



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR CHANGE IN AUTHORIZATION EMS Organization Information

1. Name of Organization: _____

2. Mailing Address: _____

Phone: _____ Fax: _____

3. Contact Person and Title: _____

4. Contact Person Phone: _____ Fax: _____

Name and Title of Person Completing this application _____

5. What Levels of License or Certification does your Service **NOW** hold? (Check all that apply)

First Responder Basic Ambulance MIC Intermediate MIC-Paramedic

6. What levels of authorization does your organization **NOW** hold? (Check all that apply)

MIC-SAED MIC-EPI MIC-MAST MIC-AIRWAY OTHER: _____

7. What levels of authorization is your organization **requesting?** (Check all that apply)

MIC-SAED MIC-EPI MIC-MAST MIC-AIRWAY OTHER: _____

How will you schedule the members of your organization who are trained at this new level to assure 24-hour coverage? _____

Sponsor Hospital Information and Treatment Protocols

Name of Sponsor Hospital: _____

Address: _____ Phone: _____

Medical Director: _____

Phone: _____ E-Mail: _____ Fax: _____

EMS Coordinator: _____

Phone: _____ E-Mail _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form.)



Phone: (860) 509-7975
Telephone Device for the Deaf: (860) 509-7191
420 Capitol Avenue-MS#12EMS
PO Box 340308 Hartford, CT 06134
Affirmative Action / An Equal Opportunity Employer

Sponsor Hospital Title of Protocols: _____

Revision Date: _____

Have the Protocols been made available to the authorized staff members of you organization?

Yes No

Please attach a copy of the protocols and Sponsor Hospital Quality Assurance Plan for this *new* level of authorization.

Please attach a list of personnel trained to the new level of authorization, including the following information: last name, first name, certification/license number, and expiration date.

Sponsor Hospital Agreement

The information within this application has been reviewed in its entirety by the following individuals and collectively we, _____ (name of sponsor hospital) agree to sponsor _____ (name of service) at the _____ (level of authorization, Defib, Epi, Mic-I, or Mic-p) level of care. We accept the responsibilities described in Connecticut Agency Regulation 19a-179-12.

Hospital Medical Director (Print)

Signature

Date

EMS Coordinator (Print)

Signature

Date

Hospital Chief Executive Officer (Print)

Signature

Date

EMS Organization Attestation

I, _____, _____ (title) of _____, (organization) acknowledge that the information provided within this application is current and accurate. I understand and agree that the approval of this upgrade is contingent upon the continuance of medical direction and compliance with the Connecticut Regulations governing the delivery of Emergency Medical Services.

Organization Chief/CEO (Print)

Signature

Date

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR CHANGE IN AUTHORIZATION

The following instructions will assist you in completing the application for change in authorization. If additional assistance is required, please contact your Regional Coordinator (see attachment for Regional Contact List), or the Mobile Intensive Care Coordinator (Lynn Piacentini), at the Office of Emergency Medical Services (OEMS) at (860) 509-7975.

General Instructions:

Please type or neatly print information. Write N/A in the space if a question does not apply.

When the application has been completed, mail the original to OEMS, and a copy to your Regional Coordinator. A Copy should be retained for you file. A copy should be retained for your file.

Please **do not** place the completed application in a binder. Stable once in the upper left-hand corner and place in large envelope.

Page-by-Page Instructions:

- No. 1: Fill in the full official/legal name of your organization.
- No. 2 Fill in the complete mailing address, phone and fax number of your organization.
- No. 3 Fill in the name and title of the contact person and his/her title. The contact person should be whomever you would like us to contact should we have questions regarding the application. It should be someone who knows your organization and is easily accessible during normal working hours. It does not have to be the Chief or EMS officer.
- No.4 Fill in the phone and fax numbers for the contact person, and also the name and title of the person who completed this application.
- No. 5 Fill in the **CURRENT** level of certification. This information is provided on your organizations license or certification of operation as an EMS provider.

- No. 6 Indicate the **CURRENT** level(s) of authorization, if any. This is the skill level that your organization is currently authorized to perform by OEMS and your sponsor hospital.
- No. 7 Indicate the level of authorization your organization is **REQUESTING** from OEMS and your sponsor hospital.
- No. 8 After you fill in your sponsor hospital information **please attach a copy of the protocols and sponsor hospital quality assurance plan for this new level of authorization.**
- No. 9 **Attach a list of personnel trained to the new level of authorization**, this is to include: last name, first name, certification/license number, and expiration date.

Sponsor Hospital Agreement:

After you have compiled all the information, and the CEO of your organization has signed the application, the entire application must be reviewed by the sponsor hospital. Submit the entire application and attachments to the EMS Coordinator or Medical Director. **Original signatures** of the EMS Coordinator, Medical Director and Hospital Chief Executive Officer of the sponsoring institution must be present on the application.

EMS Provider Organization Attestation:

The attestation must contain an original signature of the Chief Executive Officer (CEO) of the service.

Completed Application:

When the application and sponsor hospital review has been completed, mail the original application and attachments to: Department of Public Health, Office of Emergency Medical Services (see below), and Send on copy to your Regional Coordinator and keep one copy for your file.

Department of Public Health
Office of Emergency Medical Services
410 Capitol Avenue, MS #12EMS
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7975