



## Level of Care Upgrade Application

Congratulations on your decision to upgrade your level of care. In order to help guide you through the process, the Western Regional Medical Advisory Committee (WREMAC) has put together this informational packet for **transporting** agencies wishing to upgrade their level of care. If you are a first response agency or have any questions, please direct them to the County appropriate office, listed at the bottom of the page.

### Level of Care Upgrade Form

This is the WREMAC form for upgrading level of care. **(Attachment 1)**

### Letter of Intent

This letter is to state your intent to upgrade your level of care and should be addressed to the Chairman of the WREMAC. This letter should include notification of your intent to upgrade your level of care, what equipment you have or will be purchasing, and who will be the Agent of Record for maintaining records for ALS supplies. Also the letter should provide an overview of ongoing quality assurance programs. This should appear on Agency letterhead, and be signed by the Chief officer or CEO **only**. There is a sample letter attached for your convenience. **(Attachment 2)**

### Medical Director Letter of Approval

A letter from your medical director is necessary for you to upgrade your level of care. This letter needs to state that he/she consents to being your Agency's Director at the new level of care and allows your personnel to work under their medical license.

### Medical Director / ALS Agency Agreement

This is the updated agreement between both Medical Director and ALS Agency. The agreement outlines the responsibilities of both parties. **(Attachment 3)**

### Current Roster of Personnel

This roster should include all Agency EMT names, current NYSDOH certification levels, numbers and expiration dates. **(Attachment 4)**

### Agent of Record for ALS Supplies Form

This form indicates the Agent of Record for the agency, and outlines their responsibility. **(Attachment 5)**

### Sample letter of Controlled Substances Waiver (if applicable)

For those Agencies who are upgrading to the level of Critical Care or Paramedic, you need to have your controlled substances paperwork submitted to the NYSDOH. This is a lengthy process. In order to begin operating without controlled substances, your agency needs to submit paperwork for a controlled substance waiver until they receive the approval from the NYSDOH to have narcotics. There is a sample letter attached for your convenience. **(Attachment 6)**

#### WREMAC

Erie & Wyoming:

Chautauqua, Cattaraugus, Allegany:

Genesee, Niagara, Orleans:

Office of Prehospital Care

Southern Tier Emergency Medical System

Lake Plains Community Care Network

(716) 898-3600

(716) 372-0614

(585) 345-6110

## NYSDOH Operating Certificate

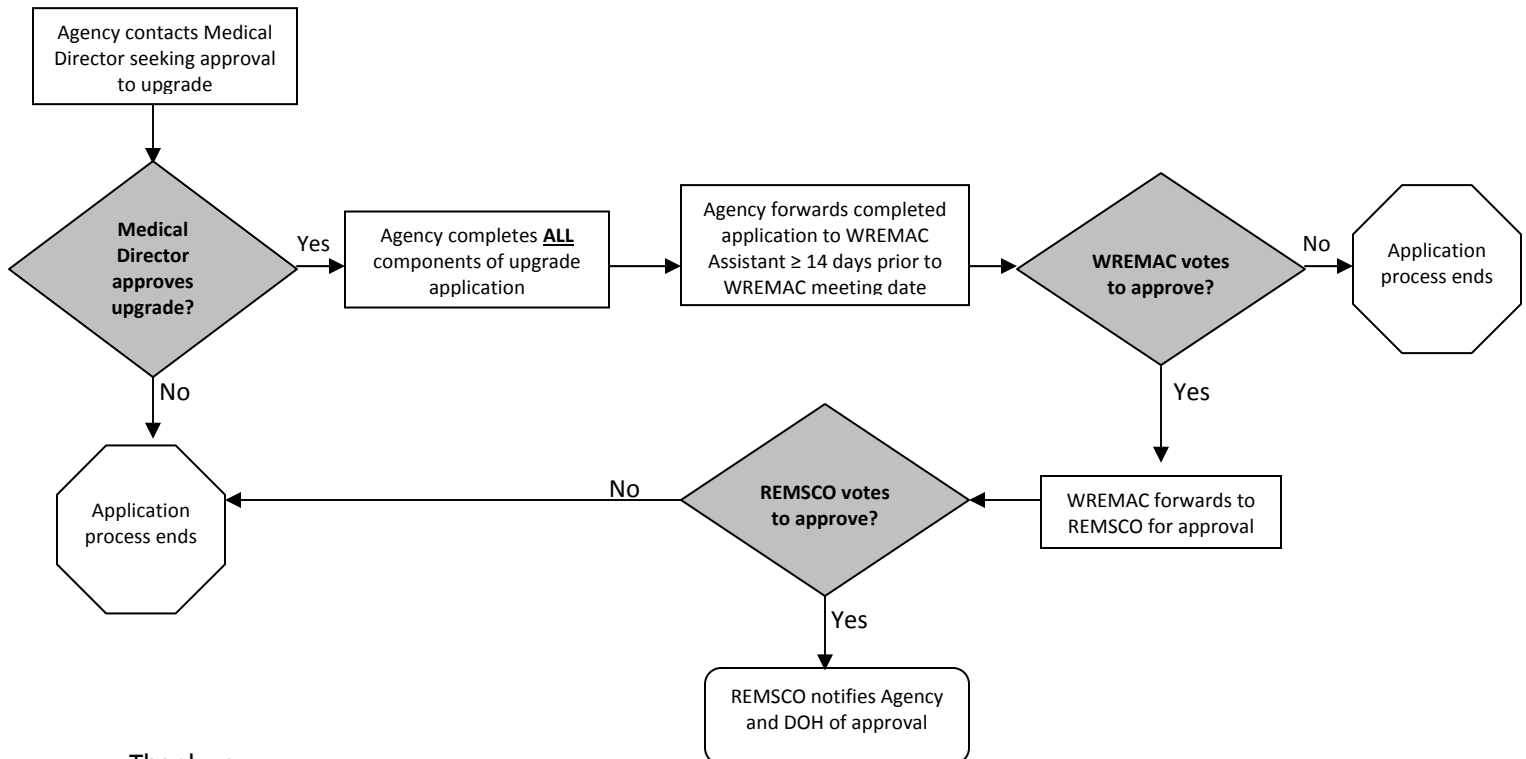
A copy of this certificate is required to process your application.

