## I. Purpose

### A. Overview:

Since the issuance on February 28, 2003 of Homeland Security Presidential Directive 5, which established a single, comprehensive national incident management system (ICS) to enhance the ability of the United States to manage domestic incidents, all emergency responders in the U.S. have had a professional responsibility to learn and put into practice this system. The means by which this responsibility is to be met has continually evolved ever since, and has manifested itself in the form of various federal training courses (e.g., ICS 100, 200, 700, 800, etc.), which are now a required component of the initial training of emergency responders of all types.

Beyond these basic courses, the principles of incident management have been incorporated into emergency response agency and system policies, procedures, and plans as a means of applying the "strategy" of ICS to the "tactics" of "day-to-day" EMS response operations to emergencies of all types and magnitudes. Within the field of Emergency Medical Services, which since its beginnings has been organized around state, regional, and local "systems", policies regarding the application of NIMS and ICS are typically issued by these systems and agencies, with greater detail at the more local/regional level.

**Incident Command:**

The Governor's Executive Order No. 26 of March 5, 1996, establishes the National Incident Management System (NIMS) as the standard system of command and control for emergency operations in New York State. The Incident Command System (ICS) does not define who is in charge, but rather defines an operational framework to manage many types of emergency situations.

One essential component of ICS is Unified Command. Unified Command is used to manage situations involving multiple jurisdictions, multiple agencies, or multiple situations. The specific issues of direction, provision of patient care, and the associated communication among responders must be integrated into each single or unified command structure and assigned to the appropriately trained personnel to carry out.

Source: (NYS DOH BLS Protocols 2016-8)

**Patient Care Responsibilities:**

The provision of patient care is a responsibility given to certified or licensed individuals who have completed a medical training specified by the NYS Public Health or Education Laws and are subject to Regional and State regulations or policy. Prehospital providers are required to practice to the standards of the certifying agency (DOH) and the medical protocols authorized by the local REMAC.

Patient care takes place in many settings, some of which are hazardous or dangerous. The equipment and techniques used in these situations are the responsibility of locally designed, specially trained, and qualified personnel. Emergency incident scenes may be under the control of designated incident commanders who are not certified or licensed emergency medical care providers. These individuals are generally responsible for scene administration, safe entry to a scene, or decontamination of patients or responders.

Pursuant to the provisions of the NYS Public Health Law, the individual having the highest level of prehospital medical certification, and who is responding with authority (duty to act) is responsible for providing and/or directing the emergency medical care and the transportation of a patient. Such care and direction shall be in accordance with all NYS standards of training, applicable state and regional protocols, and may be provided under physician medical control.

(Source: NYS DOH BLS Protocols 2016-8)

B. **Rationale:**

Implementation of ICS/NIMS improves a patient's chance for optimal recovery and survival through the establishment of a well-organized, clearly defined emergency management structure that ensures timely and optimal utilization of emergency resources. Early notification to hospitals will improve the opportunity for hospitals to prepare (assemble special resources and/or clinical teams for each inbound patient.) The goal is to minimize out-of-hospital time while optimizing pre-hospital care that will ultimately improve patient outcome and minimize disability and death. The primary mission of EMS must always be moving patients safely and expeditiously to definitive hospital care.

C. **ICS Compliance:**

This document focuses on the "Medical Branch" and the typical "Initial Response Organization" (Ref. ICS420-I). This Advisory is approved by the Susquehanna Regional EMS Council and shall be considered "best practice" within this region. It should be followed by first responders, all EMS providers and agencies operating within this three-county region. Each MCI level implementation of this protocol should be documented in the PCR and will be reviewed by the primary EMS agency leaders and their Physician Medical Director as part of their ongoing EMS Agency Quality Management Program. Appropriate general written records of these reviews along with general opportunities for development/improvement and training, will be shared with the EMS agency appropriately and with the REMAC at their next scheduled meeting.

D. **Definitions:**

The terms "Medical Branch Director", "EMS/Medical" are synonymous terms and ICS vest titles to identify the EMS or medical leader in the operations section of unified command (and functioning within the unified command post).

