



Westchester REMAC Medical Control Physician / Change of Primary Hospital

Please Type or Print Legibly

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

(Check one) MD DO

NYS Licence # _____ Expiration Date ____/____/____

Primary Hospital* _____ Hospital ID _____
 Other Hospital _____ Hospital ID _____

(* Note: Westchester Regional 911 Receiving Facility)

I am employed by the Westchester Regional 911 Receiving Facility 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.

Physician's Signature _____ Date ____/____/____

As Emergency Department Director of the _____ (Westchester Regional 911 Receiving Facility), I support the continued participation of this physician as on-line Medical Control in the Westchester Region as indicated by my signature hereon:

ED Director _____

ED Director's Signature _____ Date ____/____/____

An original copy of this completed form must be sent to:
Westchester REMAC
 4 Dana Rd.
 Valhalla, NY 10595
 ATTN: Physician Credentialing