REGION I EMERGENCY MEDICAL SERVICES

Region 1 Bylaws

Region 1 Policies and Procedures

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BLS, ILS, ALS

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Region 1 Bylaws

Policy: Bylaws – Article 1 – Board Establishment and Member Appointments

ARTICLE I Advisory Board Establishment and Member Appointments

The Illinois Department of Public Health Emergency Medical Services Region 1 Advisory Council (Advisory Council) is established pursuant to Section 3.25, 210 ILCS 50/et.seq of the Emergency Medical Services (EMS) Systems Act and Section 515.210 of the Emergency Medical Services and Trauma Center Code, 77 Illinois Administrative Code Part 515. The Advisory Council is composed of the following members approved by the Director of the Illinois Department of Public Health:

- **4 -** One (1) EMS Medical Director from each of the EMS resource hospitals located in Region 1
- **4 -** One (1) EMS System Coordinator from each of the EMS resource hospitals located in Region 1
- **3 -** One (1) Trauma Medical Director from each of the Trauma Centers located in Region 1
- **3 -** One (1) Trauma System Coordinator from each of the Trauma Centers located in Region 1
- **1 -** One (1) Associate Hospital representative affiliated with a Region 1 EMS Resource hospital
- **1 -** One (1) Participating Hospital representative located in Region 1
- **1 -** One (1) representative from the highest volume EMS provider agency
- **4 -** One (1) municipal EMS provider representative from each EMS resource hospital located in Region 1
- **4 -** One (1) private EMS provider representative from each EMS resource hospital located in Region 1
- **1 -** One (1) pediatric champion physician/EDAP representative from the EMS Region 1 PCCC hospital
- **26 - Total representatives as of 10/15/2018**

Membership of the Region 1 EMS Advisory Council will be comprised of representatives from outlined agencies or organizations serving residents of Region

1. The agencies or organizations governing body or chief executive will appoint a representative to the council. Each member will have one vote; certain staff and others outlined are non-voting members.

2. Once the initial agency or organization representative is identified as Region 1 EMS Advisory Council member, their membership will be automatically renewed each year.

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3. A member's agency or organization by resolution of its governing body or corporation will submit written notice of its intent to withdraw from the Region 1 EMS Advisory Council.

4. The Executive Committee will schedule a meeting to review any application for membership to the Advisory Council and will refer for action all eligible applicants to a regular or special meeting of the full Advisory Council. Advisory Council will define potential value of applying agency to the existing organization. Applications will be acted upon within ninety (90) days of receipt of a request for membership. Applicants will be notified within 10 days of EMS Advisory Council action.

5. Openings due to resignation or removal will be filled as soon as possible as scheduled by the Region 1 EMS Advisory Council Chairperson.

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Policy: Bylaws – Article 2 – Officers

ARTICLE II Officers

The Region 1 EMS Advisory Council/committees/subcommittees will rotate from its membership, every two years, one chairperson.

1. The Chairperson is a member of all standing committees and is responsible for:
   A. Calling all regular and special meetings of the Region 1 EMS Advisory Council.
   B. Presiding at all regular and special meetings. Robert's Rules of Order will govern the procedures at all meetings of the Region 1 EMS Advisory Council in matters not otherwise governed by these Bylaws.
   C. Appointing all committees, task forces and special study groups.
   D. Working with the EMS Coordinator to prepare meeting agendas.
   E. Representing the Region 1 EMS Advisory Council to other groups and external organizations.
   F. Appointing the chairperson and additional members as needed for all committees.

2. The Region 1 Advisory Council EMS Coordinator is a member of the Region 1 EMS Advisory Council and subcommittees. The Advisory Council EMS Coordinator is responsible for:
   A. Coordinating all meetings of the Region 1 EMS Advisory Council
   B. Participating as an ex-officio member on all committees and subcommittees.
   C. Representing the Region 1 EMS Advisory Council to other groups and external organizations.
   D. Maintaining records of meetings
   E. Providing surveillance of national, state, regional, and local EMS issues, thereby keeping the Region 1 EMS Advisory Council members informed of potential impact.
   F. Assuring accurate recording of minutes from Region 1 EMS Advisory Council or other committee meetings.
   G. Providing other duties as assigned by the Region 1 EMS Advisory Council, and endorsed by the Illinois Department of Public Health.

3. The Region 1 EMS Coordinator is a member of the Region 1 EMS Advisory Council and subcommittees. The Region 1 EMS Coordinator will act in an advisory capacity providing guidance and information in all matters related to Region and State items and business.

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Policy: Bylaws – Article 3 – Meetings and Voting

ARTICLE III Meetings and Voting

1. The Executive Committee will determine the Schedule of regular Region 1 EMS Advisory Council meetings. The chairperson, the Executive Committee, or a majority of the members expressing their desire to the chairperson in writing may call special meetings of the EMS Advisory Council. EMS Advisory committees, subcommittees, and task forces will meet as needed.
2. Regularly scheduled EMS Advisory Council meetings will be held quarterly. Special meetings of the Region 1 EMS Advisory Council will be held with written notice. The Advisory Council EMS Coordinator will ensure the timely mailing of the notices of Region 1 EMS Advisory Council meetings.
3. For Region 1 EMS Advisory Council meetings and special Region 1 EMS Advisory Council meetings, the agenda and location will be mailed/e-mailed no less than 48 hours in advance of the meeting. The EMS Chair will coordinate the development and distribution of the Region 1 EMS Advisory Council agenda with the Advisory Council EMS Coordinator. Emergency meetings of the Advisory Council may be convened with prior notice as soon as possible.
4. Business will be conducted by a quorum.
5. Except where indicated, the desired method for approving all business actions is through majority of the quorum (26 voting members, quorum is 13). A three-fourths of the quorum of the Council will be required to approve changes to Region 1 EMS Advisory Council membership or bylaws.
6. With advanced notice and approval of the chairperson members may attend via teleconference (or by phone). Should any votes be necessary all attending via teleconference must vote by a call of the roll. Region 1 Executive Council members should attend all meetings in person.
7. Any vote by proxy will be submitted in writing to the chairperson prior to the meeting being convened. The chairperson will notify all in attendance of any proxies presented for that meeting.
8. Executive committee and other sub-committee meetings may be held in closed session to discuss issues, ideas, and concerns.
9. No final action may be taken on public business in a closed session (5 ILCS 120/2).

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Policy: Bylaws – Article 4 – Standing EMS Advisory Council Committees

ARTICLE IV Standing EMS Advisory Council Committees

Executive Committee

1. The Executive Committee membership will include a Medical Director and EMS Coordinator from each participating EMS System in Region 1.

2. The Executive Committee will, in addition to those activities charged by the Region 1 EMS Advisory Council, be responsible for the following:
   a. Ensuring issues and charges to committees of the Region 1 EMS Advisory Council are addressed in a timely manner and provide monitoring of activities.
   b. Developing and reviewing Region 1 EMS Advisory Council agendas prior to Region 1 EMS Advisory Council meetings.
   c. Reviewing Committee recommendations.
   d. Reviewing and making recommendations on requests for Region 1 EMS Advisory Council membership and membership credentialing.
   e. Serving, with the input of others, as the nominating body for Region 1 EMS Advisory Council Representatives.
   f. Serving as the nominating body for the appointment of Committee chairpersons.
   g. Assigning issues or activities to committees in order to facilitate Region 1 EMS Advisory Council and committee action.
   h. Reporting to the Region 1 EMS Advisory Council, at regular meetings, a summary of previous meetings and activities.
   i. Design and write bylaw requirements for new Standing Committees or Sub-Committees.
   j. Voting for the Region 1 EMS Executive Committee will be completed by the EMS Medical Directors in person or by proxy. Three-quarters majority of all EMS Medical Directors is required to pass a vote.

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Policy: Bylaws – Article 5 – Review or Amendment of the Bylaws

ARTICLE V Review or Amendment of the Bylaws

Review of these Bylaws should occur as needed, as determined by the Executive Committee of the Region 1 EMS Advisory Council.

Amendments to Bylaws

1. Amendments to these Bylaws may be proposed by any member of the Region 1 EMS Advisory Council. A proposed amendment to these Bylaws must be submitted to the Executive Committee in writing.

2. Amendments to these Bylaws will become effective only after a regular or special meeting scheduled no less than thirty (30) days following the Region 1 EMS Advisory Council meeting where the amendment was introduced.

3. Amendments to the Bylaws must be approved by three-fourths of the quorum of the Region 1 EMS Advisory Council.

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Region 1 Policy

Policy: Resolving Regional or Inter-System Conflicts

Purpose:
Coordination of EMS in Region 1 is essential to providing optimal patient care. Should a conflict occur the following policy should be utilized to resolve the issue.

Process:
Generally, conflicts are addressed within an EMS agency or EMS System. Should a regional or inter-system conflict occur the following steps should be followed for resolution:

1. Any Region 1 provider or agency can bring issues to the Region 1 EMS Advisory Council and/or Executive Committee in writing or person.
2. All relevant information surrounding the issue in dispute is required to be provided to the Council. Issues related to EMS will be reviewed by the Region 1 Executive Committee. Issues related to trauma care may be referred to the Region 1 Trauma Committee as needed.
3. After resolution, the Region 1 EMS Executive Committee will respond to the dispute with the involved parties in writing on or before the next scheduled meeting. It is the responsibility of the Council Chairperson to initiate this written response.
4. If the Region 1 EMS Executive Committee is unable to resolve the issue the following will be sent to the IDPH Director per Section 515.230 of the Administrative Code:
   a. All relevant information surrounding the issue being disputed.
   b. A statement from the Region 1 EMS Executive Committee supporting their position; and the name, phone number and address of one person who should be contacted if further information is needed.
   c. A statement from the Region 1 Trauma Center Medical Director or Trauma Committee, whichever is applicable, supporting their position; and the name, phone number, and address of one person who should be contacted if further information is needed.
5. The IDPH Director will make a determination within 10 working days after receipt of the above information. The determination may be on or the other position or may be another option developed by the IDPH Director.
6. Once the determination is received from the IDPH Director it is the responsibility of the Chairperson of the Region 1 Executive Committee to share the determination with the other Committee members and the involved parties. The determination will be read into the Region 1 Executive Committee meeting minutes for the purpose of documentation of the resolution of the dispute.

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REGION 1 Policy

Policy: Continuing Education

Purpose: To define the requirements for Continuing Education of EMS licensed providers in EMS Region 1. To identify the process of applying for Continuing Education hours in the Region, these hours need to be approved by EMS System and Illinois Department of Public Health.

Required number of hours and renewal process:

1. Region 1 EMS requires the following hours of continuing education to be completed in each 4 year renewal.
    a. 100 hours – Paramedic and PHRN
    b. 80 hours – EMT-Intermediate / Advanced EMT
    c. 60 hours - EMT
    d. 24 hours – First Responders / Emergency Medical Responders
2. All provider agencies that have in-house Continuing Education will maintain records that includes the following:
    a. Date
    b. Topic
    c. Site code if required
    d. List of those attending
    e. Total time of education
3. The provider agency will make these records available to their EMS System.
4. Each prehospital provider is responsible for keeping their own records and maintaining a copy of time accrued. The responsibility for completing Illinois Department of Public Health required Continuing Education hours in a timely manner rests fully with the individual.
5. First Responder, EMT-Basic, EMT-Intermediate, EMT-Paramedic, ECRN and Prehospital RN providers must submit renewal information to their EMS System. The System will then reviews Continuing Education for appropriateness and endorse the provider to Illinois Department of Public Health for license renewal. License renewal forms are available at your Systems EMS office.
6. Renewal requests are due at your System EMS office 30 days prior to expiration.
7. Each prehospital provider is responsible to complete the child support and conviction statement, as well as the appropriate fee to IDPH.
8. Requests for extensions will not be considered unless for illness or extreme circumstances.

Approval of Hours:

The EMS Medical Director will determine if a particular didactic Continuing Education program is acceptable for credit within their EMS System. Approval for all hours rests with EMS System.

Required Breakdown of Hours:

Region 1 EMS requires the breakdown of hours in core content areas. The breakdown is as listed in the chart below. From January 2018 until January 2021, should a provider be unable to meet this requirement, the provider may document the hardship in writing to the EMSMD. The EMSMD will approve or deny the renewal on a case by case basis. After this January 2021 deadline this requirement must be met.

Required Breakdown of Hours in 4 years				
CORE CONTENT	**Paramedic**	**I /AEMT**	**EMT**	**FRD/EMR**
Preparatory Safety and well-being, Roles & Responsibilities, Prevention, Legal, Ethical, A & P, Medical Terminology, Pharmacology	8	6	5	
Airway Management & Ventilation	12	10	7	2
Patient Assessment Patient Assessment, History Taking, Communication, Documentation	8	6	5	
Trauma MOI, Bleeding, Soft Tissue, Burns, Head, Face, Spine, Thoracic, Abdominal, Musculoskeletal, Environmental	12	10	7	4
Cardiology	16	13	8	4
Medical Respiratory, Nervous System, Endocrine, Immune System, GI, Renal, Toxicology, Infectious Diseases, Psychiatric Disorders, Substance Abuse	20	16	12	4
Special Considerations Obstetrics, Gynecology, Neonatology, Abuse & Assault, Patient with Special Challenges, Chronic Illness Patients	16	13	10	
Operations Crime Scene, Vehicle Operations, Rescue Awareness and Operations, Haz Mat, Tactical EMS, Disaster Preparedness, Triage	4	3	2	
Elective	4	3	4	10
Additional hours may be from any of the topics or educational options				
TOTAL	100	80	60	24

Required Education

The following is a list of required education for each level of EMS provider:

1. First Responder / Emergency Medical Responders
    a. Current Health Care Provider CPR card (American Heart or Red Cross)
2. EMT
    a. Current Health Care Provider CPR card (American Heart or Red Cross)
    b. System Competencies – including skills validation and any required System education that may be needed
3. EMT-I / AEMT
    a. Current Health Care Provider CPR card (American Heart or Red Cross)
    b. ACLS (American Heart)
    c. PALS / PEPP (American Heart or American Academy of Pediatrics)
    d. PHTLS / ITLS / TNCC / TNS
    e. System Competencies – including skills validation and any required System education that may be needed
4. Paramedic / PHRN
    a. Current Health Care Provider CPR card (American Heart or Red Cross)
    b. ACLS (American Heart)
    c. PALS / PEPP (American Heart or American Academy of Pediatrics)
    d. PHTLS / ITLS / TNCC / TNS
    e. System Competencies – including skills validation and any required System education that may be needed

Note: any equivalent courses to the ones listed in the required education section above must have prior System approval. Some online courses have a certification card that looks equivalent, however they may not require any skills or testing – these will not be approved.

Standard Documentation

Documentation is required to validate the completion of all continuing education. All continuing education must be approved by the EMS Medical Director. The following should be noted to ensure that credit can be provided.

1. Courses that have an Illinois site code and /or a CAPCE number are approved for credit
2. Course completion cards may be submitted for approved courses.
3. Sign-in rosters for agency in-house training should have the following documented:
    a. Topic
    b. Date / time
    c. Signed by instructor or authorized person
4. Name of participant
5. Number of hours awarded – This needs to be actual hour for hour time, e.g. if a training session was pre-approved for 2 hours but only 1 hour was spent, 1 hour should be awarded.

Options for Accruing Didactic Hours:

Activity	Documentation	Hours	Comment
Initial education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation	Hr/Hr up to 16 hours for each course	
Advanced Trauma Life Support, Teaching EMS-related courses/ CE, Wilderness EMS Training, TEMS, MIH Community PM, Critical Care PM	Standard documentation	Hr/Hr for EMS content of course	May not exceed 20% of total hours for one subject area. Up to 50% of total hours may be earned by teaching participants at a lower level of licensure. Should be considered on a case by case basis for any topics in EMS education standards
Refresher/renewal education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation	Hr/Hr up to 8 hours	
EMTs: PEPP (BLS) course	Standard documentation	Hr/Hr up to 8 hours	
Initial courses: CPR Instructor, Emergency Vehicle Operators course, Emergency Medical Dispatch course	Standard documentation	Hr/Hr up to 12 hours max	
Locally offered CE programs	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area
Audit of entry level EMT, AEMT, Paramedic courses	Standard documentation	Hr/Hr to max content hours	Unlimited hours if subject matter is at the appropriate level for the participant's license. May not exceed 20% of total required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Clinical preceptor or evaluator	Signed letter from EMS Coordinator or lead instructor	Hr/Hr to max hours allowable	May not exceed 20% of total minimum required CE hours.
Emergency Preparedness	Written statement of participation from EMSC/ EMSMD or exercise director.	Hr/Hr up to 12 hours (Paramedic/PHRN) 10 hours (EMT-I) 8 hours (EMT)	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.
Prevention Programs: Safe Kids, Drug Prevention, Community awareness, Prom Night	Written statement of participation from EMSC/ EMSMD or exercise director.	Hr/Hr up to Max hours In content area	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.
Operations Topics: Rescue, Extrication, Hazardous Material, Helicopter Safety, Emergency Driving	Written statement of participation from EMSC/ EMSMD or exercise director.	Hr/Hr up to Max hours In content area	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.
College courses: Health-related courses that relate to the role of an EMS professional (A&P, assessment, physiology, biology, chemistry, microbiology, pharmacology, psychology, sociology, nursing/PA courses, etc.)	Catalog description of course and evidence of successful completion through minimum grade of C (official transcripts or evidence from school)	Hr/Hr 1 college credit = 8 CEU	May not exceed 20% of total hours for one subject area. Should be considered on a case by case basis for any topics in EMS education standards.

Activity	Documentation	Hours	Comment
Seminars/Conferences: EMS related education approved by CECBEMS or medical or nursing accrediting body	Copy of agenda/program plus certificate of attendance	Hr/Hr up to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Commercial CE: Electronic digital media (e.g. videotapes/CDs), journal articles with publication dates of 5 years or less prior to the date of CE completion. Approved by CECBEMS or medical or nursing accrediting body	Standard documentation	Hr/Hr up to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Trauma Nurse Specialist or TNS Review Courses: May audit for CE with prior approval of TNS Course Coordinator to ensure space availability	Standard documentation	Hr/Hr up to max content hours	May not exceed 20% of total minimum required hours in one subject area. Course covers multiple areas of A&P, fluid & electrolytes, acid base balance, shock pathophysiology and systems trauma appropriate for PMs and PHRNs for full credit.
ECRN Course (apart from Life Support courses): May audit for CE with prior approval of Course Lead Instructor to ensure space availability	Standard documentation	Hr/Hr up to max content hours	May not exceed 20% of total minimum required hours in one subject area. Course may cover multiple across the spectrum of EMS appropriate for PMs and PHRNS for full credit
On-line options Webinars and on-line offerings with subject matter found in the EMS Education Standards [e.g. sponsored by a governmental agency (infectious diseases, emergency preparedness) legal experts (documentation HIPAA) organizations or commercial offerings].	Standard documentation	Hr/Hr up to max content hours	May not exceed 20% of total minimum required hours in one subject area,

Assigning hours into core content area

All education should be documented into core content areas to ensure proper credit is given. These core content areas are listed in the Required Breakdown Chart above. Some courses or training sessions may fall into several core content areas, hours may be divided into these different areas. The assigning of hours to core content areas is subject to your Systems approval. Following is a list of examples /preapproved assignment of courses:

1. ACLS Renewal – 8 hours in cardiac or 6 hours cardiac 1 hour airway and 1 hour pharmacology
2. PALS Renewal - 8 hours in pediatric or 6 hours pediatric 1 hour airway and 1 hour pharmacology
3. PHTLS Renewal – 8 hours in trauma or 7 hours trauma 1 hour airway
4. CPR Renewal – 4 hours in cardiac or 3 hours cardiac 1 hour airway
5. System annual skills validation cover a variety of topic over the core content areas, they are considered "Wild card" and may be assigned to any of the core content areas.

REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

Policy: Protocol for Disbursement of IDPH Department Grants

Purpose

To provide equal opportunity and instructions for application by Region 1 EMS Agencies for EMS Assistance Funds Grants, when available.

Process

1. When EMS Assistance Grants are available the Region 1 EMS Coordinators will forward information to their agencies including all appropriate deadlines and parameters.
2. The EMS Agency will complete the application as defined in 515.3000 of the Administrative Code.
3. Incomplete applications will not be considered.
4. The Region 1 EMS Coordinators, or their designee, prioritize the completed applications.
5. The Chairperson of the Region 1 Executive Committee, or designee, forwards the prioritized list to IDPH in the prescribed manner.
6. When the recipients of the grant are announced the agencies will be notified by IDPH.
7. Questions regarding any agency application should be directed to the agency's EMS System Coordinator.

REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

Policy: Medical Control

Purpose

To provide a definition of who can provide Medical Control to Region 1 EMS providers or agencies.

Process

1. Region 1 EMS Systems have the responsibility and authority to provide Medical Control for their providers.
2. Medical Control is defined as an Emergency Department Physician (including MD-1) or licensed ECRN.
   a. Emergency Department Physicians may provide direction in the provider's scope of practice.
   b. ECRN's may provide directions as outlined in the Region 1 SMO's.
   c. Should another individual be approved by a receiving hospital to answer the radio/ inbound report they must call the physician or ECRN should orders be necessary or given.
3. Region 1 has an inter-system agreement on providing Medical Control.
   a. Medical Control may come from the EMS System or receiving hospital.
   b. In order for the receiving hospital to function as Medical Control they must be a Resource, Associate, or Participating that has been approved by their EMS System and IDPH.
   c. All Medical Control directions must be recorded.
4. The Resource for a provider or agency has the authority to override medical direction as needed.
5. Any concerns or conflicts should be referred to the Region 1 Executive Committee.

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Region 1 Policies

Policy: EMS Patient Care Reports

Purpose: To ensure that all required documentation occurs when services are provided by a Region One EMS provider.

Overview: Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. When a Region 1 EMS provider interacts with a patient, documentation will occur. **It is imperative that written documentation is left with the patient at the receiving facility.**

Patient Care Reports:

1. A patient care report (PCR) will be accurately completed for each patient interaction. This includes EMS responses (emergency and non-emergency) in which patient contact is made.
2. All EMS personnel who participate in patient care or assessment will be listed on the patient care report, as well as the interventions or assessments he or she performed.
3. Ideally, a PCR will be completed in its entirety and provided to the receiving facility immediately after transferring care to the ED staff and prior to departing the hospital. The PCR left will be in full compliance with Region 1 policies, IDPH rules and regulations, and NEMSIS rules and regulations.
4. If a PCR cannot be completed prior to departing the ED, then a Region 1 Short/Non-Transport Form (Appendix B) must be fully completed and left with the ED staff.
5. If the Short/Non-Transport Form is utilized the PCR should then be completed and sent (faxed or electronically) within 2 hours of completion of the call.
6. Each agency who utilized the Short/Non-Transport Form must keep a log of when they used it, which patient they used it for, the date of the transport, the time they left the Short Form at the hospital, and the time they submitted the PCR to the hospital. This form will be submitted to the agency's EMS Coordinator on a monthly basis.
7. Each Resource Hospital will submit this information to IDPH on a monthly basis including any QI conducted as part of any run report reviews.
8. If an agency repeatedly violates this policy regarding the use of the Short Form the utilization of the Short Form will no longer be an option for that agency. Suspension or termination of use will be determined by the EMSMD for that agency and details will be provided to that agency in writing.

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9. Non-transport agencies and non-emergency transports must have a PCR completed within 24 hours.
10. Documentation must be completed on a Region 1 approved electronic documentation system or approved Region 1 forms.
11. Responsibility for completing the PCR rests with the crew members listed on the report. Failure to leave written documentation and agencies and/or personnel failing to comply with documentation requirements can be considered falsification of a medical record and may result in a formal investigation by the EMS Medical Director and/or IDPH.
12. All EMS assists and refusals where patient contact is made will have an electronic PCR completed including all necessary signatures.
13. In cases of MCI, an electronic PCR may impede turnaround time of necessary resources. If not requested back to the scene of an MCI, a PCR will be completed.
14. Copies of all PCR's must be provided to your respective Region 1 EMS Office.

Medical Control Contact Criteria
When utilizing the I *Region 1 – Patient Care Report Short Form* if any discrepancy or significant omission of information is noted by the crew when filling out the full run report, they are to contact the receiving ED by phone and fax the additional information to the ED.

REGION I EMERGENCY MEDICAL SERVICES
REGION 1 Policy

Policy: Special Events

Purpose: A Special Event Form is to be completed as an amendment to an existing EMS System Plan by an ambulance provider who will be providing coverage at a specific event when the coverage will change the normal response pattern of the provider. This form with attachments, if appropriate, should be submitted to the EMS System Office ideally 60 days prior to the event. The form will be filed in the EMS System Office and will be sent to the Illinois Department of Public Health if requested.

Process: A copy of the Special Events Form and the items required by the EMS System for each level of care can be found on the IDPH Department of EMS website or requested from the EMS System Office, titles **Emergency Medical Services (EMS) Systems Special Events Request Application.**

Special event resources may include:

1. Assist Vehicles included, but not limited to:
   a. Bicycle
   b. Boat
   c. Fire/EMS Apparatus
2. Transport/Non-Transport Vehicle Assist
3. Advanced Life Support Transport Vehicles

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REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

Policy: Vehicle Staffing Requirements

Purpose: To identify minimum acceptable staffing patterns for all Region 1 EMS vehicles.

Method of Providing EMS Services:
EMS Services in Region 1 may be provided by a variety of methods:

1. Single vehicle response and transport:
   - EMS response and transport is provided by one EMS agency.

2. Dual vehicle response:
   - EMS response includes non-transport and/or transport by:
     1. A single EMS agency
     2. Multiple EMS agencies

3. Level of first response vehicle:
   A. Ambulance Assist Vehicles
      1. Ambulance assist vehicles are dispatched simultaneously with an ambulance to assist with patient care prior to arrival of the ambulance. The vehicle will not be a transport or primary response vehicle. These vehicles will not function as an assist vehicle if staff and equipment are not available.
      2. Emergency Medical Responder/First Responder ambulance assist vehicle staffed with a minimum of one Emergency Medical Responder/First Responder (or higher level).
      3. Basic ambulance assist vehicle staffed with a minimum of one EMT (or higher level).
      4. Advanced EMT/ILS ambulance assist vehicle staffed with a minimum of one Intermediate (or higher level).
      5. ALS ambulance assist vehicle staffed with a minimum of one paramedic or one PHRN.
   B. Non-Transport Vehicles
      1. Non-transport vehicles are dispatched prior to the dispatch of the transporting ambulance. These vehicles will be staffed 24-hours per day every day of the year.
      2. Basic ambulance assist vehicle staffed with a minimum of two EMTs (or higher level).
      3. Advanced EMT/ILS ambulance assist vehicle staffed with a minimum of one Intermediate (or higher level) and one EMT level or higher.
      4. ALS ambulance assist vehicle staffed with a minimum of one paramedic or one PHRN and one EMT level or higher.

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4. Level of transport vehicle:
   A. Ambulance Basic Life Support:
      All Basic Life Support vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
      1. Minimum requirement - two (2) EMT-Basics, licensed appropriately per Illinois Department of Public Health.
      2. Vehicle can be staffed with higher level providers, such as A-EMT/Intermediate, Paramedic, or PHRN, but they cannot function beyond the ambulance license level unless in the situation of Infield Upgrade.

   B. Ambulance Intermediate Life Support:
      All Intermediate Life Support vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
      1. Minimum requirement - one A-EMT/Intermediate and one EMT (or higher level) licensed appropriately per Illinois Department of Public Health.
      2. Vehicle can be staffed with higher level providers, such as A-EMT/Intermediate, Paramedic, or PHRN, but they cannot function beyond the ambulance license level unless in the situation of Infield Upgrade

   C. Ambulance Advanced Life Support:
      All Advanced Life Support vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
      1. Minimum requirement – one Paramedic or PHRN and one EMT (or higher level) of any level licensed appropriately per Illinois Department of Public Health.
      2. Vehicle can be staffed with higher level providers, such as Paramedic or PHRN, but they cannot function beyond the ambulance license unless in the situation of Infield Upgrade.

5. In-Field service level upgrade, using advanced level EMS vehicle service providers.
   A. When a lower level agency calls for an advanced level agency for assistance the advanced level provider may transfer all appropriate equipment and function at the higher level of care.
   B. The advanced level provider/agency will assume primary responsibility for care when they arrive and report is given.
   C. Should the two agencies be in different systems the advanced level provider/agency becomes the primary system for the response.

6. Ambulance service provider and vehicle service provider – rural population.
   A. A rural provider may upgrade as defined by their EMS System and approved by IDPH.
   B. Advanced equipment/medications must be secured per EMS System policies.

7. Alternate Rural Staffing/Alternate Response Authorization
   A. Providers that serve rural or semi-rural populations of 10,000 or less may be approved by EMS System and IDPH for alternate rural staffing.
   B. If approved for alternate rural staffing, the vehicle may be staffed with one licensed personnel at the level of the vehicle and one EMR/First Responder.

8. Use of mutual aid agreements.
   A. Mutual aid agreements may be agreements between agencies or the formal MABAS agreements.
   B. Mutual aid may be utilized for large events or multiple calls/multiple patients to provide the best patient care.
   C. To function on an EMS vehicle the individual provider should be listed on that agency's roster and approved to function in that agency's EMS System. In unusual or non-typical situations it may be in the patients' best interest to utilize an EMS provider from another agency and/or EMS System. This option should only be utilized in unusual or non-typical situations and the out-of-system provider is responding under a mutual-aid agreement and the EMS provider is in good standing in the neighboring/mutual aid agency and/or EMS System.

9. In the event a caller requests the estimated time of arrival of an emergency vehicle the information will be shared with the caller using the best estimate available.

10. Staffing Waivers:
   A. In the event an EMS Agency believes a staffing waiver may be necessary they should discuss this potential need with their EMS System Coordinator/EMS Medical Director to determine the best course of action.
   B. Staffing Waivers may be approved by the EMS Medical Director. Waivers are completed and sent to Illinois Department of Public Health (on WVRI/95) for final approval. Illinois Department of Public Health will approve the waiver if it determines there is no reduction in the quality of care established by the EMS Act and/or if full compliance with the regulation in the Act at issue would constitute a hardship for the applicant.
   C. Anytime that a service cannot meet its staffing obligation due to extenuating circumstances, please contact the EMS System at once to review the problem and, if applicable, complete a staffing waiver.

REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

POLICY: Student Clinical / Internship Agreement

Overview:

Each Region 1 EMS System, as part of its emergency medical services education and training program, wants to offer its students, through a clinical / internship program, the opportunity to receive supplemental clinical experience at other Region 1 EMS facilities.

1. The EMS Systems hope to jointly benefit by improving the students' education through professional preparation.

2. The EMS Systems intend to structure the requirements for an educational internship in such a way as to ensure the safety and well-being of the patients, students, and organizations involved.

EMS Systems agree to the following:

1. Duties of Supplemental Clinical Experience Facility. The EMS System that receives emergency medical services students, for the purpose of providing to those students a supplemental clinical experience at its facility from the EMS System at whose facility the students primarily receive instruction and training will:

   a. The liaison between the Supplemental Clinical Experience Facility and the Primary Instructional Facility will be the Lead Instructor for the course unless otherwise designated.

   b. Maintain a curriculum that complies with the National Educational Standards for Emergency Medical Services published by the National Highway Traffic Safety Administration and the testing and licensure requirements of the Illinois Department of Public Health.

   c. Paramedic education follows all guidelines/standards as prescribed by CoAEMSP/ CAAHEP accredited program.

   d. Permit students to use all facilities, equipment, and supplies used in the Supplemental Clinical Experience Facility's ordinary course of business.

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e. Permit students' in-library use of books, periodicals, and other related resources.

f. Take reasonable steps to provide a safe and healthy work environment in compliance with applicable State and Federal laws and regulations, and provide a secure area for students' belongings, parking facilities, and food service.

g. All preceptor will be approved by the EMS System and receive the appropriate training. A certificate of completion of the appropriate training should be on file with the EMS System and available upon request.

h. Appoint a preceptor who will maintain a record of orientation and complete a student evaluation of performance as requested.

i. Ensure the cooperation and support of the Supplemental Clinical Experience Facility's staff in assisting instructors and preceptors as supplemental teachers to provide meaningful learning experiences in their areas of expertise.

j. Allow students access to patients/clients as resources for student learning; provided, however, that the Supplemental Clinical Experience Facility will assume ultimate responsibility for the care and service rendered to such patients/clients.

k. Provide emergency medical care, or arrange transportation so that students and faculty may receive such care, if required while students and faculty are on the Supplemental Clinical Experience Facility's premises; provided, however, that any costs associated with such emergency medical treatment or transportation will be borne by the students, faculty, and/or their third-party payors.

l. Ensure that the clinical experience that each student receives is within the scope of practice permitted by that student's emergency medical services curriculum level.

