Agency Medical Director Information

Date

Agency Name _____

AGENCY LEVEL OF CARE:

☐ **EMT-P** ☐ **EMT-CC** **AEMT** ☐ **BLS PROVIDER**

MEDICAL DIRECTOR NAME: _____

MEDICAL DIRECTOR'S ADDRESS: _____

_____

(This must be an address that confidential medical information can be sent to — NOT the Agency address.)

MEDICAL DIRECTOR'S CREDENTIALS: _____

_____

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

DEPARTMENT CONTACT NAME AND TITLE: _____

DEPARTMENT CONTACT PHONE NUMBER: _____

DEPARTMENT CONTACT E-MAIL: _____

Please mail this document to: Nassau Regional Emergency Medical Advisory Committee
131 Mineola Boulevard, Suite 105
Mineola, NY 11501-3919

Or fax to (516) 542-0049

Or e-mail to: REMSCo@Nassauems.org

(1607)