Monroe Livingston Region Program Agency

Division of Prehospital Medicine, University of Rochester
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ADVANCED LIFE SUPPORT

PRECEPTOR RECOMMENDATION FORM

Provider Name: ________________________________ **NYS EMT#:** _________________

Provider Level: ________________________________

Agency: _______________________________________ **Request Date:** ________________

Years Certified at Current Level: _________________ **Clearance Date:** ______________

MLREMS Protocol Exam Score: _________________ **Exam Date:** __________________

Note: If the individual being nominated does not meet the requirements for ALS Preceptor as outlined in Monroe-Livingston Regional Policy 9.22: ALS Preceptor Policy this Recommendation must be accompanied by a letter outlining the experience and/or additional training that this individual has in order to be considered for such a waiver and that letter must be signed by the Agency Medical Director.

I affirm that the provider listed above meets all of the requirements for ALS Preceptor as outlined in Monroe-Livingston Regional Policy 9.22: ALS Preceptor Policy.

This provider does not meet all of the requirements for ALS Preceptor as outlined in Monroe-Livingston Regional Policy 9.22: ALS Preceptor Policy. I am requesting a waiver of those requirements and have attached a letter signed by the medical director as noted above.

As ALS Chief, I affirm that I and the Agency Medical Director support the nomination of this individual as a Preceptor in the Monroe-Livingston Region. I forward this recommendation for REMAC QA Committee consideration on behalf of the agency listed above.

ALS Chief Name: __________________________________ **Date:** ____________________

ALS Chief E-Mail Address: ____