



Westchester Regional Emergency Medical Services Council Life Saving Award – Supporting Documentation

To be completed by Agency. Please type or print legibly.

Agency Name _____

Agency Code _____ *(If applicable)*

Agency Address _____

City _____ State _____ Zip _____ Phone _____

Agency Medical Director Name _____

Agency Medical Director Contact Number () _____

Hospital _____

ED Director / EMS Liaison _____

The following patients were transported to your facility on the dates indicated. Please indicate which patients, based upon your review of the hospital's records, meet the previously described criteria established by the REMSCO for determining a "Lifesaving" intervention by emergency service personnel:

Date of Call	Patient Last Name	Patient DOB		Yes	No

Name of Hospital ED Director / Liaison (Type / Print) Signature of Hospital ED Director / EMS Liaison Date

To be completed by the Regional Office

Received By/ Date _____

Application Complete Yes No