### Required forms:

	ILS	Critical Care	Paramedic
Level of Care Upgrade Form	x	x	x
Letter of Intent	x	x	x
Medical Director Letter of Approval	x	x	x
Medical Director / ALS Agency Agreement	x	x	x
Current Roster of Personnel	x	x	x
Agent of Record Form	x	x	x
Controlled Substances Waiver		x	x
DOH Operating Certificate (copy)	x	x	x

Upon the completion of the aforementioned items, please mail to the WREMAC at: **P.O. Box 630  
Clarence, NY 14031.**

### Approval Process:



Thank you,

The WREMAC

### WREMAC

Erie & Wyoming:  
Chautauqua, Cattaraugus, Allegany:  
Genesee, Niagara, Orleans:

Office of Prehospital Care  
Southern Tier Emergency Medical System  
Lake Plains Community Care Network

(716) 898-3600  
(716) 372-0614  
(585) 345-6110

# **Attachment**

**1**

**Level of Care Upgrade Form**



WREMAC  
P.O. Box 630  
Clarence, NY 14031  
[www.wremac.com](http://www.wremac.com)

NYS EMS Agency Code: \_\_\_\_\_  
Agency Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Agency Director / Chief Officer: \_\_\_\_\_ Title: \_\_\_\_\_  
Contact Number: \_\_\_\_\_

Agency Current Level of Care  
Upgraded Level of Care

Checklist of **REQUIRED** elements:

- Letter of Intent
- Medical Director's letter of approval
- Current roster of personnel
- NYSDOH Operating Certificate (copy)
- Medical Director/ALS Agency agreement
- Agent of Record Form

Agency Director / Chief Officer Signature: 

--	--

  
Date

Approvals:

REMSCO Chairperson:

Name	Signature	Title	Date

WREMAC Chairperson:

Name	Signature	Title	Date

# **Attachment**

**2**

(Fire Company/Agency Name)

Date

WREMAC Chairperson  
PO Box 630  
Clarence, NY 14031

Dear Chairperson,

It is the intent of (Agency Name) to upgrade our level of care to (Upgraded level of care) in the (Town/Village) of [redacted] in [redacted] County, New York. We currently operate at the (Current level of care) level in our community. Our vehicle(s) are equipped as per New York State Department of Health guidelines and are certified.

In anticipation of upgrading to the above level of care, our agency has purchased or will be adding the following equipment, based on level of care. We will be following the NYSDOH Part 800 equipment list as well as the WREMAC Required ALS Equipment list. The equipment is as follows:

- Cardiac monitors
- Locking storage cabinets for ALS supplies
- Etc.

