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| DEPARTMENT OF HEALTH SERVICESDivision of Public HealthF-47470 (02/2022) | STATE OF WISCONSIN Wis. 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. |
| 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 NumberM.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      |
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| **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. |
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| **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** |