



REQUEST FOR TEMPORARY RECOGNITION OF OUT-OF-STATE MEDICAL PERSONNEL DURING A STATE OF EMERGENCY – (Pre-Existing Patients)

In response to the Governor's Emergency Declaration, subsection three (3), concerning the preparation and response to the COVID-19 outbreak; out-of-state medical personnel must obtain authorization from the Director of the EMS Authority before they may practice in California.

Medical providers with a pre-existing patient(s) who is moving to California may obtain a 30-day waiver to temporarily continue to provide care via telehealth.

Instructions:

1. This form must be filled out in its entirety and submitted to COVID19@emsa.ca.gov.
2. A copy of the healthcare professionals' current license/certification and a government-issued photo identification must be submitted with this form.
3. The healthcare professional must answer all of the questions in the supplemental information section.

Medical Provider's Information:

	Full Name	Healthcare Profession	Certification/ License #:	Issuing State	Expiration Date
1.					
2.					

Supplemental Information required (see page 2)

I attest that I have a pre-existing relationship with a patient that is moving to California and is need of continuation of care.

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Medical Professional's Name – Print

Facility/Agency Name

Telephone

E-mail

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Facility/Agency Address

City

State

Zip

--	--

Signature

Date

EMSA Use Only:

License(s) Confirmation Date: _____ Verifier's Signature: _____

List Approval Date: _____ Approver's Signature: _____

Supplemental Information:

Additional pages may be added to answer these questions. Each answer must be typed and should not exceed ½ a page in length. Please omit patient name(s) and other protected health information to maintain HIPAA compliance.

1. Is the patient(s) you are seeking to provide telehealth services to a pre-existing patient(s) of yours/your practice, who previously received treatment from you/your practice in the state in which you are licensed? **Please explain.**

2. Is the patient(s) relocating or recently relocated to California? **Please explain.**

3. This waiver is only for a 30-Day period. Please provide the date you would like this waiver to start.

4. Has the patient(s) sought to obtain treatment in California and been unable to? **Please explain.**

5. Are you also seeking to obtain permanent licensure in California?

6. Are you seeking to provide telehealth to patients in California who were not affiliated or treated by you/your practice prior to COVID-19?