

MEDICAL COMMAND AUTHORIZATION FORM

ALS Service Affiliate #

Calendar Year

Last Name (ALS Practitioner) _____ First _____ MI _____

Street Address _____

City _____

State _____

Zip Code _____

E-mail Address _____

Check One: EMT-Paramedic PHRN HP Physician Other _____

Department EMT-P / PHRN / HP #: _____

Name of ALS Service: _____

PHRN & Physicians Only

PA License #: _____

License Expiration Date: _____

1. List **all** ambulance services with which you have had medical command authorization in the past five years. If necessary, please use a separate sheet of paper.

Name of Service _____
Dates with Service _____
ALS Service Medical Director _____
Telephone Number _____

Name of Service _____
Dates with Service _____
ALS Service Medical Director _____
Telephone Number _____

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Telephone Number _____

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Dates with Service _____
ALS Service Medical Director _____
Telephone Number _____

Name of Service _____
Dates with Service _____
ALS Service Medical Director _____
Telephone Number _____

2. Has your medical command authorization ever been restricted? If yes, please provide a full description of each restriction on a separate sheet of paper, including name of ALS service and ALS service medical director.

- YES, Restricted for Initial Preceptoring
 YES, Restricted for Other Reason
 NO

3. Has your medical command authorization ever been denied or withdrawn? If yes, please provide a full description of each denial or withdrawal on a separate sheet of paper, including name of ALS service and ALS service medical director.

- YES NO

4. Has any disciplinary sanction been imposed against you (regardless of whether it is presently stayed pending disposition of an appeal), or is any disciplinary charge currently pending against you? If yes, please explain on a separate sheet of paper.

- YES NO

Please attach copies of the following:

- Current BCLS Course Completion
 Previous Year's Continuing Education Record
 Pennsylvania Certification
 Pennsylvania License (Physician/PHRN)
 Attachments For Questions 1-4 (If Applicable)

I hereby certify that the information provided in this application is true and correct to the best of my knowledge, information, and belief. I grant the ALS service/ medical director permission to investigate all information on this application, and I grant third parties permission to release information about my professional competence to the ALS service/ medical director. I understand that if my application is approved for medical command, this authorization will be valid for the current calendar year, unless restricted or withdrawn by the ALS service medical director. I further understand that if granted medical command authorization, it applies only to the ALS service listed on this application and only permits practice in accordance with the Statewide and regional medical treatment protocols.

Signature of Applicant _____

Date _____

RESTRICTION OR DENIAL OF MEDICAL COMMAND AUTHORIZATION

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

ACTION TAKEN

As the ALS service medical director for this ambulance service, I have taken the following action with respect to the practitioner's medical command authorization with this ambulance service:

- RESTRICTED for Initial Service Preceptoring (This option may only be used if the applicant has not previously been granted medical command authorization with this service. This option may not be used if preceptoring is being done to remediate deficiencies.)
- RESTRICTED for Other Reason
- RENEW AND REQUIRE REMEDIAL CONTINUING EDUCATION
- DENIED / WITHDRAWN

List the restriction(s) placed on the medical command authorization or describe the reasons for denial or withdrawal of medical command authorization:

If medical command authorization has been renewed and additional continuing education is required to address a demonstrated deficiency in competence, list the continuing education courses that must be successfully completed:

The ALS practitioner has been notified of this decision and received a copy of this form.

 ALS Service Medical Director (Print)

 ALS Service Medical Director (Signature)

 Date