



REQUEST FOR APPROVAL

COVID-19: Vaccination and/or Testing

Influenza: Vaccination

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. Attach a separate document for each procedure or medication.

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 please 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. _____