



REQUEST FOR APPROVAL of UNDEFINED SCOPE OF PRACTICE

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

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Description of the procedure or medication requested: |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Description of the medical conditions for which the procedure/medication will be utilized: |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Patient population that will benefit: |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Description of proposed study design including the scope of the study, research question, method of evaluating the effectiveness of the procedures or medications and the expected outcome. |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Alternatives (Please describe any alternate therapy(ies) considered for the same conditions and any advantages and disadvantages. |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Estimated frequency of utilization: |
| _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. 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

 8. Any supporting data, including relevant studies and medical literature:

 9. Recommended policies/procedures to be instituted regarding:

 Use

 Medical Control

 Treatment Protocols

 Quality assurance of the procedure or medication

 10. Description of the training and competency testing required to implement the procedure or medication:

 11. Copy of the local EMS System Evaluation and Quality Improvement Program plan for this request:

 12. Make up of local medical advisory committee, appointed by the medical director, to assist with the evaluation of the trial study:
