Request to Enter ALS Provider Orientation Program
Lord Fairfax EMS Council

Provider's Name _____Current Cert #_____
Provider's Address _____
City _____ State _____ Zip _____
Provider's Phone Number: _____ _____
Day **Evening**
Current Agency affiliation _____
Current level of certification:
_____ EMT-E _____ EMT-I _____EMT-P

By submitting a Request for ALS Provider Orientation Program, I agree to:

1. **Attend a Lord Fairfax EMS Council Protocol Review Session. This session will be conducted by an ALS Coordinator. I may attend a Protocol Review Session being conducted as part of a current Lord Fairfax EMS Council ALS certification course.**
2. **Complete the required ALS Provider Orientation Program administered through the Lord Fairfax EMS Council within the approved time frame.**
3. **Abide by all policies, procedures, rules, regulations, and directives established by the Commonwealth of Virginia Office of Emergency Medical Services and the Lord Fairfax EMS Council, Inc.**
4. **Keep my continuing education and skills current as required by the Commonwealth of Virginia Office of Emergency Medical Services and the Lord Fairfax EMS Council, Inc.**

I understand that this application is subject to verification and review by the Lord Fairfax EMS Council, Inc. and its various committees. I also understand that I may not practice at the ALS Level until I have attended a protocol review session and have been approved by the local Operational Medical Director.

Name_____Signature_____
Date_____

Agency Operational Chief's Signature _____ Date _____
Operational Medical Director's Signature _____ Date _____
Protocol Class administered by _____ Date _____

Office Use only
Orientation start date _____ Date released _____
Orientation End Date _____ Notification letters sent _____
ALS Coordinator _____