North Country EMS Program Agency

PROVIDER POLICY AGREEMENT

The practice of pre-hospital advanced life support is a privilege granted to me by the Regional Medical Director through the North Country Emergency Medical Services (NCEMS) Protocols and the NCEMS Medical Control System. To maintain that privilege, I agree to comply with the continuing medical education/skills maintenance requirements and remain in good standing while practicing within the system.

By signing below I:

- **Acknowledge that I have received the current NCEMS 2007 Protocols.**
- **Agree to abide by the Policies and Protocols of the North Country Emergency Medical Services System.**

Date: / / _____ _____ _____
Print Name **NYS EMT #** **Card Expiration**

_____ _____ _____
Signature **Primary Agency** **NYS DOH Code**

Please check one of the following: __ New provider in the system __ Changing level in the system

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Mailing Address: Street/PO Box: _____
City, State, Zip Code: _____

Telephone Numbers:
(h) (Or evening) _____ (w) (daytime) _____ (cell) _____ (fax) _____

Email Address: _____

Please Provide to the Program Agency:

- **A copy of your driver's license**
- **If you do not have a license: a copy of another Photo ID**
- **A copy of your EMT card**

~This information is confidential to the Program Agency. It is not released to any other agency and will enable us to inform you of CME Updates and other refreshers important to your continued success in our region.~

( ) Agreement Signed? ( ) Copy of EMT Card? ( ) Protocol Exam Taken? Score: _____ (Minimum Grade: 80%)

( ) Copy of Photo ID ( ) Ltr From Squad Comments: _____