REQUEST FOR APPROVAL

Check One: ☐ **Local Optional Scope of Practice** ☐ **Trial Study**

EMS Medical Director:_____ **Date:**_____

Local EMS Agency:_____

Proposed Procedure or Medication:_____

Please provide the following information. For information provided, check "yes" and describe. For information not provided, check "no" and state the reason it is not provided.

Yes	No	
☐	☐	**1. Description of the procedure or medication requested:**_____
☐	☐	**2. Description of the medical conditions for which the procedure/medication will be utilized:**_____
☐	☐	**3. Alternatives (Please describe any alternate therapy[ies] considered for the same conditions and any advantages and disadvantages):** _____
☐	☐	**4. An estimate of frequency of utilization:**_____
☐	☐	**5. Other factors or exceptional circumstances:** _____

Please attach the following documents. Check "yes" for each document attached; for documents not attached, check "no" and state the reason it is not attached.

Yes	No	
☐	☐	**6. Any supporting data, including relevant studies and medical literature.**_____
		7. Recommended policies/procedures to be instituted regarding:
☐	☐	**Use** _____
☐	☐	**Medical Control**_____
☐	☐	**Treatment Protocols**_____
☐	☐	**Quality assurance of the procedure or medication**_____
☐	☐	**8. Description of the training and competency testing required to implement the procedure or medication.**
☐	☐	**9. Copy of the local EMS System Evaluation and Quality Improvement Program plan for this request.**