HEMS
SYSTEM PROTOCOLS
OPTIONAL
BLS NEBULIZED BRONCHODILATOR APPLICATION FOR ENDORSEMENT

Date: March 22, 2019 Section: 12.14

WAYNE COUNTY MEDICAL CONTROL AUTHORITY
BLS NEBULIZED BRONCHODILATOR APPLICATION FOR ENDORCEMENT

AGENCY INFORMATION

Agency Name: _____

Type: BLS Transport ☐ BLS Non-Transport ☐

Address: _____

Emergency Service Area: _____

Chief/Director: _____ e mail: _____

Telephone: _____ Fax: _____

Proposed program implementation date*: _____

Documentation of initial and annual refresher education, as must be submitted to HEMS MCA prior to program implementation and with the annual license renewal package and at the request of the MCA.

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 BLS Nebulized Bronchodilator administration

Signature: _____ Date: _____

PHYSICIAN DIRECTOR

Name: _____

Medical Control Hospital: _____

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.

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I have reviewed 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 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 program. 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. Training Program Outline
☐ 4. Qualified Training Instructor for the Program

Operations Committee Action: Date: _____

☐ Recommend MCAB approval
☐ Returned for additional information/corrections

MCAB Approval Date: _____

HEMS Medical Director Signature: _____

Comments: