

CASAC Meeting

Minutes – March 19th, 2026



Meeting called to order by Chairman Rosenberg

Approval of minutes – the minutes from the January meeting were sent out by SOCALR.

Are there any additions or corrections to the minutes? None

Motion was approved by Matt Larrabee and seconded by Tyler Stroh.

No objections to the motion – minutes approved.

State Medical Director's Report – Dr. Chizmar

Protocol Updates – Dr. Chizmar

Dr. Chizmar reported that SEMSAC and the EMS Board approved the updates to the protocols for 2026, which will go live July 1st, 2026.

The goal is to have the spiral bound books and the online education ready to go on or about May 1st, or that first week of May.

We do have a variety of updates this year. There are no new devices and no new medications. Dr. Chizmar shared a few highlights.

There will be a second indication for ketamine. Actually, not really a second indication, probably the fourth indication overall. Fourth indication for ketamine, which is the use in seizures for patients who receive the maximum dose of midazolam and still continue to seize. Not a new drug, but adding it to the ALS formulary for patients in status that continue to seize. We do not have a ton of patients, but about 140 to 150 patients statewide who have continued to seize after receiving the max dose of midazolam. This grew out of a couple of different things, evidence from other states, as well as the proposal to add Kepra to all ALS units. That sounds lovely until you have to go through the process of purchasing Kepra for use of 150 times per year in a system that runs over a million calls a year. That's a purchase for a very limited population. That was entertained by the PRC. We choose to go with ketamine and because we already have it, and it's effective.

Labetalol was added last year for pregnancy. We will be expanding its use this year for stroke patients with markedly elevated blood pressure, systolic greater than 220, diastolic greater than 120. We will also be adding it, with consult, for patients with suspected aortic dissection, realizing that it's really hard to pick out patients with aortic dissection with any degree of accuracy. But it will be in there for now under chest pain, with selected circumstances. There will be consult required when suspected dissection, as well as stroke, in addition to the things that is was already in there for hypertensive disorders and pregnancy.

The refusal checklist has been restructured. I realize this is maybe not as much of an issue for you, but it's been restructured slightly to take the focus off of drugs and alcohol and look more holistically of whether the person have the mental capacity to make a medical decision. We have cleaned that up and it's a little clearer.

Probably less relevant, but worth mentioning with regard to trauma, we have restructured the trauma protocol to focus on exsanguinating hemorrhage first, followed by airway, breathing, and circulation. We also made the provisions for deescalating from a tourniquet, particularly a tourniquet that was hastily applied or for prolonged transport times. We have seen a lot of good with Stop the Bleed. We have seen a lot of good with layperson-initiated tourniquets or police-initiated tourniquets. We all know that there are some tourniquets that are applied when maybe a pressure dressing could do an adequate job. ATLS embraced this, as well, in their latest revisions. This is actually just following off ATLS. Having a paramedic re-evaluate the need for a tourniquet. If it can be replaced by a pressure dressing, that would be great. It will sort of spell out a procedure though if the bleeding continues and to put the tourniquet back on.

Another big pediatric update is the Pedi Tree, which is in the back of the book as a research protocol currently. We will be moving it to the front of the book in the general patient care section. It will give a lot more guidance on who might benefit from a hospital that has pediatric capability versus one that maybe does not. This will be particularly relevant for places that are a little more rural with medical patients, not just trauma patients. I know that Cindy is in the process of doing hospital surveys and that she will probably share more on the hospital surveys that she and Dr. Anderson have been doing on the Pedi Tree. There are a couple of different designations of different levels of hospitals that go into that.

Dr. Chizmar wanted to shift gears. Asked if any questions on the protocols before he changing directions. No questions were asked.

