Associate Affiliation Affirmation

Member Name:_____ Date: _____

Instructions: This form is to be completed by Associate Provider Members of Highland County Volunteer Rescue Squad (HCVRS) to remain *in compliance with the Bylaws of HCVRS and the VAOEMS Regulations. This form must be completed annually to ensure that Associate Provider Members are currently affiliated in good standing by an additional agency within the CSEMS Region or if specified by the Operational Medical Director (OMD,) Asher Brand, MD*

Affiliation Information

Check One: Career:☐ **Volunteer:**☐ **Region:** ○CSEMS /○TJEMS /_____

Primary Agency Name:_____

Level Authorized to Practice (Circle One): EMR / EMT / AEMT / EMT-Intermediate / Paramedic

Medical Director:_____ **Contact Phone:**_____

Contact Email:_____

Operational Supervisor:_____ **Contact Phone:**_____

Contact Email:_____

Supervisor Verification

Instructions: By signing this form, it verifies that the provider list above is currently practicing as a provider in good standing at the level selected above as of the completion of this document. It is the responsibility of said member to notify HCVRS if the provider's status changes.

Member Making Report (Print):_____ **Date Completed:**_____

Member Making Report (Signature):_____

Supervisor (Print):_____ **Title:**_____

Member Making Report (Signature):_____ **Date Completed:**_____

Do not write below this line

Received By:_____ Date Received:_____ Logged By:_____ Date Logged:_____