WREMAC Provider Privileges Application

Provider: _____ **Agency:** _____
Last Name *First Name* *Maiden Name or Alias*

E-Mail Address: _____ **Contact Number: (____) _____ - _____**

	Paramedic	Critical Care	AEMT	EMT-B	CFR
NYS Certification # (6 digits):					
Expiration Date:					
Date of agency orientation: (new providers with agency only)					
Date skills verification complete:					
Date of WREMAC protocol exam:					
CPR Course Name:					
Expiration Date:					
Trauma Life Support Course:					
Expiration Date:					
Pediatric Life Support Course:					
Expiration Date:					
Cardiac Life Support Course:					
Expiration Date					

List **all** EMS agencies with which you have **ever** been affiliated as a certified provider (use back of form if necessary)

Name of Service	Dates with Service	Service Medical Director	Telephone Number

If you answer ***"Yes"*** to any question below, provide a full description on a separate sheet of paper.

1. **Has your medical command authorization ever been restricted?** ☐ No ☐ Yes (explain)

2. **Has your medical command authorization ever been denied or withdrawn, or have you ever voluntarily resigned from an EMS agency to avoid any form of discipline?** ☐ No ☐ Yes (explain)

3. **Has any disciplinary sanction been imposed against you (regardless of whether it is presently stayed pending disposition of an appeal), or is any disciplinary charge currently pending against you?** ☐ No ☐ Yes (explain)

By signing below, I attest that all information contained on this form is completely accurate and no information has been omitted or misrepresented. I give permission to the WREMAC, the EMS Program Agency, or any affiliates to verify all information which may be relevant in determining my eligibility for privileges. I understand that any decision is final and that privileges are not rights, they are privileges which may be revoked (all or in part) at any time for violation of just cause. I agree to meet the continuing education requirements of the WREMAC and this agency's medical director and understand that failure to do so will result in suspension or revocation of my privileges. I understand that a loss of privileges in any agency will affect my privileges in all agencies with which I have an affiliation, regardless if volunteer or paid. I agree to hold harmless the WREMAC, the EMS Program Agency, the Medical Director, and all affiliates for any loss incurred related to my eligibility for privileges as a pre-hospital care provider. I grant permission to the WREMAC, the EMS Program Agency, the Medical Director, and all affiliates to notify all relevant credentialing or certifying entities if my privileges are suspended or revoked for any reason.

_____ _____

Provider's Signature Date Agency Officer Signature Date

Date reviewed by medical director: _____

WREMAC Provider Privileges Application Continuation

Name of Service	Dates with Service	Service Medical Director	Telephone Number