

MEDICAL DIRECTION COMMITTEE
1041 Technology Park Dr, Glen Allen, Virginia
Conference Rooms A and B
October 10, 2013
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Marilyn McLeod, M. D. - Chair Paul Philips, D.O. George Lindbeck, M.D. Asher Brand, M.D. Charles Lane, M.D. Theresa Guins, M.D. Forrest Calland, M.D. E. Reed Smith, M.D. Allen Yee, M.D. Christopher Turnbull, M.D. Scott Weir, M.D. Cheryl Lawson, M.D. Stewart Martin, M.D.	Nael Hasan, M.D. Chief Eddie Ferguson	Gary Brown Michael Berg Warren Short Greg Neiman Debbie Akers George Lindbeck, M.D.	Chad Blosser Cathy Cockrell Gary Critzer E. Wayne Perry Bradley Beam John Dugan

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
1. Welcome	The meeting was called to order by Dr. McLeod at 10:37 AM	
2. Introductions	Introductions were made.	Meeting Sign-in Roster Attachment "H"
3. Approval of Minutes	Approval of minutes from the April 11, 2013 meeting.	Motion by Dr. Weir, seconded by Dr. Lane to approve. Passed.
4. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues	Dr. Lindbeck stated nothing new to report. Discussion was held about the delivery of drugs that are expired. Discussion concerning whether EMD's are offering instructions to not administer a drug that is expired.	
5. New Business		
A Drug Diversion – Charles	Discussion by committee concerning growing issue of drug diversion, whether it is from drug boxes	Dr. Lane and Dr. McLeod to get

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
	Lane, M.D and Marilyn McLeod, MD	maintained on the EMS agencies in the region or from stealing from the patient. Examples were given by various regions experiencing this issue and concern was expressed about lack of prosecution by the law enforcement investigating the situation. Michael Berg offered insight from OEMS on the procedure followed when made aware of the situation. Michael Berg also discussed the one for one drug exchange by EMS systems in Virginia and Board of Pharmacy will be implementing changes on this procedure. Discussion concerning regional drug kits and the pharmacies and how this could be impacted.	together and start work on a plan to be brought back to Medical Direction.
B	MIHP - Community Paramedicine – Marilyn McLeod, MD	Dr. McLeod notified committee of meeting held on October 9, 2013 to begin work on the process of implementation of MIHP-CP programs throughout Virginia. Some of the discussion was that EMS is not a home-health agency but who is going to regulate and should a license be required if crossing the boundary of home health.	Dr. McLeod will keep committee
C	Naloxone article – Marilyn McLeod, MD	Dr. McLeod had forwarded an email in September 5, 2013 concerning the use of Naloxone by the general public. Asked for feedback from committee. Dr. Yee discussed his agencies involvement in promoting this idea in his area.	
D	Scope of Practice - Intermediate – Asher Brand, MD	Dr. Brand discussed issues in his area of Intermediates doing Critical Care transports and the use of blood products and arterial line maintenance. It is creating an issue for his rural hospitals to get patients out of hospitals due to Intermediates not being authorized to perform these skills. Discussion by committee concerning need for higher level of care for these types of patients. Feeling of committee is that the hospital is responsible for the provision of care of the patient and is placing this responsibility on the EMS system. Responsibility should fall on the attending physician.	Dr. McLeod to ask Dr. Mark Franke to present the results of his pilot study on EMT-Intermediates performing RSI in his region.
E	Tactical Emergency Casualty Care/Northern VA high threat response initiatives – E. Reed Smith, MD	PowerPoint presentation of Tactical Emergency Casualty Care and the EMS approach to such incidences. Presented information on Tactical Combat Casualty Care and applying lessons learned to civilian high threat prehospital care and the establishment of C-TECC (Civilian Tactical Emergency Casualty Care). Link to material is www.C-TECC.org . Will share information with anyone interested. Dr. Lane stated that initiative was taken last year and applied for RSAF but grant was denied. Feelings expressed were those that this type of initiative should be supported.	
6. Old Business			
A	Status of removal of recertification test requirement and test waiver	Michael Berg reported that the change has been sitting in secretariats office now for 31 days. Effort has been made to reach out to secretary to see if this can be promoted. Will then move to the governor for signature and after that signature will have to sit for a 30 day comment period.	
B	HB1856 Work Assignment – BLS Template – George Lindbeck, MD	Reviewed by the Committee and discussion concerning the initial template was held. Recommendations to change spinal immobilization to spinal motion restriction. Further discussion concerning cardiac arrest management slide. See Attachment ‘A’	Motion by Dr. Yee to approve as an initial draft of a working concept but that it remains a work in progress. Seconded by Dr. Martin,

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
			Motion carried.
C	HB1856 Work Assignment – OMD Appeals Process – Marilyn McLeod, MD	Dr. McLeod presented the revised template for EMS Provider appeals. Discussion concerning the template and revisions made. See Attachment ‘B’.	Dr. McLeod to submit revised template to satisfy HB1856 work assignment.
7. Research Notes		No Items presented.	
8. State OMD Issues – George Lindbeck, MD			
A & B	Scope of Practice Grids	Dr. Lindbeck presented revised Scope of Practice. Discussion and review conducted by MDC. See Attachment ‘C’.	Motion by Dr. Weir, seconded by Dr. Lane to approve revised Scope of Practice. Action item to be presented to EMS Advisory Board to approve revised Scope of Practice Procedure and Formulary Grids.
C	BLS Patient Care Template	Covered above under Old Business	
Office of EMS Reports			
A	BLS Training Specialist – Greg Neiman	Reviewed the ALS clinical and competency hours. Dr. Yee wanted to discuss the need for only one intubation. Requested that a survey be conducted of the hospitals/anesthesia groups to find out if the availability of rotations for students in the OR. Stated that the TCC will be reviewing the Clinical Education requirements and the ability to offer experiential credit. Will be working with a subcommittee to review the practice and establish new guidelines based on the revision to the clinical and competency hours. Will specifically review the RN to Paramedic bridge requirements.	
B	Funding and Accreditation – Debbie Akers	Distributed EMS Training Funds Summary effective October 8, 2013. Advised that there had been a reduction of \$800,000 in the monies available to offer for funding this year from \$3.2 to \$2.4 million. Allocated monies are approaching \$2.1 million. See Attachment ‘D’. Distributed the Accredited Training Center report. Noted that several programs have been through their CoAEMSP accreditation visit in the past several months. All Paramedic programs are now either CoAEMSP accredited or under Letter of Review. One program is currently working toward submission of a Paramedic self-study. Notification has been received of a new request for Intermediate accreditation from a program in Southwest Virginia. See Attachment ‘E’.	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
D	Division of Educational Development – Warren Short	Warren reviewed with the committee the TCC proposal on HB1856 that will be presented as an action item to the EMS Advisory Board. MDC committee expressed their support of the proposal. See Attachment ‘F’. Distributed the National Registry results as of 09/26/2013. See Attachment ‘G’. Stated there is concern by the Division of Educational Development on the pass percentage at the EMT level. A working group will be established working with TCC to address Best Practices. Stated that the OMD portal is in the final stages of development and will become active with a target date of December, 2013.	
E	Regulation and Compliance – Michael Berg	Stated the practitioner signature was approved by the Board of Pharmacy on 9/25/13. It has been fast tracked and is with the AG’s office for review. Discussed regulatory changes and review. Stated RSAF are looking at making some technical changes and that Medevac will be reviewing their section at a meeting on November 9 th and 10 th . Section 9.10 – the word affiliation was left off, this has gone to the AG for review. Stated there is no fast track for training. They will have to work on revisions to the regulations	
PUBLIC COMMENT		None	
For The Good Of The Order			
Meeting Dates for 2014		January 9, 2014, April 10, 2014, July 10, 2014, October 9, 2014	
Adjournment		13:54	