## II. Medical/EMS Incident Management Protocol Activation

### A. Day-to-Day EMS Operations Implementation

**This protocol should be considered an everyday use "Best Practices" guideline.**

**SEGMENTS OF THIS WILL BE UTILIZED TO MORE EFFICIENTLY MANAGE EMS SCENES, COMPLEX CALLS, AND EXPEDITE IMMEDIATE FLOW TO HOSPITALS (DEFINITIVE CARE).**

EMS providers operating in this region will utilize the National Incident Management System (NIMS) and Incident Command System (ICS) during EMS/medical operations. This policy shall be formally implemented every time:

1) There are two or more patients requiring EMS care and transport at an EMS incident/call.
2) The potential for multiple patients is likely to exist or evolve

Examples:

- Fire Rescue/Heavy Rescue
- High Risk Law Enforcement Operations, "active shooter", SWAT Activation, TEMS Activation
- High Risk Warrant
- Diving
- Water/Ice Rescue
- Multi Motor Vehicle Crashes
- IED's
- HazMat Scenes
- Major Public Events
- ATV/Snowmobile Incidents, Off-road Rescue
- "Cave In - Collapse"
- Complex Low or High Angle Rescue
- Plane Crashes, Balloon or Ultra Light Crash
- Electrocution
- Bombs, Bombing

### B. Utilize this Policy for Single "Critical" Patient Situations:

1) EMS providers will use parts of this guideline to better manage a single "serious" or "critical" patient emergency. For example, by having the "in-charge" EMS provider wear the "Medical Branch Director or EMS/Medical vest" or by establishing an on-scene command you will improve care through better coordination of on-scene operations that focus on rapid movement of the patient to appropriate definitive hospital care.

2) EMS Providers/agencies responding to a call where there is a single or multiple patients with serious/critical injuries or illness will participate in a very quick, brief pre-incident briefing while

en-route, or as they arrive on scene that delineates provider roles, responsibilities, priorities, equipment needs, goals, and scene staging.

**C. Incident Timer. Dispatch or County 911 Center/s will "start a clock" for all:**

a) "Guideline" Activations: (i.e., Ambulance Eight establishing "Medical or EMS Branch Director").
b) MCI declaration at any level
c) When a single major emergency is identified (and broadcast) on a scene, e.g., major trauma, Peds CPR, Peds major trauma, imminent delivery, major burn by EMS, etc.

Related to the incident timer, the dispatch center or 911 center will notify the Command (when established) or "EMS/Medical Branch Director" after they have been on scene 5 minutes and then at 10-minute intervals thereafter unless cancelled by Command (e. g., "ambulance 77 your on-scene clock is at 5 min). Following each notification, the 911 center will ask "Command" for a status update, advise of resources en-route and will inquire if any additional resources are needed.

**NOTE:**
**ALL EMS INCIDENTS, REGARDLESS OF SIZE OR COMPLEXITY, WILL HAVE AN INCIDENT COMMANDER, EITHER SINGULAR OR UNIFIED COMMAND.**

**D. Pre Arrival**

1) If anticipated that you will be the first arriving EMS unit, utilize all available information at your disposal (e.g., dispatch, fire, law enforcement, bystanders, etc.) to request the response of additional specific emergency resources at the earliest indication of need.

2) If Command is already established, ascertain staging information and your first tasks or assignments either directly from Command or from dispatch.

3) Have your dispatch center advise likely destination hospital/s if serious/critical or multiple patients exist at your incident.

**E. Arrival Actions: First Due EMS**

1) Establish scene safety. Reassess scene safety continuously. Broadcast hazards.

2) The first arriving EMS unit should broadcast a "size-up" to include what you can see or what you are told (e.g., number of vehicles, actual or potential hazards, number of patients and severity of injuries, or illness; red, yellow, green, black, injury or illness types, including a description of the structure or scene, etc.)

3) Establish Command and then broadcast the location of the command post or announce "joining command functions post structure". EMS/Medial Branch Director will participate in unified command with police and fire/rescue at a minimum.

**Example: "EMT/Medic _____from _____ (name of EMS agency) establishing command or joining the existing command post which is located at _____ and will be operating on freq. _____."**

4) Put on the EMS/Medical vest or bib. (Actual title is EMS/Medical Branch Director)

5) Initiate a detailed scene survey and if safe begin Triage operations. Consider assigning **Triage** Unit. Use SMART triage tags/tools and vest/bib.

6) Establish **Treatment, Transport** and other units and Group Supervisors as needed.

