NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Medical Director Verification

Notice to Service

Please identify the physician providing Quality Assurance oversight to your individual agency. If your agency 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 agency has more than one 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 Central Office for filing with your service records.

Check all special regional approvals and the single highest level of care applicable to your agency

☐ Defibrillation / PAD (BLS Level Services)
☐ Epi Pen
☐ Albuterol
☐ Blood Glucometry
(Epi / Albuterol / Blood Glucometry per regional protocol)
☐ Naloxone

☐ Paramedic Level of Care
☐ Critical Care Level of Care
☐ AEMT Level of Care
☐ Controlled Substances (BNE License on file)
☐ Regional CPAP
☐ BLS 12 Lead

EMS Agency (Please Type or Print Legibly)

Agency Name _____

Agency Code Number _____

Agency Type ☐ Ambulance ☐ ALSFR ☐ BLSFR

Agency CEO _____
Name

Medical Director _____
Name

_____
NYS Physician's License Number

Ambulance/ALSFR Agency Controlled Substance License # if Applicable: 03C – _____

Ambulance/ALSFR Agency Controlled Substance License Expiration Date: _____

Medical Director Affirmation of Compliance

I affirm that I am the Physician Medical Director for the above listed EMS Agency. I am responsible for oversight of the pre-hospital Quality Assurance/Quality Improvement program for this agency. This includes medical oversight on a regular and on-going basis, in-service training and review of Agency 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 Agency.

If the service I provide oversight to is not certified EMS agency 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.

Medical Director _____
Signature

_____
Date of Signature