2. Primary Instructional Facility Duties. The Primary Instructional Facility will:

a. Maintain a curriculum that complies with the National Educational Standards for Emergency Medical Services published by the National Highway Traffic Safety Administration and the testing and licensure requirements of the Illinois Department of Public Health.

b. Ensure the effective flow of communication between instructors and unit managers and preceptors for the purpose of providing feedback for improvement through prompt notice to the Supplemental Clinical Experience Facility of irregularities found in student evaluation forms.

c. Ensure that students and faculty comply with all applicable Supplemental Clinical Experience Facility policies and procedures.

d. Ensure that students use the Supplemental Clinical Experience Facility's equipment and materials in a manner consistent with standard industry practice;

e. Maintain proof that all students have obtained the following:

1. TB Test – Testing for tuberculosis is performed through a blood draw or two-step skin test.
2. Immunizations –
    a. Mumps, measles and rubella x 2 or positive titers
    b. Tdap, which includes diphtheria, tetanus and pertussis
    c. Varicella (Chicken Pox) times 2 or positive titer
    d. Influenza (or mask during designated flu season)
3. Hepatitis B – the vaccination series is strongly recommended but not required. If you choose not to have this you must sign a waiver.
4. Urine Drug Screen – Per EMS System the Program Director reserves the right to conduct urine drug screen testing.

f. Maintain proof that all students have current professional liability insurance (this may be person or institutional).

g. Complete a background check and notify the Supplemental Clinical Experience Facility of any potential barriers to a student for course completion and/or licensure.

h. Maintain proof to the Supplemental Clinical Experience Facility that all students have health insurance that covers the care and treatment of emergency medical conditions, or a signed waiver of responsibility that provides that the student is responsible for any cost associated with care received.

i. Require students to display photo identification at all times while on the Supplemental Clinical Experience Facility's premises;

j. Remove, upon request by the Supplemental Clinical Experience Facility: (i) any student whose performance is unsatisfactory, in the Supplemental Clinical Experience Facility's sole discretion, after the Supplemental Clinical Experience Facility has given written notice to the student and allowed such student ten (10) days to cure the unsatisfactory condition; (ii) any student who knowingly violates any Supplemental Clinical Experience Facility policy or procedure, as provided to the Primary Instructional Facility pursuant to Section 2(c) of this Agreement; or (iii) any student who, due to a health condition, cannot satisfy the requirements of the internship program;

k. Take reasonable steps to ensure that its employees and agents, in performing the Primary Instructional Facility's duties pursuant to this Agreement, comply with all Federal and State laws and regulations regarding the confidentiality of protected health information, as defined by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); and

l. Ensure that all students, prior to beginning clinical education on the Supplemental Clinical Experience Facility's premises, satisfactorily complete a life safety training course.

REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

POLICY: Medication and Equipment Exchange

Purpose
To provide instructions for the exchange of medications and equipment at Region 1 Resource Hospitals

Process

1. Each Region 1 hospital will have their own policy regarding the exchange of medication and equipment for restocking of supplies that are provided to patients during transport to their hospital. This includes all Resource, Associate, and Participating hospitals in the Region.

2. If at all possible all medications should be replaced using the recommended concentrations on the Region 1 Restocking Form (Appendix C).

3. Medications utilized during transport will be restocked at the receiving hospital. If the medication is not available at the receiving hospital the EMS agency will contact their Resource Hospital for replacement and provide appropriate documentation (patient care report) in order to receive the replacement medication.

4. Any billing for medications or equipment is conducted between the EMS agency and the receiving hospital.

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REGION I EMERGENCY MEDICAL SERVICES
Region 1 Policy

POLICY: Prehospital RN (PHRN)

Prehospital RN (PHRN),
Prehospital Advanced Practice Register Nurse (PHAPRN)
Prehospital Physician Assistant (PHPA):
Education, Certification and Recertification

I. DEFINITIONS

A **Prehospital Registered Nurse (PHRN)** is a registered professional nurse licensed under the Illinois Nursing Act who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to the Act and who is approved by an EMS Medical Director (EMS MD) to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports" (Section 3.80 of the Act). This individual was formerly called a Field RN.

A **Prehospital Advanced Practice Registered Nurse (PHAPRN)** is an advanced practice registered nurse licensed under the Nurse Practice Act who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to this Act, and who has the approval of an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports (Section 3.80 of the Act).

A **Pre-Hospital Physician Assistant (PHPA)** is a physician assistant licensed under the Physician Assistant Practice Act of 1987 who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to this Act, and who has the approval of an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports (Section 3.80 of the Act).

For the purpose of this policy when PHRN is used, PHAPRN and PHPA will also apply.

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II. POLICY

A. All persons that wish to be licensed as a PHRN must demonstrate the same minimum mastery of cognitive objectives and psychomotor skills as set forth in the U.S. National EMS Education Standards for Paramedics.

B. The process of credentialing specifically involves the verification by an EMSMD that the PHRN provider possesses required competencies in the domains of cognitive, affective, and psychomotor abilities.

C. Authorization to practice is a function of state licensure and local credentialing by the EMSMD.

D. Illinois EMS Rules require a PHRN candidate to complete an education curriculum formulated by an EMS System and approved by IDPH, which consists of classroom and practical training for both the adult and pediatric populations, including extrication, telecommunications, and prehospital cardiac and trauma care (Section 3.80(c)(1)(A) of the Act). They must also complete a supervised field internship as authorized by the EMS MD.

III. PROCEDURE

Nurses desiring to be approved as a PHRN shall complete the following:

A. Prerequisites

1. Registered nurse with current Illinois license in good standing in accordance with the Illinois Nurse Practice Act (PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (225 ILCS 65/) Nurse Practice Act (225 ILCS 65/Art. 60 heading);
2. Current healthcare provider CPR card through the AHA or a recognized affiliate;
3. Minimum of two year clinical practice in emergency or critical care nursing; and
    a. Current AHA* - ACLS (or equivalent) provider certification
    b. Current AHA* - PALS (or equivalent) provider certification
    c. Current AHA* - BLS (or equivalent) provider certification

(*Equivalent AHA course must have written and skills testing component)

    d. Current Trauma provider certification (PHTLS, ITLS, TNS, TNCC)
4. Written approval to ride with for field internship purposes, or evidence of employment by, an approved Region 1 ALS Provider Agency.
5. Liability insurance coverage
6. Healthcare insurance coverage or signed waiver
7. System approved drug screening and immunizations
8. Criminal background check, any potential barrier to licensure or participating in clinical experience must be addressed by Program Director and EMSMD

