REQUEST FOR PROVIDER AGREEMENT/APPLICATION

Date of Request: _____

Name of Agency: _____

Fire Chief/Manager: _____

Address: _____

City, State, Zip: _____

Phone #_____ Fax #: _____

Agency e-mail Address: _____

Base Hospital: _____

Program Manager/Coordinator: _____

Alternate Phone #: _____

Note: The Nor-Cal EMS Policy and Procedure Manual is available at www.norcalems.org

LEVEL OF SERVICE TO BE PROVIDED

- ❑ AED
- ❑ BLS Transport
- ❑ BLS Ambulance Non-Transport
- ❑ ALS Transport
- ❑ ALS Non-Transport
- ❑ ALS Tactical Weapons
- ❑ ALS Aircraft
- ❑ BLS Aircraft

ALS AND BLS PROVIDER ONLY

Base Hospital Assignment _____
(Hospital name)

The above named hospital has agreed to be the assignment hospital for _____ _____ (provider name). This will be effective upon approval of the provider by Nor-Cal EMS, and at such time, a copy of the Provider Approval/Agreement is on file with this hospital.

_____ Base Hospital Medical Director Signature

_____ Base Hospital Administrator Signature

Please fax email or mail this to:

Nor-Cal EMS
1890 Park Marina Drive, Suite 200
Redding, California 96001
530-229-3979 / Fax 530-229-3984
mail@norcalems.org

NOR-CAL EMS USE ONLY

Date Request Received: _____

Date Agreement Mailed: _____

Date Agreement Returned: _____