Charlotte Hungerford Hospital
Department of EMS

Initial Medical Control Application

Level: [ ] EMT-Paramedic **[ ] Advanced-EMT** **[ ] EMT-B** **[ ] MRT**

Last Name: _____ First: _____ MI: ___

Home Address: _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) ___-____ Work Phone: ( ) ____-_____ Other: ( ) ____-_____

Email: _____@_____ Date of Birth: __/ __/ ____

- [ ] Bantam Fire Company
- [ ] Campion Ambulance Service
- [ ] Colebrook Vol. Fire Department
- [ ] Goshen Vol. Fire Company
- [ ] Harwinton Ambulance Association
- [ ] Harwinton Westside Vol. Fire Company
- [ ] Litchfield Vol. Ambulance
- [ ] New Hartford Vol. Ambulance Association
- [ ] Norfolk Lions Club Ambulance
- [ ] Northfield Volunteer Fire Company
- [ ] Torrington Fire Department
- [ ] West Hartland Vol. Fire Department
- [ ] Winchester Police Department
- [ ] Winsted Area Ambulance Association

Check only one EMS Organization affiliated with Charlotte Hungerford Hospital

Current EMS Affiliations (List below those services with whom you are currently affiliated. Applicant must furnish a letter verifying EMS affiliation from his/her primary CHH Sponsor Hospital EMS Affiliation)

Start Date Month/Year	Name of Service	Position (EMT, EMT-P)	Employment Status (F/T, P/T, Volunteer)	Sponsor Hospital*

* Applicants must provide a letter from each Sponsor Hospital verifying control authorization in good standing
Attach a copy of each with your application

Certification	Number	Level	Expiration
State of Connecticut OEMS		[ ] Advanced-EMT [ ] EMT-Paramedic	
CPR		[ ] Instructor [ ] Provider	
ACLS		[ ] Instructor [ ] Provider	
PALS		[ ] Instructor [ ] Provider	
PHTLS		[ ] Instructor [ ]Provider	

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Prior EMS Experience List below all prior EMS experience. If on the ALS level, also indicate the Sponsor Hospital and /or Medical Control Authorizing Organization. Attach additional sheets as necessary. Paramedics *please attach a copy of your current resume.*

Dates (From - To)	**EMS Service Address**	**Position** (EMT, Paramedic) **Status** (F/T, P/T, Vol.)	**Sponsor Hospital Contact Person**

Background Information

Have you ever been named a party in a medical malpractice suit?	[ ] Yes	[ ] No
Have you ever been denied medical control authorization as an MIC provider?	[ ] Yes	[ ] No
Have you ever had medical control authorization suspended or revoked?	[ ] Yes	[ ] No
Have you ever had your medical control authorization placed on probation?	[ ] Yes	[ ] No
Have you ever had your medical control authorization restricted in any manner?	[ ] Yes	[ ] No
Have you ever had your state DPH OEMS certificate/license suspended/restricted/revoked?	[ ] Yes	[ ] No

If you answered yes to any question above, please attach an explanation of the situation(s) in detail.

Release of Information.
I hereby apply for medical control authorization through the Charlotte Hungerford Hospital Sponsor Hospital Program. I, the undersigned, declare the information provided herein is both accurate and truthful and I understand that any incorrect statement or omissions may be the basis for my disqualification for or revocation of medical control authorization. I hereby grant authority to The Charlotte Hungerford Hospital to conduct an investigation into my past employment, training records and personal background as applicable to medical control authorization. **I will also provide updated copies of all certifications as they become renewed and annually 30 days prior to my affiliation's MIC due date and as requested.** I further declare that I am willing to commit to attend any continuing medical education as required by the Sponsor Hospital and to undergo any review of skills and personal qualifications as deemed appropriate. I also agree to follow all applicable guidelines, policies, procedures and protocols appropriate for my level of authorization.

Applicant Signature: _____ Date: _____

The above applicant has demonstrated competency on all skills and procedures approved by OEMS and the Sponsor Hospital for the EMS Agency, and has demonstrated knowledge on all policies, procedures and protocols.

Signature: _____ Date: _____
Chief / President of Service

Office Use Only

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