CONNECTICUT
Public Health

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

MOBILE INTENSIVE CARE AND AUTHORIZED SKILL UPDATE SIGNATURE PAGE

PROVIDER AGREEMENT

I, _____, _____, of
(CEO-NAME) **(TITLE)**

_____, acknowledge that the information
(ORGANIZATION)

provided with this recertification packet is current and accurate. I understand and agree that the skill(s) for which we are authorized is contingent upon the continuance of sponsor hospital medical control and compliance with Section 19a-179-12 of the Regulations which govern the delivery of prehospital emergency medical services.

CEO (PRINT NAME)	**CEO SIGNATURE**	**DATE**

SPONSOR HOSPITAL AGREEMENT

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 BLS 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 above)	Yes ☐	No ☐
Twelve Lead ECG Acqusition and Transmission (EMT and above)	Yes ☐	No ☐

The above provider has complied with all conditions as set forth by this Sponsor Hospital for Mobile Intensive Care and/or BLS skill authorization including, but not limited to, initial provider training and ongoing maintenance of competency. Therefore, on behalf of the Sponsor Hospital, we agree to continue to provide medical control in accordance with Section 19a-179-12 of the Regulations of Connecticut State Agencies which govern the delivery of pre-hospital emergency medical services.

MEDICAL DIRECTOR (PRINT)	**SIGNATURE**	**DATE**
EMS COORDINATOR (PRINT)	**SIGNATURE**	**DATE**