WREMAC

Western Regional
Emergency Medical Advisory Committee
462 Grider Street
Buffalo, New York 14215

Application for Change in Level of Care

NYS Agency Code: _____

Agency Name: _____

Address: _____ State: New York Zip: _____

Contact Name: _____ Contact Title: _____

Contact E-Mail: _____ Contact Phone: (___) _____-_____

Name of Agency Medical Director: _____

Current Level of Care: _____ Level of Care Requested: _____

Reason for change request: _____

Completed applications must include:

- ☐ This WREMAC Application Form
- ☐ Signed letter of intent on agency letterhead (sample letter of intent provided)
- ☐ Revised Medical Director Verification Form (DOH-4362)
- ☐ Revised Medical Director/ALS Agency Agreement (sample provided)
- ☐ Roster of NYS Certified Providers on "active" status with agency
- ☐ Copy of current NYSDOH Operating Certificate (ambulance services & ALSFR only)

Send all items above to your EMS Program Agency (see list by county)

- END OF APPLICATION -

THIS SECTION IS FOR THE EMS PROGRAM AGENCY TO COMPLETE:

1. Date received by Program Agency (complete): _____

   Note to Program Agencies: Verify that each active provider on roster has a completed *Provider Privilege Application* on file with the agency before the application is presented to WREMAC.

2. Date acted upon by WREMAC: _____

3. OUTCOME (circle): Approved Denied (if denied provide reason below):

Dear WREMAC Chairperson:

It is the intent of _____ to change its level of care from the _____ level to the _____ level of care. Our reason for requesting this change is _____
_____.

Our EMS agency fully understands the requirements to operate at this level of care as set forth by our Medical Director, the WREMAC, and the NYS Department of Health's Bureau of EMS. We agree to fully comply with all applicable policies, laws, rules and regulations.

Our EMS agency understands that sufficient financial resources are needed to support this change. As such, we express our immediate and continued financial commitment to support this level of care.

In addition to this letter of intent, we have executed a revised Medical Director/EMS Agency Agreement with our medical director. We understand that the medical director may establish, as a condition of receiving medical direction, requirements beyond those stated within the Agreement (i.e. monthly quality assurance meetings, special patient care equipment, training and education initiatives, etc). We understand that failure to meet the requirements established in the Agreement and by the medical director could result in termination of our Agreement and/or sanctions imposed on our agency by the medical director and/or WREMAC.

Our agency has a designated contact person for all EMS communications from the medical director, WREMAC, EMS program agency, and Bureau of EMS. Any time there is a change in contact, we understand our obligation to immediately notify all of the aforementioned parties – providing the name of a new contact.

Our dispatch center is _____. Upon the WREMAC's approval of this request we will provide written notice to the dispatch center, advising of the change in our status.

Thank you for any consideration given to this request. Should have any questions regarding our request, please contact me by phone at _____.

Sincerely,

Name (signed): _____

Name (printed): _____

Title: _____

Date: _____

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: _____

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Medical Director/EMS Agency Agreement

This agreement dated _____ by and between _____ herein referred to as the **EMS Agency**, and _____, Physician, herein referred to as the **Medical Director**.

The purpose of this agreement is to identify a Medical Director of record for the EMS Agency and establish minimum guidelines for medical oversight of the EMS Agency by the Medical Director. The Medical Director may have a "designee" who represents the interests or opinions of the Medical Director. Such designee shall be identified to the EMS Agency by the Medical Director.

This relationship may be terminated by written notice served upon the Medical Director at least 5 business days prior to the effective date of said termination. The Medical Director may suspend or terminate the relationship at will for cause, as defined hereinafter, or upon five business days' notice without cause.

The EMS Agency Agrees to:

1. Be responsible for the transmission of all communications from the Medical Director (or his/her designee) to all Agency providers
2. 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.
3. Monitor the activities of each provider and keep accurate records, which shall be made available to the Medical Director (or his/her designee) upon request. An officer shall be appointed to maintain such records.
4. Forward immediately to the Medical Director (or his/her designee) any and all complaints, notification, summonses, subpoenas, letters and communication 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.
5. Abide by and strictly adhere to all standards and protocols and other requirements by the Medical Director and agrees to suspend provider privileges for failure to comply with this provision.

Signed:

_____ _____
Medical Director **Date**

_____ _____
Agency Chief / CEO **Date**

Personnel Roster

Name	Certification Level	NYS EMT #	Expiration Date

WREMAC EMS Program Agencies

All documents shall be provided to the EMS Program Agency contracted to serve the region in which your EMS agency is registered with the Bureau of EMS.

Niagara, Orleans, & Genesee Counties

Lake Plains Community Care Network
575 East Main Street
Batavia, NY 14020
Phone: 585-345-6110
Fax: 585-345-7452
www.lpccnems.org

Director: Charlotte Crawford
ccrawford@lakeplains.org

Wyoming & Erie Counties

Office of Prehospital Care
462 Grider Street
Buffalo, New York 14215
Phone: 716-898-3600
Fax: 716-898-5988
www.opcems.org

Director: Scott Wander
swander@ecmc.edu

Chautauqua, Cattaraugus, & Allegany Counties

Southern Tier EMS (STEMS)
One Blue Bird Square
Olean, New York 14760
Phone: 716-372-0614
Fax: 716-372-5217
www.sthcs.org

Director: Donna Kahm
dkahm@sthcs.org