7) Broadcast unit locations and identify/label areas. Command will broadcast the following: (to all incoming units)

   a) Scene safety hazards (current, ongoing)
   b) Number of patients and severity (red, yellow, green, black)
   c) Cause(s) of injuries/illnesses (if known)
   d) Best access for EMS to the scene (road blocked?)
   e) Number of patients trapped/type of rescue required
   f) Staging area location (if required)

**F. Command**

1) Once Command has been established and the location broadcast to all inbound and on-scene responders, size-up and resource requests will **then** originate from Command.

2) Command designation will be named after the Incident **location** (e.g., "Route 207 West...Command).

3) The "In-Charge EMS Provider" will don the "EMS Medical vest" and is the designated Medical/EMS representative to Command and will be responsible to ensure that:

   - Command recognizes that certain medical decisions are dictated in regulation and in New York State law and require a New York State DOH certified CRF, EMT or Advanced EMT certification (or Physician Medical License) to practice and make most EMS/medical clinical decisions.

   - Often, the Certified First Responder or Emergency Medical Technician will need to communicate directly with the destination hospital/s and the Hospital E.D. Medical Control Physician. Physician consultation and physician medical direction relative to on-scene medical operations, patient clinical decisions, and for physician orders (e.g., medications/fluid orders, fly/no-fly clinical decision making, treatment priorities will occur between EMS and the Hospital Medical Control Physicians. The need for specific additional EMS resources that might include ALS, MedEvac helicopter(s), management of burn and pediatric patients, etc. could also be discussed.

   - The "In-Charge EMS Provider" at Unified Command will either become a component of Unified Command or will become "Medical Branch Director" within the operations sector. Regardless of EMS role in the Command operations, effective communications up and down the "Chain of Command" is essential.

4) **Triage tags will be available and applied to all patients triaged at the scene.**

5) Requesting Resources:

Request through Command the dispatch of additional resources:

Considerations:

- ☐ Additional ambulances & EMS personnel (Plan on an ALS ambulance for every "red" patient.) May need additional CFR's EMT/Medics as well. Consider med teams also.
- ☐ ALS rapid response vehicles and medics
- ☐ Aero MedEvac units/MedEvac helicopters,
- ☐ EMS agency leadership/management
- ☐ County EMS Coordinator and Deputies response, EMS Physician response
- ☐ County 911 field operations vehicles
- ☐ Additional medical supplies/assets for prolonged operations. Special needs?
- ☐ Consider the need for public health department resources
- ☐ EMS MCI Trailer
- ☐ Fire/rescue units and personnel
- ☐ Law enforcement
- ☐ Specialty terrain vehicles (boat, ATVs, snowmobiles, etc.)
- ☐ Boats
- ☐ Physician Response Team

**In Broome County**, you might consider requesting EMS Coordinator/s, CV-1, HAZMAT-1, the Technical Response Unit, Broome County Medical Support Trailer, etc.
**In Tioga County**, you might consider requesting the 911 Communications Trailer, County EMS Coordinator. Mass Casualty Unit is located at GVEMS in Sayre, PA.
**In Chenango county**, you might consider requesting the Co. Communication Unit and/or County EMS Coordinator and Co. or EMS Agency Physician Medical Director.

## G. County EMS Coordinators/Co. Deputy EMS Coordinator and/or Co. or Agency EMS Physicians' Roles/Responsibilities/Response

1) Co. EMS Coordinators will be notified of activation of this advisory and will respond at their discretion. County EMS Coordinators and Deputies will be dispatched priority one to the scene of all MCI I, II and III declarations. On scene Medical Branch Director or Command can cancel when indicated.

2) Significance EMS/Medical Incident/s effecting the community.

3) County EMS Coordinator Staff Roles:
County EMS Coordinators/Deputies and/or County EMS physician/s will support the "Medical Branch Director" and Command Post as directed by the home or lead EMS agency or by Command.

4) They may perform the following functions as assigned:
   a) Vest the Command Post or Leadership Staff
   b) Poll hospitals for capacity and/or establish regular or continuous communications with hospitals (Charge RN, Shift Lead RN, or Medical Control Physician)

c) Record incident/command data for command post/update status boards
d) Issue radios, ICS vests or assist with medical communication functions
e) Support/Consultant to Medical Branch Director
f) Arrange for Physician response to scene. Set up physician medical control hotline to ED's.
g) Work with Regional Level I Hospital Trauma Centers that may be able to accept patients by ground or Helicopter (i.e., Peds, Burns, Hyperbaric, etc.)
h) Other duties as assigned by Medical Branch Director or Command (within scope of expertise or practice)

**H. EMS Functions with Other Disciplines On-Scene:**

1) EMS personnel shall work in a unified manner with on-scene fire/rescue and police to provide the most expedient care possible to all patients.

