Hudson Valley Regional Emergency Medical Services Council, Inc.
33 Airport Center Drive ~ Suite 204 Second Floor
New Windsor, NY 12553
Phone: (845) 245-4292
www.hvremsco.org

Agency Affiliation Form

Provider

Last Name | **First Name** | **Middle Initial**

Address Line 1:

Address Line 2:

City | **State** | **Zip Code**

Contact Information: **Home Phone** | **Mobile Phone** | **Work Phone**

E-Mail Address

Level of Care: ◯ **Paramedic** ◯ **Critical Care** ◯ **AEMT**

NYS EMT# | **Expiration Date** | **HVREMAC#**

If you are currently credentialed to practice at the level indicated above by another REMAC participating in the Collaborative Protocols, please submit a letter of good standing from that REMAC.

**** Paramedic and EMT-Critical Care providers must also submit copies of valid BCLS, ACLS, and PALS (or PEPP) cards ****

Agency Name | **Agency Number**

Affiliation Type: ◯ **Primary** ◯ **Secondary** **Request Type:** ◯ **Add to roster** ◯ **Remove from roster**

For providers seeking HVREMAC credentialing:

Does the agency support the applicant's request to be credentialed in the Hudson Valley Region as an Advanced Life Support Provider at the level indicated above? ◯ YES ◯ NO

In supporting this application/revocation, the Agency acknowledges it is responsible for adhering to all policies and procedures promulgated by the HVREMSCO and HVREMAC.

I certify all of the information in this application is true and correct, the signature below is mine, and I am authorized to act on behalf of the agency. I understand offering or providing false information on this document may subject any certification to revocation or other action deemed appropriate by the HVREMAC.

Chief of Operations or Designee Name | **Title**

Email Address | **Phone Number**

Signature | **Date**

RESET **PRINT**