

DEFIBRILLATION PROVIDER SERVICE APPLICATION

INSTRUCTIONS: *Please type or print all information and provide all requested documentation.*

3. Enter, in the box below, name and address of Provider Service receiving approved application.

2. Defibrillation Provider Service

- a. Provider Service Name: _____
 Business Address _____
 City/Town/State/Zip _____
 Phone/Fax Number _____
- b. Program Coordinator for Provider Service. This person will serve as the official liaison between the program Medical Director, Regional Council and The Office of Emergency Medical Services (OEMS).

Name: _____
 Telephone # () _____ - _____ Fax # () _____ - _____ E-mail _____

- c. Delivery of service: indicate number and type of response unit (s) that will carry defibrillation equipment (ambulance, rescue vehicle, etc.): _____

3. Memorandum of Agreement/Policy and Procedures The Service listed above has put in effect a memorandum of agreement and/or Policy and Procedures document with the following Medical Control System .

- a. Name of **Hospital**: _____
 Contact Person: _____
 Telephone # () _____ - _____ Fax # () _____ - _____ E-mail _____
 Street Address _____
 City/Town/State/Zip _____

- b. Name of **Medical Director** (M.D.): _____
 Telephone # () _____ - _____ Fax # () _____ - _____ E-mail _____
 Street Address _____
 City/Town/State/Zip _____

- c. If applicant is an **Ambulance Service**, and licensed at Basic Life Support (BLS) or Intermediate (ALS) level, a Policy and Procedures document for utilization of Paramedic (ALS) Service as outlined in 105 Code of Massachusetts Regulations (CMR) 170.235 (E) (5), is current and on file; Yes No
- d. If the Service is **First Responder only**, a Memorandum of Agreement with transporting ambulance service as outlined in 105 Code of Massachusetts Regulations (CMR) 171.225 (B) (5), is current and on file; Yes No

Name of **Patient Transport** Service Provider: _____

Telephone # () _____ - _____ Fax # () _____ - _____ E-mail _____

Street Address _____

City/Town/State/Zip _____

4. Type of Defibrillator to be used

Manufacturer	Model Name	Model Number
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5. I (Provider Service Director) hereby attest that the program will be conducted in conformance with the standards as set forth in 105 CMR 170.235 (E) / 171.225 (B).

Print name: _____ Signature: _____ Date: _____

Phone _____ e-mail _____ fax _____

(Region use only)

6. The Regional Council recommends Defibrillation program approval, does not recommend program.

Region I Region II Region III Region IV Region V

Reviewed by: _____
Date Print Name / Title Authorized Signature

(OEMS USE ONLY)

7. Meets the requirements for Provider Service Defibrillation program:
 The Program does not meet requirements for approval (*explanation attached*).

Date Print Name / Title Authorized Signature

OEMS APPROVAL NUMBER