DEPARTMENT OF HEALTH
...in pursuit of good health

MEDICAL COMMAND AUTHORIZATION FORM

ALS Service Affiliate #	Calendar Year

Last Name (ALS Practitioner) 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_____

   Name of Service_____
   Dates with Service_____
   ALS Service Medical Director_____
   Telephone Number_____

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   Dates with Service_____
   ALS Service Medical Director_____
   Telephone Number_____

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   Dates with Service_____
   ALS Service Medical Director_____
   Telephone Number_____

   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 Has your medical command authorization ever been denied or withdrawn?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

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ALS Service Medical Director Checklist

Initial Determination (Applicant has never had medical command authorization within PA). Must check each of the following.

- ☐ Verify continuing education requirements met
- ☐ Verify certification through regional EMS council
- ☐ Verify through regional EMS council that no disciplinary sanction is currently imposed against the individual that prevents the individual from receiving medical command authorization

Verification of competence to perform ***all*** services within the individual's scope of practice. Check at least one of the following:

- ☐ Direct observation
- ☐ Consult suitable physician, PHRN, or EMT-P who has directly observed performance of services

Name:_____
Name:_____

Annual Review or Other Review with this ALS Service (Applicant has had previous medical command authorization within PA).

- ☐ Verify continuing education requirements met

Verification of competence to perform ***all*** services within the individual's scope of practice. Check at least one of the following:

- ☐ Direct observation
- ☐ Consult suitable physician(s), PHRN(s), or EMT-P(s) who directly observed performance of services.

Name:_____
Name:_____

- ☐ Perform medical audit of records of service
- ☐ Consult emergency department physician(s) who has received patients treated by applicant

Name:_____
Name:_____

- ☐ Consult medical command physician(s) who has given command

Name:_____
Name:_____

- ☐ Consult ALS service medical director(s) who has granted, restricted, or denied command

Name:_____
Name:

Decision Rendered (Choose Only One Column)

Initial (with any ALS service)	Initial (with this ALS service)	Review (annual or other)
☐Grant	☐Grant	☐Renew
☐Restrict for Preceptoring	☐Restrict for Preceptoring	☐Renew and Require Con. Ed.
☐Restrict for Other	☐Restrict for Other	☐Restrict for Other
☐Deny	☐Deny	☐Withdraw

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

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RESTRICTION OR DENIAL OF MEDICAL COMMAND AUTHORIZATION

ALS Service Affiliate #	Calendar Year

Last Name (ALS Practitioner) 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 (This option may only be used if the applicant has not previously been granted medical command authorization with this service. This option may not be used if preceptoring is being done to remediate deficiencies.)
- ☐ 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:

_____

_____

_____

_____

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_____

_____

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:

_____

_____

_____

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

_____
ALS Service Medical Director (Print)

_____ _____
ALS Service Medical Director (Signature) Date