2) Fire Rescue shall be responsible for the following on-scene tasks (examples of these functions might include):
   a) Fire suppression
   b) Extrication of patients/rescue
   c) Lighting and hazard mitigation
   d) Assist with spinal motion restriction of patients for transport to treatment sector/hospital
   e) Assist with moving patients
   f) Establish landing zone/s

## III. Declaring an MCI, MCI Levels Defined

This "Best Practice Plan" further defines the local framework for declaration of an MCI. This framework is a supplement to Fire Scope Field Operations Guide ICS 420-1, "Mutli-Casuality" chapter.

An MCI will be declared when:

- 4 or more patients are ill or injured at an EMS incident
- OR 3 or more serious/critical patients are ill or injured
- AND more than a second ambulance is required

The field EMS provider shall be responsible for informing dispatch of:

1. Declaration of an MCI
2. Number of patients
3. Condition (color code) of patients – after initial Triage.

Based on the number of patients, dispatch will assign the MCI a Level and activate the appropriate preplan.

MCI will be defined and declared in this region as:

4 – 10 Patients = "Level I MCI" (OR 3 or more serious/critical)
11 – 20 Patients = "Level II MCI"
21+ Patients = "Level III MCI"

This declaration will be announced by 911 centers over the air and will be preceded by an emergency or alert tone. It will be broadcast to all responding units (EMS, police, fire, etc.) and agency and county leaders and should state, i.e., "Ambulance 77 is on-scene and has declared a level two MCI. The Command Post is located at _____. Emergency radio traffic only."

The County EMS Coordinator may be responsible to poll each hospital ED charge RN or medical control physician (be sure to talk with the same RN/MD each time you call to avoid confusion) telling the them the total number of known patients at the incident, type and severity based on that total red, yellow and green patient count. Ask each ED to indicate their capacity to receive patients.

Example: "OK, "xyz" hospital understands there are ____ total number of patients at scene and that there are:

| | |
|---|---|
| # Red _____/Total_____<br># Yellow ____/Total____<br># Green ____/Total____ | If an ED or hospital is full, then the hospital is asked to implement their disaster plan and then very quickly advise (after activation) on the number and type of MCI patients they can accept. |

For all levels of MCI declaration that have patients with critical burns or critical pediatric patients, strongly consider helicopter use. County EMS Coordinator will also obtain the availability of helicopter(s) and air ambulance(s).

The Medical Branch Director, County EMS Coordinator(s) or 911 Center will also obtain the availability and ETA of Medevac helicopter/s.

**A. MCI Dispatch Protocol**

1) Level 1 MCI: (4 to 10 patients) and 3 or more with serious/critical injuries/illness.
   a) Normal dispatch of home agency/s and their leaders
   b) Make routine notifications (EMS & Fire Coordinators to scene as needed, 911 Director, Emergency Manager/s, etc.)
   c) Dispatch mutual aid as requested by EMS/Medical Branch Director or by Command Post.
   d) Notify and roll-call area hospitals
   e) CISM needed? Where? (scene, Hospital?)

2) Level 2 MCI: (11 to 20 patients)
   a) Normal dispatch of home agency and their leaders
   b) Dispatch nearest County MCI unit to the scene
   c) Make routine notifications (EMS & Fire Coordinators to scene, 911 Director, Emergency Manager/s, hospital leaders) through E.D. Charge RN/MD.

d) Dispatch other mutual aid/stand-by assignments as requested by EMS/Medical Branch Director or by Command Post.
e) Dispatch County Emergency Management Office to the scene
f) CISM needed Where? (Scene, hospital?)

3) Level 3 MCI: (21+ patients)
a) Normal dispatch of home agency and leaders
b) Dispatch nearest County MCI unit to the scene
c) Make routine notifications (EMS & Fire Coordinators, 911 Director, response required)
d) Dispatch other mutual aid/stand-by assignments as requested by EMS/Medical Branch Director or by Command Post.
e) Dispatch County Emergency Management Office to the scene
f) Emergency Manager to Notify County and Local Chief Executive Officers, as requested/directed. Consider town, city or county EOC activation.
g) Consider requesting CISM Team to the scene
h) As needed, NYS DOH EMS notifications through state warning print

IV. **Consider and reconsider need for additional resources** (Available and required resources change frequently. Be smart and think outside the box when needed.) *Think about the possibility that incident may be prolonged. Think about the next 4, 8 or 12 hours and beyond.