The (Agency Name) has designated an individual as the Agent of Record to purchase, as well as be responsible for the records and storage of all medications and syringes. These individuals are indicated on the attached form.

Quality Assurance is important to our organization. In this effort, we will participate in the NYSDOH PCR Program by submitting our PCRs to the appropriate Program Agency each month. We will attend the (Name of Medical Director/Hospital) QI meetings each month. Additionally, we agree to participate in QA/QI activities as directed by our Medical Director.

If you require any further information, please feel free to contact me at: [redacted].

Sincerely,

(Name)  
(CEO/Chief)

# **Attachment**

**3**



**Medical Director / ALS Agency Agreement**

This agreement, dated \_\_\_\_\_ by and between \_\_\_\_\_ herein referred to as the **EMS Agency**, and \_\_\_\_\_, Physician, herein referred to as the **Medical Director**.

The purpose is to provide the agency with a Medical Director to enable them to provide advanced and/or intermediate life support to the community it serves.

This relationship may be terminated by written notice served upon the Medical Director at least five business days prior to the effective date of said termination. The Medical Director may suspend or terminate the relationship at will for cause, as defined hereinafter, or upon five business days notice without cause.

**The Medical Director agrees to:**

1. Meet regularly with agency and providers at least once per quarter or as often as necessary.
2. Be Medical Director of record for the agency as required by 10 NYCRR Part 800.5 (a) (1) and will perform all duties associated therewith.
3. Be available to agency officers when needed to advise on EMS issues.

**The Agency Agrees to:**

1. Be responsible for the transmission of all communications from the Medical Director to all Agency providers
2. Take necessary steps to ensure participation by its providers in all programs and courses required by the Medical Director including but not limited to Protocol requirements, Continuing Medical Education and Quality Improvement.
3. Monitor the activities of each provider and keep accurate records, which shall be made available to the Medical Director or designee upon request. An officer shall be appointed to maintain such records.
4. Forward immediately to the Medical Director any and all complaints, notification, summonses, subpoenas, letters and communication of any nature received which in any way bears on the quality of service rendered, is suggestive of any possible lawsuit or legal proceeding or in any way bears on the competence of any agency provider.
5. Abide by and strictly adhere to all standards and protocols and other requirements by the Medical Director and agrees to suspend any ALS medical privileges for any 'provider' for failure to comply with this provision.

**Signed:**

\_\_\_\_\_  
**Medical Director**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agency Chief / CEO**

\_\_\_\_\_  
**Date**



# **Attachment**

**4**



# **Attachment**

**5**

Date: \_\_\_\_\_

Agency: \_\_\_\_\_

To Whom It May Concern:

The above Agency has named the following individual as Agent of Record to purchase and maintain records and stores of medications (including narcotics at the ALS level) and syringes for use for upgrade to the \_\_\_\_\_ level of care. The following Agents must possess certification at or above the Agency's upgraded level.

Name of Primary Agent: \_\_\_\_\_

Name of Alternate Agent: \_\_\_\_\_

Sincerely,

Agency Chief / CEO: \_\_\_\_\_

Signed:

# **Attachment**

**6**

WREMAC Chairperson  
PO Box 630  
Clarence, NY 14031

Dear Chairperson,

Agency Name: \_\_\_\_\_

It is the intention of our Agency to upgrade our level of care from \_\_\_\_\_ to \_\_\_\_\_.

We understand that until we receive a response from the New York State Department of Health Narcotics Division on our Part 80 paperwork, that we are unable to carry and dispense controlled substances.

As such, we understand that to operate at our intended level of care, we are required to follow the WREMAC Benzodiazepine Policy and either carry diazepam/lorazepam or a waiver by which a mutual aid organization will be simultaneously dispatched to all calls of seizures or possible seizures.

Our dispatch center is \_\_\_\_\_. They have been notified that there is required to be an immediate simultaneous dispatch of an additional ALS agency **with** controlled substances to all seizure or possible seizure calls.

Our Agency's service area is the \_\_\_\_\_ of \_\_\_\_\_. Therefore, our initial request for ALS will be from \_\_\_\_\_. Our secondary request for ALS will be from \_\_\_\_\_. (Note: this may be the same agency if they have more than one Paramedic level response unit)

At the time when our paperwork is approved by the NYS DOH Narcotics Division, the anticonvulsant is obtained and is placed in service, we will notify you of such occurrence, and will absolve this waiver agreement.

If you have any questions, please feel free to contact me at any time.

Sincerely,