NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Certified EMS Agency
Information Update Form

Name of Service	DOH Agency ID #:
DBA or Assumed Name if any	
Physical Location / Address	
Service Mailing Address	
City, State, Zipcode	City: State: Zip:
County	
Business Phone Number	
Fax Phone Number	
Emergency Phone Number	☐ Check Box if Called Thru 911
Chief Operations Officer & Title	
Chief Officer Day Phone	
Chief Officer Home / Night Phone	Cell / Pager #:
Name of Dispatching Agency	☐ Check box if Self Dispatched
Dispatch Communications	Radio Frequency: FCC Callsign:
Number of Certified Providers	CFR: EMT-D: EMT-I**: EMT-CC**: EMT-P**:
Number of Response Vehicles	Ambulance: EASV: ALS-FR:
Service Medical Director: Name	NYS License #:
REMAC Authorized Level of Care	Circle Highest Level *: EMT EMT-D EMT-I EMT-CC EMT-P
Email Address of Chief Ops officer	
Number of EMS Calls Annually	# of Calls Dispatched to- Total: #Calls - Emergency:
Please print legibly name & title of person Completing this form	Name: Title:
Signature and Date of Person Completing This Information Form	Signed: Date:

* NOTE: DEFIB and ALS levels of care require written REMAC approval. Contact your REMSCO for ALS credentialing criteria.
** NOTE: ALS Certified personnel may ONLY provide care at BLS level when responding with BLS authorized services.

REMINDER: Please submit an update for your agency if your location, mailing address, Chief of Operations or contact information / phone numbers change.   – **THANK YOU!** -

Certified Services: Please complete form with your Information and send it to the address to the right. If you have questions about Filling out this form, please contact the DOH Bureau of EMS, Operations Section for Assistance at 518-402-0996 extension 2.

Return Completed Form to:

Attn: Agency Update - OPS
NYS DOH Bureau of EMS
433 River Street Suite 303
Troy, New York   12180-2299

Do Not Write or Mark in Box Below

Update Rcd:	Data Entry:	Entry By:	Notes: