

Appendix F

APPLICATION FOR MEDICAL CONTROL AUTHORIZATION



INSTRUCTIONS:

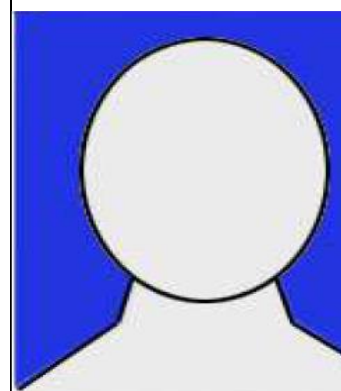
Sponsor Hospital Council of Greater Bridgeport (SHCGB) extends Medical Control Authorization for advanced-level providers during a two-year cycle. This application form is valid for new medical control authorizations and all medical control renewals for the October 1, 2025 – March 31, 2028 cycle. For renewal applications, to ensure uninterrupted Medical Control Authorization, it is suggested you complete the application & submit it four business days prior to the deadline. Later applications will be accepted; however, there is no guarantee it will be processed by the March 31, 2028, deadline. There is a 30-day suspension required for all late submissions after the closing date and from the time application approved as complete.

- EMRs and EMTs: NO application is required. SHCGB will extend medical control to all EMRs and EMTs with active, unencumbered State of Connecticut certification unless a review is deemed necessary due to prior medical control issues. Your service must advise SHCGB before you are functioning at the EMR or EMT level. This also applies to paramedics functioning with an EMS Organization at a BLS provider level.
- Paramedics: Application required. **Current Medical Control Authorizations expire on March 31, 2028**. Providers must submit completed application packages for renewal.

Medical Control Authorization is provided to EMS Providers in conjunction with active affiliation with an SHCGB-sponsored EMS Organization. Once authorized, a provider may add a service affiliation by submitting pages 1-2 of this application

**ATTACH A PASSPORT-SIZED
(2" X 2")
COLOR PHOTOGRAPH**

NEW APPLICATIONS ONLY



Please Print Clearly on all sections

TYPE OF APPLICATION

- ☐ Initial
- ☐ Renewal
- ☐ Site Addition

NREMT #

St License #

DATE OF APPLICATION

M	M	D	D	Y	Y	Y	Y
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LAST NAME										FIRST NAME									
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MAILING ADDRESS

STREET ADDRESS																			
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CITY										STATE		ZIP CODE							
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HOME PHONE										MOBILE PHONE									
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EMAIL ADDRESS																			
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OTHER SPONSOR HOSPITAL MEDICAL CONTROL AUTHORIZATIONS:

☐	Greenwich Hospital	☐	Bridgeport Hospital Milford MC	☐	Norwalk Hospital
☐	Griffin Hospital	☐	New Haven Sponsor Hospital	☐	Stamford Hospital
☐	Other:				

Has your license/certification ever been subject to disciplinary action by the State of Connecticut, SHCGB, or another Sponsor Hospital?

☐
☐

No

Yes (Attach details)

ATTESTATIONS & SERVICE AFFILIATIONS**APPLICANT**

I attest that the information provided in this Medical Control Authorization Application has been completed by myself and is accurate and truthful. I understand that any false or misleading information may result in withholding Medical Control Authorization and notification to the Connecticut Department of Public Health (DPH) and other Sponsor Hospitals with whom I have Medical Control Authorization.

I give the EMS Coordinators and EMS Medical Directors permission to request further proof or audit my attendance from the instructor/coordinator of any continuing medical education programs listed in my application. I further permit the EMS Coordinators and EMS Medical Directors to both request and share information with other Sponsor Hospitals and the DPH regarding my Medical Control Authorization. I further give the EMS Coordinators permission to email me SHCGB information from time to time.

I understand that my responsibility is always to maintain the minimum requirements for Medical Control Authorization and follow all current policies of SHCGB. Failure to maintain such minimum requirements shall result in my Medical Control Authorization being withheld automatically without further notice. The minimum requirements are:

- Maintain active, unencumbered DPH licensure or certification at the authorized level
- Current CPR certification at the AHA BLS or ARC BLS level
- Paramedics must maintain active certification in both AHA or ARC ACLS and PALS.
- **New graduate Paramedics attest to having completed at least three (3) successful live intubations during school or will notify the EMS Coordinators.**

Printed Name of EMS Provider	Signature of EMS Provider	Date

SERVICE AFFILIATION(S) – (ALS Services Only)

I attest that the individual named on this application is affiliated as an active member/employee or an applicant with whom our EMS Organization is considering for membership/employment. Our EMS Organization wishes to permit the applicant to function for our service at the advanced level indicated on this application. I further attest that our EMS Organization is not aware of any unreported, outstanding quality assurance issues relative to the applicant's prehospital care.

- For INITIAL / RENEWAL applications: COMPLETE BELOW FOR **ALL** AFFILIATED SERVICES and submit the entire package
- To ADD A SERVICE AFFILIATION ONLY: COMPLETE BELOW **ONLY** FOR THE ADDITIONAL SERVICE and submit only pages 1-2

✓	Service	Name of Signing Official	Title	Signature	Date
☐	AMR - Bridgeport				
☐	Monroe EMS / VEMS				
☐	Yale EMS (Nelson)				
☐	Stratford EMS				
☐	Trumbull EMS				

CONTINUING MEDICAL EDUCATION

- ☐ Complete the log below and attach copies of license and certification cards including- CT Paramedic, AHA-BLS CPR, American Heart Association or American Red Cross ACLS & PALS certifications.
- ☐ Ensure you have met total requirements: You must show a variety, including medical, trauma, pediatrics, and OBGYN, as detailed in the renewal document.
 - Paramedics: 32 hours of CME -Training certificates are not required unless audited.
- ☐ Maximum Contact Hours to Claim (refer to the document "CME Requirements" for clarification)

Additional Training		1st Year of renewal cycle Refresher Training	2nd Year of renewal cycle Refresher Training	
SCT Trained	Yes ☐ No ☒	Date	Date	
Blood Trained	Yes ☐ NO ☐	Date	Date	
RSI Trained	Yes ☐	Date	Date	
Date	Subject	Location	Instructor	Contact Hours
	AHA or ARC BLS-CPR Certification			
	AHA/ ARC ACLS and PALS Initial only			
	2- Hour SHCGB Protocol Update CME Course (Renewal only)			
	Paramedic Refresher if Done			
	PHTLS or ITLS (initial apps only)			
	Practical Skills Session			
TOTAL HOURS THIS PAGE				

CME LOG – PAGE 2 (IF NEEDED)

PLEASE VERIFY THAT YOUR APPLICATION IS COMPLETE BEFORE SUBMISSION:

- ☐ Your information is completed on page 1
- ☐ Your name is printed on top of all pages of the application
- ☐ Your signature on page 2
- ☐ Signature(s) from all Services where you have affiliation
- ☐ Completed CME log
- ☐ Copies of all the attachments noted in the above section

SUBMIT COMPLETED APPLICATION TO EITHER EMS COORDINATOR: Note: if the document is scanned or faxed color copy is required

Leigh Goodman Bridgeport Hospital 267 Grant Street Bridgeport, CT 06610 Office: 203-384-3116 Fax: 203-384-3639 Leigh.Goodman@bpthosp.org	Elizabeth Egan St. Vincent's Medical Center 2800 Main Street Bridgeport, CT 06606 Cell: 203-305-9310 Elizabeth.Egan@hhchealth.org
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