SERVICE PROVIDER APPLICATION FOR EMERGENCY MEDICAL TECHNICIAN (EMT) OPTIONAL SCOPE FORM

Please write clearly and answer all questions or your application may be rejected.

Agency Name: Website:

Phone: Fax:

Physical Address:

City: State: Zip:

Mailing Address:

City: State: Zip:

Contact Person: Title:

Phone: Fax: Contact Person Email:

Proposed Base Hospital:

EMT Optional Scope (check all that apply):

❑ Supraglottic Airway

Attach the following documents to application:

❑ Letter-of-Intent to provide EMT Optional Scope
❑ Statement of Need
❑ Service Provider's Medical Records Policy
❑ Training Program
❑ Geographical Boundaries
❑ Continuous Quality Improvement (CQI) Program
❑ Instructor Form

I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature *Date*

Print Name and Title of above signature

*This application and **all** required items may be mailed or emailed.*
If you would like to meet with someone to drop off your paperwork, please make an appointment by calling (530) 666-8665.

YEMSA USE ONLY			
Received:	Reviewed by:	Approved by:	Updated: