MEDICAL DIRECTOR AGREEMENT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
(07/2011, 02/2012)

INSTRUCTIONS: This form may be completed electronically or by hand. Once completed please print, sign and mail or fax it to the address listed above. A current medical director agreement must be on file for each service at all times. All license applications, etc. must be signed by the medical director on record or they will be returned.

Physician Medical Director			
First Name	Last Name		MI
Street Address / PO Box		City	
State	Zip Code	Telephone Number	
ND License Number			

I, Dr. _____ agree to function as Physician Medical Director for _____ Ambulance Service, it's associated substation units and/or Quick Response Unit(s). As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service and its associated substation(s) and/or Quick Response Unit(s). The emergency medical services personnel working either as volunteers or as compensated employees for these services are acting as my designated agents when providing patient care. It is my duty to assure that a system for quality improvement is developed and implemented. I will provide input on training issues and provide online medical direction when necessary.

The expiration date of this agreement will coincide with the expiration date of the ambulance or may be terminated upon written notification to the Division of Emergency Medical Service and Trauma.

Medical Director Signature	Date

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
600 E. BOULEVARD AVE. DEPT 301
BISMARCK, ND 58505-0200
dems@nd.gov
Fax: 701.328.1702

Click here to print form. Once printed sign and mail or fax to DEMST.