PROVIDER AGENCY & TRAINING PROGRAMS

Organization's Name: ____

Effective Date: ___________________________ (Check all that apply)

[ ] Personnel Change

Public Provider Agency:

[ ] AED Program Coordinator
[ ] EMS Educator
[ ] EMS Director
[ ] Fire Chief
[ ] Medical Director
[ ] Paramedic Coordinator
[ ] QI Coordinator
[ ] Professional Standards Director

Public Provider Agency Dispatch

[ ] Manager
[ ] Medical Director

Private Provider Agency:

[ ] AED Program Coordinator
[ ] CEO (attach resume)
[ ] General Manager (attach resume)
[ ] Operations Manager (attach resume)
[ ] EMS Educator
[ ] Paramedic Coordinator
[ ] QI Coordinator
[ ] SCT Coordinator

Private Provider Agency Dispatch

[ ] Manager
[ ] Medical Director

Approved Training Programs: (EMT/Paramedic/MICN/Expanded Scope/Skills and CE)**

***Additional information required, contact the Office of Program Approvals**

[ ] Clinical Director/Coordinator
[ ] Medical Director (Paramedic/MICN)
[ ] Program Director
[ ] Principal Instructor (EMT only)
[ ] **Other:** _________________
[ ]

Change Name From: ____

Change Name To/Add: ____

[ ] Change Address/Contact Numbers

Address/Street ____________________ City/State/Zip ____________________

Telephone ____________________ Fax ____________________

Telephone: Disaster Command Post ____________________ Fax: Disaster Command Post ____________________

Pager Number/Cellular Number ____________________ E-mail address ____________________

Name of person completing form ____________________ Title ____________________ Date ____________________