Attachment A

BLS Patient Care Template

DRAFT

9/12/13

Universal Patient Care Guideline

Scene Safety/ Personal Protective Equipment
Primary Survey
Supplemental O2
Obtain and document: Vital signs SAMPLE history Pain assessment OPQRST (medical) DCAP BTLS (trauma)
Appropriate guideline/ consider differential diagnoses If no guideline applies or condition is unknown, consult on-line medical control
Transport per guidelines

Cautions and notes:

Complete vital signs should be taken every 5 min for critical and 15 min for non-critical patients.

Complete vital signs include a minimum of HR, RR, and BP

Complete vital signs include pulse oximetry

Do not delay oxygen therapy to obtain pulse oximetry reading.

Abdominal Pain

B	Universal Care Protocol	B
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Cautions and notes:

Consideration should be given to other causes of pain that could be interpreted as abdominal in origin such as cardiac pain

For patients who require pain medication or nausea medication, ALS care should be requested .

Acute Psychological Agitation

B	Universal Care Protocol	B
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Cautions and notes:

Careful consideration should be given to acute injuries and/or illnesses that could be responsible for acute changes in behavior, such as hypoglycemia and hypoxia, head injury, or stroke/ICH.

Consultation with law enforcement, mental health professionals, and medical command should guide patient disposition. ALS care should be requested for patients who require sedation for agitation of a degree that represents a risk of injury to themselves or others.

Physical restraint should be undertaken with caution, and in cooperation and collaboration with law enforcement.

Allergy/Anaphylaxis

B	Universal Care Protocol	B
B	Remove from source of exposure.	B
B	Administer epinephrine using an auto-injector device for severe hives, respiratory distress, and/or shock.	B

Envenomation

B	Universal Care Protocol	B
B	Refer to allergy/anaphylaxis guideline if needed.	B
B	Minimize activity, remove tight clothing or jewelry, immobilize extremity at level of heart.	B
B	For exotic animals contact Poison Control. Do not delay transport.	B

Cautions and Notes:

Signs of envenomation include swelling that begins at the bite mark and spreads proximally within minutes, ecchymosis, hemorrhagic blisters, and severe pain.

Do not use constricting bands or tourniquets, apply cold, incise, or use suction or extractor devices in pit viper envenomations.

Notify the receiving facility if the animal involved is co-transported.

Black widow spider envenomations may present with painful muscle spasms.

Consider contacting Poison Control at 1-800-222-1222

Hyperthermia

B	Universal Care Protocol	B
B	Move to cooler environment, remove excess clothing, protect from further heat gains.	B
B	For heat exhaustion, PO water if patient can tolerate. Cool with wet towels or fans.	B
B	For heat stroke, use aggressive evaporation (fine mist water spray, ice packs to groin and axillae).	B

Cautions and Notes:

Prescription medications and alcohol may predispose patients to hyperthermia.

ALS care should be sought for patients with heat exposure and inability to tolerate oral rehydration, lack of response to oral hydration, or altered mental status.

Hypothermia

B	Universal Care Protocol	B
B	Refer to Special Arrest: Hypothermic Arrest Protocol if needed	B
B	Remove wet/cold garments.	B
B	Protect from further heat loss. Increase ambient temperature.	B
B	Apply heat packs if patient is responsive.	B
B	If moderate to severely hypothermic, wrap head and core with blankets.	B

Cautions and Notes:

If patient is centrally cold to touch, consider severe hypothermia.

Avoid rough handling of the severely hypothermic patient.

Consider hypothermia as a component of acute medical illnesses.

For local cold injury, do not initiate re-warming if there is a risk of re-freezing.

For review – Alaska guidelines

SEVERE HYPOTHERMIA WITH NO LIFE SIGNS:

Rewarming is key to arrest survival in hypothermia. Field techniques are ineffective. The goal is to deliver a viable patient to a facility that can perform effective rewarming (most clinics and hospitals).

Treat as above.

Use **mouth-to-mask** breathing.

An AED may help determine cardiac activity. If any organized (other than VT) electrical rhythm is shown, do not start CPR.

If no pulse (after checking for up to 60 seconds) and no respirations and no contraindications, start CPR. Initiation of chest compressions should only follow careful and adequate ventilation for 3 minutes.

Be careful to not hyperventilate patient-blows off CO₂ and causes vasoconstriction.

If CPR can not be continued, it should not be started.

If facility or transport unit is available in less than 3 hours, do not start CPR. If not, and indicated, do CPR for 30 minutes and terminate if no response. If the core temperature is **86° F (30°C) or greater, defibrillation may be used** when indicated.

If core is less than **86° F (30°C)**, one set of three stacked shocks may be given if indicated.

If resuscitation has been provided in conjunction with rewarming techniques for more than 60 minutes without the return of spontaneous pulse or respiration contact the base physician for recommendations. If contact with a physician is not possible and delivery of the patient to the receiving facility will be delayed, Emergency Medical Technicians may consider terminating the resuscitation in accordance with AS 18.08.089.

