AUTHORIZATION TO PRACTICE IN THE LORD FAIRFAX EMS COUNCIL REGION

The 2017 Edition of the Pre-Hospital Standard Patient Care Treatment Protocols is to be utilized within the Lord Fairfax EMS Council (LFEMSC) by authorized Basic and Advanced Life Support (BLS and ALS) personnel to provide life-saving treatment.

Authorization to function at the Basic and Advanced Life Support level within the LFEMSC pursuant to these guidelines and standing orders shall not be valid without the endorsement of the Agency Operational Medical Director (OMD).

Authorization to Practice may be withdrawn under such conditions as, but not necessarily limited to, intoxication/substance abuse while on duty, practicing without a valid BLS or ALS certification, failure to comply with LFEMSC BLS and ALS Standards and Regional Protocols or failure to comply with requests/directions of the Agency OMD, LFEMSC Regional OMD, and/or LFEMSC Medical Direction Board.

Any Emergency Department Physician in the LFEMSC Region who feels that there is reasonable cause to immediately, but temporarily withdraw, the Authorization to Practice, may do so according to this policy. In circumstances where it is necessary for an Emergency Department Physician to immediately withdraw the Authorization to Practice, he/she must immediately inform:

1. The BLS or ALS provider's immediate supervisor.
2. The BLS or ALS provider's Jurisdictional EMS Coordinator.
3. The LFEMSC Agency OMD or Chairman of the Medical Direction Board.
4. The Virginia Office of Emergency Medical Services Program Representative.

When an immediate withdrawal of Authorization to Practice occurs, a meeting of the LFEMSC Medical Direction Board shall be called at the earliest possible opportunity to review the circumstances of the case, and shall make recommendations to the LFEMSC Regional OMD for resolution.

****THIS BOX IS TO BE COMPLETED BY THE AGENCY OPERATIONAL MEDICAL DIRECTOR****

This provider is authorized to provide care at the level.

Agency OMD (Print)	Agency OMD (Sign)	Date

THIS IS NOT A CONTRACT

I have attended a pre-hospital standard patient care treatment protocols session and acknowledge receipt of this authorization.

Provider's Name (Print)	Provider's Name (Sign)	Cert. Number
Provider's Email	Agency Affiliation	City/County
Protocol Instructor (Print)	Protocol Instructor (Sign)	Date of Class