



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 ____/____/____