

MEDICAL COMMAND AUTHORIZATION FORM

ALS Service Affiliate #	Calendar Year 2012
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Last Name (ALS Practitioner) First MI

ALS Service Medical Director Checklist

<p>Initial Determination (Applicant has never had medical command authorization within PA). Must check each of the following.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Verify continuing education requirements met <input type="checkbox"/> Verify certification through regional EMS council <input type="checkbox"/> Verify through regional EMS council that no disciplinary sanction is currently imposed against the individual that prevents the individual from receiving medical command authorization <p>Verification of competence to perform all services within the individual's scope of practice. Check at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Direct observation <input type="checkbox"/> Consult suitable physician, PHRN, or EMT-P who has directly observed performance of services <p>Name: _____ Name: _____</p>	<p>Annual Review or Other Review with this ALS Service (Applicant has had previous medical command authorization within PA).</p> <ul style="list-style-type: none"> <input type="checkbox"/> Verify continuing education requirements met <p>Verification of competence to perform all services within the individual's scope of practice. Check at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Direct observation <input type="checkbox"/> Consult suitable physician(s), PHRN(s), or EMT-P(s) who directly observed performance of services. Name: _____ Name: _____ <input type="checkbox"/> Perform medical audit of records of service <input type="checkbox"/> Consult emergency department physician(s) who has received patients treated by applicant Name: _____ Name: _____ <input type="checkbox"/> Consult medical command physician(s) who has given command Name: _____ Name: _____ <input type="checkbox"/> Consult ALS service medical director(s) who has granted, restricted, or denied command Name: _____ Name: _____
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Decision Rendered (Choose Only One Column)

<p>Initial (with any ALS service)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Grant <input type="checkbox"/> Restrict for Preceptoring <input type="checkbox"/> Restrict for Other <input type="checkbox"/> Deny 	<p>Initial (with this ALS service)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Grant <input type="checkbox"/> Restrict for Preceptoring <input type="checkbox"/> Restrict for Other <input type="checkbox"/> Deny 	<p>Review (annual or other)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Renew <input type="checkbox"/> Renew and Require Con. Ed. <input type="checkbox"/> Restrict for Other <input type="checkbox"/> Withdraw
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As the ALS service medical director of the referenced ambulance service, I have evaluated the individual's qualifications based upon the individual's ability to competently perform each of the services set forth within the scope of practice authorized by the individual's certification or recognition.

ALS Service Medical Director (Printed)

Signature of ALS Service Medical Director

Date

