Saint Francis Hospital and Medical Center
Emergency Medical Services

Dear Medical Control Applicant,

Enclosed in this packet you will find the following items:

1. Application form for Medical Control
2. Current Policy on Medical Control Annual Renewal
3. Website to obtain Patient Care Protocols

All forms enclosed must be completed and returned with the following additional information before being considered for medical control.

1. Copy of EMS Provider State of Connecticut License or Certification Card. A website print is acceptable.

2. The website to obtain patient care protocols is: https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/Statewide-EMS-Protocols

3. A reference letter from your current or most recent medical control.

4. A letter from your service administrator acknowledging your active status with the service and requesting either precepting (if you currently do not have medical control elsewhere) or requesting medical control (if you currently have held medical control for a minimum of one year elsewhere in Connecticut).

5. Documentation of completed continuing education hours since your last license or certification renewal.

6. A copy of your current CPR certification and for paramedic applicants, ACLS and PALS.

7. A copy of any other EMS certification you currently hold, (CPR, PHTLS, Nat'l Registry, etc.).

If you have any questions, I can be reached at 860-714-5549 or jquinlav@stfranciscare.org . I look forward to receiving your application.

Sincerely,

John P. Quinlavin, Pm
EMS Manager

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EMERGENCY MEDICAL SERVICES CREDENTIALING APPLICATION

DEMOGRAPHICS **DATE** ____________________________

Name: ____ Date of Birth: _________________________

Address: ____

____ Home Number: ________________________

____ Work Number: _________________________

E-MAIL : ____________________________________ Pager/cell Number: __________________________

Current CERTIFICATION/LICENSURE LEVEL

☐ EMT-A ☐ EMT-I ☐ PARAMEDIC ☐ Other: _____ CT License/Cert. # ___________
Date obtained __________ Exp. Date: _________

National Registry # _______________ Exp Date:________________

Primary Service Affiliation for which you are requesting medical control

☐ AMR ☐ BVA ☐ East Granby ☐ EHFD ☐ Granby ☐ Hamilton Sund ☐ Pratt Whitney ☐ Simsbury
☐ Wethersfield ☐ Windsor Locks ☐ Other: ___________

Secondary Service Affiliation- any other services you presently work for:

☐ AMR ☐ BVA ☐ East Granby ☐ EHFD ☐ Granby ☐ Hamilton Sund ☐ Pratt Whitney ☐ Simsbury
☐ Wethersfield ☐ Windsor Locks ☐ Other: ___________

ADDITIONAL OR EXISTING MEDICAL CONTROL HOSPITALS:

☐ Brad ☐ Brist ☐ Johnson ☐ JDemps ☐ Hart ☐ NBrit ☐ Manch/rockville ☐ Other ________

PREVIOUS EXPERIENCE:

MRT _________ YRS. EMT-A ________ YRS. EMT-I _________ YRS. Paramedic ________ YRS.

EMS-I ________YRS

EDUCATION

High School: ____ ________________________
date graduated

College: ____ ____
date graduated/degree earned

College: ____ ____
date graduated/degree earned

CERTIFICATION/CREDENTIALS
Please complete currently held licenses/certifications. Dates should be listed as month and year.

Basic EMT
EMT Number ____________________ Expiration Date ____________

Location of EMT Course ____________________ Completion Date ____________

EMT-I (aemt)
EMT-I Number ____________________ Expiration Date ____________

Location of EMT-I Course ____________________ Completion Date ____________

PARAMEDIC
Paramedic Number ____________________ Expiration Date ____________

Location of Paramedic Course ____________________ Completion Date ____________

EMS-I
EMS-I Number ____________ Expiration Date ____________

OTHER: Please list all other EMS related certification such as: ACLS, PHTLS, PALS, BTLS, Triage & Mass Casualty, CISD Peer, etc. **ATTACH A COPY OF CERTIFICATION CARDS TO APPLICATION!!!**

Type	Location of Course	Completion Date	Expiration Date

I attest that the information provided in this Credentialing Application is accurate and truthful. I understand that false or misleading information may result in a loss of sponsorship and notification to the CT Department of Health and other Sponsor Hospitals with whom I have medical control.

In addition, I give the EMS Coordinator and/or Medical Director permission to conduct inquiries necessary to verify any information provided in this application or to obtain additional information. Furthermore, I authorize the release of my medical control status, at any time, to other Sponsor Hospitals with whom I have Medical Control and to the CT Department of Public Health.

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Printed Name of EMS Provider   Signature of EMS Provider   Date

EMS work history

EMPLOYMENT: Start with your most recent employment/membership. **This is not the service for which you are requesting for medical control.**

Most recent EMS Employer

1. Name ______________________________ ______________
   dates from - to
   Address ______________________________ ______________
   average hours per week
   Positions held with dates ______________________________

____

Sponsor Hospital: ______________________________

Address: ______________________________

Medical Director ______________________________

EMS Coordinator ______________________________

Next most recent or secondary EMS Employer/Affiliation

2. Name ______________________________ ______________
   dates from - to
   Address ______________________________ ______________
   average hours/week
   Positions held with dates ______________________________

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Sponsor Hospital: ______________________________

Address: ______________________________

Medical Director ______________________________

EMS Coordinator ______________________________

Other Non-EMS Employer

1. Name ______________________________ ______________
   dates from - to
   Address ______________________________ ______________
   average hours/week

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Have you ever lost medical control or had your License/certification suspended or revoked?

