EMERGENCY MEDICAL SERVICES
INDIVIDUAL PROTOCOLS ROSTER

Oklahoma State Department of Health

INSTRUCTIONS: *To be completed by Ambulance Services and EMR Agency Administration. This form shall include 911 personnel under* ***INDIVIDUAL PROTOCOLS (IP's)*** *and must be signed by* ***EACH*** *Provider, The Medical Director, and Administrator. If additional spaces are needed please reprint and reuse blank form. You must also obtain applicable signatures on each additional page.*

PLEASE TYPE OR PRINT LEGIBLY!

Name of Service: _____

_____ _____ _____

(Agency Address) **(Point of Contact Email)** **(Point of Contact Fax #)**

As The Medical Director and Administrator for the named Ambulance/EMR Service, I hereby verify that the information on this document is true and correct, to the best of my knowledge.

Medical Director: _____

_____

(Medical Director's Signature) ***(Email)*** ***(Date)***

Agency Administrator: _____

_____ _____

(Signature) ***(Title)*** ***(Date)***

NAME	OK LIC #	Level	Signature	Date