

Application for Participation in an Optional/Pilot Program

Name of Local Program:	Date:
Desired Optional Program:	
Method of Quality Assurance Review (please	e use separate sheet as needed):
	n :
Individual responsible for Quality Assurance	Keview:
Name:	Telephone:
Name:	Address:
E-Mail:	
Manner in which Jurisdictional Medical Director will be involved in Quality Assurance review:	
Individual responsible for forwarding Option Medical Director and State EMS Medical Dir	
Name:	Telephone:
Approval of Optional Program Participation a Process:	and Proposed Quality Assurance Review
Print Name EMS Operational Program Medical Director	State EMS Medical Director
Signature EMS Operational Program Medical Director	Date