



**Charlotte Hungerford Hospital
Department of Emergency Medicine
Division of EMS**

Application For Medical Authorization

Initial Renewal

Level: EMT-Paramedic EMT-Intermediate

Personal Information

Last Name: _____ First: _____ MI:

Home Address:

City: _____ State: _____ Zip: _____ -

Home Phone: () ____-____ Work Phone: () ____-____ Other: () ____-

Email: _____ Date of Birth: __/ __/ ____

Gender: () Male () Female Social Security Number: ____-____-____

Primary Sponsor Hospital:

NOTE: If you are changing your primary Sponsor Hospital, please have all of your CME records forwarded to the EMS Director at The Charlotte Hungerford Hospital.

Current EMS Affiliations (List below those services with whom you are currently affiliated. Applicant must furnish a letter verifying EMS affiliation from his/her primary CHH Sponsor Hospital EMS Affiliation)

Start Date Month/Year	Name of Service	Position (EMT, EMT-P)	Employment Status (F/T, P/T, Volunteer)	Sponsor Hospital*

* Applicants should provide a letter from each Sponsor Hospital verifying control authorization in good standing

Certifications (Attach a copy of each with your application. You are Responsible for providing updated copies as they are renewed and a copy of all certifications prior to December 15th of each year)

Certification	Number	Level	Expiration
State of Connecticut OEMS		<input type="checkbox"/> EMT-Intermediate <input type="checkbox"/> EMT-Paramedic	
CPR		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	
ACLS		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	
PALS		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	
PHTLS		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	
Other		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	
Other		<input type="checkbox"/> Instructor <input type="checkbox"/> Provider	

EMS Training Information If recent graduate and/or less than 1 year of experience, please include a letter from program director which describes the program including the number or hours [lecture, labs, clinical rotations] and any additional course requirements [i.e. number of successful IV, ET, etc.].

Level	Sponsor	Program Director/Instructor	Dates of Course
EMT-I			
EMT-P			

Prior EMS Experience List below all prior EMS experience. If on the ALS level, also indicate the Sponsor Hospital and /or Medical Control Authorizing Agency. Attach additional sheets as necessary. *Please attach a copy of your current resume/CV.*

Dates (From - To)	EMS Service Address	Position (EMT, Paramedic) Status (F/T, P/T, Vol.)	Sponsor Hospital Contact Person

Check here if additional information is attached regarding prior EMS experience.

Background Information

- | | | |
|---|------------------------------|-----------------------------|
| Have you had any felony or criminal conviction other than a moving violation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been named a party in a medical malpractice suit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been denied medical control authorization as an MIC provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had medical control authorization suspended or revoked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had your medical control authorization placed on probation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had your state DPH OEMS certificate/license suspended/revoked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any question above, please attach an explanation of the situation(s) in detail.

Release of Information

I hereby apply for medical control authorization through the Charlotte Hungerford Hospital Sponsor Hospital Program. I, the undersigned, declare the information provided herein is both accurate and truthful and I understand that any incorrect statement or omissions may be the basis for my disqualification for or revocation of medical control authorization. I hereby grant authority to The Charlotte Hungerford Hospital to conduct an investigation into my past employment, training records and personal background as applicable to medical control authorization. I will also provide updated copies of all certifications as they become renewed and at least once annually on or before December 15th. I further declare that I am willing to commit to attend any continuing medical education as required by the Sponsor Hospital and to undergo any review of skills and personal qualifications as deemed appropriate. I also agree to follow all applicable guidelines, policies, procedures and protocols appropriate for my level of authorization.

Signature: _____

Date: _____

Office Use Only

Application Checklist	Skills Performance Evaluation	Interviews/Evaluation
<input type="checkbox"/> OEMS Certification/license <input type="checkbox"/> CPR <input type="checkbox"/> ACLS <input type="checkbox"/> PALS <input type="checkbox"/> EMS Affiliation letter <input type="checkbox"/> Other Sponsor Hospital(s) <input type="checkbox"/> Letter EMS Training Program <input type="checkbox"/> Protocol Exam Score: ____ <input type="checkbox"/> Guidelines Exam Score: ____ <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Defibrillation <input type="checkbox"/> PASG <input type="checkbox"/> IV <input type="checkbox"/> ET/Combitube <input type="checkbox"/> Interosseous Infusion <input type="checkbox"/> Needle Cricothyrotomy <input type="checkbox"/> Needle Decompression <input type="checkbox"/> Medication Administration <input type="checkbox"/> <input type="checkbox"/> _____ Evaluator Date	EMS Director/Coordinator _____ Signature Date Sponsor Hospital MIC Medical Director _____ Signature Date