Westchester Regional Emergency Medical Advisory Committee

Service Medical Director Affirmation Form

Please Type or Print Legibly

Last Name _____ **First Name:** _____ **M.I.** _____

Birth date: _____ ☐ **Male** ☐ **Female**

Address: _____

City: _____ **State:** _____ **Zip** _____ **Email** _____

Primary Phone # _____ **Secondary Phone #** _____

License/Certification Type:

☐ MD ☐ DO NYS License/Certification # _____ Expiration Date _____

Primary Hospital Affiliation *(if applicable)* _____

As a Physician licensed by New York State (NYS), I agree to serve as the Service Medical Director in charge of the oversight and coordination of all pre-hospital medical care provided by the NYS Department of Health (DOH) certified and Westchester Regional Emergency Medical Advisory Committee (WREMAC) credentialed providers who are affiliated with the following EMS Agency:

_____ _____

EMS Agency **NYS Agency Code**

In conjunction with the WREMAC, I will serve as the medical resource for continuing medical education (CME) and quality control of all pre-hospital emergency medical care. Furthermore, I acknowledge my responsibility to become familiar with the NYS DOH Basic Life Support (BLS) Adult and Pediatric Treatment Protocols, policies and regulations related to EMS agency operations and medical oversight, as well as any WREMAC approved triage, treatment and transportation protocols, medical control plan, continuing medical education procedures and quality improvement policies and procedures and will renew this affirmation upon any revisions, additions, deletions, or changes to such documents, as directed by the WREMAC.

I herby certify that all of the information in this application is true and correct and that the signature below is mine as the applicant. I agree to notify the WREMAC in writing of any contact information or EMS Agency affiliation changes.

_____ _____

Service Medical Director Signature **Date**

The EMS Agency acknowledges that the Service Medical Director is in charge of the oversight and coordination of all pre-hospital medical care provided by the NYS certified and WREMAC credentialed providers who are affiliated with this organization. In supporting this application, the EMS Agency acknowledges that it is responsible for ensuring that the identified Service Medical Director meets or exceeds all of the provisions indicated in the WREMAC approved Regional Medical Control Plan. Should the Service Medical Director, for any reason, discontinue his or her association with the EMS Agency, the EMS Agency shall notify the REMAC in writing of the discontinuation within ten (10) calendar days.

_____ _____

Executive EMS Agency Officer **Title**

_____ _____

Signature **Date**