North Country EMS Program Agency
"Serving Jefferson, Lewis & St. Lawrence Counties"
www.ncemsprogramagency.org

Agency Letter of Intent for Participation in the BLS Naloxone Administration Program

We, the members of _____, hereby request permission to participate in the
(name of agency)
North Country REMAC BLS Naloxone Administration Program.

We agree to abide by the following:

1. All providers will complete the Naloxone Administration Training Material

2. All agency and personnel must follow all policies, procedures and protocols set forth by the Regional Medical Advisory Committee and NY State.

3. Our agency will provide and document annual BLS Naloxone updates with competency skill testing for all active providers.

4. Our agency agrees to participate in the Regional Quality Improvement Program. All calls in which IN Naloxone are administered must be reviewed by the agency CQI representative and Medical Director. A copy of the PCR and screen will be submitted monthly to the Program Agency.

5. If our agency, or one of our personnel disregards these guidelines and/or other applicable protocols, the privilege of providing pre-hospital Naloxone treatment may be revoked or suspended by the Medical Advisory Committee.

6. Any changes to the Required Agency Information will be reported to Program Agency within 30 business days.

The signatures below certify that the above conditions will be maintained and that we will be responsible for all aspects of participation in this Regional program.

_____ _____

Agency Representative *Agency Medical Director*

Required Agency Information (please print)

Agency Name: _____ **Agency Phone Number:** _____

Agency Mailing Address: _____ **City:** _____ **Zip**_____

1. Designated representative responsible for the BLS Naloxone Administration Program:

Name: _____

Daytime #: _____

Email (if applicable): _____

2. Agency Designated Administrator:

Name: _____

Daytime #: _____

Email (if applicable): _____

3. Agency Medical Advisor:

Name: _____

Daytime #: _____

Email (if applicable): _____

4. Agency QI Coordinator:

Name: _____

Daytime #: _____

Email (if applicable): _____

5. We will receive Overdose Prevention Rescue Kits from: _____

_____

_____

6. Naloxone will be stored in the Agency's station in the following manner:

_____

_____

7. Naloxone will be carried and secured on the ambulance(s) in the following manner:

_____

_____

8. The following ALS agencies will be called for intercepts:

_____

_____

Must Be Completed By BLS Non-transporting Agencies ONLY:

9. Primary transporting ambulance service:

Name: _____

North Country Regional Emergency Medical Advisory Committee

"Serving Jefferson, Lewis & St. Lawrence Counties"

www.ncemsprogramagency.org

Medical Director Statement of Agreement

I hereby agree to serve as the Medical Director for:

_____.

(name of agency)

I understand that all patient care will be provided under my license, in accordance with NYS and North Country REMAC regional protocols and training guidelines, except in cases of gross negligence resulting in injury or death. *Upon signing this document, I agree to:*

- Provide and/or assist with annual Naloxone in-services/updates and training
- Annually renew the Naloxone agreement with this agency
- Participate in Q.I., and review all calls in which Naloxone was administered and any other calls as necessary
- Provide medical leadership
- Act as a resource for continuing education
- Remain familiar with regional and NY State BLS protocols

MD signature: _____

MD name printed: _____

Date: _____ MD daytime phone #: _____

MD address: _____

_____