Casa Grande Regional Medical Center

ALS Base Hospital

Initial Application
Administrative Medical Direction

Name: _____ Cert Level _____ Cert # _____

Address: _____ City: _____, AZ Zip: _____

Home # _____ Cell # _____Other_____

Email: _____DOB: _____

Expir. Dates: ADHS _____ CPR _____ ACLS _____ Nat. Registry: _____

Name of Primary Employer for purposes of administrative medical direction:

_____

List other current EMS employers: _____

Previous Base Hospital: _____ Dates: _____

ALS: Training Program: _____ Dates: _____

BLS: Training Program: _____ Dates: _____

I certify that the information provided above is true to the best of my knowledge that

1. I am in good standing as a certified provider in the State of Arizona.
2. I will review and agree to abide by the Policy and Procedures of this Base Hospital.
3. I will maintain current status in CPR, and if applicable, ACLS, and understand that if either certification lapses, I may not function as a certified provider of this base hospital.
4. I understand that I am only covered by the Administrative Medical Directions (as well as on-line and off-line medical direction) of this Base Hospital when employed by one of the Administrative Base Hospital Agencies. I understand that I may only be assigned to one Administrative Base Hospital at a time.
5. I agree that I will function within my scope of practice at all times, as defined by the Arizona Revised Statutes and Administrative Code, and the administrative medical direction of this Base Hospital.
6. I understand that meeting the certification requirements of my certification level is my sole responsibility.

Signature: _____ Date: _____

Witnessed by (Name) _____Position:_____

Casa Grande Regional Medical Center

ALS Base Hospital

Renewal Application
Administrative Medical Direction

Name: _____ Cert Level _____ Cert # _____

Address: _____ City: _____, AZ Zip: _____

Home # _____ Cell # _____ Other _____

Email: _____DOB: _____

Expir. Dates: ADHS _____ CPR _____ ACLS _____ Nat. Registry _____

Circle Administrative Base Employer (primary) and **Check** all other current employers (part-time):

[ ] Ak Chin Fire Dept	[ ] Arizona City Fire Dept	[ ] Casa Grande Fire Dept
[ ] Eloy Fire Dept	[ ] Gila River EMS	[ ] Gila River Casinos
[ ] Southwest Ambulance	[ ] Kett Engineering	[ ] Regional Fire Dept
[ ] Coolidge Fire Dept	[ ] Silverbell Fire Dept	

List other current EMS employers: _____

I certify that the information provided above is true to the best of my knowledge that

1. I am in good standing as a certified provider in the State of Arizona.
2. I have reviewed the Base Hospital Policy and Procedures and agree to abide by the Policy and Procedures of this Base Hospital.
3. I will maintain current status in CPR, and if applicable, ACLS, and understand that if either certification lapses, I may not function as a certified provider of this base hospital.
4. I understand that I am only covered by the Administrative Medical Directions (as well as on-line and off-line medical direction) of this Base Hospital when employed by one of the Administrative Base Hospital Agencies listed above. I understand that I may only be assigned to one Administrative Base Hospital at a time.
5. I agree that I will function within my scope of practice at all times, as defined by the Arizona Revised Statutes and Administrative Code, and the administrative medical direction of this Base Hospital.
6. I understand that meeting the certification requirements of my certification level is my sole responsibility.

Signature: _____ Date: _____

Witnessed by (Name) _____ Position: _____