Nassau Regional Emergency Medical Services

Policies	Syringe Epinephrine for Basic EMTs	I. N
	Reviewed: 7/17/2017	**Approved: 8/02/2017**
		Effective: 9/01/2017

The NYS SEMSCo & SEMAC have approved the use of Syringe Epinephrine by properly trained basic EMT personnel operating with an EMS agency. The NYS Commissioner of Health has approved this skill to be brought to the basic EMT skill level. Any Nassau agency wishing to implement this skill **MUST** receive approval from the Nassau REMAC. Agencies that were previously approved, by the Nassau REMAC, to participate in the "Check & Inject" program, and have trained their personnel, are not required to apply again to the Nassau REMAC

Agencies must review NYS Bureau of EMS Policy # 17-06 for training and requirements that must be met before an agency can place syringe epinephrine in service. This does not preclude the use of epinephrine auto-injectors which remain as an acceptable means of administration. In order for an agency to be approved they must have personnel trained in the skill and possess the necessary equipment to perform the skill

The NYS DOH BEMS has developed a course of instruction which is available to CLI's & CIC's. The trainers must utilize the provided training to teach and qualify those personnel in the agency that will be performing this skill. The agency is responsible to maintain accurate records that indicates who is trained, when they were trained and a record of successful completion of the skill.

An agency applying for approval must submit the Agency Request to Participate in Syringe Epinephrine for Basic EMT form (I.N-1) signed by the Agency Chief and Agency Medical Director that attests to the completion of training, has a quality assurance and appropriateness review plan, and a continuing education program. In addition, a completed Syringe Epinephrine for Basic EMT Agency Information form (I.N-2) must be submitted with the request.

The agency will receive a letter from the REMAC once it is approved, the agency must then complete the Medical Director Verification Form DOH-4362 (which will be provided with the approval letter) and submit a copy to the NYS Bureau of EMS and Trauma Systems and to the Nassau REMSCo office.

Agency Request to Participate

Syringe Epinephrine for Basic EMTs

The _____, hereby requests to be authorized to use Syringe Epinephrine for Basic EMT personnel. In accordance with the following:

1. We possess and will maintain the equipment necessary: a manufacturer marked syringe(s) indicating a dosage for "P" (Pediatric at 0.15mg) and for "A" (Adult at 0.3mg) and Epinephrine (1:1000) 1mg in 1ml vial(s).

2. Only EMT personnel that have successfully completed the training program will be authorized to utilize this skill in accordance with REMAC Protocol M-3.

3. All personnel authorized to utilize this skill will be trained in accordance with the training plan provided by the NYS DOH BEMS&TS. We will provide continuing education to insure maintenance of competencies. We will maintain documentation of training to include lists of attendees, dates attend, and a record of successful completion of the skill by each attendee.

4. Our agency and personnel agree to follow all program policies, procedures, and protocols set forth by the Nassau REMAC.

5. We have a quality assurance and appropriateness review plan. Our agency agrees to participate in the Regional Quality Improvement Program. We will provide information and documentation, when requested, to the Nassau Regional QI Coordinator.

6. Any changes to the Required Agency Information will be reported to the Nassau REMAC within 30 days.

The signatures below certify that the above request is being made and that we will be responsible for all aspects of participation in this Regionally approved program.

_____	_____
Agency Chief – Signature & date	Agency Medical Director – Signature & date
_____	_____
(Print Name & Title of individual)	(Print Medical Director's Name)

Nassau Syringe Epinephrine for Basic EMT

Agency Information (please print)

Agency Name: _____ Agency Code: _____

Address: _____ State: ____ Zip Code: _____

Designated representative responsible for the Epi Syringe Program:

Name: _____

Daytime Phone #: (____) _____

E-mail address: _____

Agency Administrator (Chief, Captain or President)**:**

Name: _____

Daytime Phone #: (____) _____

Email address: _____

Agency Medical Director:

Name: _____

Daytime Phone #: (____) _____

Email address: _____

Designated Agency Trainer:

Name: _____

Level of Certification: _____

Credentials (if applicable):_____

Daytime Phone #: (____) _____

Email address: _____