WAYNE COUNTY MEDICAL CONTROL AUTHORITY
EMERGENCY MEDICAL DISPATCH PROGRAM APPLICATION

AGENCY INFORMATION

Agency Name: _____

Type: Medical First Responder ☐ Basic Life Support ☐

Limited Advanced Life Support ☐ Advanced Life Support ☐ 911 PSAP ☐

Address: _____

_____

Emergency Service Area: _____

Chief/Director: _____ e mail: _____

Telephone: _____ Fax: _____

Nationally Recognized EMD System: _____

Proposed program implementation date: _____

I affirm that the above information is true and that the above named department/agency will abide by all BETP EMS Section and Wayne County MCA requirements/protocols for participation as an EMD provider.

Signature: _____ Date: _____

PHYSICIAN DIRECTOR

Name: _____

Medical Control Hospital: _____

Address: _____

E mail: _____ Telephone: _____Fax: _____

☐ All currently approved Wayne County MCA policies and procedures for EMD programs will be used without modification for the above named department.

☐ I have attached policies and procedures, which I have approved, for use in this specific EMS operation.

I agree to serve as Physician Director for the above named EMD program. I have reviewed all policies, procedures and training for the proposed program. I am familiar with applicable MCA rules, policies and protocols and will assure that the provider's EMD program is operated in compliance thereof.

Signature: _____ Date: _____

EMD/TRAINING COORDINATOR

Name: _____

Training Program Sponsor: _____

Address: _____

E mail: _____ Telephone: _____Fax: _____

I agree to serve as EMD/Training Coordinator for the above named EMS program. I have developed, reviewed and approved all training procedures and schedules in coordination with the Physician Director. I am familiar with applicable BETP EMS Section and MCA rule, policies and protocols and will assure that all training will be conducted in compliance thereof.

Signature: _____ Date: _____

MCA USE ONLY

Application Package Complete: Date Received: _____

☐ 1. Application
☐ 2. Letter of Compliance
☐ 3. Training Program Outline
☐ 4. Qualified Training Instructor for the National EMD Program
☐ 5. _____Acceptance of Protocols _____Physician Director Modified Protocols

Operations Committee Action: Date: _____

☐ Recommend MCAB approval
☐ Returned for additional information/corrections

MCAB Approval Date: _____

HEMS Medical Director Signature: _____

Comments: