

Prehospital Care

Forbes Tower, Suite 10018
200 Lothrop Street
Pittsburgh, PA 15213
T 888-647-9077 x1
F 412-647-1111

Medical Command Authorization for 2012

Thank you for your interest in medical command authorization. Attached you will find the necessary forms to process your request.

Please Complete the **Medical Command Authorization Form** and the **ALS Provider File Update** and return it with **ALL** of the appropriate documentation to the EMS Specialist assigned to your ALS Service. If you are new to the UPMC integrated medical command system you will also need to pass a written protocol examination prior to providing ALS-level care.

The PA Department of Health (PA-DOH) requires the following:

- Completed and signed PA DOH Medical Command Authorization Form (with any necessary attachment).
- Copy of Certification/Recognition by the PA DOH as an EMT-Paramedic or PHRN (PHRN must supply copy of PA RN License).
- Copy of documentation of biennial attendance/completion of a course in Basic Cardiac Life Support that includes adult, child and infant and obstructed airway procedure (CPR card). Course must be approved by the Bureau of EMS.
- Previous year's PA DOH *Continuing Education Status Report*. Must have at least 18 hours with a minimum of 9 hours recognized as medical/trauma.
- Verification of Skills applicable to the scope of practice and approved by the ALS Service Medical Director.
- Documentation of affiliation with an Advanced Life Support ambulance service.

The ALS Service Medical Director requires the Following:

- Completed ALS Provider Update Form (with necessary Attachments)
- Documentation of current or previous medical command authorization, if applicable.
- Copy of documentation of biennial attendance/completion of an Advance Cardiac Life Support course (ACLS).
- Copy of documentation of successful completion of Pediatric Advance Life Support or its equivalent and Basic Trauma Life Support or its equivalent (may be expired).

Should you have any questions please contact us at 412-647-9077 extension 1.

UPMC Prehospital Care Medical Command Application

Initial Application Renewal Application

Name: _____ E-mail: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Pager: _____

Date of Birth: _____ Alternate Phone: _____

Certification Level:

- EMT-Paramedic DOH Certification #: _____
- National Registry Certification #: _____ Exp: _____
- Prehospital RN DOH Certification #: _____ Nursing License #: _____ Exp: _____
- HP Physician DOH Certification #: _____ State License #: _____ Exp: _____

Required Documentation: (Please attach copies of all cards, certifications and/or licenses.)

- EMT-P certification
- PHRN/HCP certification and DOH license
- Basic Cardiac Life Support (Must meet PA-DOH requirements) Expires: _____
- Advanced Cardiac Life Support (ACLS) or equivalent Expires: _____
- Pediatric Advanced Life Support (PALS)/Advanced PEPP Expires: _____
- Trauma Life Support (ITLS/PHTLS) Expires: _____

Other Information:

- Current Preceptor If yes, how long: _____ No
- PA - DOH EMT Instructor Expires: _____
- Basic Cardiac Life Support Instructor Expires: _____
- Advanced Cardiac Life Support (ACLS) Instructor Expires: _____
- Pediatric Advanced Life Support (PALS) Instructor Expires: _____
- Trauma Life Support (ITLS/PHTLS) Instructor Expires: _____

This form will be kept as part of your Medical Command Authorization file. The information listed on this form is confidential and will not be distributed to anyone other than is necessary for the purpose of evaluation and maintaining your Medical Command Authorization.

All applicants will be considered without regard to race, creed, color, religion, sex, sexual orientation, national origin, age, qualified disability, handicap or veteran status.

Signature

Date

THIS PAGE FOR PREHOSPITAL CARE USE ONLY

- Applicant accepted without conditions
- Applicant accepted with the following conditions:

Command Level Assigned:

- Level 1 Preceptee Date assigned: _____
- Level 2 Provisional Date assigned: _____
- Level 3 Full Command Date assigned: _____
- Level 4 Preceptor Date assigned: _____

Other Notes:

EMS Specialist (Print Name) EMS Specialist Signature Date

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: _____ |

| | |
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| <p>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.</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> <p>Name of Service _____ Dates with Service _____ ALS Service Medical Director _____ Telephone Number _____</p> | <p>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.</p> <p><input type="checkbox"/> YES, Restricted for Initial Preceptoring <input type="checkbox"/> YES, Restricted for Other Reason <input type="checkbox"/> NO</p> <p>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.</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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.</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please attach copies of the following:</p> <p><input type="checkbox"/> Current BCLS Course Completion <input type="checkbox"/> Previous Year's Continuing Education Record <input type="checkbox"/> Pennsylvania Certification <input type="checkbox"/> Pennsylvania License (Physician/PHRN) <input type="checkbox"/> Attachments For Questions 1-4 (If Applicable)</p> |
|--|---|

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

MEDICAL COMMAND AUTHORIZATION FORM

| | |
|-------------------------|---------------|
| ALS Service Affiliate # | Calendar Year |
|-------------------------|---------------|

Last Name (ALS Practitioner) First MI

ALS Service Medical Director Checklist

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| <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. <p>Name: _____ Name: _____</p> <ul style="list-style-type: none"> <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 <p>Name: _____ Name: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Consult medical command physician(s) who has given command <p>Name: _____ Name: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Consult ALS service medical director(s) who has granted, restricted, or denied command <p>Name: _____ Name: _____</p> |
|---|---|

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 |
|--|---|---|

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

RESTRICTION OR DENIAL OF MEDICAL COMMAND AUTHORIZATION

| | |
|-------------------------|---------------|
| ALS Service Affiliate # | Calendar Year |
|-------------------------|---------------|

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