REQUEST FOR Local Optional Scope of Practice (LOSOP) REVISION

This document is a template only. It is not required to request a revision to an already approved LOSOP. It is being provided as a courtesy to promote successful submission of a change in LOSOP policy or procedure.

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

Local EMS Agency: _____

Name of Currently Approved LOSOP: _____

Please complete the areas below. Should additional space be needed, pages may be added to this document.

1. Reason (issue/cause) for the amendment:

2. Description of the change(s) being requested (include QA/QI, reporting, if applicable):

3. Impact (patient care, fiscal, etc.) to the EMS system if amendment is not approved:

4. Description of any alternatives, should the amendment not be approved:

State Use Only

Revision Approval Date: _____

Approved by: _____
EMSAAC Optional Scope of Practice Subcommittee (member name)

_____
EMSA (Representative)

Created:2021
Revised:01/12/23