



CHANGE IN MEDICAL DIRECTOR / ASSOCIATE MEDICAL DIRECTOR

CoAEMSP Program Number:

**Sponsoring Institution/
Consortium Name:**

City: **State:** **Zip:**

MEDICAL DIRECTOR STATUS

<p>Medical Director</p> <p>Permanent Temporary Acting</p>	<p>Associate Medical Director</p> <p>Effective Date:</p>	<p>Please keep in mind, the same individual cannot simultaneously hold the position of Program Director and the position of Medical Director [Policy XVb].</p>
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***Explanation of status is located in Accreditation Policies XV Personnel Changes**

FORMER MEDICAL DIRECTOR / ASSOCIATE MEDICAL DIRECTOR

Name: **Credentials:**

NEW MEDICAL DIRECTOR / ASSOCIATE MEDICAL DIRECTOR (Office Contact Only)

Name: **Credentials:**

Address:

City: **State:** **Zip:**

Email: **Phone:** **Fax:**

State License Number: **Expiration Date:**

Add'l State License Number (if applicable): **Expiration Date:**

Add'l State License Number (if applicable): **Expiration Date:**

Add'l State License Number (if applicable): **Expiration Date:**

Please Note: The Medical Director / Associate Medical Director must 1) be a physician currently licensed and authorized to practice in the location of the program, with experience and current knowledge of emergency care of acutely ill and injured patients; 2) have adequate training or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care; 3) be an active member of the local medical community and participate in professional activities related to out-of-hospital care; 4) be knowledgeable about the education of the Emergency Medical Services Professions, including professional, legislative and regulatory issues regarding the education of the Emergency Medical Services Professions. **[Standard IIIB2b / IIIB3b] [see also Accreditation Policies XV]**

REQUIRED DOCUMENTATION (Submit All Items Together)

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| 1. This completed form | 4. CV with formal education/degrees & related exp. |
| 2. Signed/dated Letter of Appointment | 5. Signed/dated Letter of Acceptance |
| 3. Copy of the State License for EACH State the MD is licensed | |

SUBMISSION OF ALL REQUIRED DOCUMENTATION

Email all items above to: Lynn Caruthers at lynn@coaemsp.org

