



MEDICAL COMMAND AUTHORIZATION FORM

ALS Service Affiliate # Calendar Year

Last Name (ALS Provider) First MI

Street Address

City State Zip Code

E-mail Address

Check One: [ ] EMT-Paramedic [ ] PHRN [ ] HP Physician [ ] Other

Department EMT-P / PHRN / HP #:

Name of ALS Service:

PHRN & Physicians Only
PA License #:
License Expiration Date:

1. List all ambulance services with which you have had medical command authorization in the past five years. If necessary, please use a separate sheet of paper.
Name of Service
Dates with Service
ALS Service Medical Director
Telephone Number

2. Has your medical command authorization ever been restricted? If yes, please provide a full description of each restriction on a separate sheet of paper, including name of ALS service and ALS service medical director.
[ ] YES, Restricted for Initial Preceptoring
[ ] YES, Restricted for Other Reason
[ ] NO
3. Has your medical command authorization ever been denied or withdrawn? If yes, please provide a full description of each denial or withdrawal on a separate sheet of paper, including name of ALS service and ALS service medical director.
[ ] YES [ ] NO
4. Has any disciplinary sanction been imposed against you (regardless of whether it is presently stayed pending disposition of an appeal), or is any disciplinary charge currently pending against you? If yes, please explain on a separate sheet of paper.
[ ] YES [ ] NO
Please attach copies of the following:
[ ] Current BCLS Course Completion
[ ] Previous Year's Continuing Education Record
[ ] Pennsylvania Certification
[ ] Pennsylvania License (Physician/PHRN)
[ ] Attachments For Questions 1-4 (If Applicable)

I hereby certify that the information provided in this application is true and correct to the best of my knowledge, information, and belief. I grant the ALS service/ medical director permission to investigate all information on this application, and I grant third parties permission to release information about my professional competence to the ALS service/ medical director. I understand that if my application is approved for medical command, this authorization will be valid for the current calendar year, unless restricted or withdrawn by the ALS service medical director. I further understand that if granted medical command authorization, it applies only to the ALS service listed on this application and only permits practice in accordance with the Statewide and regional medical treatment protocols.

Signature of Applicant Date



**MEDICAL COMMAND AUTHORIZATION FORM**

ALS Service Affiliate #	Calendar Year
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\_\_\_\_\_  
 Last Name (ALS Provider)                      First                      MI

**ALS Service Medical Director Checklist**

<p><b>Initial Determination (Applicant has never had medical command authorization within PA).</b>          Must check each of the following.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Verify continuing education requirements met</li> <li><input type="checkbox"/> Verify certification through regional EMS council</li> <li><input type="checkbox"/> Verify through regional EMS council that no disciplinary sanction is currently imposed against the individual that prevents the individual from receiving medical command authorization</li> </ul> <p>Verification of competence to perform each of the services within the individual's scope of practice. Check at least one of the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Direct observation</li> <li><input type="checkbox"/> Consult suitable physician, PHRN, or EMT-P who has directly observed performance of services</li> </ul> <p>Name: _____          Name: _____</p>	<p><b>Annual Review or Other Review with this ALS Service (Applicant has had previous medical command authorization within PA).</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Verify continuing education requirements met</li> </ul> <p>Verification of competence to perform each of the services within the individual's scope of practice. Check at least one of the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Direct observation</li> <li><input type="checkbox"/> Consult suitable physician(s), PHRN(s), or EMT-P(s) who directly observed performance of services.</li> </ul> <p>Name: _____          Name: _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Perform medical audit of records of service</li> <li><input type="checkbox"/> Consult emergency department physician(s) who has received patients treated by applicant</li> </ul> <p>Name: _____          Name: _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Consult medical command physician(s) who has given command</li> </ul> <p>Name: _____          Name: _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Consult ALS service medical director(s) who has granted, restricted, or denied command</li> </ul> <p>Name: _____          Name: _____</p>
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**Decision Rendered (Choose Only One Column)**

<p>Initial (with any ALS service)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Grant</li> <li><input type="checkbox"/> Restrict for Preceptoring</li> <li><input type="checkbox"/> Restrict for Other</li> <li><input type="checkbox"/> Deny</li> </ul>	<p>Initial (with this ALS service)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Grant</li> <li><input type="checkbox"/> Restrict for Preceptoring</li> <li><input type="checkbox"/> Restrict for Other</li> <li><input type="checkbox"/> Deny</li> </ul>	<p>Review (annual or other)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Renew</li> <li><input type="checkbox"/> Renew and Require Con. Ed.</li> <li><input type="checkbox"/> Restrict for Other</li> <li><input type="checkbox"/> Withdraw</li> </ul>
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As the ALS service medical director of the referenced ambulance service, I have evaluated the individual's qualifications based upon the individual's ability to competently perform each of the services set forth within the scope of practice authorized by the individual's certification or recognition.

\_\_\_\_\_  
 ALS Service Medical Director (Printed)

\_\_\_\_\_  
 Signature of ALS Service Medical Director

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 ALS Provider (Printed)

\_\_\_\_\_  
 Signature of ALS Provider

\_\_\_\_\_  
 Date



RESTRICTION OR DENIAL OF MEDICAL COMMAND AUTHORIZATION

ALS Service Affiliate # | Calendar Year

Last Name (ALS Provider) | First | MI

ACTION TAKEN

As the ALS service medical director for this ambulance service, I have taken the following action with respect to the practitioner's medical command authorization with this ambulance service:

- RESTRICTED for Initial Service Preceptoring... RESTRICTED for Other Reason... RENEW AND REQUIRE REMEDIAL CONTINUING EDUCATION... DENIED / WITHDRAWN

List the restriction(s) placed on the medical command authorization or describe the reasons for denial or withdrawal of medical command authorization:

Multiple horizontal lines for text entry.

If medical command authorization has been renewed and additional continuing education is required to address a demonstrated deficiency in competence, list the continuing education courses that must be successfully completed:

Multiple horizontal lines for text entry.

The ALS practitioner has been notified of this decision and received a copy of this form.

ALS Service Medical Director (Print) | Director (Signature) | Date
ALS Provider (Print) | ALS Provider (Signature) | Date