SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Medical Control Physician

South Carolina Department of Public Health
Division of EMS and Trauma
Medical Control Physician Update Form

Section I

1. **Service Information**

Service Name _____ SC DPH License #: _____

Service Mailing Address _____

City/State/Zip Code _____

Telephone Number _____ FAX Number _____

2. **Medical Control Physician Information**

☐ Primary ☐ Assistant

_____
Name Med Control Physician SC Lic.#

_____
E-Mail Address

_____
Mailing Address

_____
City/State/Zip

(____) _____ (____) _____
Telephone Number Emergency Number

Gender: ☐ Male ☐ Female

Race: (Select)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race

Ethnicity: (Select)
☐ Hispanic or Lantino
☐ Not Hispanic or Lantino

Statement of Understanding & Authorized Signatures:
I have read and understood the duties & responsibilities of the Medical Control Physician as outlined in Regulation 61-7 § 402 (A through G) and § 44-61-130. Of the EMS law also included on this form. Further, If my EMS service has a State-Approved In-Service Training program, I accept full responsibility for the program and understand that I may not waive anyone from the State recertification examination until I have attended a State-Approved EMS Medical Control Workshop. If I have not already attended a Medical Control Physician Workshop, I understand that I must attend the next available workshop within the next twelve (12) months in order to remain as Medical Control Physician for the above EMS service.

☐ I have Attended a Medical Control Workshop ☐ I have not Attended a Medical Control Workshop

_____ _____
Signature Primary Med Control Physician/Date **Signature ASSISTANT Med Control Physician/Date**

I understand that I must Notify the SCPH Division of EMS & Trauma of any change in Medical Control, Drug List, and/or Standing Orders/Protocols within ten (10) days (Regulation 61-7 ,§ 402 E)

_____
Signature EMS Director/Date