
MEDICAL CONTROL PRIVILEGES

(Please Print or Type) Date _____

1) Name in full _____

2) Current employer _____ Phone _____

3) Current resident address _____ Phone _____

City _____ State _____ Zip _____

4) Social Security Number _____ / _____ / _____ (optional)

5) EMT Education:

School _____ Level _____ Dates _____

School _____ Level _____ Dates _____

6) Licensure (list past and present licenses from all states):

State	Identification #	Date of Issue	Expiration Date
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7) Have any of the following been either voluntary or involuntary, revoked, suspended, reduced, denied, refused, or not renewed?

a. Privileges in another Medical Control Authority? () No () Yes

If yes, () Past or () Pending Please explain:

b. State License? () No () Yes If yes, () Past or () Pending Please explain:

8) Are you, or have you been subject to disciplinary action by any Medical Control Authority or State Licensing Authority?

() No () Yes If yes, () Past or () Pending Please explain:

9) Have you ever been a participant in a malpractice suit in which your care has been questioned? () No () Yes If yes, () Past or () Pending Please explain:

10) Have you in the past, or within the last 30 days, illegally used a controlled substance? () No () Yes If yes, please explain :

11) Have you ever used alcohol while on the job? () No () Yes If Yes, please explain:

12) Are you able to exercise all Medical Control privileges without any difficulties? () No () Yes If no, please explain:

In making application for Medical Control Privileges:

- A) I fully understand that any mis-statements in or omissions from this application may be cause for denial of privileges or cause for withdrawal of Medical Control.
- B) I verify that I have read the Newaygo County Medical Control Authority Protocols, Policies and Procedures and agree to abide by the terms thereof. Specifically, I recognize the right of representatives of the Newaygo County Medical Control Authority and the inquiries of members of other Medical Control Authorities, and others who may have information bearing on my competence, character, and ethical qualifications.

SIGNATURE

DATE

PRINTED NAME