



Westchester Regional Emergency Medical Advisory Committee BLS Nebulized Albuterol Application

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

Agency Name _____

Agency Code _____

Agency Address _____

City _____ State _____ Zip _____ Email _____

Contact Name _____ **Title** _____

Agency Phone () _____ **Agency Fax** () _____

Medical Director _____

Medical Director Address _____

City _____ State _____ Zip _____ Email _____

MD Phone () _____ **MD Fax** () _____

The following documentation is attached to this application:

- ▶ Signed BLS Nebulized Albuterol Collaborative Agreement
- ▶ Listing of EMTs who have received training to provide BLS Nebulized Albuterol

Number of Vehicles that will carry Albuterol _____

Has a Restocking Plan been developed with the Agency Medical Director? Yes No

The Agency and the Medical Director understand that this program must be conducted in accordance with the protocols and policies established by the Westchester Regional Emergency Medical Advisory Committee and the NYS Department of Health. Any deviation from these protocols and policies must be immediately reported to the Agency Medical Director and the Regional Medical Director and may result in the revocation of approval to participate in this program.

Signature of EMS Agency Executive Officer Date _____
Signature of Agency Medical Director Date

To be completed by the Regional Office

Received By/ Date _____

Application Complete Yes No

REMAC Approval Date _____