****APPLICATION MUST BE COMPLETE, MAILEDTO AND HAVE ARRIVED AT THE PREHOSPITAL CARE DEPARTMENT AT LEAST TWO WEEKS PRIOR TO THE NEXT ORIENTATION DATE IN ORDER FOR THE PROVIDER TO BE CONSIDERED FOR THAT ORIENTATION. ONCE REFERENCES CHECKS ARE COMPLETED ON THE APPLICANT A CALL WILL BE MADE TO THE AGENY EMS COORDINATOR. ****

APPLICATION FOR MEDICAL DIRECTION

Date of Application:_____ Agency:_____

Level of Certification:_____ AZ Certification #_____ Exp. Date:_____

Name:_____

Address:_____

_____

Telephone:_____ E-mail Address:_____

List any previous/concurrent Base Hospital/Central Medical Control Affiliations?

Name	Date(s)
_____	_____
_____	_____
_____	_____

List any previous Administrative Medical Director Affiliations?

Name/Phone #	Date(s)
_____	_____
_____	_____
_____	_____

List Pre Hospital Education (initial training and refreshers) completed within the last 10 years.

Dates	Location	Instructors
_____	_____	_____
_____	_____	_____
_____	_____	_____

List 3 references: Name, affiliation, address & phone number

1. _____
2. _____
3. _____

Are you currently on probation with the Dept. of Health Services?

Yes No

If yes please explain._____

List any disciplinary/probationary action(s) related to a healthcare certification or license within the last 10 years.

Agency	Current Status	Supervisors Name
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that if I leave Flagstaff Medical Center's Pre Hospital Medical Control/Direction while under disciplinary review or action, a meeting must occur with the Pre Hospital Coordinator and Pre Hospital Medical Director or a report will be made to the Department of Health Services Bureau of Emergency Medical Services or your present Medical Director.

I certify that the information furnished in this application and any supporting documents are true and complete to the best of my knowledge and belief. I have not withheld any fact which might adversely affect my application, and I understand that any omission of fact or any false statements will be considered ground for refusal for medical direction, or if approved, immediate dismissal, no matter when discovered.

I agree that all former employers or their designees may furnish Flagstaff Medical Center Pre Hospital Care Department with all information regarding my character and qualifications, including disciplinary action, if any. I give permission to the Pre Hospital Care Department to obtain employment references and conduct background checks necessary to make the decision to approve medical direction and hold person giving such reference and Flagstaff Medical Center harmless and free of any and all liability that could result from the process.

_____ _____

Applicant Signature Date

Application must include a letter of recommendation from the provider's current medical director, copies of agency application or a resume, current certification cards (State, National Registry, CPR, ACLS, PALS, PHTLS/ITLS)