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 □

1. Description of the procedure or medication requested:

___________________________________________________________________________________________________________________

□ □

2. Description of the medical conditions for which the procedure/medication will be utilized:

___________________________________________________________________________________________________________________

□ □

3. Patient population that will benefit:

___________________________________________________________________________________________________________________

□ □

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.

___________________________________________________________________________________________________________________

□ □

5. Alternatives (Please describe any alternate therapy(ies) considered for the same conditions and any advantages and disadvantages.

___________________________________________________________________________________________________________________

□ □

6. Estimated frequency of utilization:

___________________________________________________________________________________________________________________

□ □

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:

________________________________________________________