

**Stamford Hospital Sponsor Hospital Program**

**Application for ALS Authorization**

Date \_\_\_\_\_

Name \_\_\_\_\_

ID No. \_\_\_\_\_  
(Company Emp #)

Address \_\_\_\_\_

City, ST \_\_\_\_\_

Zip \_\_\_\_\_

Phone #1 \_\_\_\_\_

Phone #2 \_\_\_\_\_

E-Mail \_\_\_\_\_

ALS Level Requested:  AEMT

Paramedic

Agency Affiliation:  Stamford EMS

Access Ambulance

Will Stamford be your primary medical control authorization?  YES  NO

*If your status is full-time with either sponsored agency, or you are per diem and have no other sponsor hospital affiliation, SSHP must be your primary sponsor hospital.*

**EMS TRAINING**

Please complete for your requested level of authorization.

AEMT  PARAMEDIC

Program \_\_\_\_\_

City, ST \_\_\_\_\_

Date of Completion \_\_\_\_\_

**EMS AFFILIATIONS**

Please provide the following information for ALL current and past EMS agencies and sponsor hospitals where you maintained advanced-level authorization (AEMT/Paramedic) at the level you are requesting.

Dates of Practice	EMS Agency	Position	Status (F/T, P/T, Vol)	Sponsor Hosp

*\*Applicants must provide a letter from the most recent Sponsor Hospital verifying medical control authorization in good standing. SSHP reserves the right to contact any and all previous medical oversight authorities.*

**BACKGROUND**

Have you ever been named a party in a medical malpractice suit?  Yes  No

Have you ever been convicted of any crime (other than a minor traffic violation)?  Yes  No

Have you ever been denied medical control authorization as an ALS provider?  Yes  No

Have you ever had medical control authorization suspended or withdrawn?  Yes  No

Have you ever had your medical control authorization placed on probation?  Yes  No

*If you answered yes to any above, please attach a detailed explanation.*

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**CREDENTIALS** (ATTACH COPIES OF CARDS)

**Connecticut DPH Number** \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_  
 Has the CT Department of Public Health limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?  Yes  No *If Yes, submit a detailed explanation.*

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**BLS-HCP (CPR)**  PROVIDER  INSTRUCTOR  
 Expiration Date: \_\_\_\_\_

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**ACLS**  PROVIDER  INSTRUCTOR  
 Expiration Date: \_\_\_\_\_

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**PALS**  PROVIDER  INSTRUCTOR  
 Expiration Date: \_\_\_\_\_

**Candidate Attestation**

I attest that the provided information is true and accurate to the best of my knowledge. I understand that any incorrect statement or omissions may be the basis for my disqualification for or revocation of medical control authorization. Verification of all information may be required at any time during the application process or once authorization is granted. I further declare that I am willing to commit to attend any continuing medical education as required by the Sponsor Hospital and to undergo any review of skills and personal qualifications as deemed appropriate. I also agree to follow all applicable guidelines, policies, procedures and protocols appropriate for my level of authorization.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Affiliation Verification**

I verify that the candidate named on this form is currently an active employee or member with our organization. The candidate has met all applicable internal, local, state and federal requirements. This individual will be providing EMS care as an employee/member of this agency.

Printed Name of Agency Representative: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

<input type="radio"/> Completed Application	Received: _____
<input type="radio"/> Past Sponsor Hospital Letter	Received: _____
<input type="radio"/> SSHP Guidelines	Issued: _____
<input type="radio"/> Guideline Exam	Date: _____
<input type="radio"/> Pass <input type="radio"/> Fail	
<input type="radio"/> Physician Interview	Date: _____
Probationary Authorization <input type="radio"/> Granted <input type="radio"/> Denied	
Signature: _____	Date: _____