DEA & CDS Updates – Dr. Chizmar

Dr. Chizmar advised that Claire, himself, and a couple of others have had some meeting with our state Control Dangerous Substance (CDS) Office. For those of you that have been following along, the federal government passed changes into the law in 2017. They did not promulgate regulations or put any rules into effect until last month. Nine years to make the change. One of the major substantive changes with this is that the DEA and hence the state level CDS office will be shifting from licensing individual medical directors to licensing services, EMS agencies, or EMS services. So, what this will look like on the 9-1-1 side is that they will be licensing jurisdictional EMS operational programs like Anne Arundel County, Howard County, and so forth.

With the commercial services, this will be the individual service that does business within the state. These are not my rules. The DEA has expressed that they believe that every EMS agency that does business within a state should have a DEA license specific to that state.

So, for those of you that only do business in Maryland, it should be pretty easy, right? You will have a DEA license and a Maryland CDS license. They will not give you a DEA license until you first have a state license. In order for you to get the new style DEA license, the Office of Controlled Substances Administration will have to change first. For those of you that do business in multiple states, it is our understanding that they will require a DEA license in every state that you regularly do business in. So, if you do business in Maryland, Delaware, and Pennsylvania, you will have three DEA licenses.

The upshot of this is that Maryland OCSA, right now, only has the ability to license services with a physical address in Maryland. They are having to change their processes and figure this out so you can meet the DEA requirement. This is all shifting pretty quickly here. DEA said the rule went into effective about a month ago, maybe around February 9th. Obviously, no one can make things move that fast. So technically, the rule is in effect. We have been working with OCSA to talk about how we gradually transition EMS agencies from having their medical director's license to having an EMS service license. I think this has some benefits, one of which is when you change medical directors the license won't change.

There is a little bit of extra paperwork, but it's fair. They are going to ask you where your core office is located and then ask you to list any satellite locations where you regularly have ambulances. They call them station houses; I think that is what it says in their rules. So, we are going to be working with you to make sure this is transitioned over. I believe as part of our inspection process that people are generally going to meet the DEA storage requirements in terms of substantially constructed safes, cabinets, and so forth. But for those of you that have just been storing meds in a bag that is not locked, this might be a little bit of a culture shock for you. On that note, the DEA has also said that you can store meds in bags, but when the meds are left unattended, then they have to be locked up, which makes sense. You can't just leave the med bag out on the kitchen counter and expect that the drugs are not going to wander.

There is a lot to this DEA rule. The other piece that Claire and I have been looking at very carefully is that they embedded within this rule is that when controlled dangerous substances are administered, there needs to be two things, which are already built into eMeds and many of your PCRs already, and that is there needs to be an authorization. So, whether that's a protocol or online medical direction, or some other standing order, there needs to be an authorizing physician. They are actually asking for the initials of the online physician or the last name of the online physician to be noted on the patient care report. These are not MIEMSS rules, these are what the DEA is saying. I am just giving you all of this information so that you can be DEA complaint.

What we are doing with eMeds, what I am asking Jason to do with eMeds, is if somebody writes down that they administer a controlled dangerous substance, like fentanyl, then the fields in eMeds will automatically validate. They will turn red and you have to put in something in those fields. You have to put in the protocol and then you will have to put the authorizing physician in. Claire did an in-depth legal analysis and if it is a protocol

med, my name doesn't go in there. It's consistently the name of the service medical director and there's a whole bunch of legal reasons why that should be the case.

There is a fair amount of this kind of stuff that took me by surprise. I don't know if anybody else was an insider and knew that after nine years that we were going to have to launch these rules, so we are playing a little bit of catch-up. We are trying to make sure that we move the state CDS licensing agency along with it so we can all be complaint. If there is anyone high level that has no idea what I am talking about, the DEA has put this out. If you want to read all the questions, answers, and so forth, it is online. I encourage you to take a look at that and the DEA rule. This will be an issue that Scott and everyone will work on together.

A question was asked if there is a ballpark of a timeframe for actually operationalizing these changes. Dr. Chizmar advised that in order for you to go under the DEA process you will need to have the state license first. His understanding from our state partners is that they have contracted with a web developer to change their application and their processes online. Our hope is by the end of this calendar year. I think our hope is sooner than that, but plan on the end of the year.