☐ NO ☐ YES If yes, explain ______________________________

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SELF SKILL EVALUATION

The following chart lists procedures and/or skills which the applicant must evaluate themselves for Training, Number Done and Mastery: Please indicate your qualifications/ability to perform each of them by the following criteria:

Column 1: Training Definitions:
Indicate the source of training you received on each of the following skills/procedures using the following definitions:

- Graduate Training (GT) : Received training in initial education program.
- Post Graduate Training (PGT): Received training after initial education program through continuing education.
- Clinical Practice (CT) : Received training through clinical practice.
- No Training (NT): No training

Column 2: Estimated Number Done:
Indicate the ***approximate*** number of times you have performed ***successfully*** the following skills/procedures since the beginning of your practice as a paramedic.

Column 3: Level of Mastery Definitions:
Using the following definitions, estimate what you feel your success rate is for each of the following skills/procedures listed.

- 1 - 95% - 100% success rate at performing skill/procedure
- 2 - 80% - 95% success rate at performing skill/procedure
- 3 - 70% - 80% success rate at performing skill/procedure
- 4 - 50% - 70% success rate at performing skill/procedure
- 5 - less than 50% success rate at performing skill/procedure
- 6 - received training but have never had opportunity to use skill/procedure
- 7 - no training or experience with this skill/procedure

Procedure/Skill	Training	Estimated # Done	Mastery
Intravenous Access Peripherally	GT, PGT, CP, NT	LIVE / SIM	1 2 3 4 5 6 7
External Jugular Access	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Pediatric IV Access	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Intraosseous Insertion	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Oral Intubation of Adult	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Nasal Intubation of Adult	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Oral Intubation of Child	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Oral Intubation of Newborn	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Cricothyrotomy, Surgical	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Cricothyrotomy, Needle	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Chest Decompression	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Rapid Sequence Intubation	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Child Birth	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Nasogastric/oral tube insertion	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Insertion of Morgan Lens	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
External Pacing	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
Combi-Tube	GT, PGT, CP, NT	/	1 2 3 4 5 6 7
	GT, PGT, CP, NT	/	1 2 3 4 5 6 7

ATTESTATION

I certify that I am competent and qualified by training and/or experience to perform the indicated procedures/skills noted above.

Signature of Applicant: Date:

FOR SPONSOR HOSPITAL USE ONLY. DO NOT WRITE BELOW THIS LINE

Personal reference: ( ) ____
date received from

Personal reference: ( ) ____
date received from

Med. Ctl. reference:( ) ____
date received from

Comments on references: ____

____

____

Interview: Date: ___/___/___ ____

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Protocol test score ___________________ date: ______________

Precepting period beginning _____________________ ending ______________________ (Date)

Name of Preceptor ____

Probationary period beginning ___________________ ending ______________________ (Date)

Available for permanent medical control ____ (Date)

Letter of medical control sent _________________ (Date)

APPROVED: May 1993
Revision: 9/6/95; 11/97, 1/03, 10/04, 1/06, 11/08, 1/13, 8/13. 10/18

********DO NOT SUBMIT WITH YOUR APPLICATION******

KEEP THE FOLLOWING PAGES FOR YOUR FUTURE REFERENCE.

SUBJECT: Authorization for Medical Control for Paramedics

I. Purpose
To provide a mechanism for certified/licensed EMT-Paramedics to obtain medical control authorization.

II. Procedure
A. Step I
1. The candidate must provide the following documentation to the EMS Coordinator:
   a. a completed application and/or current resume.
   b. complete a paramedic skill self assessment.
   c. copies of current certification cards including ACLS, PALS, State certification.
   d. a letter from the service verifying the candidate's status of employment or membership.
   e. a letter of recommendation from the last medical director, if applicable, indicating satisfactory performance as a paramedic.

B. Step 2
1. Upon receipt of the above information, the candidate may be scheduled for an interview with the EMS Coordinator and/or the Medical Director.
2. The regional protocol exam is administered, as indicated.
3. An assessment of the candidate's base of knowledge and familiarity with the patient care guidelines is conducted by the EMS Coordinator and/or the Medical Director. A practical skill assessment exam may also be scheduled at the discretion of the coordinator and/or medical director.

C. Step 3
1. The medical director either grants or denies conditional medical control authorization. Conditional medical control allows the paramedic to practice independently during the service's orientation period.
2. At the discretion of the medical director or coordinator a field performance evaluation may be done during the candidate's service orientation.

