

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services**

**Notice of Intent to Possess and Use
Epinephrine Auto Injector**

Name of Entity	Agency Code #	Business Phone () -
Mailing Address		Fax No. () -
City :	State:	
Zip:		
Primary County of Operation:		

Type: Ambulance Service ALSFR Service Overnight Camp Summer Day Camp

Traveling Summer Day Camp Other _____

If a camp check all that apply: Camp Premises or Infirmary Off-Site Trips/Events

Name of Emergency Health Care Provider (MD or Hospital)	Business Phone No. () -
If a Hospital Provide Name of Contact:	Fax No. () -
Address	
City:	State: Zip:

Number of Trained Providers to Use Auto Injector in EMS service or camp:

Minimum Number of Injectors to be Maintained On-Site: _____

Maximum Number of Injectors to be Maintained On-Site: _____

Authorizations:

Print Name of Service CEO or Camp Director	Date	Print EHC Provider (name)	Date
Signature		Signature	

Send this form and your Collaborative Agreement to the Regional EMS Council listed in the attachment.