Will questioned "How is the state addressing the provision that says you can only give a controlled dangerous substance in the state in which you are licensed with the DEA? So, in other words, if you take a patient from here to Delaware, but you don't do business in Delaware, so you don't have a license there. But you cross over the Delaware line and you want to give them a narcotic.

Dr. Chizmar advised this is a really gray zone here and nobody in this room holds you accountable for those regulations. One role here is an advisory one. So, if you go and give fentanyl in Delaware and you aren't authorized to do that and nobody catches you on it, I guess you have no problem, but we not the ones that control who is authorized to do business in the individual states. Our regulatory authority stops at the state board.

Will stated that it doesn't. If you pick up a patient in Maryland and drop off at a rehab across the line or at another trauma center and you are using your Maryland protocols. You give fentanyl, say it is a traumatic femur fracture, and you give fentanyl in accordance to the protocols, technically the DEA can say you cannot do it now. If you read it and their new rule. So how is the state, Dr. Delbridge, addressing this with the feds?

Dr. Chizmar advised that we don't have any mechanism in place or desire to police that. Will advised that these rules have been created, but now you are accountable to more than just MIEMSS, you are accountable to the DEA because you are going to be a DEA registered agency. There was discussion about how this was written and being licensed or not licensed when you are out of the state. Dr. Chizmar advised he would not have written the rule this way. He would have written the rule to say that essentially that where the home base of operations is, is where you get the DEA.

Will advised this rule has ramifications. If a provider chooses not to give something, say it is a seizure medication. It is controlled. Because they are outside the state of which they are licensed in, it is falling back on the Maryland protocols and Maryland Medical Direction, so you can't say it out of our hands or it's not our roles. It affects the patient care of a patient picked up in the State of Maryland. Dr. Chizmar agreed. Absolutely, hands down. There was more discussion back and forth about a provider making choices based on following Maryland protocols vs protecting themselves from the DEA.

Dr. Chizmar advised if the service is doing a lot of business in the other state, the service should obtain a DEA in that state. Will pointed out that the service would need a fixed building address in that state to obtain the DEA registration. Dr. Chizmar advised that's why we are having conversations to actually change that. Dr. Chizmar advised he has a DEA license in West Virginia and he doesn't have a fixed address. So, the DEA is not the problem with the fixed address, it's at the state level process.

So, Will advised he would ask the question a little differently. How is MIEMSS working with the adjoining states that all of these services or many of these services are going to be affected by? Dr. Chizmar advised he doesn't have all the answers on this. This was brought up at the national meetings and there are national organizations writing letter to the DEA that they can't write up something like this and expect to enforce it a month later. It's just impractical. Dr. Chizmar advised he is just sharing information and reporting what he knows.

Several people were talking and Will said that Claire just made a statement that is concerning. She said that the services should be licensed in states that they provide patient care. However, if you pick up a patient in Harford County and that patient is going to the State of New York. Claire spoke up and advised that she is not saying you need to be licensed in every state, but you need to be licensed in states where you are regularly doing business. Will stated that the DEA has created a regulation whereby they could put Maryland providers in a difficult lose-to-lose scenario, especially in the counties surrounding the DC area. These units go back and forth.

Dr. Chizmar advised that some of the CDS offices are giving feedback to the DEA. Dr. Chizmar said he doesn't think a Montgomery County ambulance going into the district to drop off a patient at Washington Hospital Center has to be licensed in the district to give fentanyl, just because they happen to be on Michigan Avenue. Will said the way the regulations are written, they do. Again, Dr. Chizmar advised that is why we are all providing feedback.

