# 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 yearly by February 28th we must inform your medical director that your agency is not compliant.

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

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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

Controlled Substance Agency: ☐ Yes ☐ No License #:

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 ☐ Syringe Epinephrine

**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)

Have you submitted DOH-5136? ☐ Yes ☐ No

# Finger Lakes Regional EMS Council, Inc.

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### Agency Officers for Year: 2021

**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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# Finger Lakes Regional EMS Council, Inc.

## Prehospital Care Agency Information Form

**Personnel Roster for Year:** 2021

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