



Application for Participation in an Optional/Pilot Program

Name of Local Program: \_\_\_\_\_ Date: \_\_\_\_\_

Desired Optional Program: \_\_\_\_\_

Method of Quality Assurance Review (please use separate sheet as needed): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Individual responsible for Quality Assurance Review:

Name \_\_\_\_\_ Telephone: \_\_\_\_\_

Print Name

Name \_\_\_\_\_ Address \_\_\_\_\_

Signature

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

Manner in which Jurisdictional Medical Director will be involved in Quality Assurance review: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Individual responsible for forwarding Optional Program Occurrences to the Regional Medical Director and State EMS Medical Director:

Name \_\_\_\_\_ Telephone: \_\_\_\_\_

Approval of Optional Program Participation and Proposed Quality Assurance Review Process:

\_\_\_\_\_  
Print Name  
EMS Operational Program Medical Director

\_\_\_\_\_  
State EMS Medical Director

\_\_\_\_\_  
Signature  
EMS Operational Program Medical Director