Mike Moretti spoke up advising Keystone and Lifestar are both multistate and based up in Pennsylvania. They have had two DEA presentations. They have people that are assigned to EMS and they do presentations to groups. They gave us two presentations to the leadership in Pennsylvania. It is our understanding that the rule is based on where your narcotics are being stored, not where they are physically being given. That is what the DEA wants. So, if you have narcotics being stored in multi-states, because that is where you operation and you have office in them, that is fine. It's not physically where

the narcotic is being given. It's where it is stored. I would suggest that you reach out to the DEA and find out who the regional rep is. That is the EMS subject matter expert in this ruling and maybe they can give a presentation to us.

Will spoke up and stated Mike's point is valid, but he thinks the DC rep has the exact opposite interpretation of what the Pennsylvania rep does. Dr Chizmar advised that the DEA does split Maryland into two. There is a Baltimore field office and a Washington field office in DC, essentially covering the entire western half of the state. Mike advised they have the same field rep for both Pennsylvania and Delaware that he is working with and obviously Maryland would be different.

Claire said that Maryland has had the position that we need to be licensed. We have had conversation about that previously with other issues. Will advised there was a flight service who put a comment in the chat that said that it's a nightmare. They go to as far as North Carolina and Connecticut on their flights. Dr. Chizmar said that he would like to back up to what Claire is saying here. He thinks on the physician side, it's been that way. When he has had services in other states, he had an individual DEA license in those states. He currently has one in Maryland, Pennsylvania, and West Virginia. The DEA doesn't view themselves as departing significantly from what they have done when they licensed individual practitioners.

On Mike's point, that was what would make sense to me, but he thinks it's going to be a harder argument from the state and the federal partners to say that you are regularly doing business enough to be licensed as an EMS agency in the State of Maryland. It's a different scenario than you're driving through the district or driving into the district and you're not licensed there, just because you are dropping off. Somebody's going to find that it's a little bit different situation than being a regularly licensed EMS service in another state.

There was discussion between Will and Dr. Chizmar regarding the way the DEA regs are written in some states indicate that you must have a state license first, and these state licensing agencies require you to have a physical practice. Dr. Chizmar advised that is what they are trying to navigate through. This is a process and we have had about a month to try to figure out how to pivot large state agencies. Will advised we all appreciate his help, but he feels it's a lot bigger than most people realize.

Dr. Chizmar advised he had nothing additional to share. Will asked if anyone had questions for Dr. Chizmar.

Jason Moore questioned if we are still proceeding with the Metoprolol replacement with the Diltiazem shortage? Dr. Chizmar advised yes and questioned Scott Legore if we are doing a formal waiver or getting a notice. Scott said we are doing a formal waiver. Dr. Chizmar advised there is no progress in sight in bringing back Advantage Diltiazem, to his knowledge. Many of the agencies, both 9-1-1 and commercial, are cutting over to Metoprolol. That may actually become the new normal if you are not SCT.

Will questioned if anyone else had questions for Dr. Chizmar. No additional questions.

Clinician Services – Aaron Edwards

Aaron Edwards shared that they have about 950 ALS clinicians that still need to recertify. They are having an issue with the online training center and they are aware of it. They are working every day trying to fix it. We are not going to leave anybody behind. We are going to make sure everybody gets through that has done all the training that they needed to do.

Other than that, reciprocity seems to be going well in the last month and a half. We are down to eight days on reciprocity, with seven of those days being the protocol orientation that the clinician has to do.

Will asked if there were any questions for Mr. Edwards. No questions.

SOCALR Report – Scott Legore

Inspection/License/Renewal Update – Marty Johnson

Marty Johnson mentioned that with the renewals, we are now using the portal mainly. We are trying to get everyone to use the portal. We had one glitch with one service, but we haven't been able to duplicate the problem. Other than that incident, it's working perfectly. So please, when you get your renewal stuff, just submit everything through the portal. You can be done in one day if you get everybody's signatures. Scott Legore spoke up and reminded everyone the importance of getting your renewal documentation in sooner than later. We are at March 19th and we have two services renewing in the month of March that have yet to submit all of their paperwork. It's becoming increasingly frustrating to try to ensure that you are renewed in that timeframe before you expire due to your untimeliness.

