes responsibility and medical oversight within the scope and intent of Article 30 of Public Health Law, NYCRR Part 800 and NYCRR Part 80 as applicable. A separate form must be completed and signed if service has more than one medical director.

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 ☐ Other: _____

☐ AEMT– Paramedic ☐ AEMT– Critical Care ☐ AEMT– Intermediate ☐ 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: _____