WAYNE COUNTY MEDICAL CONTROL AUTHORITY
12 LEAD PROGRAM APPLICATION

AGENCY INFORMATION

Agency Name: _____

Type: ALS Transport ☐ ALS Non-Transport ☐
BLS Transport ☐ BLS Non-Transport ☐

Address: _____

_____

Emergency Service Area: _____

Chief/Director: _____ e mail: _____

Telephone: _____ ☐ Fax: _____

Make/Model of 12 Lead Monitor to be used: _____

Ability to send 12-Lead ECG electronically to hospitals with pre-hospital receiving capability ☐ Yes ☐ No

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 a 12 Lead Provider.

Signature: _____ Date: _____

PHYSICIAN DIRECTOR

Name: _____

Medical Control Hospital: _____

Address: _____

E mail: _____ Telephone: _____Fax: _____

☐ All currently approved Wayne County MCA policies, procedures and protocols for EMS 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 12 Lead program. I have reviewed all policies, procedures and training for the proposed program. I am familiar with applicable BETP EMS Section and MCA rules, policies and protocols and will assure that the provider's 12 Lead program is operated in compliance thereof.

Signature: _____ Date: _____

TRAINING COORDINATOR

Name: _____

Training Program Sponsor: _____

Address: _____

E mail: _____ Telephone: _____Fax: _____

I agree to serve as Training Coordinator for the above named 12 Lead 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 rules, 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 12 Lead 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: