NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services
Blood and Tissue Resources Program

Notice of Intent to Provide Ambulance Transfusion Services

☐ Original Notification ☐ Update Date _____

Ambulance Service Information

Name of Organization	E-mail
Name of Primary Contact Person	Telephone Number
Address	Fax Number
City	State ZIP

Type of Ownership (please check the appropriate box)

☐ Fire Department ☐ Commercial ☐ Municipal/Government ☐ College/University
☐ Independent ☐ Hospital Owned ☐ Industrial

Level of Care (as approved by the local REMAC and recognized by DOH EMS)

☐ EMT – Critical Care ☐ EMT - Paramedic

Type of Ambulance Service

☐ Air ☐ Ground ☐ Both

Education Program Information

Name of Course Sponsor	Number of Trained EMS Providers EMT-Ps _____
Name of Instructor(s)	EMT-CCTs _____

Service Medical Director

Name of Ambulance Service Physician Medical Director	NYS License Number
Address	Telephone Number
City State ZIP	Fax Number

Authorization Names and Signatures

CEO or Designee (Please print)	Signature	Date
Medical Director (Please print)	Signature	Date

FOR DEPARTMENT USE ONLY

Bureau of EMS (Please print)	Signature	Date
Blood and Tissue Resource Program (Please print)	Signature	Date