Near Drowning

B	Remove from water if trained and safe to do so.	B
B	Spinal immobilization if spine injury is suspected or not able to be determined	B
B	Prevent heat loss, refer to "Hypothermia" protocol if indicated.	B

Cautions and Notes:

All near drowning patients should be transported/evaluated

Almost all near drowning victims will be hypothermic to a greater or lesser extent.

Assess type of incident for the risk of other injuries (surface impacted, object strike, propeller trauma).

Assess water conditions (depth of submersion, length of time).

Monitor airway status closely.

Poisoning/ Overdose

B	Universal Care Protocol	B
B	Identify substance and assure decontamination.	B
B	Flush skin/membranes with water unless contraindicated.	B
B	Naloxone (Narcan) 2 mg IN, titrate to reverse respiratory depression for suspected narcotic overdose.	B

Cautions and notes:

Poison control should be contacted **at 1-800-222-1222**.

ALS care should be sought for patients with abnormal vital signs, significantly altered mental status, and any need for assistance with airway and ventilation.

Aeromedical resources will not transport contaminated patients.

Cardiac Arrest: General Management

B	Universal Care Protocol	B
B	Criteria for Death/ No Resuscitation?	B
B	CPR Interrupt compressions only as per AED prompt or every 2 minutes (5 cycles of CPR)	B
B	AED If witnessed or bystander CPR in progress, apply immediately If unwitnessed, use after 2 minutes of CPR	B
B	Advanced Airway Management Ventilate no more than 10/min (1 breath every 6-8 seconds)	B

Cautions and notes:

Change compressors every 2 minutes.

Allow full chest recoil.

Check femoral/carotid pulse to verify effective CPR.

Chest Pain/ Acute Coronary Syndrome

B	Universal Care Protocol	B
B	Obtain 12 Lead ECG per 12-lead guideline, Transmit 12 Lead ECG per local protocol Consult on-line medical control if acute myocardial infarction or STEMI criteria recognized Transport to closest appropriate facility per local/regional STEMI guidelines	B
B	Aspirin 162 to 324 mg (2-4 baby aspirin) chewed	B
B	Nitroglycerin 0.4 mg every 5 minutes as needed for continued chest pain. No maximum, keep BP >100 mmHg.	B
B	Apply 1 inch 2% Nitropaste (15 mg) topically keeping BP >100 mmHg.	B

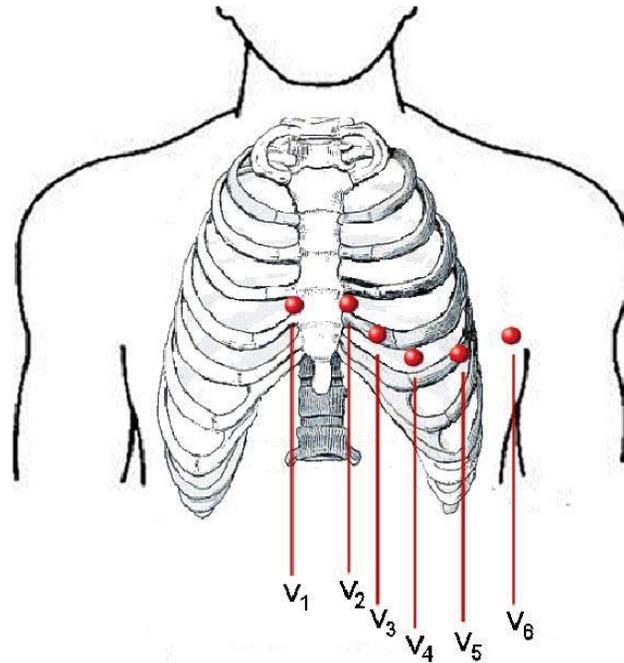
Cautions and Notes:

ALS care should be sought for all patients treated for chest pain or who have had a 12 lead EKG obtained.

If use of Viagra, Levitra, or Cialis within the last 72 hours, contact medical command prior to administering nitroglycerine.

Achieving the most rapid transport to a PCI capable hospital may require consideration of the use of air medical resources.

12-lead EKG



First intercostal space is below the clavicle at the sternal border.
The first palpable space at the sternal border is considered the second intercostal space.

V1—4th intercostal space at the right sternal border

V2—4th intercostal space at the left sternal border

V3—Directly between V2 and V4

V4—5th intercostal space at midclavicular line

V5—5th intercostal space at anterior axillary line

V6—5th intercostal space at midaxillary line

Altered Level of Consciousness

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B	<p>For proven or suspected hypoglycemia: Glucose orally if patient can swallow normally and protect airway Glucagon 1 mg IM if oral glucose is not appropriate.</p> <p>For suspected opiate overdose: Naloxone (Narcan) 2 mg IN</p>	B

Cautions and Notes:

Medications are a common cause of altered mental status, including new medications, changes in medication dosages, and discontinued medications (either by design or by accident).

A complete medication list is particularly important in the evaluation of these patients.

Glucometers may be very helpful but results must be interpreted cautiously, particularly if values are borderline.

The goal of naloxone therapy in opiate overdose is to reverse respiratory depression and circulatory collapse, not to restore normal mental status or completely reverse opiate effects. Repeated administration of escalating doses beginning with a conservative dose is desirable.

Seizures

B	Universal Care Protocol	B
B	Protect patient. Do not attempt to restrain.	B
	If patient is hypoglycemic refer to diabetic emergencies guideline.	
B	If patient is pregnant and no history of seizure, refer to OB/GYN Eclamptic Seizure protocol	B

Cautions and notes:

Care during the post-ictal phase should focus on supportive measures.

Status epilepticus is defined as a prolonged seizure without recovery interval, and/or lack of response to first line therapy; it is a true emergency.

Family members, friends, and bystanders can often give a great deal of information about the patient's seizure history as well as the circumstances surrounding current episode.

Care should be given to evaluating each patient for any injuries suffered as a result of a seizure.

Although seizures may not be at all uncommon for patients treated for seizures, new onset seizures require thorough evaluation to exclude a serious cause for the seizure.

Remember that anyone can suffer a seizure when under sufficient metabolic stress, such as hypoglycemia or hypoxia.