QA Review/Data Import – Scott Legore

Scott Barquin is not on today. I know he is working with ImageTrend on updating some stuff that may improve how data comes over from TraumaSoft. I don't have an update on where that stands.

Equipment Update – Scott Legore

Scott Legore advised we had a request from one of the services, it was more of a question than a request on 4% Lidocaine. Why is it still on the ALS equipment list if we don't carry nasal intubation equipment anymore. So, speaking with Dr. Chizmar, he is not opposed to removing the 4% Lidocaine from the ALS equipment list. You could still carry it if you would like, but it won't be required anymore. That will go into effect July 1st, 2026 with the new protocols.

Will asked if anyone had additional questions for SOCALR. No questions.

Committee Reports

PEMAC Report – Jill Dannenfelser – Not available

Scott Legore mentioned that at the last PEMAC meeting there was a discussion about changing the requirement for something that would affect the services. Dr. Chizmar said that change was for next year, not in the next couple of months. Dr. Chizmar and Tyler Stroh have been talking about broadening the antimicrobial OSP to include children, to include children ages 1 and up. Tyler said maybe go all the way down to 28 days. We asked PEMAC about this change a couple of times, but it seems like we got a good reception with PEMAC this time. Scott Legore advised that change is going to go to PEMAC and the protocol review committee. We will probably look at this next year around this time.

SEMSAC Report – Danny Platt

Dr. Chizmar already gave an update on the approval from SEMSAC for the protocols. The next meeting is in two weeks, beginning of April.

MIH Report – Deb Ailiff – Not available. No report.

SCT Committee Report – Will Rosenberg

Will Rosenberg advised it was a very productive SCT meeting and it went down to the wire on their allotted time so some things were tabled until May.

The SCT short form is getting some revisions based on a template from John Hopkins Lifeline. MD ExpressCare and some others will be adding their thoughts. Dr. Chizmar will review. We are going to bring it back to the May SCT meeting.

Clarification, dopamine is definitely ALS. Dopamine is getting moved to its own category, hopefully... clerical error.

There was a discussion / push to move vasopressin to an SCT medication rather than a nurse medication.

There were further questions about xylazine and it really has to do with Prestadex moving to SCT for xylazine overdoses.

There is going to be some clarity in the language in regards to Sodium Bicarb because it crosses over between the interfacility and 9-1-1.

Potassium chloride and potassium phosphate... we're going to add the word, or change to read potassium solutions. Potassium containing IV solutions less than 20 milli equivalents because phosphate was previously excluded and some people got hung up on it and only said chloride.

There was conversation reference IV pump as it is listed under SCP in the SCT chart, but it's an OSP for ALS 9-1-1 jurisdictions. The plan is to make it an OSP for all services except the SCT services and to take it away from the SCT chart because it is an ALS skill with additional training.

Going to update the language on VADSs, instead of just saying discharge to a residence or a SNP. It's essentially going to say not to a higher level of care for clinical decompensation.

Working on some clarify regarding the baby pod, indicating it is not an isolate. The new isolate language will hopefully read "with electricity". It is really to clarify that they are temperature controlled.

There was some discussion in reference to cardiac sheaths and arterial lines. There will need to be more review on these items. Dr. Chizmar is going to take that subject back to his team.

OB transports got tabled until May. We are inviting some OB experts to the May meeting so we may discuss OB transports in more detail.

SCT staffing configurations was tabled until the May meeting. This may involve a COMAR change and/or a better triage of SCT calls to possibly be able to handled by a nurse and/or critical care paramedic instead of exclusively a nurse.

Old Business – Will Rosenberg – None to report.

