WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE,
GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

Medical Direction Application

In order to help guide you through the process of applying for an Agency Medical Director, the Western Regional Medical Advisory Committee (WREMAC) has put together this informational packet. If you have any questions, please direct them to the County appropriate office, listed at the bottom of the page.

Medical Director Application Form (Attachment 1)

This is the WREMAC form to officially establish Medical Direction. It is to include signatures from the appropriate agency official, and your intended Medical Director.

Letter of Intent (Attachment 2)

This letter is to state your intent to establish Medical Direction and should be addressed to the Chairman of the WREMAC. This letter should provide an overview of ongoing quality assurance programs. This should appear on Agency letterhead, and be signed by the Chief officer or CEO **only**. There is a sample letter attached for your convenience.

Medical Director Verification Form (Attachment 3)

This form, to be filled out by the intended medical director, establishes the physician's consent to being your Agency's Director, and allows your personnel to work under their medical license.

Medical Director / Agency Agreement (Attachment 4)

This is the updated agreement between both Medical Director and ALS Agency. The agreement outlines the responsibilities of both parties.

Current Roster of Personnel (Attachment 5)

This roster should include all Agency EMT names, current NYSDOH certification levels, numbers and expiration dates.

Upon the completion of the aforementioned items, please mail to the WREMAC at: **P.O. Box 630 Clarence, NY 14031.** Please be advised that your medical director application **is not effective** until your agency is notified that it has been approved by both the WREMAC and the appropriate REMSCO.

Thank you,

The WREMAC

Attachment 1

Medical Director Application Form

WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE, GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

WREMAC
P.O. Box 630
Clarence, NY 14031
www.wremac.com

NYS EMS Agency Code: _____

Agency Name: _____

Street Address: _____

City, State, Zip: _____ County: _____

Agency Director / Chief Officer: _____ Title: _____

Contact Number: _____

Agency Level of Care

Checklist of **REQUIRED** elements:

- ☐ Letter of Intent
- ☐ Medical Director's letter of intent
- ☐ Current roster of personnel
- ☐ Medical Director/Agency agreement

Agency Director / Chief Officer Signature:		Date

Intended Medical Director:

Name	Signature	Title	Date

Approvals:

REMSCO Chairperson:

Name	Signature	Title	Date

WREMAC Chairperson:

Name	Signature	Title	Date

Attachment 2

(Fire Company/Agency Name)

Date

WREMAC Chairperson
PO Box 630
Clarence, NY 14031

Dear Chairperson,

It is the intent of (Agency Name) in the (Town/Village) of in County, New York to apply for medical direction. We currently operate at the (Current level of care) level in our community. Our vehicle(s) are equipped as per New York State Department of Health guidelines and are certified.

We wish to establish medical direction because . Our intended medical director is . He/she has signed and completed the attached verification form, in affirmation of their relationship with our agency.

Quality Assurance is important to our organization. In this effort, we will participate in the NYSDOH PCR Program by submitting our PCRs to the appropriate Program Agency each month. We will attend the (Name of Medical Director/Hospital) QI meetings each month. Additionally, we agree to participate in QA/QI activities as directed by our Medical Director.

If you require any further information, please feel free to contact me at: .

Sincerely,

(Name)
(CEO/Chief)

Attachment 3

MEDICAL DIRECTOR VERIFICATION

Notice to Service:

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

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

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

☐ AEMT– Paramedic Level of Care ☐ AEMT– Critical Care Level of Care ☐ AEMT– Intermediate Level of Care ☐ Controlled Substances (BNE License on file)

Please Type or Print Legibly:

Name of EMS Service: _____

Agency Code Number: _____ Service Type: ☐ Amb ☐ ALSFR ☐ BLSFR

Name of Service CEO:_____

Name of Service Medical Director: _____

NYS Physician's License Number: _____

Ambulance/ALSFR Service Controlled Substance License # if Applicable**:** 03C-_____

Ambulance/ALSFR Service Controlled Substance License Expiration Date: _____

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.

If the service I provide oversight to is not certified 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.

Signature – Service Medical Director: _____

Date of Signature: _____

Attachment 4

WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE,
GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

Medical Director / Agency Agreement

This agreement, dated _____ by and between _____ herein referred to as the **EMS Agency**, and _____, Physician, herein referred to as the **Medical Director**. The purpose of this agreement is to provide the agency with a Medical Director to enable them to provide Basic, Intermediate or Advanced life support to the community they serve.

This relationship may be terminated by written notice served upon the Medical Director at least five business days prior to the effective date of said termination. The Medical Director may suspend or terminate the relationship at will for cause, as defined hereinafter, or upon five business days notice without cause.

The Medical Director agrees to:

1. Meet regularly with agency and providers at least once per quarter or as often as necessary.
2. Be Medical Director of record for the agency as required by 10 NYCRR Part 800.5 (a) (1) and will perform all duties associated therewith.
3. Be available to agency officers when needed to advise on EMS issues.
4. Provide oversight to the agency's pre-hospital Quality Assurance/Quality Improvement program.

The Agency Agrees to:

1. Be responsible for the transmission of all communications from the Medical Director to all Agency providers.
2. Take necessary steps to ensure participation by its providers in all programs and courses required by the Medical Director including but not limited to Protocol requirements, Continuing Medical Education and Quality Improvement.
3. Monitor the activities of each provider and keep accurate records, which shall be made available to the Medical Director or designee upon request. An officer shall be appointed to maintain such records.
4. Forward immediately to the Medical Director any and all complaints, notification, summonses, subpoenas, letters and communication of any nature received which in any way bears on the quality of service rendered, is suggestive of any possible lawsuit or legal proceeding or in any way bears on the competence of any agency provider.
5. Abide by and strictly adhere to all standards and protocols and other requirements by the Medical Director and agrees to suspend any ALS medical privileges for any 'provider' for failure to comply with this provision.

Signed:

_____ _____

Medical Director **Date**

_____ _____

Agency Chief / CEO **Date**

Attachment 5

Personnel Roster

Name	Certification Level	NYS EMT #	Expiration Date