B. Didactic component

1. Certain principles required for prehospital ALS practice are not included in an RN's education program, so must be obtained and mastered through the PHRN or a Paramedic course. These topics include, but may not be limited to:
    a. Introduction to EMS; roles and responsibilities of EMS personnel
    b. Medical/legal issues in EMS; EMS communications
    c. Documentation using the Prehospital patient care reporting system
    d. Regional / System Standing Medical Orders
    e. ALS interventions.
    f. Scene control and patient assessment in the prehospital environment; including specific prehospital stroke, STEMI and trauma assessments
    g. Application of sensors and interpretation of capnography waveforms and numeric results.
    h. Invasive airway adjuncts and EMS oxygen delivery devices
    i. Cardiac monitoring (including interpretation of 12L ECGs) and dysrhythmia management; prehospital cardiac arrest management
    j. Pleural decompression
    k. Prehospital childbirth, newborn resuscitation
    l. Ambulance Operations - Hazardous materials awareness; rescue techniques; Patient access and conveyance options; Incident command system and triage
    m. System policies.

C. Psychomotor component

1. PHRN students must complete all mandatory skill competency labs/exams. Mandatory skill competencies include, but may not be limited to:
    a. Assessment: Adult, pediatric, and infant
    b. Airway access: Manual opening; NPA, OPA, suction; obstructed airway maneuvers; oral endotracheal, sedation, DSI, in-line, digital, and nasal intubation; Supraglottic airway, needle and surgical cricothyrotomy.
    c. Oxygen delivery/ventilatory support: Use and maintenance of portable O2 cylinders; NC, NRM, CPAP, BVM; SpO2 and capnography monitoring
    d. Cardiovascular support: Peripheral venous & intraosseous access; infusions, cardiac monitoring using 3 and 12 leads; cardioversion, defibrillation, transcutaneous pacing; and code management
    e. Drug administration techniques used in Regional / System SMOs
    f. Spinal Restriction: KED, helmet removal, splinting techniques: limb splints, traction splints,
    g. Misc.: Capillary glucose monitoring, pleural decompression, use of restraints, etc.

D. Hospital clinical component

All students must complete or show clinical experience / proficiency of all clinical experiences listed in the EMS Systems Paramedic course curriculum. All students requesting credit for prior clinical experiences must request this in writing, any credit may be approved by the EMSMD on a case by case determination.

E. Capstone Field Internship

PHRN students shall complete the same System prehospital internship requirements as paramedic students with an approved ALS provider.

F. PHRN testing:

Applicants must successfully complete all didactic requirements including paramedic course final written and practical exams.

G. Terminal Competency and PHRN recognition:

1. Applicants must successfully complete all didactic requirements including paramedic course final written and practical exams.
2. Terminal Competency, which indicates readiness to sit for state or national exam, includes:
    a. Completion of the didactic portion of the course.
    b. In-House Clinical completed.
    c. Capstone Field Internship completed.
    d. Letter from Preceptor.
    e. Student reviewed and approved by Program Director and EMS Medical Director.
3. When the above terminal competencies are met the EMSMD shall approve the PHRN candidate to take the State / National Assessment Paramedic exam.
4. Successful completion of the State / National Assessment Paramedic exam shall constitute a recommendation to license them as a PHRN in Illinois.

H. Records maintenance:

A PHRN shall notify their EMS System(s) and IDPH within 30 days after any change in name, affiliation, or address per local policy.

I. 77 Ill Adm.

Code 515.190(c) requires "all licensees and certificate and permit holders under the Act shall report all new felony convictions to the Department within seven days after conviction. Convictions shall be reported by means of a letter to the Department".

J. PHRN recertification:

Recertification is required every four years. A PHRN shall maintain their credential in the same manner as a Paramedic.

K. Certificate expiration:

The certificate of a PHRN who has failed to file an application for renewal shall terminate on the day following the expiration date shown on the license.

L. Requests for extension:

Recognition as a PHRN may be extended by IDPH only when appropriate documents substantiating hardship is provided in writing accompanied by a recommendation from the EMS MD. To request an extension, complete and submit the IDPH EMT Extension Form to their EMS System office for processing with IDPH.

M. Inactive Status:

Prior to the expiration of the current approval, a PHRN may request to be placed on inactive status. The request shall be made in writing on the IDPH Inactive/Reactivation Form. Submit the form to the local Resource Hospital EMSS office for review and processing with IDPH. The form shall contain a statement that explains the reasons for requesting inactive status and must be accompanied by the current PHRN license (copies not accepted by IDPH). IDPH will review and grant or deny requests for inactive status. If approved, the nurse may not function as a PHRN.

PHRN Student Clinical Experience Requirements – Credit for Previous Experience
(Template for System)

All students must complete or show clinical experience / proficiency of all clinical experiences listed in the EMS Systems Paramedic course curriculum. All students requesting credit for prior clinical experiences must request this in writing. All credit must be approved by the EMSMD on a case by case determination.

Students Name: _____ Date: _____

Course Location: _____ Site Code: _____

System clinical requirements for Paramedic / PHRN course:

1. Emergency department - ____ hours
2. OR (intubation) - _____ hours/ _____ intubations
3. OB - ____ hours
4. Pediatric - ____ hours
5. Intensive Care Unit - ____ hours
6. Respiratory - _____ hours
7. Other _____ - _____ hours
8. Capstone Field Internship – ____hours/ ____ ALS runs/ ____BLS runs

I am requesting credit for prior clinical experiences. Attached is documentation stating the requested credit and supporting documentation outlining previous clinical experience / proficiency.

The following credit for previous clinical experience / proficiency has been approved:

_____

_____

_____

_____

_____

_____

EMS Coordinator (signature & date) _____

EMSMD (signature & date) _____

Appendix A – Region 1 Short/Non-Transport Form

Region 1- Patient Care Report-Short/Non-Transport Form

Company _____ Unit # _____ Date _____

Receiving Facility _____ Time _____

Patient Name _____

Address: _____

Age _____ DOB _____

Vital Signs: HR _____ RR _____ B/P _____ O2 Sat _____

Chief complaint /Mechanism of Injury _____

Crew Telephone Contact # _____

Crew Member #1 _____

Crew Member #2 _____

LOC
Alert ☐
Verbal ☐
Pain ☐
Unresponsive ☐

Glascow Coma Scale: _____

Lung Sounds
Clear ☐
Bilateral ☐
Wheezes ☐
Rales/Crackles ☐
Ronchi ☐
Diminished ☐

Gluco Check: _____

Treatments
IV/IO Rate _____ TKO ☐
Monitor On: Yes ☐ No ☐
Time: _____

12 Lead: Yes ☐ No ☐ Time: _____
STEMI: Yes ☐ No ☐
Transmitted: Yes ☐ Time: _____ No ☐
Interpretation:
NSR ☐ Brady ☐ Tach ☐ Other _____

