NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Notice of Intent to Possess and Use Epinephrine Auto Injector

Name of Entity	Agency Code #	Business Phone (____) _____-________
Mailing Address City : Zip: Primary County of Operation:	State:	Fax No. (____) _____-________

Type: Ambulance Service ALSFR Service Overnight Camp Summer Day Camp

Traveling Summer Day Camp Other________________________________

If a camp check all that apply: Camp Premises or Infirmary Off-Site Trips/Events

Name of Emergency Health Care Provider (MD or Hospital)	Business Phone No. (____) _____-_______
If a Hospital Provide Name of Contact:	Fax No. (____) _____-_______
Address City:	State: Zip:

Number of Trained Providers to Use Auto Injector in EMS service or camp:

Minimum Number of Injectors to be Maintained On-Site: ___________

Maximum Number of Injectors to be Maintained On-Site: ___________

Authorizations:

Print Name of Service CEO or Camp Director Date	Print EHC Provider (name) Date
Signature	Signature

Send this form and your Collaborative Agreement to the Regional EMS Council listed in the attachment.

DOH – 4188 (4/00) Distribution: REMSCO (White Copy) & NYSDOH – EMS (Canary Copy)