MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

CHANGE OF MEDICAL DIRECTOR

FOR DOH OFFICE USE ONLY DO NOT WRITE IN THIS SPACE

Reviewed by _____

Date _____

☐ AIR AMBULANCE SERVICE
☐ GROUND AMB. SERVICE
☐ EMRA
☐ TRAINING ENTITY

LICENSE OR ACCREDITATION NUMBER ☐☐☐☐☐☐

DATE FORM RECEIVED ☐☐ ☐☐ ☐☐

LICENSEE MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

1. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)*

☐ M.D. ☐ D.O.

MAILING ADDRESS *(STREET, ROUTE, ETC.)*

OFFICE TELEPHONE NUMBER ( )

CITY STATE ZIP CODE

E-MAIL

FAX NUMBER ( )

☐ **BOARD CERTIFICATION** ☐ **ACLS** ☐ **ATLS** ☐ **PALS**

I HEARBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance services medical director (190.103 RSMo Supp. 1998 & 19 CSR 30-40.303) and I agree to serve as medical director.

SIGNATURE OF AMBULANCE SERVICE MEDICAL DIRECTOR

DATE

PLEASE ATTACH COPIES OF DOCUMENTATION OF THE ABOVE CREDENTIALS

2. CONSULTANT MEDICAL DIRECTOR

NAME (LAST, FIRST, MI)

☐ M.D. ☐ D.O.

MAILING ADDRESS (CITY, STATE, ZIP CODE)

OFFICE TELEPHONE NUMBER

☐ **BOARD CERTIFICATION** ☐ **ACLS** ☐ **ATLS** ☐ **PALS** ☐ **LETTER OF AGREEMENT**

I HEARBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance service medical director (190.103 RSMo Supp. 1998 & 19 CSR 30-40.303) and I agree to serve as consultant medical director.

SIGNATURE OF AMBULANCE SERVICE CONSULTANT MEDICAL DIRECTOR

DATE

3. CHECK APPROPRIATE BOX

☐ AIR AMBULANCE SERVICE ☐ EMERGENCY MEDICAL RESPONSE AGENCY

☐ GROUND AMBULANCE SERVICE ☐ TRAINING ENTITY

LICENSE OR ACCREDITATION NUMBER ☐☐☐☐☐☐

NAME OF POLITICAL SUBDIVISION OR CORPORATION

NAME OF CEO

TELEPHONE NUMBER-BUSINESS ( )

BUSINESS ADDRESS *(STREET, ROUTE, ETC.)*

TELEPHONE NUMBER-EMERGENCY ( )

CITY STATE ZIP CODE

E-MAIL

FAX NUMBER ( )

I HEREBY CERTIFY that this form contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named service or entity has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 1998.

I have attached all licensure or accreditation and related administrative licensure actions taken against this service or entity or owner by any state agency in any state.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF SERVICE OR ENTITY **DATE**

WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri statutes 575.060.

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102