Consider overdose or accidental drug ingestion in cases of new onset or unexplained seizures; in children, be sure to consider medications of other family members or household contacts

Stroke

B	Universal Care Protocol	B
	Focused neurological exam. Cincinnati Prehospital Stroke Scale. Repeat every 15 minutes.	
B	Identify witness to last time pt was seen normal. Transport medical decision maker with pt if possible or obtain contact info for immediate contact by ED physician upon arrival.	B
	If patient's symptoms occurred less than two hours ago, refer to agency/local/regional stroke plan and/or on-line medical control to determine transport destination	
B	If patient is hypoglycemic refer to diabetic emergencies guideline.	B

Table 1: Cincinnati Prehospital Stroke Scale

Sign of Stroke	Patient Activity	Interpretation
Facial Droop	Have patient look up at you, smile and show his teeth.	Normal: Symmetry to both sides. Abnormal: One side of the face droops or does not move symmetrically.
Arm Drift	Have patient lift arms up and hold them out with eyes closed for 10 seconds.	Normal: Symmetrical movement in both arms. Abnormal: One arm drifts down or asymmetrical movement of the arms.
Abnormal Speech	Have the patient say, "You can't teach an old dog new tricks."	Normal: The correct words are used and no slurring of words is noted. Abnormal: The words are slurred, the wrong words are used, or the patient is aphasic.

Pearls:

For a stroke patient to be considered for intervention, it is crucial to determine the onset of their symptoms, or "last time seen normal", and for a medical decision maker to be available for provision of informed consent if intervention is considered.

An accurate medication list is also important in the evaluation of the stroke patient, particularly to determine whether or not the patient is taking warfarin (Coumadin) or other anticoagulants (heparin, pradaxa, or others).

CHF/ Pulmonary Edema

B	Universal Care Protocol	B
B	CPAP protocol if available Start at 5-7.5 cm H2O	B
B	12 Lead EKG, proceed to Chest Pain protocol if acute coronary syndrome is suspected	B
B	<p>If systolic BP is > 140 mm Hg: 1 inch nitropaste and NTG 0.4 mg SL every 3-5 min, repeat as needed until BP <140 mmHg</p> <p>For systolic BP between 100 mm Hg and 140 mm Hg: Maintain nitropaste and hold further SL NTG</p> <p>For systolic BP < 100 mm Hg Remove nitropaste</p>	B

Cautions and Notes:

Allow patient to assume a position of comfort, usually sitting up.

Use of nitropaste may be preferable to SL NTG if hypotension is likely to occur.

Sublingual nitrates and nitropaste may be used at the same time – sub lingual dosing used until topical nitrates have had time to achieve an effect.

Avoid NTG with use of Viagra, Cialis, or Levitra or herbal equivalents within past 72 hours.

The patient's medications may give important clues to the nature of their respiratory distress – “medication constellations” may indicate that the patient is receiving care for a primary problem such as asthma or congestive heart failure.

COPD/Asthma/Bronchospasm

B	Universal Care Protocol Refer to Allergic Reaction Protocol if needed	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B
B	Consider CPAP Protocol if available Start at 5-7.5 cm H2O	B

Cautions and Notes:

All wheezing is not asthma – consider other causes of respiratory distress including congestive heart failure, infection/pneumonia, or inhalation injury in appropriate patients. The patient’s medications may give important clues to the nature of their respiratory distress – “medication constellations” may indicate that the patient is receiving care for a primary problem such as asthma or congestive heart failure.

Pneumonia

B	Universal Care Protocol	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B
B	Consider CPAP Protocol if available Start at 5 to 7.5 cm H20	B

Cautions and Notes: Patients with pneumonia will generally have had symptoms for hours to days prior to developing severe distress. Other symptoms such as fever and the production of purulent sputum may also be present and suggest pneumonia as the cause of the patient's symptoms.
Patients with pre-existing lung disease may develop symptoms such as prominent wheezing as a result of infection.

Sexual Assault

B	Universal Care Protocol	B
B	Confirm scene safety.	B
B	Do not examine genitalia unless a hemorrhage requires bleeding control.	B
B	Save any clothing and place in paper bag.	B
B	Advise patient not to urinate, defecate, douche, or wash before ED evaluation.	B
B	Transport to facility with sexual assault examiner capabilities.	B

Cautions and Notes:

Obtain only pertinent facts related to the trauma.

Do not question about prior events or information not directly related to care (assailant description, etc).

Ensure law enforcement has been informed.

Transport with provider of same gender if possible.

Vaginal Bleeding

B	Universal Care Protocol	B
B	Collect any tissue or fetal parts. Place in paper bag then into plastic bag for physician examination.	B
B	If hypotensive, refer to hypotensive protocol.	B

Caution and Notes:

Determine last menstrual period.

Always consider pregnancy and complications in women of child bearing age.

3rd trimester bleeding may constitute a medical emergency; contact medical command promptly.

Diabetic Emergencies

B	Universal Care Protocol	B
B	Glucometer protocol per agency medical direction and/or manufacturer recommendations	B
B	For proven or suspected hypoglycemia: Glucose orally if patient can swallow normally and protect airway Glucagon 1 mg IM if no IV access if oral glucose is not appropriate	B

Cautions and Notes:

If a glucometer is not available, or if there is a question about the accuracy of blood sugar measurements, then the patient should be treated if there is any question about hypoglycemia.

Blood sugar levels may fall again after treatment, changes in the patient's condition should prompt re-evaluation and re-treatment if indicated.

Glucometers are least accurate at the extremes of their range, borderline low readings should suggest empiric treatment with glucose.

An accurate medication list is very important in assessing patients with diabetic emergencies, particularly if there have been recent changes in medications or dosages.

Acute illnesses may frequently underlie diabetic emergencies, and providers should be alert for history or circumstances that suggest illness or injury.

Glucometers vary in their requirements for maintenance; agencies should follow the manufacturers recommendations for maintenance and calibration.

Seizures in Pregnancy/Eclamptic Seizures

B	Universal Care Protocol	B
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Cautions and Notes:

Hypertension in the pregnant patient is defined as 140/90 or an increase of 30 mmHg systolic or 20 mmHg diastolic from patient's normal BP.

A prior history of seizures in a pregnant patient is very important and can greatly change management. New onset seizures during pregnancy represent a medical emergency for mother and fetus, contact medical command promptly to ensure that appropriate resources are available.

Pregnant women should be placed in recovery position whenever possible, on their left side, with legs flexed.

Trauma: General Management

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B	Notify on line medical control of possible trauma alert: Advise mechanism of injury, age and sex of patient, sites of injury, vitals and GCS if available, ETA.	B
B	Split columns within the general table for blunt and penetrating trauma?	B
B		B
B	Maintain patient warmth.	B

Amputation

B	Universal Care Protocol	B
B	For uncontrolled extremity bleeding, refer to hemorrhage control protocol.	B
B	If incomplete amputation, splint entire digit or limb in physiological position.	B
B	Place part in damp gauze, place in plastic bag, wrap in dressing, place on ice/water mix.	B

Burns

B	Universal Care Protocol	B
B	Apply dry sterile dressings.	B
B	Spinal immobilization if indicated.	B
B	Irrigate chemical burn with water if water is appropriate to chemical. If powdered chemical, brush off.	B
B	Splint fractures after applying dressing.	B

Cautions and Notes:

Electrical burns may be associated with significant internal and associated traumatic injuries.

In thermal burns associated with inhalation of products of combustion, consider carbon monoxide and cyanide exposure.

Remove jewelry and non-adherent clothing.

Avoid use of wet dressings to avoid the development of hypothermia.

Head Injuries

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B		B
B	Maintain patient warmth.	B

Cautions and Notes:

GCS should be assessed and documented.

Intracranial pressure may cause hypertension, bradycardia, and altered respiratory rate.

Pediatric: Allergic Reaction

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Remove from source of exposure.	B
B	Administer epinephrine using a pediatric auto-injector device for severe hives, respiratory distress, and/or shock.	B

Cautions and Notes:

All patients who have received epinephrine should be transported for evaluation

Pediatrics: Hyperthermia

B	Universal Care Protocol	B
B	Move to cooler environment, remove excess clothing, protect from further heat gains.	B
B	For heat exhaustion, oral fluids if patient can tolerate. Cool with wet towels or fans.	B
B	For heat stroke, use aggressive evaporation (fine mist water spray, ice packs to groin and axillae).	B

Cautions and Notes:

The major difference between heat exhaustion and heat stroke is CNS impairment.

Avoid dramatic decreases in temperature which can cause shivering and increase temperature.

Prescription medications and alcohol may predispose patients to hyperthermia.

ALS care should be sought for patients with heat exposure and inability to tolerate oral rehydration, lack of response to oral hydration, or altered mental status.

Pediatric: Near Drowning

B	Universal Care Protocol	B
B	Remove from water if trained and safe to do so.	B
B	Spinal immobilization if indicated.	B
B	Prevent heat loss, refer to "Hypothermia" protocol if indicated.	B

Cautions and Notes:

All near drowning patients should be transported/evaluated

Almost all near drowning victims will be hypothermic to a greater or lesser extent.

Assess type of incident for the risk of other injuries (surface impacted, object strike, propeller trauma).

Assess water conditions (depth of submersion, length of time).

Monitor airway status closely.

Pediatric: Poisoning/ Overdose

B	Universal Care Protocol	B
B	Identify substance and assure decontamination.	B
B	Flush skin/membranes with appropriate solution if indicated.	B
B	Naloxone 0.1 mg/kg IN for suspected narcotic overdose. Max 2 mg.	B

Cautions and notes:

Poison control should be contacted **at 1-800-222-1222**.

ALS care should be sought for patients with abnormal vital signs, significantly altered mental status, and any need for assistance with airway and ventilation.

Aeromedical resources will not transport contaminated patients.

Pediatrics: General Management of Cardiac Arrest or Pre-Arrest

B	Universal Care Protocol	B
B	Check adequacy of CPR. Perform chest compressions if HR persistently <60 in child/infant or <80 in newborn. 15:2 for multiple rescuer / 30:2 for single rescuer	B
B	AED protocol using pediatric pads if stand alone defibrillator. Use adult pads when using multifunction device in AED mode. Ensure pads do not touch.	B
B	Ensure patient warmth.	B
B	Transport immediately with BLS measures while requesting ALS.	B

Pearls:

If pediatric pads are not available, use of adult pads is acceptable. Ensure they do not touch.

Pediatric: Newborn Resuscitation

B	Universal Care Protocol	B
B	Assess ABC's using base of umbilical cord, brachial or femoral artery, or auscultation of heart sounds.	B
B	Place newborn on back with neck in neutral position.	B
B	Suction mouth prior to nose. Note any meconium presence.	B
B	After delivery, use mild stimulation (dry, warm, suction). If effective respirations are not present after 5-10 seconds of stimulation, BVM at 40-60 breaths/minute.	B
B	If heart rate is <80 bpm with no improvement after BVM for 30 seconds, begin CPR.	B
B	Dry the newborn, wrap in blanket, head cap to maintain warmth. Do not allow newborn to become hypothermic.	B
B	Record APGAR's at 1 and 5 minutes.	B

Pediatric: Altered Level of Consciousness

B	Universal Care Protocol	B
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Pediatric: Seizures

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Consider hypoglycemia Glucagon 1 mg IM if oral glucose is not appropriate.	B

Pediatric: Respiratory Distress

B	Universal Care Protocol	B
B	Allow child to assume position of comfort.	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B

Pediatric: General Trauma Management

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Spinal immobilization if indicated.	B
B	Notify MedCom if possible trauma alert (red or yellow category): Advise mechanism of injury, age and sex of patient, sites of injury, vital if available, ETA.	B
B	For evisceration, cover with moist sterile dressing then with plastic. Do not push organs back into abdominal cavity.	B
B	Maintain patient warmth.	B

Pediatric: Amputation

B	Universal Care Protocol	B
B	Spinal Immobilization if appropriate.	B
B	Apply direct pressure to control hemorrhage. Hemorrhage control protocol	B
B	If incomplete amputation, splint entire digit or limb in position found.	B
B	Place part in damp gauze, place in plastic bag, wrap in trauma dressing, place on ice/water mix.	B

Pediatric: Burns

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Apply dry sterile dressings.	B
B	Irrigate chemical burn with water if water is appropriate to chemical. If powdered chemical, brush off.	B

Cautions and Notes:

In electrical burns, consider potential for additional traumatic injury.

In thermal burns, assess for carbon monoxide exposure.

Remove jewelry and nonadherent clothing.

Pediatric Trauma: CNS Injuries

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Spinal immobilization if indicated.	B
B	Maintain patient warmth.	B

Hemorrhage Control

In cases of uncontrolled extremity bleeding:

In cases of uncontrolled bleeding and signs/symptoms of hemorrhagic shock on first patient contact, proceed directly to tourniquet procedure

Initial attempts at control should focus on direct pressure to the wound

Compression dressings and hemostatic dressings may be applied in conjunction with direct pressure on the wound

If direct pressure does not control bleeding, or signs/symptoms of shock develop, move promptly to tourniquet procedure

In cases of gaping wounds or wounds with significant tissue loss, the wound may be packed with gauze to hemostatic dressing to control bleeding

Durable Do Not Resuscitate (DNR)

Emergency regulations governing the Durable Do Not Resuscitate (DDNR) program, adopted by the Virginia State Board of Health, became effective January 3, 2000. The emergency regulations amend the EMS Do Not Resuscitate (DNR) regulations and establish a DDNR order that follows the patient throughout the entire health care setting. Once issued by a physician for his patient, the DDNR Order applies wherever that patient may be – home, EMS vehicle, hospital, nursing home, adult care residence or other health care facility.

DDNR Orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR Order. Durable DNR Orders can be recognized by qualified EMS personnel at all times and in all settings. Valid EMS DNR Orders are considered Durable DNR Orders and do not expire on or after July 2, 1998. Qualified EMS personnel may honor written DNR Orders written for patient in a licensed health care facility.

Other orders regarding treatment have been approved by the Office of EMS, including the applicable portion of Physician Orders for Life Sustaining Treatment (POST or POLST).

The responding EMS provider should:

Perform routine patient assessment and resuscitation or intervention until it is confirmed that the patient has either a Virginia Durable DNR Order or the EMS DNR Order, issued on or after July 2, 1998, a written physician's order in a skilled care facility, or another accepted DNR order.

Request the original Virginia Durable DNR Form or the EMS DNR Order or POST or look for either form at patient's bedside, on the back of the patient's bedroom door, on the refrigerator or in the patient's wallet. If either of these forms has been defaced, consider the DNR Order to be invalid.

Make a good faith effort to verify identity of the patient through family, friends, and other health care personnel present or photo ID (such as a driver's license).

Be aware that a Virginia Durable DNR Form can be revoked by the following persons:

The patient, by destroying the Virginia Durable DNR Form or EMS DNR Form or by verbally withdrawing consent to the order.

The person authorized to consent on the patient's behalf.

A physician who is physically present at the patient's side.

These comforting interventions are encouraged:

Airway (excluding intubation or advanced airway management)

Suction

Supplemental oxygen delivery devices

Pain medications or intravenous fluids

Bleeding control

Patient positioning

Other therapies deemed necessary to provide comfort care or alleviate pain

Contact patient's physician or On-Line Medical Direction if questions or problems arise.

These Resuscitative measures should be avoided:

Withhold or withdraw if resuscitation has begun prior to confirmation of DNR status:

Cardiopulmonary Resuscitation (CPR)

Endotracheal intubation or other advanced airway management

Artificial ventilation

Defibrillation

Cardiac resuscitation medications

Continuation of related procedures, as prescribed by the patient's physician or medical protocols

Document the call:

Use the standard Pre-Hospital patient Care Report (PPCR) or agency run report to document which identification was used to confirm DNR status: Virginia Durable DNR Order Form, approved alternate form of identification, EMS DNR Order Form or other DNR form.

Indicate the Virginia Durable DNR Order Form number and the patient's attending physician's name.

Comfort the family if the patient has expired on arrival and follow agency's procedure for death at home.

Complete a PPCR or the agency run report.

Criteria for Death/ Withholding Resuscitation

DNR Patients

Indications:

Pulseless, non-breathing patient who would normally require resuscitation AND
Possess and on scene, properly completed, Virginia DDNR form, physician's order, or other accepted DNR form

Procedure:

Verify that the patient is the person named on the DNR form.
Cease all resuscitation efforts.
Notify law enforcement
Attach original or copy of DNR order to the completed PPCR.

Considerations:

If the patient requires care and is NOT in cardiac arrest, provide care up to the limits of the DNR and transport patient and DNR form.
Prehospital providers cannot honor other legal documents (living wills, etc) without contacting medical command.
DDNR forms may be overridden by patient, guardian of patient, or on-scene physician

Deceased Patients

Indications:

Rigor mortis and/or lividity
Decapitation
Traumatic cardiac arrest upon arrival

Procedure:

Do not resuscitate any patient who meets the above criteria. If resuscitation efforts are in progress, consider consulting medical command for discontinuation of efforts (see Discontinuation Policy)
Notify law enforcement

Emergency Custody Order

Order of substitute decision makers for incompetent patient: (Virginia Code § 54.1-2986)

- Legal guardian for patient (such as Medical Power of Attorney or agent for healthcare decisions in writing)
- Patient's spouse (except where divorce has been filed and is not final)
- Adult child of the patient
- Parent of the patient
- Adult brother or sister of the patient
- Other relative in descending order of blood relationship.

(Girlfriends, neighbors, others with no blood relationship DO NOT qualify as legal substitute decision makers).

Criteria for any ECO: a condition that is an immediate or imminent life threat with

• a patient who "because of mental illness . . . or any other mental disorder or physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment . . ."

1. Note religious caveat (i.e. Jehovah Witness) that "no person shall authorize treatment . . . that such person knows is contrary to the religious beliefs of the patient unable to make a decision, whether expressed orally or in writing."

2. Virginia Code § 16.1-336. Definitions:

3. "Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor fourteen years of age or older and by a parent or a legally authorized custodian.

4. "Incapable of making an informed decision" means unable to understand the nature, extent, or probable consequences of a proposed treatment or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to the treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

Psych ECO (Virginia Code § 37.2-808).

Does NOT require a physician assessment to get from magistrate—family or witness to suicidal thoughts / actions / evidence of significant risk of self-harm can call magistrate and request.

"probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

Emergency Custody Order

Medical ECO (Virginia Code § 37.1-134.21, § 37.2-1103). Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.

Requires:

Application by a licensed physician verifying that the “adult patient is incapable of making an informed decision as a result of physical injury or illness AND that the medical standard of care indicates that testing, observation, and treatment are necessary to prevent imminent and irreversible harm.”

The physician’s opinion of incapacity shall only be rendered after:

either personal evaluation or electronic communication with EMS personnel on scene
regarding their evaluation
an attempt to communicate directly (or electronically) with the adult person to corroborate the
EMS assessment of incapacity
an attempt has been made to obtain consent from the adult person
the adult person has failed to consent

The magistrate shall ascertain that the adult person:
has no legally authorized person to give consent AND
is incapable of making an informed decision regarding necessary treatment AND
has refused transport AND
has indicated intention to resist transport AND
is unlikely to become capable of making an informed decision within the time required.
Should the patient’s condition change and the patient become capable of making an informed decision (i.e. hypoglycemia resolved),
the physician must be contacted and the patient’s wishes respected.

