Check & Inject NY

Syringe Epinephrine Kit for BLS Providers

AGENCY ENROLLMENT PAGE

Agency Participating: _____
EMS Region: _____
Mailing Address: _____
_____

Agency Type: ALS FR BLS FR BLS Transport ALS Transport

Staffing configuration: Volunteer Volunteer/Career Career

2014 emergency responses (total for EMS): _____

Number of providers expected to be trained: _____

We, the undersigned, hereby attest our Agency will abide by the project guidelines outlined above. We attest that all information provided is true, accurate and complete to the best of our knowledge. We understand that any falsification, omission, or concealment will result in the rejection of our application and/or the removal of our Agency from further participation in the Check & Inject NY pilot program.

By: _____ _____
Print Name: _____ Date
Title: Agency Check & Inject NY Coordinator

By: _____ _____
Print Name: _____ Date
Title: Agency Chief/Director of Operations or Equivalent

By: _____ _____
Print Name: _____ Date
Title: Agency Medical Director

Reviewed and approved by:

By: _____ _____
Name: Jeremy Cushman, MD, MS, EMT-P, FACEP Date
Title: Check & Inject NY Administrator

Please return completed enrollment to checkinjectny@mlrems.org or via US Mail to:
Division of Prehospital Medicine, 601 Elmwood Avenue, Box 655, Rochester, NY 14642