STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services

CHANGE IN EMS SPONSOR HOSPITAL APPLICATION

1. Name of EMS Organization: _____
2. Mailing Address: _____

   Phone: _____ Fax: _____
3. Contact Person and Title: _____
4. Contact Person Phone: _____Email: _____
5. At what level(s) is your organization **currently** licensed, certified and/or authorized? *(check all that apply)*

☐ First Responder ☐ Basic Ambulance ☐ AEMT ☐ Paramedic

6. What BLS skills is your organization **currently** authorized to perform? *(check all appropriately)*

AED (EMR and above)	Yes ☐	No ☐
Aspirin (EMT and above)	Yes ☐	No ☐
Continuous Positive Airway Pressure (CPAP) (EMT and above)	Yes ☐	No ☐
Glucometer (EMT and above)	Yes ☐	No ☐
Epinephrine Auto injector (EMT and above)	Yes ☐	No ☐
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and above)	Yes ☐	No ☐
Twelve Lead ECG Acquisition and Transmission (EMT and above)	Yes ☐	No ☐

CURRENT EMS Sponsor Hospital Information

Name of Current Sponsor Hospital: _____

Address: _____

EMS Medical Director: _____ Phone: _____

E-mail: _____ Fax: _____

EMS Coordinator: _____ Phone: _____

E-mail: _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

For Office of EMS use only

OEMS Approval: ☐ yes ☐ no Date: _____

Notice sent to **Service and Both Hospitals** ☐ yes ☐ no Date: _____

Signature: _____ Date: _____

PROPOSED EMS SPONSOR HOSPITAL INFORMATION

Name of Proposed EMS Sponsor Hospital: _____

Address: _____

EMS Medical Director: _____ Phone: _____

E-mail: _____ Fax: _____

EMS Coordinator: _____ Phone: _____

E-mail: _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

Title of Proposed Sponsor Hospital's Protocols: _____

Revision Date: _____

Have the Protocols been made available to authorized staff members of your organization?

☐ Yes ☐ No

Please attach a copy of the protocols and Sponsor Hospital Quality Assurance Plan for this ***New Sponsor Hospital***. Electronic copy is acceptable.

##########

In the preceding 12 months, what percentage of your patients were transported to your ***current*** EMS sponsor hospital: _____%

In the preceding 12 months, what percentage of your patients were transported to your ***proposed*** EMS sponsor hospital: _____%

Where else will your patients be transported:

7. ***Please attach a separate sheet explaining the reason(s) for changing EMS sponsor hospital.***

8. ***Please attach a separate sheet explaining how patient care will remain at the present standard of care or be improved by the proposed change in sponsor hospital.***

EMS Sponsor Hospital Termination Acknowledgement

The information within this application has been reviewed in its entirety by the following individuals and collectively we, _____ acknowledge
(name of current EMS sponsor hospital)

sponsorship of _____ will terminate at the
(name of EMS organization)

_____ level on _____ at _____.
(level of authorization) *(date)* *(time)*

_____ _____
EMS Medical Director *(print and sign)* Date

_____ _____
EMS Coordinator *(print and sign)* Date

_____ _____
Hospital CEO *(print and sign)* Date

EMS Sponsor Hospital Sponsorship Agreement

The information within this application has been reviewed in its entirety by the following individuals and collectively we, _____ agree to sponsor
(name of new EMS sponsor hospital)

_____ at the _____
(name of EMS organization) *(level of authorization)*

level and for the selected, authorized BLS skills indicated below commencing on_____
(date)

at _____. The above provider has complied with all conditions as set forth by this
(time)

EMS sponsor hospital for mobile intensive care and/or BLS skill authorization including, but not limited to, initial provider training and ongoing maintenance of competency. We agree to comply with the provisions of section 19a-179-12 of the Regulations of Connecticut State Agencies and other statutory or regulatory requirements which may apply.

Authorized BLS skills *(check all appropriately)*:

AED (EMR and above)	Yes ☐	No ☐
Aspirin (EMT and above)	Yes ☐	No ☐
Continuous Positive Airway Pressure (CPAP) (EMT and above)	Yes ☐	No ☐
Glucometer (EMT and above)	Yes ☐	No ☐
Epinephrine Auto injector (EMT and above)	Yes ☐	No ☐
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and above)	Yes ☐	No ☐
Twelve Lead ECG Acquisition and Transmission (EMT and above)	Yes ☐	No ☐

_____ _____
EMS Medical Director *(print and sign)* Date

_____ _____
EMS Coordinator *(print and sign)* Date

_____ _____
Hospital CEO *(print and sign)* Date