Hudson Valley Regional
Emergency Medical Services Council
45 academy Avenue ~ Cornwall On Hudson, NY 12520
(845) 534-2430 ~ fax: (845) 534-3070
www.hvremsco.org

Medical Control Credential Affirmation Form

License/Certification Type:

❒ Physician ❒ Nurse Practitioner ❒ Physician Assistant

NYS License/Certification # _________________ Expiration Date _____ / _____ / _________

Please Type or Print Legibly

Last Name __________________________________ First Name: ______________________________ M.I. ____

Birth date: _______ / _______ / __________ ❒ Male ❒ Female

Address: ____

City: ___________________________________ State: ______ Zip: _____________ Email: __________________

Primary Phone # _____________________________ Secondary Phone # ____________________________

As required by the Hudson Valley Regional Emergency Medical Advisory Committee (REMAC), I understand that the Medical Control Credentials issued to me by the REMAC are contingent upon my continued affiliation with a REMAC approved Medical Control Hospital. Therefore, I hereby declare that my Medical Control Hospital Affiliation is that listed below. I agree to notify the REMAC in writing of any changes to my Medical Control Hospital affiliation.

Medical Control Hospital: ____

Furthermore, I acknowledge my expertise with the New York State Basic Life Support Adult and Pediatric Treatment Protocols as well as the Hudson Valley REMAC approved triage, treatment and transportation protocols, medical control plan, continuing medical education procedures and quality improvement policies and procedures and will renew this affirmation annually, or upon any revisions, additions, deletions, or changes to such documents, whichever may occur sooner.

I herby certify that all of the information in this application is true and correct and that the signature below is mine as the applicant. I further understand that offering or providing false information on this document may subject any certification to revocation or other action deemed appropriate by the REMAC.

____ ____________________

Signature REMAC Identification Number

The Medical Control Hospital supports the request of the applicant to be credentialed by the Hudson Valley REMAC as a Medical Control Representative (Physician, Physician Assistant, and/or Nurse Practitioner as applicable).
In supporting this application, the Medical Control Hospital acknowledges that it is responsible for all of the provisions indicated in Section 9 of the Hudson Valley REMAC approved Medical Control Plan and will ensure that all Medical Control Representatives meet all of their respective requirements set forth in Sections 10 through Section 15 of this Plan. The Medical Control Hospital acknowledges and accepts the responsibility for providing to this applicant any future updates or revisions to the New York State Basic Life Support Adult and Pediatric Treatment Protocols as well as the Hudson Valley REMAC approved triage, treatment and transportation protocols, medical control plan, continuing medical education procedures and quality improvement policies and procedures as well as providing all related in-service training required by the Hudson Valley REMAC. Should the Medical Control Representative, for any reason, discontinue his or her association with the Medical Control Hospital, the Medical Control Hospital shall notify the REMAC in writing of the discontinuation within ten (10) calendar days.

____ ____

Name of Emergency Department Director REMAC Identification Number

____ ____

Contact Phone # E mail Address

____ ____

Signature Date

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