D. Step 4
1. A letter from the service is presented to the EMS Coordinator indicating successful completion of the service's orientation and a recommendation that the candidate be granted full medical control authorization.
2. The candidate is then granted independent medical control authorization for a probationary period of six (6) months.

E. Step 5
1. The candidate will be placed on six (6) months probation during which time the paramedic is continuously monitored for compliance with continuing education requirements, quality improvement activities, patient care guidelines, and policy and procedures.
2. Any time during the probationary period medical control can be withdrawn. The paramedic can then be requested to return to a preceptor status for remediation, or be denied permanent independent medical control authorization.
3. If no actions have been taken against the paramedic during the six (6) month probationary period, then permanent medical control status automatically occurs.

Approved 1/03, 10/04, 1/06, 8/13

Subject: **Annual Sponsorship Renewal Process for Paramedics**

I. PURPOSE

To specify requirements of this institution as a sponsor hospital for maintaining sponsorship at the paramedic level.

II. POLICY

Paramedics must obtain thirty-six hours of Continuing Education Units (CEU's) annually between January 1st and December 31st of each year. It is the responsibility of each paramedic to maintain personal education logs and submit to the EMS Coordinator no later than January 15th of each year a completed ***Annual Renewal for Sponsorship*** form. Failure to submit the completed Annual Renewal Form by the prescribed date will result in immediate withdrawal of medical control privileges without additional notice and continued practice as a paramedic will be in violation of Connecticut General Statutes and subject to criminal prosecution. **Compliance with Medical Control (Sponsor Hospital) policies is required for renewal.**

Accepted forums for Continuing Education Credits

A. Class "A" Continuing Education

1. Eighteen (18) the annual thirty-six (36) hours of CEU requirements must be Class "A" courses. The following courses are approved as Class "A":
    a) Monthly Inservice held at SFH (hour per hour)
    b) Regional Concert Program
    c) Other sponsor hospital inservices which are two (2) or more hours in length. (hour per hour)
    d) Case Review Sessions at a hospital (hour per hour)
    e) National Registry Recertification Course (48 hours)
    f) Connecticut State Conference (hour per hour)
    g) ***Pre-approved*** service sponsored EMS related inservices (hour per hour)
    h) EMS Conferences other than CT State Conference (hour per hour)
    i) ACLS Recertification Course (4 hours annually)
    j) PALS Recertification Course (4 hours annually)
    k) BCLS Recertification Course (2 hours annually)
    l) Annual Regional Skills session (2 hours annually)
    m) Journal Club (hour for hour in session and one hour prep)

B. Class "B" Continuing Education

1. No greater than Eighteen (18) the annual thirty-six (36) hours CEU requirements can be from Class "B" CEU courses. The following courses are approved as Class "B":
    a) Video courses which include a post-test verified by service's Training Officer. Equivalent time for videos to the closest half hour.
    b) Case Review Sessions at the service (hour per hour)
    c) Articles from Professional Journals which provide a certificate of successful completion. Hours as awarded by journal certificate.
    d) PHTLS course (8 hours)
    e) HAZMAT course other than Awareness level (8 hours)

f) Other courses which have been pre-approved by EMS Coordinator.
g) ED clinical time with physician (hour per hour)
h) EMS instructional time (hour per hour)
i) Preceptor time (4 hours per preceptee) (maximum of 8 hours)
j) Research projects
k) Quality assurance/improvement projects

C. Certification Requirements
1. Maintain current certification in CPR biannually
2. Maintain current certification in ACLS biannually
3. Maintain current certification in PALS biannually
4. Certification in PHTLS is recommended but not required
5. Maintain current state license at all times

D. Compliance with Quality Improvement Program
1. Sponsored individuals shall comply with all requests for additional documentation for QI, systems analysis or other reasons.
2. Each paramedic is to participate in Quality Improvement Sessions as required above.

E. Skill Maintenance
1. Must demonstrate competency of the following skills annually through successful completion of practical skill stations:
   a) Oral/Nasal Intubation
   b) Chest Decompression
   c) Intra-osseous Infusion
   d) Needle Cricothyroidotomy

F. Service Affiliation
1. To maintain medical control, an individual must maintain active service affiliation with sponsored service. Upon notification from the service or individual that this affiliation has been terminated, medical control will be suspended or withdrawn.

G. Documentation of Continuing Educational Hours
1. It shall be the responsibility of each sponsored paramedic to maintain documentation of continuing education attendance.
2. For the purposes of medical control, each individual needs to maintain his/her own continuing education records for a period of three years. *This may be different than the state requirement for licensure.*

H. National Registry Recertification
1. It is the responsibility of each individual to complete the National Registry Recertification form and present it to the EMS Coordinator for Medical Director signature.
2. Required documentation shall be attached, particularly for skills review.

Effective: August 1993
Revised: 12/94; 12/95; 1/97; 1/98; 11/02, 1/03, 10/04, 1/06, 2/08, 1/13, 8/13