BLS Ambulance Service Medical Director's Agreement

I, the undersigned physician, agree to perform the duties for the following BLS ambulance service or quick response service (QRS):

Service Name:____

AFFILIATE #:____

Qualifications:

1. Hold a currently registered license as a physician in Pennsylvania.
2. Possess a valid Drug Enforcement Agency (DEA) number.

Recommended not required:
Has completed 3 years in a residency program in emergency medicine or ACLS certified.

Responsibilities:
I accept the following responsibilities associated with being a BLS service medical director for the above referenced service. My duties and responsibilities will include, but are not limited to the following:

1. Provide liaison with the medical community and other organizations.
2. Provide approved training and interpretation on the use and application of the AED; Pulse Oximetry; Epinephrine Auto-Injector; and/or nerve agent antidote kits (Mark I/Duodote.)
3. Development, review and approval of all service operations relevant to patient care.
4. Participate in the development and implementation of quality improvement activities recommended by the regional council and the PA Department of Health, in connection with the above referenced service.
5. Performing medical audits of patient care provided by the BLS ambulance service's pre-hospital personnel.
6. Provide 30 days written notification to the regional council regarding his/her intention to resign as medical director of the above referenced service.
7. I understand that this agreement will continue until cancelled in writing by either party thirty (30) days prior to the effective date, unless notice requirement is waived by both parties.

I agree to provide medical direction for this BLS service, including the following programs:

- ☐ Automated External Defibrillator (AED) Recognized Service
- ☐ Pulse Oximetry
- ☐ Epinephrine Auto-Injector
- ☐ Nerve Agent Antidote (Mark I/Duodote) - Personal Protection
- ☐ CPAP for BLS

Signature of Physician:____

Printed Name of Physician:________________________________ Date: ______________

Medical License #:_________________________________DEA#: __________________

Physician Mailing Address:____

Revised: October 2008
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City, State, Zip:____