WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE,
GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

Application for Change of Medical Director

In order to help guide you through the process of changing your Agency Medical Director, without altering your level of care, the Western Regional Medical Advisory Committee (WREMAC) has put together this informational packet. If you have any questions, please direct them to the county appropriate office, listed at the bottom of the page.

Medical Director Application

This is the WREMAC form to officially change medical directors. It is to include signatures from the appropriate agency official and the new, intended medical director.

Medical Director Verification Form

This form, to be filled out by the intended medical director, establishes the physician's consent to be your agency's medical director and allows your personnel to work under his/her medical license.

Prior to selecting a new medical director please ensure he/she meets the requirements as outlined in WREMAC policy #1995-2, Requirements and Responsibilities of a Service Medical Director. An agreement between your agency and the intended medical director must be in place and available to WREMAC upon request. The agreement outlines the responsibilities of both the agency and medical director. It should include, not be limited to, the following:

This physician:

- Is directly responsible for the medical care provided by the certified personnel for that EMS service.
- Lends medical expertise to the service's quality improvement program, including the medical review of specific EMS calls, the evaluation of patient care, etc.
- Assists in the design and implementation of continuing medical education and other service-based educational programs.
- Serves as a resource for any medical aspects of squad related activities, policies, procedures, etc.

The agency agrees to:

- Be responsible for the transmission of all communications from the Medical Director to all agency providers.
- Take necessary steps to ensure participation by its providers in all programs and courses required by the Medical Director including but not limited to Protocol requirements, continuing medical education, and Quality Improvement.
- Monitor the activities of each provider and keep accurate records, which shall be made available to the Medical Director or designee upon request. An officer shall be appointed to maintain such records.
- Forward immediately to the Medical Director any and all complaints, notifications, summonses, subpoenas, letters and communications of any nature received which in any way bears on the quality of service rendered, is suggestive of any possible lawsuit or legal proceeding or in any way bears on the competence of any agency provider.
- Abide by and strictly adhere to all standards and protocols and other requirements by the Medical Director and agrees to suspend any ALS medical privileges for any 'provider' for failure to comply with this provision.

Upon completion of these forms, please mail to the appropriate program agency at the address below. Please be advised that your medical director application **is not effective** until your agency is notified that it has been approved by both the WREMAC and the appropriate REMSCO.

Thank you,

The WREMAC

STEMS • One Blue Bird Square • Olean, NY 14760
Office of Prehospital Care • 462 Grider Street • Buffalo, NY 14215
Lake Plains Community Care Network • 56 Harvester Avenue, 3rd Floor, Suite 1 • Batavia, NY 14020

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Medical Director Application

This form must be submitted along with a completed copy of NYS DOH-4362, Medical Director Verification Form

NYS EMS Agency Code: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Agency Director/Chief Officer: _____ Title: _____

Contact Number: _____

Intended Medical Director: _____

I affirm that the current Medical Director, Dr. _____, has:

- □ been notified he/she will no longer be our medical director
- □ has not been notified due to _____
  (Please state reason)

Agency Director Initials: _____

I affirm that as medical director, I meet the following requirements: (*Intended medical director must initial)*

_____ Licensed in the State of New York.

_____ Have knowledge and experience in the delivery of emergency medical care.

_____ Actively work in an Emergency Department.

_____ Completed a Base Station Course or equivalent as approved by the WREMAC.

I affirm that an agency/medical director agreement has been executed between _____
(Agency)

and _____ and is available on request.
(Medical Director)

Agency Director:

Signature:	Date:

Medical Director:

Name:	Signature:	Title:	Date:

WREMAC use only

Approved by WREMAC on _____ WREMAC Chairperson Signature: _____
(Date)

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NEW YORK STATE DEPARTMENT OF HEALTH **EMS Agency**
Bureau of Emergency Medical Services **Medical Director Verification**

Notice to Service:

Please identify the physician providing Quality Assurance oversight to your individual service. If your service provides Defibrillation, Epi-Pen,, Blood Glucometry, Albuterol or Advance Life Support (ALS), you must have specific approval from your Regional EMS Council's Medical Advisory Committee (REMAC) **and** oversight by a NY state licensed physician. If you change your level of care to a higher ALS level, you must provide the NYS DOH Bureau of EMS a copy of your **REMAC's written approval notice.**

If your service wishes to change to a lower level of care, provide **written notice** of the change and the level of care to be provided, and the effective date of implementation, to your REMAC with a copy to the NYS DOH Bureau of EMS.

If your service has more than one Service Medical Director, please use copies of this verification and indicate which of your operations or REMAC approvals apply to the oversight provided by each physician. Please send this form to your DOH EMS Area Office for filing with your service records.

Check all special regional approvals and the single highest level of care applicable to your service:

☐ Defibrillation / PAD (BLS Level Services) ☐ Epi Pen ☐ Albuterol ☐ Blood Glucometry (Epi / Albuterol / Blood Glucometry per regional protocol)

☐ AEMT– Paramedic Level of Care ☐ AEMT– Critical Care Level of Care ☐ AEMT– Intermediate Level of Care ☐ Controlled Substances (BNE License on file)

Please Type or Print Legibly:

Name of EMS Service: _____

Agency Code Number: _____ Service Type: ☐ Amb ☐ ALSFR ☐ BLSFR

Name of Service CEO: _____

Name of Service Medical Director: _____

NYS Physician's License Number: _____

Ambulance/ALSFR Service Controlled Substance License # if Applicable: **03C-**_____

Ambulance/ALSFR Service Controlled Substance License Expiration Date: _____

Medical Director Affirmation of Compliance:

I affirm that I am the Physician Medical Director for the above listed EMS service. I am responsible for oversight of the pre-hospital Quality Assurance/Quality Improvement program for this service. This includes medical oversight on a regular and on-going basis, in-service training and review of service policies that are directly related to medical care.

I am familiar with applicable State and Regional Emergency Medical Advisory Committee treatment protocols, policies and applicable state regulations concerning the level of care provided by this service.

If the service I provide oversight to is not certified and provides AED level care, the service has filed a Notice of Intent to Provide Public Access Defibrillation (DOH-4135) and a completed Collaborative Agreement with its Regional EMS Council.

Signature – Service Medical Director: _____

Date of Signature: _____