MOBILE INTENSIVE CARE AND AUTHORIZED SKILL UPDATE SIGNATURE PAGE

PROVIDER AGREEMENT

I, _____, _____, of
(CEO-NAME) **(TITLE)**

_____, acknowledge that the information
(ORGANIZATION)

provided with this recertification packet is current and accurate. I understand and agree that the skill(s) for which we are authorized is contingent upon the continuance of sponsor hospital medical control and compliance with Section 12a-179-12 of the Regulations which govern the delivery of prehospital emergency medical services.

_____ _____ _____
(CEO-PRINT NAME) **(CEO - SIGNATURE)** **(DATE)**

SPONSOR HOSPITAL AGREEMENT

The _____ is currently the
(NAME OF HOSPITAL)

Sponsor Hospital for: _____ at the level of
(NAME OF ORGANIZATION)

(specify highest level of service) ☐**EMR** ☐**EMT** ☐**AEMT** ☐**Paramedic**

and for the following authorized BLS skills:

Please check all appropriately:

AED (EMR and above)	Yes ☐	No ☐
Aspirin (EMT and above)	Yes ☐	No ☐
Continuous Positive Airway Pressure (CPAP) (EMT and above)	Yes ☐	No ☐
Glucometer (EMT and above)	Yes ☐	No ☐
Epinephrine Auto injector (EMT and above)	Yes ☐	No ☐

The above provider has complied with all conditions as set forth by this Sponsor Hospital for Mobile Intensive Care and/or BLS skill authorization including, but not limited to, initial provider training and ongoing maintenance of competency. Therefore, on behalf of the Sponsor Hospital, we agree to continue to provide medical control in accordance with Section 19a-179-12(a) of the Regulations of Connecticut State Agencies which govern the delivery of pre-hospital emergency medical services.

_____ _____ _____
(MEDICAL DIRECTOR) (PRINT) **(SIGNATURE)** **(DATE)**

_____ _____ _____
(EMS COORDINATOR) (PRINT) **(SIGNATURE)** **(DATE)**