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Have you ever had medical control authorization suspended or withdrawn?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.*		
BLS-HCP (CPR)	☐ PROVIDER	☐ INSTRUCTOR
Expiration Date:		
ACLS	☐ PROVIDER	☐ INSTRUCTOR
Expiration Date:		
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

- o Completed Application — Received: _____
- o Past Sponsor Hospital Letter — Received: _____
- o SSHP Guidelines — Issued: _____
- o Guideline Exam — Date: _____
  - o Pass o Fail
- o Physician Interview — Date: _____

Probationary Authorization o Granted o Denied

Signature: Date: