

**SIERRA-SACRAMENTO VALLEY EMS AGENCY
EMT OPTIONAL SKILL
SERVICE PROVIDER APPLICATION**

AGENCY		
CONTACT PERSON		PHONE #
TITLE		FAX #
ADDRESS		EMAIL
CITY	STATE	ZIP
PROPOSED BASE HOSPITAL		
a. EMT optional skill being applied for: <input type="checkbox"/> ETAD <input type="checkbox"/> King Airway <input type="checkbox"/> Epinephrine by auto-injector for anaphylaxis &/or severe asthma <input type="checkbox"/> Atropine and pralidoxime chloride (Mark-I / DuoDote Kit)		

Attach the following:	CHECK LIST
b. Letter-of-Intent to provide EMT optional skill	
c. Geographical boundaries	
d. Statement of need	
e. Letter from base hospital	
f. CQI program	
g. Instructor form	
h. Training program	
i. Service Provider's Medical records' policy	

**SUBMIT APPLICATION TO:
Sierra-Sacramento Valley EMS Agency
5995 Pacific Street
Rocklin, CA 95677**

SIGNATURE _____ **DATE** _____

PRINT NAME AND TITLE _____