New York State Department of Health
Bureau of Emergency Medical Services

Notice of Intent to Provide Epinephrine Auto-Injector

☐ Original Notification ☐ Update

Entity Providing Epinephrine Auto-Injectors

Name of Entity (ambulance service, ALSFR, BLSFR, children's camp) | ( ) Telephone Number

Name of Primary Contact Person | E-Mail Address

Address

City | State | Zip | ( ) Fax Number

Type of Entity (please check the appropriate box)

☐ Day Camp ☐ Traveling Day Camp ☐ Overnight Camp ☐ Ambulance Service ☐ ALSFR agency ☐ BLSFR agency

Epinephrine Auto-Injector Training Program

(Indicate the training program chosen. Only the approved programs may be used.
Please see Policy Statement 11-08 [http://www.health.state.ny.us/nysdoh/ems/policy/11-08.htm]).
Children's camps should reference the following URL: http://www.health.ny.gov/environmental/outdoors/camps/epipen.htm

Emergency Health Care Provider

Name of Emergency Health Care Provider (Hospital or Physician) | ( ) Telephone Number

Address

City | State | Zip | ( ) Fax Number

Name of Ambulance Service and 911 Dispatch Center

Name of Ambulance Service and Contact Person | ( ) Telephone Number

Name of 911 Dispatch Center and Contact Person | County

Authorization Names and Signatures

CEO/COO or Designee (Please print) | Signature | Date

Physician or EHCP (Please print) | Signature | Date

Complete and sign this form and submit the original to the appropriate Regional Emergency Medical Services Council with the original of your completed and signed collaborative agreement attached.

DOH- 4188 (7/13)

Epi Pen Collaborative Agreement Between
Agency
And
EHCP/Physician Medical Director

I

hereby agree to abide by the following terms and conditions consistent with § 3000-c of the Public Health Law (PHL) of the State of New York as amended by Chapter 578 of the Laws of 1999 for the provision of Epinephrine via Auto-Injector as outlined in the NYS DOH BEMS policy statement 14.02.

The terms of the agreement are as follows:

1) The Agency and its trained personnel will operate under appropriate protocols for the use of epinephrine auto-injectors as promulgated by the New York State Department of Health.

2) The Agency will ensure that all persons designated to use an epinephrine auto-injector will successfully complete a training module following the training guidelines for the use of epinephrine for allergic reactions as developed by the New York State Department of Health.

3) The Agency's training officer and Medical Director will maintain a record of all training dates, a roster of those attending, refresher training dates, the curriculum followed and a subsequent list of those authorized to use epinephrine auto-injectors.

4) The Agency's training officer and the Medical Director will ensure that all authorized personnel complete refresher training on the use of epinephrine auto-injectors for allergic reactions at least annually.

5) Prior to the addition of epinephrine auto-injectors to the Agency's equipment, the agency's dispatch center will be notified that the Agency has the capability of providing epinephrine via auto-injector.

6) The Agency will ensure that all patients administered epinephrine in accordance with this agreement are transported without delay to a hospital emergency department for further care/evaluation.

7) The Agency will notify the Medical Director within 24 hours of the administration of an epinephrine auto-injector.

8) The Agency will ensure that the epinephrine auto-injectors are maintained, stored, accounted for and disposed of in accordance with New York State Department of Health Policy.

9) The Agency and the Medical Director will file a new copy of this agreement any time there is a change or amendment to said agreement. The Agency will file a new agreement with the regional council within five business days of a change in the Medical Director. Additionally, the Medical Director will notify the regional council in writing upon termination of this agreement with said Agency.

10) The agency will report any epinephrine auto injector use to the MLREMS program agency by emailing the use form on our website to: mlrems@mlrems.org.

Agreed to and signed,

For the Agency:

_____ _____
Printed Name of Chief Officer Title

_____ _____
Signature of Chief Officer Date

For The EHCP/Physician Medical Director:

_____
Hospital Name (if applicable)

_____ _____
Printed Name of Physician NYS License Number

_____ _____
Physician Signature Date