THE University of Vermont HEALTH NETWORK
Elizabethtown Community Hospital
EMERGENCY MEDICAL SERVICES PROGRAMS

ECH / Essex County QA/QI Program Agreement

Agency: _____ Care Level: ____ Year: ____

Primary Representative:
_____
Phone Number: _____
E-Mail: _____

Medical Director:
_____
Phone Number: _____
E-Mail: _____

Alternate Representative:
_____
Phone Number: _____
E-Mail: _____

ALS Coordinator:
_____
Phone Number: _____
E-Mail: _____

Alternate Representative:
_____
Phone Number: _____
E-Mail: _____

Controlled Substance Officer:
_____
Phone Number: _____
E-Mail: _____

Chief Officer:
_____
Phone Number: _____
E-Mail: _____

Please attach a membership roster to this form including names, certification levels, certification numbers, and TEK numbers.

By signing below, agencies have read and agree to the ECH/ Essex County QA/QI Plan, and agree to abide by the requirements of the plan. Agencies participating with the program consent to allow the ECH/ Essex County representative, currently Michael Weller, access to their Patient Care Reports, Data, and the New York State ImageTrends Bridge, for the sole purpose of gathering regional data and program coordination. Agencies should update information with the program anytime they have a change in representatives.

Agency Representative: _____

Medical Director: _____

ECH QA Representative: _____