Application for Participation in an Optional/Pilot Program

Name of Local Program: _____ Date: _____

Desired Optional Program: _____

Method of Quality Assurance Review (please use separate sheet as needed): _____

Individual responsible for Quality Assurance Review:

Name _____ Telephone: _____
Print Name

Name _____ Address _____
Signature

E-Mail: _____

Manner in which Jurisdictional Medical Director will be involved in Quality Assurance review: _____

Individual responsible for forwarding Optional Program Occurrences to the Regional Medical Director and State EMS Medical Director:

Name _____ Telephone: _____

Approval of Optional Program Participation and Proposed Quality Assurance Review Process:

_____ _____
Print Name
EMS Operational Program Medical Director — State EMS Medical Director

_____ _____
Signature — Date
EMS Operational Program Medical Director

Form Revised 1/2024