New Business – Jimmy Pixton

I just wanted everyone know, and make it official, we are the new owners of Hart to Heart Ambulance Service. Will Rosenberg said "Congratulations". Question to Jimmy was "Is the name changing or is it going to continue to operate under Hart to Heart?". However, Jimmy had already signed off. Scott Legore replied that they are remaining as separate services, or at least under the Hart to Heart name until their license renewal which is October. They may be combining at that point, more to come. Jimmy Pixton signed back into the meeting and indicated he hit the wrong button to mute. Will let him know about the question on their name and if they would be operating as one service or separately. Jimmy advised they will be operating as separate services due to licensing reasons, but the medical control will be under Am-Van. Jimmy advised the name will be around for a while as they will not be re-lettering all the trucks at this time.

Will Rosenberg asked if there was any other new business. He wanted to throw something out for discussion. He is sure MIEMSS will not have the appetite for this change, but he wanted to see how the services feel about this change. He mentioned a lot of surrounding states, and other states around the U.S., have a license for the ambulance. The ambulance is not licensed as ALS or BLS. Similar to how we don't have a license for critical care ambulances or NICU ambulances. We just license the service as a NICU or critical care. Will would like to see if there is any appetite for trying to convince MIEMSS to stop the "this is ALS, this is BLS", and just license the service as ALS or BLS, having the appropriate equipment on the ambulance to provide the care needed. Danny Platt asked "The idea would be what? Everything is licensed as a basic BLS truck and if you have enough ALS equipment, you could operate as an ALS unit, SCT unit, or whatever your service is?" Will advised that a lot of states do it as it allows

interoperability. Most people overstock their ALS units. They don't have to worry about upgrading, downgrading, and everything else. Sometimes you put a BLS crew on an ALS truck, which creates COMAR challenges, with the theory they have an AED. A lot of states, actually greater than 30, allow you to license just the service. Maryland is one of the minorities in the U.S. that license by the level of the service.

Will mentioned that we used to license NICU truck, but we got away from that. Instead of saying it's NICU, as long as you have NICU equipment, you could transport as NICU. So, Will just wanted to throw the idea out there. If everyone thinks it is a dumb idea, we can move on from it. Will said he was curious what his colleagues' thoughts were on this idea. Danny Platt agreed with Will that it is not a dumb idea. Will mentioned that several states that he operates in do it that way and Maryland is one of two states that doesn't. The other state is changing their regulations this year to go by licensing the ambulances to licensing the service. It becomes a fiscal responsibility at some point as you are overstocking and over staffing the ambulances to make sure you have plenty of ALS. The surveys track in the comments that there were at least three or four positive responses to that idea.

Scott Legore advised from our side of the house we would need to talk to Will more about how we would incorporate the inspections. If we are just licensing the service, how do we ensure that all the equipment that you are carrying on the unit is being inspected. Some services have spare ALS equipment that isn't on the trucks at the time of the inspection and we don't set eyes on it. But that equipment could make its way onto the truck during the year, but we feel that we should inspect call of the equipment that is carried on the trucks. We would have to work out a different inspection process to ensure that the ALS equipment, whether it's two set for one service or 15 sets for one service, that it is all inspected. We would need to work that out and then it doesn't matter basically what truck you are carrying it on.

Will said that we talk about SCT for a second. He could have four SCT bags or he could have one. Either way will get him the same license. If he decides that he wants nine SCT bags, he could run nine SCT trucks. Other than in March of every year, whether he has 1, 9, or 15 bags is completely irrelevant from an SCT license in the regulations right now. Correct? Scott Legore agreed.

Will went on to say it's unlikely that someone is going to do that. NICU is the same way. Whether he runs six trucks as NICU today or one truck as NICU today, the only real provision is whether we have an isolate or not. And the clinician staff in it, right? Will continued on that ALS is largely driven by cardiac monitors. If you have enough cardiac monitors, you should be able to have whatever other equipment you need to staff an ALS truck and the medications. Scott said the cardiac monitors are the expensive part. Will continued that the cardiac monitors are definitely the thing at this point that makes it ALS. Will said he could only speak for his service, but they use to have 32 ALS trucks last year. They went down to 29 due to the monitors. They may run 18, 19, or 20 in a day, so they have 10 or 11 monitors to spare. Why? Because they don't want to constantly be sending memos to upgrade and downgrade units every time, they do it. So,

it's a convenience factor. Not that we couldn't upgrade one for 30 days and downgrade one, but that's an administrative headache. It's an absolute disaster, we have chosen to overstock.

