Finger Lakes Regional EMS Council, Inc.

Prehospital Care Agency Information Form

The information below is required to be updated annually and it is a requirement of NYSDOH that the Council, Program Agency, and REMAC keep this information on file and up-to-date.

Any changes to the information provided below must be submitted on this form.

If we do not receive an updated copy from your organization by 9/1/17 we must inform your medical director that your agency is not compliant. Please return this as quickly as possible. If you have elections after the 9/1/17 deadline, please make a copy of this form and return the updated information after your elections.

We are no longer accepting written responses. This form is available in a fillable PDF and will then be uploaded to a master database. When sending this form back please change the word "Fillable" in the file name to your Agency Number. If you have any questions please call: 315-789-0108 or 800-357-3672

Agency Information

Name of agency: ______________________________

Street address: ______________________ City: ______________________ Zip: __________

☐ Mailing address is different from above

Mailing address: ______________________ City: ______________________ Zip: __________

Non-emergency phone: ______________________ Fax: ______________________

Does your Agency have a Website: ☐ Yes ☐ No Web Address: ______________________

Does your Agency have a Facebook Page: ☐ Yes ☐ No Page Name: ______________________

New York State Certified: ☐ Yes ☐ No Agency No:__________________

(Copy of Certificate Required)

Transporting Agency: ☐ Yes ☐ No

Certificate of Insurance: ☐ Yes ☐ No

(Copy of Certificate Required)

Registered and Approved Level of Certification: ☐ CFR ☐ BLS ☐ AEMT ☐ ALS

An agency cannot provide services higher than the approved level of service by NYSDOH and the Finger Lakes Regional Emergency Medical Advisory Committee (REMAC).

Other Services Provided: *(Check all that apply)*

☐ Loan Closet ☐ Community Training ☐ Community Blood Pressures ☐ Bariatric transports

☐ ALS Intercept ☐ RSI ☐ SCT

Specialized BLS Skills: *(Check all that your agency is currently participating in)*

☐ ASA ☐ Albuterol ☐ Epi Auto Injector ☐ Narcan ☐ CPAP ☐ Check and Inject (EpiSafe)

Equipment

Number of Ambulances: _________ Number of non-transporting EMS vehicles: _________

Number of Defibrillators: AED: _________ Manufacturer(s): ______________________

Manual: _______ Manufacturer(s): ______________________

Number of other Specialized Items:

Hand held pulse oximetry: _______ Glucometer: _______ CO Monitor/RAD 57: ______

Hand held capnography: _______ IO Gun: _______ Cyano Kits: ______

CME Recertification Program

Does your agency participate the CME Recertification Program? ☐ Yes ☐ No

Electronic PCRs

Does your agency submit patient care reports (PCRs) electronically? ☐ Yes ☐ No *(Mandated by NYSDOH-BEMS)*

EPCR System in use: ______________________

Does your agency have an account on the State Data Bridge? ☐ Yes ☐ No (https://newyork.emsbridge.com)

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Agency Officers for Year: 2017

Medical Director
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Chief/Director of Operations
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Asst. Chief/Asst. Director of Operations
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Training Director/Officer
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

QA/QI Coordinator/Director
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Safety Officer/Director
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Infection Control Officer (Ryan White Officer)
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

ALS Chief/Director (*if applicable*)
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

ALS Committee Representative (*if applicable*)
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

Narcotics Officer (*if applicable*)
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

CME Program Coordinator (*if applicable*)
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

E-PCR Contact
Name: ______________________________ Title: ____________________
E-mail Address: ____
Day Phone: ______________ Evening Phone: ______________________

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Personnel Roster for Year: 2017

Last Name	First name	Certified Level	Cleared Level	EMT Number	Exp. Date	Certified in the last 12 months	RSI	Preceptor

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