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| DEPARTMENT OF HEALTH SERVICES Division of Public Health  F-47470 (02/2022) | | | | STATE OF WISCONSINWis. Admin. Codes 110, 111, 112, 113, 608-266-1568 | | | |
| CHANGE OF EMS MEDICAL DIRECTOR | | | | | | | |
| This form is authorized under Wisconsin Stat. § 256, and Wisconsin Administrative Codes DHS 110, 111 112 and 113. Completion of this form is mandatory for a change of emergency medical service medical director. Personally identifiable information requested on this form will be used for Wisconsin EMS Section and licensure purposes only. | | | | | | | |
| **INSTRUCTIONS:** Complete this word-fillable form. Save and print. Sign and send a copy to the address at the bottom of this form or scan and email to [dhsemssmail@wisconsin.gov](mailto:dhsemssmail@wisconsin.gov). | | | | | | | |
| MEDICAL DIRECTOR INFORMATION | | | | | | | |
| Emergency Medical Service Provider Name (If more than one service is affected, submit a separate form per service.) | | | | | | | |
| Medical Director Name | | | Wisconsin Medical License Number  M.D.       or D.O. | | | | |
| Address | | | Mailing Address (if different) | | | | |
| City | | State | Zip Code | | | | County |
| Date of Birth | | E-mail Address | | | | | |
| Effective Date | Gender  Male  Female | | Daytime Telephone Number | | | | Other Telephone Number |
|  | | | | | | | |
| **MEDICAL DIRECTOR CERTIFICATION** | | | | | | | |
| I am aware of and have reviewed the EMS Medical Directors’ Resources at <http://www.dhs.wisconsin.gov/ems/system/meddirresources.htm> including the Medical Director Course, s. 256, Wisconsin Statutes and applicable administrative code. I have reviewed and approve this service’s current patient care protocols/guidelines and operational plan and will participate in periodic training and evaluation to assure individuals’ competency. I will provide medical direction for this service in accordance with applicable Wisconsin Statutes and administrative code pertaining to emergency medical services. | | | | | | | |
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| **SIGNATURE** – Medical Director | | | | | | Date Signed | |
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| **SERVICE DIRECTOR CERTIFICATION** | | | | | | | |
| I acknowledge and request this change of medical director for the above-named service. | | | | | | | |
|  | | | | |  |  | |
| **SIGNATURE** – Service Director | | | | | | Date Signed | |
| Return this document along with a copy of the medical directors’ resume (curriculum vitae) to:  **DIVISION OF PUBLIC HEALTH**  **WISCONSIN EMS SECTION**  **PO Box 2659**  **Madison, WI 53701-2659** | | | | | | | |