2nd 45-day Public Comment Period

REQUEST FOR APPROVAL of UNDEFINED SCOPE OF PRACTICE

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.

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. ~~Alternatives (Please describe any alternate therapy[ies] considered for the same conditions and any advantages and disadvantages)~~: Patient population that will benefit:** ________________________

☐ ☐ **4. ~~An estimate of frequency of utilization~~: 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. ~~Other factors or exceptional circumstances~~: 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 state the reason it is not attached.

Yes No

☐ ☐ **~~6. Any supporting data, including relevant studies and medical literature.~~**___

☐ ☐ ~~7. Recommended policies/procedures to be instituted regarding:~~

☐ ☐ ~~Use~~ ______________________________

☐ ☐ ~~Medical Control~~ ______________________________

☐ ☐ ~~Treatment Protocols~~ ______________________________

☐ ☐ ~~Quality assurance of the procedure or medication~~ ______________________________

☐ ☐ 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 ______________________________

☐ ☐ ~~8. Description of the training and competency testing required to implement the procedure or medication.~~

____

☐ ☐ ~~9. Copy of the local EMS System Evaluation and Quality Improvement Program plan for this request.~~

____

☐ ☐ 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:

____