

OFF LINE MEDICAL DIRECTION

Medical Director Name or Group: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Business Phone(____) _____ Ext: _____ Fax Number: (____) _____

Cell Number: (____) _____ E-mail Address: (____) _____

Do you have a Medical Supervision Plan consistent with the State of Idaho Emergency Medical Services Physician Commission Standards Manual Yes No

This agency's Off-Line Medical Director provides the following: **(Check all that apply)**

Medical Control Plans Skills Workshops Protocol & Standing Order Development

Training Program Chart Reviews Quality Assurance

Other (List) : _____

Medical Control, Treatment Protocols, Written Standing Orders and Medications

Current agency protocols and/or written standing orders including Air Medical Utilization, POST, & Safe Haven are included.

A list of all medications carried by ALS agencies is included.

A copy of the Written Agreement with the agency Medical Director, to include an effective date, an expiration date or provision for renewal and assurance of medical director access to agency licensure and personnel certification records.

Infection Control Plan

This agency has established an infection control plan to reduce exposure to pathogens: Yes No

This agency maintains safety equipment and personal protective supplies for personnel as specified in the

Minimum Equipment Standards for Licensed EMS Services: Yes No

APPLICATION SIGNATURES

Agency Signature

I attest that all information supplied is true and correct to the best of my knowledge. I further attest that the information contained reflects the intended operation for the term of licensure and agree to contact the EMS Bureau with changes to the information, as needed.

Signature _____ Printed

Name _____

Date _____

Medical Director Signature

As the off line medical director for _____, I agree to provide medical direction services to this agency.

Signature _____ Printed

Name _____

Date _____ License
Number _____