**A.**

- ☐ Additional ambulances & EMS personnel (Plan on an ALS ambulance for every "red" patient.) May need additional CFR's EMT/Medics as well. Consider fire dept. med teams also.
- ☐ ALS fly vehicle/EMS supervising unit/s, chief/capt.
- ☐ Fire/rescue
- ☐ Law enforcement/fire police
- ☐ Specialty terrain vehicles (boat, URVs, ATVs, snowmobiles, etc.)
- ☐ Medevac helicopter/s
- ☐ Agency leadership/management/supervision
- ☐ County EMS coordinator staff (resources)
- ☐ County OES vehicle (e.g., CV-1, hazmat 1, etc.)
- ☐ County emergency medical support trailer/s
- ☐ Rest Rooms and running water
- ☐ Beverages, food, shelter
- ☐ Law enforcement/Sheriff's office command vehicle
- ☐ Tactical law enforcement/EMS team/s/TEMS
- ☐ Additional supplies/assets for prolonged operations (i.e., additional medications, IV fluids, pain control)
- ☐ Specially trained teams (e.g., HAZMAT, dive team, dogs, etc.)
- ☐ Critical incident stress debriefing/management team
- ☐ Forest rangers, ENCON police, FBI, CPS, clergy, etc.
- ☐ Rehabilitation operations, staff and supplies (e.g., beverages, nutrition, shelter, rest area/s, rest rooms, heat, cold, etc.)
- ☐ Anticipate need to manage media, family
- ☐ Weather Forecasting
- ☐ State resources?

**B. Special Note:**

Responding EMS agencies/department/county officials will NOT cancel or divert resources while in route to a situation or scene. They may request additional resources to be placed In quarters on **stand-by** or **to the scene** and/or coordinate additional stand-by/back-fill resources (especially if scene providers are initially overwhelmed or over committed). Every effort should be made to notify command prior to deployment.

**C. Establishing Sectors/Sector Roles/Responsibilities**

Once a function is delegated, the person responsible shall wear the appropriate vest/bib/identification. The following are EMS sector titles and functions:

1) Medical Branch Director
2) Triage Unit Leader
3) Treatment Unit Leader
4) Transportation Unit Leader
5) Staging Officer
6) Rehab Unit Leader
7) Safety Officer
8) Operations
9) Other functions as dictated by the incident

**TRIAGE UNIT LEADER;**
Radio ID: Triage
Location: Triage Area
1) Ensures that all patients receive primary triage using SMART triage tags
2) Supervises initial patient care at site
3) Supervises patient packaging and transportation back to a treatment area, if appropriate
4) Coordinates EMS activities, including equipment and personnel needs within the triage sector
5) Appoints triage support personnel (as needed)
6) Coordinates patient movement through 2nd stage triage to treatment or transportation sectors (may have fire personnel help do this)

**(EMS/MEDICAL) TREATMENT UNIT LEADER**
Radio ID: Treatment
Location: Transportation (Patient Loading) Area
1) Establishes a treatment area (if requested by Medical Branch Director or Unified Command)
2) Supervises treatment, re-triage and tagging of patients in the treatment area or any area set up to hold patients prior to transport from the scene
3) Coordinates the activities of all EMS personnel assigned to the sector
4) Oversees the provision of patient care by all assigned providers
5) Determines need for and requests personnel and equipment
6) Coordinates patient evacuation in conjunction with the transportation officer

**TRANSPORTATION UNIT LEADER**
Radio ID: Transportation
Location: Transportation (Patient Loading) Area
1) Establishes and maintains patient loading area
2) Supervises patient evacuation in conjunction with treatment officer
3) Determines and monitors local/area hospital capabilities
4) Coordinates helicopter evacuation in conjunction with fire command
5) **Prior to any patient leaving the scene**, the person functioning as transportation officer shall keep part of their MCI tag and log the following information:
   a) Tag #
   b) Priority
   c) Patient's name
   d) Unit transporting
   e) Time out
   f) Destination/disposition
6) May appoint hospital communicator and other support staff (PRN)

**STAGING OFFICER**
Radio ID: Staging
Location: Staging area
1) Establishes safe assembly and mobilization area for EMS personnel and equipment
2) Releases resources to incident based on operational needs as requested by sector officers
3) Works with fire services to ensure a safe landing zone is established and maintained (a representative of the fire service shall act a landing zone officer – per normal protocol)

