



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR CHANGE IN EMS SPONSOR HOSPITAL

- 1. Name of EMS Organization:
2. Mailing Address:
Phone: Fax:
3. Contact Person and Title:
4. Contact Person Phone: Email:
5. At what level(s) is your organization currently licensed, certified and/or authorized? (check all that apply)
[] First Responder [] Basic Ambulance [] AEMT [] Paramedic

- 6. What BLS skills is your organization currently authorized to perform? (check all appropriately)
AED (EMR and above) Yes [] No []
Aspirin (EMT and above) Yes [] No []
Continuous Positive Airway Pressure (CPAP) (EMT and above) Yes [] No []
Glucometer (EMT and above) Yes [] No []
Epinephrine Auto injector (EMT and above) Yes [] No []
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and above) Yes [] No []
Twelve Lead ECG Acquisition and Transmission (EMT and above) Yes [] No []

CURRENT EMS Sponsor Hospital Information

Name of Current Sponsor Hospital:
Address:
EMS Medical Director Phone:
E-mail: Fax:
EMS Coordinator: Phone:
E-mail: Fax:

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

SHADED AREA FOR OEMS USE ONLY

OEMS Approval: [] yes [] no Date:
Notice sent to Service and Both Hospitals [] yes [] no Date:
Signature: Date:

PROPOSED EMS Sponsor Hospital Information

Name of Proposed EMS Sponsor Hospital: _____

Address: _____

EMS Medical Director _____ Phone: _____

E-mail: _____ Fax: _____

EMS Coordinator: _____ Phone: _____

E-mail: _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

Title of Proposed Sponsor Hospital's Protocols: _____

Revision Date: _____

Have the Protocols been made available to authorized staff members of your organization?

Yes No

Please attach a copy of the protocols and Sponsor Hospital Quality Assurance Plan for this *New Sponsor Hospital*. Electronic copy is acceptable.

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In the preceding 12 months, what percentage of your patients were transported to your *current* EMS sponsor hospital: _____%

In the preceding 12 months, what percentage of your patients were transported to your *proposed* EMS sponsor hospital: _____%

Where else will your patients be transported:

7. Please attach a separate sheet explaining the reason(s) for changing EMS sponsor hospital.

8. Please attach a separate sheet explaining how patient care will remain at the present standard of care or be improved by the proposed change in sponsor hospital.

