

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 Contract	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.