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Medical Director's Agreement for Licensure Add-Ons

Name of Medical Director:			(Circle One) M.D. D.O.
Street Address		P.O Box / Suite / Apartment number	
City	State	Zip	Phone Number (Home Work Cell)

*It is recommended that the medical director be Board Certified in emergency medicine or an ACLS provider

The above-mentioned M.D/D.O., being duly licensed within the Commonwealth of Pennsylvania, hereby agrees to accept responsibilities as the Medical Director for:

(Name of Service)

As such, I agree to the following roles and responsibilities:

- Verify that the service and its personnel meet minimum training requirements.
- Oversee all quality assurance requirements.
- Authorize clinicians for the primary use of and review the service's roster of authorized clinicians.
- Identify skill maintenance requirements.
- Q/A review of EVERY case where a drug and/or intervention was or should have been used.

I do hereby acknowledge and accept the roles and responsibilities of the Medical Director for the above-mentioned service and am in support of their application. I have reviewed the attached personnel roster and do hereby authorize those practitioners listed as authorized providers for this service.

Signature of Medical Director

Date