Hudson Valley Regional
Emergency Medical Services Council

33 Airport Center Drive Suite 204, Second Floor
New Windsor, NY 12553
Phone (845) 245-4292
Fax: (845) 245-4181
www.hvremsco.org

EMS Agency Medical Director Affirmation Form

License/Certification Type:

❒ MD ❒ DO

NYS License/Certification # _____ Expiration Date _____ / _____ / _____

Please Type or Print Legibly

Last Name _____ First Name: _____ M.I. ____

Birth date: _____ / _____ / _____ ❒ Male ❒ Female

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Phone # _____ Secondary Phone # _____

As a Physician licensed by New York State, I agree to serve as the Medical Director in charge of the oversight and coordination of all pre-hospital medical care provided by the New York State certified and Hudson Valley Regional Medical Advisory Committee (HVREMAC) credentialed Emergency Medical Services personnel whom are affiliated with the below identified EMS Agency. In conjunction with the HVREMAC, I will serve as the medical resource for continuing medical education (CME) and quality control of all pre-hospital emergency medical care. I agree to notify the HVREMAC in writing of any changes to my EMS Agency affiliation.

EMS Agency: _____ Agency Code: _____

Furthermore, I acknowledge my expertise with the New York State Basic Life Support Adult and Pediatric Treatment Protocols as well as the Hudson Valley REMAC approved triage, treatment and transportation protocols, medical control plan, continuing medical education procedures and quality improvement policies and procedures and will renew this affirmation upon any revisions, additions, deletions, or changes to such documents, as directed by the REMAC.

I herby certify that all of the information in this application is true and correct and that the signature below is mine as the applicant. I further understand that offering or providing false information on this document may subject this agreement to revocation or other action deemed appropriate by the REMAC.

_____ _____
Signature Date

The EMS Agency acknowledges that the Medical Director is in charge of the oversight and coordination of all pre-hospital medical care provided by the New York State certified and HVREMAC credentialed Emergency Medical Services personnel whom are affiliated with the identified EMS Agency. In supporting this application, the EMS Agency acknowledges that it is responsible for ensuring that the identified EMS Agency Medical Director meets or exceeds all of the provisions indicated in Section 16 and 17 of the Hudson Valley REMAC approved Medical Control Plan. The EMS Agency also acknowledges and accepts the responsibility for providing to this applicant any future updates or revisions to the New York State Basic Life Support Adult and Pediatric Treatment Protocols as well as the Hudson Valley REMAC approved triage, treatment and transportation protocols, medical control plan, continuing medical education procedures and quality improvement policies and procedures, and will provide all related in-service training required by the Hudson Valley REMAC. Should the Medical Director, for any reason, discontinue his or her association with the EMS Agency, the EMS Agency shall notify the REMAC in writing of the discontinuation within ten (10) calendar days.

_____ _____
Name of Authorized EMS Agency Representative Title

_____ _____
Contact Phone # E mail Address

_____ _____
Signature Date

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