

## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Office of Emergency Medical Services

## MOBILE INTENSIVE CARE AND AUTHORIZED SKILL UPDATE SIGNATURE PAGE

## **PROVIDER AGREEMENT**

I,,,,,			(TITLE), acknowledge that the information		
(ORGANIZATIO	, acknowl				
provided with this recertification p which we are authorized is con compliance with Section 19a-17 emergency medical services.	tingent upon the	e continuance of	sponsor hosp	oital medical control	
CEO (PRINT NAME)		CE	CEO SIGNATURE DATE		
SP	ONSOR HOSP	PITAL AGREEN	<u> MENT</u>		
The		is currently the Sponsor			
Hospital for:			at the level of		
(specify highest level of service)	EMR	EMT	AEMT	Paramedic	
and for the following authorized B	LS skills:				
Please check all appropriately:					
Aspirin (EMT and above)			Yes	No	
Continuous Positive Airway Pressure (CPAP) (EMT and above)			Yes	No	
Glucometer (EMT and above)			Yes	No	
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and al			Yes	No	
Twelve Lead ECG Acqusition and Transmission (EMT and abov			Yes	No	
he above provider has complied wintensive Care and/or BLS skill authorized maintenance of competency rovide medical control in accordangencies which govern the delivery of	norization includ . Therefore, on l ce with Section 1	ing, but not limite behalf of the Spon 9a-179-12 of the I	d to, initial pr sor Hospital, Regulations of	ovider training and we agree to continue to	
MEDICAL DIRECTOR (PRINT) SIGNATU		RE	DATE		
FMS COORDINATOR (PRINT)	MS COORDINATOR (PRINT) SIGNATUR		DF	DATE	