



W e s t c h e s t e r R E M A C  
On-Line Medical Control Physician Application

Please Type or Print Legibly

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

NYS License # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Check one)  MD  DO

Primary Hospital\* \_\_\_\_\_ Hospital ID \_\_\_\_\_  
Other Hospital \_\_\_\_\_ Hospital ID \_\_\_\_\_

(\* Note: Westchester Regional Medical Control or Special Resource Hospital)

The following documentation is attached to this application:

- ▶ Copy of Valid Driver's License or other State issued photo Identification
- ▶ Copy of Valid NYS MD or DO License

*I am employed by the Westchester Regional Medical Control or Special Resource Hospital indicated above and will maintain all training and certifications required by the Westchester Regional Emergency Medical Advisory Committee to provide on-line medical control to pre-hospital providers in the Westchester regional "911" EMS system.*

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**THIS SECTION TO BE COMPLETED BY THE MEDICAL CONTROL OR SPECIAL RESOURCE HOSPITAL**

**As Emergency Department Director (or his or her designee) of \_\_\_\_\_ (a Westchester Regional Medical Control or Special Resource Hospital), I support the application of this physician to become a Medical Control Physician in the Westchester Region as indicated by my signature hereon:**

ED Director or designee (Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_