Wayne County Medical Control Authority
Inter-Facility ALS Expanded Scope of Practice Transfer & Critical Care Transport Application

AGENCY INFORMATION

Agency Name: ____

Address: ____

____

Proposed type of Transfer Service:

ALS Expanded Scope of Practice Transfer ________

Critical Care Transfer ________ Critical Care Ambulance MEDCOM #s:
__________, __________, __________, __________, __________, __________,

Proposed Program Service Area: ____

Chief/Director: ______________________________ e mail: ____________________

Telephone: ________________________________ Fax: _______________________

Proposed Program Implementation Date: ______________________________________

I affirm that the above information is true and that the above named department/agency will abide by all MDHHS and Wayne County MCA requirements/protocols for participation as an Interfacility ALS Expanded Scope of Practice Transfer Provider and/or Critical Care Transfer Provider.

Signature: ____ Date: ______________

PHYSICIAN DIRECTOR

Name: ____

Medical Control Hospital: ____

Address: ____

E mail: ______________________ Telephone: ____________________Fax: ___________

☐ All currently approved Wayne County MCA policies, procedures, protocols and the HEMS Inter-Facility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Protocol (8-15) will be used without modification for the above named department.

I agree to serve as Inter-Facility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Program Physician Director for the above named agency's Inter-Facility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Program. I have reviewed and approved all policies, procedures and training for the proposed program. I am familiar with applicable MDHHS and MCA rules, policies and protocols and will assure that the provider's Interfacility ALS Expanded Scope of Practice Transfer Provider and/or Critical Care Transfer Program is operated in compliance thereof.

Signature: ____ Date: ________________

Interfacility Transfer Coordinator for the Agency

Name: ____

Address: ____

E mail: ______________________ Telephone: ____________________Fax: ___________

I agree to serve as Inter-Facility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Program Coordinator. I have developed, reviewed and approved all training procedures and schedules in coordination with the Physician Director. I am familiar with applicable MDHHS 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 Instructor(s) for the Program
☐ 5. _____Acceptance of Protocols

Operations Committee Action: Date: _________________________

☐ Recommend MCAB approval
☐ Returned for additional information/corrections

MCAB Approval Date: _________________________

HEMS Medical Director Signature: ____

All Inter-Facility ALS Expanded Scope of Practice Transfer and/or Critical Care Transfer Programs must be approved by the MCA before implementation.

Comments: