



ADIRONDACK-APPALACHIAN REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL

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APPLICATION FOR CREDENTIALLING AS A MEDICAL CONTROL PHYSICIAN

NAME _____

HOSPITAL AFFILIATION _____

[If currently credentialed in another Region, please note ID number here _____]

I hereby apply for identification as a medical control physician in the Adirondack-Appalachian Emergency Medical Services region.

I have completed the orientation training as required by the AAREMS REMAC, including the written exam provided. I will provide medical control services as outlined, and as per the AAREMS ALS protocols and New York State BLS protocols.

Signature

Date

ED Director Signature

#

AAREMS Office Use Only	
Date Received	_____
ID Number Issued	_____