

SIERRA-SACRAMENTO VALLEY EMS AGENCY

**PARAMEDIC INTERFACILITY TRANSPORT OPTIONAL SKILLS
SERVICE PROVIDER APPLICATION**

SERVICE PROVIDER:	CHIEF OPERATIONS OFFICER:
CONTACT PERSON:	MEDICAL DIRECTOR:
MAILING ADDRESS:	
CITY:	ZIP CODE:
PHONE #	FAX #
E-MAIL ADDRESS:	

Attach the following:

<i>DESCRIPTION</i> (For detailed description, see S-SV Policy Reference No. 442.)	<i>ENCLOSED</i>	<i>APPROVED</i> (S-SV use only)
a. Letter of Intent , signed by Chief Operations Officer, to provide paramedic monitoring of pre-existing blood transfusions, and/or pre-existing magnesium sulfate / nitroglycerin / heparin / amiodarone infusions, and/or Automatic Transport Ventilators (ATV's) during interfacility transports.		
b. Call Volume of anticipated interfacility transports.		
c. Equipment Identification. Mechanical infusion pump and/or Automatic Transport Ventilator information.		
d. CQI program.		
e. Program instructor. Name and CV/resume of the instructor.		
f. Training Program.		
g. Policies & Procedures.		
h. Personnel Information: <ul style="list-style-type: none"> ▪ # of proposed paramedic personnel to be trained & authorized. ▪ # of ALS staffed ambulances staffed with paramedic personnel to be trained and authorized. ▪ Proposed target date for beginning service. 		

Chief Operations Officer **Date** **Medical Director** **Date**

Submit this application, with appropriate supporting documentation, to:

QI/Education Coordinator
S-SV EMS Agency
5995 Pacific Street
Rocklin, CA 95677

Phone (916) 625-1714
Fax # (916) 625-1730

S-SV EMS AGENCY USE ONLY						
<i>Date rec'd</i>	<i>Reviewed by</i>	<i>Date Approved</i>	<i>Letter sent</i>	<i>Personnel list</i>	<i>Orientation Completed</i>	<i>Provider #</i>