Stroke Assessment
G - + -
F - + -
A- + -
S- + -
T- _____
Last seen normal

Skin
Normal ☐
Pale ☐
Flushed ☐
Moist ☐
Diaphoretic ☐

Pain
Yes ☐
No ☐
Severity (1-10)
On Arrival _____
At Hospital _____

Oxygen
liters/Minute _____
Nasal Cannula ☐
NRB ☐
ETT ☐
King Airway ☐
CPAP ☐

Immobilization
Yes ☐ No ☐
Long Board ☐
Cervical Collar ☐
HIM ☐

Time	BP	Pulse	Resp	02 Sat	Temp

Time	Rhythm	Time	Rhythm

Medications

Med	Time/Dose	Time/Dose	Time/Dose

Defibrillation X _____

Medical History:

Patient's Meds: None ☐

Allergies: None ☐
List:

Other Information:

Final Report Completed-Date _____ Time: _____

Final Report Faxed To Rec Hosp. Date _____ Time _____

Original-Hospital Photocopy-EMS Agency (Make a copy at the hospital) Region 1 modified June 2019

Appendix B – Region 1 Short/Non-Transport Form Log

Short Form Utilization Log

Date of Transport	Receiving Hospital	Time Call Ended	Time Report Sent	Comments

Each agency that uses the Short Form must forward this log to their EMS System monthly

Appendix C – Region 1 Medication Restocking Form

MEDICATIONS: Region I Medication Restocking Form

Patient Name:_____
Account Number:_____
Agency:_____
Ambulance Number:_____
Signature:_____
Resource Hospital Signature: _____

Quantity	Name: Generic	Name: Trade	Strength & unit of use	Recommended Par Level/Max
	Adenosine	Adenocard	6 mg/2 ml Syringe	18 mg
	Albuterol	Proventil or Ventolin	2.5 mg/3 ml Neb	5 mg
	Albuterol/Ipratropium	DuoNeb	2.5 mg/0.5 mg/3 ml Neb	5/1 mg
NOTE: Carry 2 additional Ipratropium/Albuterol if no Duo-Neb				
	Amiodarone	Cordarone	150 mg/ 3 ml Vial	450 mg
	Aspirin Chewable		81 mg Tablet	648 mg
	Atropine Sulfate		1 mg/10 ml Syringe	4 mg
	Calcium Gluconate		1 gram/10 mL Vial	3 grams
	D10		50 grams/500ml Bag	500 ml
	D50	Dextrose 50%	25 g/50 ml Syringe	50 grams
	Diazepam	Valium	10 mg/2 ml Syringe	30 mg (30 mg max)
	Diphenhydramine	Benadryl	50 mg/ml Vial	100 mg
	Dopamine	Intropin	400 mg/250 ml Bag	400 mg
	Epinephrine	Epi Pen	0.3 mg/0.3 ml Auto Injector	1
	Epinephrine	Adrenalin	1 mg/ml Vial	2 mg
	Epinephrine	Adrenalin	30 mg/30 ml Vial	30 mg
	Epinephrine	Epi Pen Jr	0.15 mg/0.3 ml Auto Injector	1
	Epinephrine	Adrenalin	1 mg/10 ml Syringe	4 mg
	Etomidate	Amidate	40 mg/20 ml Vial	40 mg (max 80 mg)
	Fentanyl	Sublimaze	50 mcg/ml Vial	400 mcg (400 mcg max)
	Furosemide	Lasix	100 mg/10 ml Vial	100 mg
	Glucagon	GlucaGen	1 mg/ml Vial	1 mg
	Ipratropium	Atrovent	0.5 mg/2.5 ml Neb	2 mg
	Ketamine IM	Ketalar	500 mg/5 ml Vial	500 mg (max 500 mg)
	Ketamine IV	**Ketalar**	**200 mg/20 ml Vial**	**200 mg (200 mg max)**
	Ketorolac	Toradol	15 mg/ml Vial	45 mg
	Lidocaine 2%	Xylocaine	100 mg/5 ml Syringe	300 mg
	Lorazepam	**Ativan**	**2 mg/ml Vial/Syringe**	**8 mg (30 mg max)**
				Page 1 of 2

Quantity	NAME: Generic	NAME: Trade	Strength and unit of use	Recommended Par Level/Max
	Magnesium Sulfate	$MgSO_4$	2 GM/50 ml	2 GM
	Methylprednisolone	Solu-Medrol	125 mg/2 ml Act-O-Vial	125 mg
	Metoprolol Tartrate	Labetalol	5 mg/5ml Vial	15 ml
	Midazolam	Versed	5 mg/ml Vial	30 mg (30 mg max)
	Morphine Sulfate		10 mg/ml Syringe	20 mg (20 mg max)
	Naloxone	Narcan	2 mg/2 ml Syringe	16 mg
	Nitroglycerin	Nitrostat	0.4 mg SL Tablet	2 bottles
	Ondansetron	Zofran	4 mg/2 ml Vial	8 mg
	Ondansetron	Zofran ODT	4 mg ODT	8 mg
	Oral Glucose			
	Rocuronium	**Zemuron**	**10 mg/ml Vial**	**150 mg (150 mg max)**
	Sodium Bicarbonate	$NaCHO_3$ 8.4%	50 meq/50 ml Syringe	150 meq
	Sodium Chloride	NaCl 0.9%	10 ml Syringe	100 ml
	Sodium Chloride	NaCl 0.9%	100 ml Sealed bag	200 ml
	Sodium Chloride	NaCl 0.9%	1000 ml Bag	1000 ml
	Sodium Chloride	NaCl 0.9%	1000 ml Bag	2000 ml
	Succinylcholine	Anectine	200 mg/10 ml Vial	200 mg (400 mg max)
	Tetracaine 0.5% eye drops	Pontacaine OP 0.5%	20 mg/4 ml Eye Drops	4 ml
	Tranexamic Acid (TXA)	Cyklokapron	1000 mg/10 ml Vial	1000 mg
	Vecuronium	**Norcuron**	**10 mg Powder Vial**	**30 mg (30 mg max)**
	Mercyhealth Additional Medications			
	Calcium Chloride 10% Solution		1 GM/10 ml preload syringe	
	Diltiazem	Cardizem	5 mg/ml – 5 ml vial	
	Hydromorphone	Dilaudid	1 mg/ml	
	Magnesium Sulfate 50%		5 GM/10 ml preload syringe or 2 GM bags	
	Lactated Ringers		1000 cc	**Page 2 of 2**