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. Patient population that will benefit:**
☐	☐	**4. 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. 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	
☐	☐	**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**
☐	☐	**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:**