In other states they know what the ALS trucks need, so they have a certain amount of ALS monitors and bags. When a truck goes in for PM, they just grab their ALS bag, their ALS monitor, and move onto the next ambulance. It is a fiscally responsible way to do business. There are some things we can't control, but this is one of the ones we can control. Will understands this would require a COMAR change, but he would like to at least start the conversation because it is going to bring up a lot more questions and create a lot more conversation. What he is asking is that we look at what other states are doing and bring it back to Maryland.

Danny Platt asked if there is a way that we could do it that if you have said 15 monitors at inspection that you could only run 15 trucks a day at that level, or whatever your peak equipment would be. Will advised it could be done that way and he wouldn't be opposed to that. Will advised he has been doing this over 25 years now and he is not trying to skirt the regulations. He thinks that at some point in time, there needs to be a level of trust, responsibility, and ownership upon a service to do the right thing. Yes, monitors are the driving force behind how many ALS vehicles you have. You could not have more ALS trucks than you have monitors, because that is never going to work.

Scott Legore said that he would be open to further discussions. We would just have to figure out how we could incorporate it. It would require a regulation change and how we would change the inspection process. We are already having discussions about some other topics. Will said he thought was to try to get this in for the 2027 licensing cycle. Obviously 2026 we'd run the whole thing as it is currently, knowing it would need a COMAR change. Will advised he just wanted to throw it out there for thought and maybe we can bring it back in our Old Business in May and let SOCALR and the powers of MIEMSS take it back to their leadership team and think about it. Will feels it allows for flexibility and as the world changes, we will need to adapt with it.

Will Rosenberg asked if there was any other New Business. No response.

For the Good of the Committee –

Scott Legore – Today is the 56th anniversary of MSP Aviation's first civilian scene MedEvac in Maryland. They flew their first mission 56 years ago on a Bell Jet Ranger.

Scott Legore – Pulse doesn't have any representatives on here today, but he wanted to share an email with the group as they had an ambulance fire earlier this year. They found out information after the fact. The manufacturer for this particular unit had overheating problems with the four yellow marker lights on top of the cab. Apparently, these remain on whenever the master switch is on and for a time period afterwards. Whatever circuitry they have is becoming hot to the touch, even with LEDs their mechanic is sufficiently concerned. They are in the process of removing all the light balances and replacing them

with rubber gaskets. Scott is sharing this information. Will questioned if it was a relatively new truck. Scott advised he thinks it was a 2024 truck. It wasn't an old truck that caught fire. Scott said he would get more information from ach and pass along what manufacturer was involved.

Will Rosenberg asked if there was anything else for The Good of the Committee. No response.

Adjournment

Meeting adjourned

Attendance:

In Person: Will Rosenberg, Scott Legore, Dr. Tim Chizmar, Aaron Edwards, Marty Johnson, Sarah Pysell, Tyler Stroh, Claire Pierson, Seth Torbit, and Mustafa Sidik.

Virtual: Donna Geisel, Jim Pixton, Jason Moore, Kenny Barajas, Mike Moretti, Teddy Baldwin, Abby Butler, Chad Bowman, Danielle Telesford, Frank Waller, Jeff Kreimer, Joel Atwell, John Damiani, Justin Webster, Kate Passow, Lara Snyder, Leigha McGuin, Mike Herndon, Mary Bell, Matt Larrabee, Matthew Kravetsky, Owen Siford, Steven Rawheiser, and Todd Abramovitz.

Callers: #01 – Brian Fletcher
#02 – Jimmy Harsh
#03 – Danny Platt
#04 – Will Stinson