



Medical Control Physician

South Carolina Department of Health and Environmental Control
Bureau of EMS & Trauma
Medical Control Physician Update Form

1. Service Information

Service Name _____ SC DHEC License # _____

Service Mailing Address _____

City/State/Zip code _____

Telephone Number _____ Emergency Number _____

2. Medical Control Physician (MCP) Information

Primary Assistant

Name of MCP _____

SC BOME # _____ SC DHEC BEMS# _____ SC _____

Email Address _____ Gender: Male Female

Mailing Address _____ Race: (Select)

City/State/Zip _____ American Indian or Alaskan Native

Phone # _____ Asian Black or African American

Emergency # _____ Native Hawaiian or Pacific Islander

White Other

Ethnicity: (Select)

Hispanic or Latino

Not Hispanic or Latino

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 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 of Primary MCP & Date

Signature of Assistant MCP & Date

I understand that I must Notify the SCDHEC Bureau 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 of EMS Director & Date _____