

# MEDICAL DIRECTOR VERIFICATION

## *Notice to Service:*

Please identify the physician providing Quality Assurance oversight to your individual service. If your service provides Defibrillation, 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 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.

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*Check all approvals and the highest level of care which are applicable to your service:*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Defibrillation<br>EMT-D / CFR-D      | <input type="checkbox"/> Albuterol<br>(per regional protocol) | <input type="checkbox"/> AEMT– Intermediate<br>Level of Care            |
| <input type="checkbox"/> AEMT– Critical Care<br>Level of Care | <input type="checkbox"/> AEMT– Paramedic<br>Level of Care     | <input type="checkbox"/> Controlled Substances<br>(BCS License on file) |

## *Please Type or Print Legibly:*

Name of EMS Service: \_\_\_\_\_

Agency Code Number: \_\_\_\_\_ Service Type:  Amb  ALSFR

Name of Service CEO: \_\_\_\_\_

Name of Service Medical Director: \_\_\_\_\_

NYS Physician's License Number: \_\_\_\_\_

Ambulance/ALSFR Service Controlled Substance License # if Applicable: \_\_\_\_\_

Ambulance/ALSFR Service Controlled Substance License Expiration Date: \_\_\_\_\_

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## *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.*

Signature – Service Medical Director: \_\_\_\_\_

Date of Signature: \_\_\_\_\_