**It essential that the staging sector be established early in any incident to preclude resources being exposed to any hazard or blocked in by later arriving units.**

**SAFETY OFFICER**
Radio ID: EMS Safety
Location: Roam site
Monitor the activities of personnel and assist in the correction of any safety problems

**D. Incident Reporting**
**Ambulance Crews**

1) On Level 1 MCI and Level 2 MCI, crews shall complete a PCR on each patient and obtain the following minimal information:
   a) Name
   b) Address
   c) Chief complaint
   d) Vital signs

2) On Level 3 MCI, the crew shall complete either a PCR (as in #1 above) or keep a copy of the completed MCI tag receipt. (Preferably so a PCR can be generated after the incident)

**Hospital Contact/Hospital Communications:**

Maintain early contact with destination hospitals. Develop a single charge RN or single physician contact at each hospital (command physician, charge RN or designee) in order to maintain consistency and accuracy of information. It can get confusing fast.

1) Consider continuous, open-line of communication with hospital. Consider use of aviation quality cell phone with headset at scene and possibly in ER.

2) Provide hospital medical command physician with event details, number of actual and/or suspected patients, nature of injuries/illness, contamination, special needs, etc.

3) Continue to discuss with hospitals their capacity to accept patients (i.e., if full hospital, disaster plan implemented).

4) Provide updates as they become available.

5) Consider appointment of a dedicated "EMS scene hospital communicator" to maintain contact with hospitals from the scene.

6) Consider notification of "out of area hospitals" – burn/trauma/pediatric centers for larger incidents (consult with Co. EMS coordinator staff). Potentially notify NYS DOH EMS Bureau through the State Warning Print.

**Additional**

1) Consider direct air transport of isolated stable major burn injuries and stable pediatric patients from scene to a regional center. Consult with medical control physician.
2) Assign additional responders to appropriate roles.
3) May transfer Medical Branch Director role to more qualified EMS leader in command post as needed (e.g., at the end of the operational period or event). Broadcast transfer of command information. Consider appropriate operational periods of all staff.
4) Keep track of resources and personnel. Use an accountability and/or command board for this purpose.
5) Debrief incident/consider psychological aftermath and concerns and make necessary resources available via command for both emergency responders and civilian casualties.

## V. Prolonged Operations and Demobilization

A. If it is anticipated that operations will extend into another operational period, then request additional command and support staff early so they can be properly briefed.
B. Always assess the need for on-scene resources (vehicles, personnel, etc.). There is finite and limited amount of resources in the region and normal day-to-day operations must continue. Release unneeded resources so they may continue to serve the community.
C. Ensure a comprehensive operational incident debrief is conducted.
D. Terminate command and return to normal operations by clearly communicating this over the radio.
E. Demobilize unused equipment/personnel.
F. Closeout ICS and command operations (broadcast same) via command.
G. Consider EOC or Red Cross to support operations.
H. Assure adequate rest for staff. Replenish supplies and equipment.
I. Prevent stress related illness, injury homicide or suicide. Always offer CISM and related screening and support. S/S may be hours, days or weeks before surfacing.

**APPROVAL PAGE:**

Resolutions enacted and unanimously approved by Susquehanna Regional E.M.S. Council at their regular meeting held on September 13, 2018 at the Broome County Public Safety Complex.

Signature

11/1/18
Date

Michael Ponticello President
Printed Name/Title
Chair/SREMSC

Approved for implementation by the REMAC Chairperson:

Signature

11/1/18
Date

Ann Tenga DO MPH
Printed Name/Title
Chair/SREMSC-REMAC

**Appendix A: EMS Agency Attestation – Authorization**

As the Chief Executive/Chief Operating Officer/Chief of _____,
(Agency Name)

I will assure that all CFR's, EMT's and Advanced EMS providers will complete initial and approved annual training, education or drill related to this SREMS/SREMS-REMAC guideline.

I further request and authorize Co. EMS Coordinators/Co. EMS Deputy Coordinators and/or REMAC or Agency physician response in compliance with the provision/s contained herein.

**Authorized by Agency CEO/COO/Chief:**

_____ _____
Signature Date

_____
Printed Name

_____
Title

**Authorized by Agency Medical Director:**

_____ _____
Signature Date

_____
Printed Name/Agency Physician Medical Director

Return to Co. EMS Coordinator
Copy to REMAC Exec. Director