HUDSON VALLEY REGIONAL
EMERGENCY MEDICAL SERVICES COUNCIL, INC.

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

COLLABORATIVE AGREEMENT

Use of CPAP by EMT

As per Hudson Valley Regional Medical Advisory (HVREMAC) requirements,

Agency Name: _____
(Hereafter referred to as the Agency)

and

Medical Director: _____
(Hereafter referred to as the Agency Medical Director)

Enter into this collaborative agreement in which;

1. The Agency will acquire CPAP devices according to written policies and procedures which have been developed as recommended by New York State Department of Health Policy Statement 15- 02 “Continuous Positive Airway Pressure (CPAP) for BLS EMS Agencies”;
2. The Agency will ensure that the BLS/ALS Collaborative Protocols are utilized by all participating personnel for the proper use of CPAP;
3. The Agency will ensure that CPAP will only be used by authorized EMT(s) who have successfully completed the Hudson Valley REMAC approved training program;
4. The Agency will require that all CPAP uses are documented appropriately by utilizing the New York State approved Patient Care Report (PCR) or e-PCR. Additionally, all CPAP uses will be reported to the HVREMAC utilizing the approved quality improvement form;
5. The Agency agrees to include the review of all BLS CPAP uses in the Agency’s quality improvement plan that is required by the New York State Department of Health;
6. The Agency will review this agreement on an annual basis and will file a new Collaborative Agreement with the Hudson Valley Regional EMS Council if the Agency Medical Director, or any of the contents of this agreement, changes.

_____ _____
Name of Authorized Agency Representative **Title**

_____ _____
Signature **Date**

_____ _____
Agency Medical Director’s Signature **Date**

MEDICAL DIRECTOR VERIFICATION

Notice to Service:

Please identify the physician providing Quality Assurance oversight to your individual service. If your service provides Defibrillation, Epi-Pen,, Blood Glucometry, Albuterol or Advance Life Support (ALS), you must have specific approval from your Regional EMS Council's Medical Advisory Committee (REMAC) **and** oversight by a NY state licensed physician. If you change your level of care to a higher ALS level, you must provide the NYS DOH Bureau of EMS a copy of your **REMAC's written approval notice.**

If your service wishes to change to a lower level of care, provide **written notice** of the change and the level of care to be provided, and the effective date of implementation, to your REMAC with a copy to the NYS DOH Bureau of EMS.

If your service has more than one Service Medical Director, please use copies of this verification and indicate which of your operations or REMAC approvals apply to the oversight provided by each physician. Please send this form to your DOH EMS Area Office for filing with your service records.

Check all special regional approvals and the single highest level of care applicable to your service:

☐ Defibrillation / PAD (BLS Level Services) ☐ CPAP (BLS Level Services) ☐ Epi Pen ☐ Albuterol ☐ Blood Glucometry (Epi / Albuterol / Blood Glucometry per regional protocol)

☐ AEMT– Paramedic Level of Care ☐ AEMT– Critical Care Level of Care ☐ AEMT– Intermediate Level of Care ☐ Controlled Substances (BNE License on file)

Please Type or Print Legibly:

Name of EMS Service: _____

Agency Code Number: _____ Service Type: ☐ Amb ☐ ALSFR ☐ BLSFR

Name of Service CEO: _____

Name of Service Medical Director: _____

NYS Physician's License Number: _____

Ambulance/ALSFR Service Controlled Substance License # if Applicable: 03C-_____

Ambulance/ALSFR Service Controlled Substance License Expiration Date: _____

Medical Director Affirmation of Compliance:

I affirm that I am the Physician Medical Director for the above listed EMS service. I am responsible for oversight of the pre-hospital Quality Assurance/Quality Improvement program for this service. This includes medical oversight on a regular and on-going basis, in-service training and review of service policies that are directly related to medical care.

I am familiar with applicable State and Regional Emergency Medical Advisory Committee treatment protocols, policies and applicable state regulations concerning the level of care provided by this service.

If the service I provide oversight to is not certified and provides AED level care, the service has filed a Notice of Intent to Provide Public Access Defibrillation (DOH-4135) and a completed Collaborative Agreement with its Regional EMS Council.

Signature – Service Medical Director: _____

Date of Signature: _____