Information needed from you for magistrate to issue medical ECO (“adult person” = patient)

Name and permanent address of “adult person” if known

Name of law enforcement agency on scene (+ officer, badge # if possible)

Name, hospital affiliation, and contact number of licensed physician requesting ECO

Present location of “adult person”

Name and address of hospital that “adult person” is to be transported to. (UVA Hospital, 1215 Lee Street, Charlottesville, VA 22908)

You may also be asked what evaluation you plan to undertake. Since you haven’t seen the patient yet, but you can’t legally do anything that isn’t on the order unless the patient consents, you may want to be fairly broad here. Some options may be: physical exam, radiologic studies (potentially including CT scan or MRI), intravenous access, medication therapy, possible mechanical ventilation, hospital admission, laceration repair, fracture management.

Attachment B

Provider Appeals Template

In Virginia's EMS System, an EMS provider's right to practice is based on endorsement by their Operational Medical Director. For the purposes of this procedure, a "provider" is any individual certified as an EMS provider in Virginia at the level of First Responder or higher. Operational Medical Directors are recognized as having responsibility for the oversight of patient care activities provided by EMS agencies and for remedial training or discipline of the EMS providers that they endorse. (12VAC5-31-1890. Responsibilities of Operational Medical Directors) . If in the opinion of the Operational Medical Director (OMD or Medical Director) after review of appropriate information, an action (or failure to act) on the part of a provider has been determined to compromise patient care directly or indirectly, the actions described below shall occur.

- 1) The provider will be notified in writing of the issues/concerns that merit attention by the Medical Director. Notwithstanding this written notice provision, the provisions of 2 and 3 below, and based on the severity and nature of the act (or failure to act), the Medical Director may immediately suspend a practitioner's right to practice upon receipt of information sufficient in the judgment of the Medical Director to present an immediate threat to patient safety pending further investigation. If the Medical Director invokes an immediate suspension, this shall be followed by written notice to include electronic notice within an appropriate time frame of such immediate suspension.
- 2) A written, or electronic, explanation by the provider explaining the incident shall be presented to the Medical Director within three (3) working days of receipt of the Medical Director's issues/concerns. If no written explanation of the incident is sent to the Medical Director by that deadline, the Medical Director may base his/her decision upon such information that is available to him/her as of that deadline.
- 3) The Medical Director, or the provider, may request a meeting to further discuss the issues/concerns. If this option is exercised, the meeting shall occur within an appropriate time frame of receipt of the request.
- 4) After reviewing all materials, the Medical Director will issue a disposition of the matter. The Medical Director may exercise one or more of the following options:
 - a) No action taken/matter resolved.
 - b) Recommendation for remedial training.
 - c) Written warning.
 - d) Requirement to precept at the endorsed level for a period of time or number of calls/runs.
 - e) Temporary suspension of all practice privileges or suspension of specific practice privileges.
 - f) Permanent suspension of practice privileges.

Any disciplinary action(s) taken by the OMD may extend to all agencies in which the provider is endorsed by the OMD. In addition, any disciplinary action(s) taken by the OMD may result in further endorsement action by the Office of EMS.

After the individual is notified in writing of the Medical Director's decision, he/she may appeal as per the agencies standard operating guidelines (SOG). This appeal must be presented in writing within an appropriate time frame of the decision of the Medical Director to the Medical Director or his/her designee.

- 5) The committee reviewing the recommendations of the OMD will meet as soon as is practical after the receipt of the written request for appeal. If the practitioner's ability to practice has been suspended for greater than seven (7) days, this meeting will be held with all deliberate speed and effort will be made to convene the meeting within ten (10) days. The committee may consist of the following representatives:
 - a) Two (2) Physician members who are not the Medical Director such as the Regional Medical Director, other physicians on the regional council.
 - b) In cases involving ALS providers, two (2) paramedics plus one (1) physician.
 - c) In cases involving BLS providers, one (1) ALS provider, one (1) BLS provider and one (1) physician.
- 6) One member of the review committee shall be designated as the presiding officer for purposes of hearing an appeal. The presiding officer may elect to hear the witnesses and cross examination is not allowed. The only individual who may address the committee is the provider. The recommendations of the committee shall be presented in writing to the Medical Director.
- 7) In the event that the committee recommends that the provider be returned to practice under the license of the Medical Director, the Medical Director may continue the suspension. However, it is expected that the recommendations of the committee be considered in the Medical Director's final decision.

Attachment C



Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

This SOP represents *practice maximums*.

CATEGORY		EMR	EMT	AEMT	I	P
Analgesics						
	Acetaminophen		●	●	●	●
	Nonsteroidal anti-inflammatory		●	●	●	●
	Opiates and related narcotics			●	●	●
	Dissociative analgesics					
	Ketamine 0.5 mg/kg or less IV/IN				●	●
Anesthetics						
	Otic			●	●	●
	General - initiate					●
	Ketamine greater than 0.5 mg/kg					●
	General - maintenance				●	●
	Ocular			●	●	●
	Inhaled-self administered		●	●	●	●
	Local			●	●	●
Anticonvulsants						
				●	●	●
Glucose Altering Agents						
	Glucose Elevating Agents		●	●	●	●
	Glucose Lowering Agents				●	●
Antidotes						
	Anticholinergic Antagonists				●	●
	Anticholinesterase Antagonists	●	●	●	●	●
	Benzodiazepine Antagonists					
	Narcotic Antagonists		●	●	●	●
	Nondepolarizing Muscle Relaxant Antagonist					
	Beta/Calcium Channel Blocker Antidote				●	●
	Tricyclic Antidepressant Overdose				●	●
	Cyanide Antidote				●	●
	Cholinesterase Reactivator	●	●	●	●	●

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Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.



Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P	
Antihistamines & Combinations			●	●	●	●	
Biologicals							
	Immune Serums				●	●	
	Antibiotics		●	●	●	●	
Blood/Blood products							
	Initiate					●	
	Maintain				●	●	
Blood Modifiers							
	Anticoagulants				●	●	
	Antiplatelet Agents		●	●	●	●	
	Hemostatic Agents		●	●	●	●	
	Thrombolytics					●	
	Anti-fibrinolytics (eg tranexamic acid)				●	●	
Cardiovascular Agents							
	Alpha Adrenergic Blockers				●	●	
	Adrenergic Stimulants				●	●	
	Antiarrhythmics				●	●	
	Beta Adrenergic Blockers				●	●	
	Calcium Channel Blockers				●	●	
	Diuretics				●	●	
	Inotropic Agents				●	●	
	Vasodilatory Agents		●	●	●	●	
	Vasopressors				●	●	
	Epinephrine for allergic reaction		●	●	●	●	Added per MDC discussion 10-10-13

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CATEGORY		EMR	EMT	AEMT	I	P		
Central Nervous System	Antipsychotic				●	●		
	Sedatives							
	Benzodizepines				●	●	Added per MDC discussion 10-10-13	
Dietary Supplements/Electrolyte	Vitamins							
	Minerals - start at a health care facility	See section: Intravenous Fluids						
	Salts - start at a health care facility							
	Electrolytes Solutions - start at a health care facility							
	Hypertonic Saline				●	●		
Gas	Oxygen	●	●	●	●	●		
	Heliox				●	●		
Gastrointestinal	Antacids							
	OTC			●	●	●		
	Antidiarrheals		●	●	●	●		
	Antiemetics		●	●	●	●		
	EMT SL/PO route only							
	H2 Blockers		●	●	●	●		
Hormones	Steroids			●	●	●		
Intravenous Fluids	isotonic			●	●	●		
	hypotonic			●	●	●		
	hypertonic				●	●		
	M = Maintenance I = Initiate							
	Crystalloid, +/- Dextrose/Lactate		M	I/M	I/M	I/M		
	with Multi=vitamins		M	M	M	M		
with Thiamine		M	M	M	M			
Neuromuscular Blockers						●		
Respiratory	Anticholinergics		●	●	●	●		
	Sympathomimetics							
	Beta agonists		●	●	●	●		

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CATEGORY		EMR	EMT	AEMT	I	P	
	Epinephrine (nebulized)				●	●	clarification - refers to nebulized not systemic epinephrine MDC 10-10-13
Dosage and Concentration Calculation				●	●	●	
M = Maintenance							
I = Initiate							
	Note: EMT's may administer medications within their scope of practice in addition to assistance in administration of those medications. EMT's may access a drug kit to access those medications. MDC discussions.						

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Virginia Office of Emergency Medical Services

Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Specific tasks in this document shall refer to the Virginia Education Standards.							
AIRWAY TECHNIQUES							
Airway Adjuncts							
	Oropharyngeal Airway		●	●	●	●	●
	Nasopharyngeal Airway		●	●	●	●	●
Airway Maneuvers							
	Head tilt jaw thrust		●	●	●	●	●
	Jaw thrust		●	●	●	●	●
	Chin lift		●	●	●	●	●
	Cricoid Pressure		●	●	●	●	●
	Management of existing Tracheostomy		●	●	●	●	●
Alternate Airway Devices							
	Non Visualized Airway Devices	Supraglottic	●	●	●	●	●
Cricothyrotomy							
	Needle						●
	Surgical	Includes percutaneous techniques					●
Obstructed Airway Clearance							
	Manual		●	●	●	●	●
	Visualize Upper-airway				●	●	●
Intubation							
	Nasotracheal						●
	Orotracheal - Over age 12					●	●
	Pharmacological facilitation with paralytic	Adult Neuromuscular Blockade					●
	Confirmation procedures			●	●	●	●
	Pediatric Orotracheal						●
	Pediatric paralytics						●
	Pediatric sedation						●
** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic							

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Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Oxygen Delivery Systems							
	Nasal Cannula		●	●	●	●	●
	Venturi Mask			●	●	●	●
	Simple Face Mask		●	●	●	●	●
	Partial Rebreather Face Mask			●	●	●	●
	Non-rebreather Face Mask		●	●	●	●	●
	Face Tent			●	●	●	●
	Tracheal Cuff			●	●	●	●
	Oxygen Hood					●	●
	O2 Powered Flow restricted device			●	●	●	●
	Humidification			●	●	●	●
Suction							
	Manually Operated		●	●	●	●	●
	Mechanically Operated		●	●	●	●	●
	Pharyngeal		●	●	●	●	●
	Bronchial-Tracheal			●	●	●	●
	Oral Suctioning		●	●	●	●	●
	Naso-pharyngeal Suctioning			●	●	●	●
	Endotracheal Suctioning			●	●	●	●
	Meconium Aspiration Neonate with ET						●
Ventilation – assisted / mechanical							
	Mouth to Mask		●	●	●	●	●
	Mouth to Mask with O2		●	●	●	●	●
	Bag-Valve-Mask Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Adult		●	●	●	●	●
	Bag-Valve-Mask Pediatric		●	●	●	●	●

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Virginia Office of Emergency Medical Services

Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Bag-Valve-Mask with supplemental O2 Pediatric		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Pediatric		●	●	●	●	●
	Bag-Valve-Mask neonate/infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Neonate/Infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Neonate/Infant		●	●	●	●	●
	Noninvasive positive pressure vent.	CPAP, fixed pressure	●	●	●	●	●
		CPAP, BiPAP, PEEP adjustable				●	●
	Jet insufflation						●
	Mechanical Ventilator (Manual/Automated Transport Ventilator)	Maintain long term/established			●	●	●
		Initiate/Manage ventilator				●	●
Anesthesia (Local)							
Pain Control & Sedation							
	Self Administered inhaled analgesics			●	●	●	●
	Pharmacological (non-inhaled)				●	●	●
	Patient controlled analgesia (PCA)	Maintain established			●	●	●
	Epidural catheters (maintain)	Maintain established				●	●
Blood and Component Therapy Administration							
		Maintain				●	●
		Initiate					●
Diagnostic Procedures							
	Blood chemistry analysis			●	●	●	●
	Capnography			●	●	●	●
	Pulmonary function measurement				●	●	●
	Pulse Oximetry			●	●	●	●
	Ultrasonography						●
Genital/Urinary							
	Bladder catheterization						
	Foley catheter	Place bladder catheter					●
		Maintain bladder catheter		●	●	●	●

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Virginia Office of Emergency Medical Services

Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Head and Neck							
	ICP Monitor (maintain)						●
	Control of epistaxis		●	●	●	●	●
		Inserted epistaxis control devices			●	●	●
	Tooth replacement		●	●	●	●	●
Hemodynamic Techniques							
	Arterial catheter maintenance						●
	Central venous maintenance				●	●	●
	Access indwelling port					●	●
	Intraosseous access & infusion				●	●	●
	Peripheral venous access and maintenance				●	●	●
	Umbilical Catheter Insertion/Management						●
	Monitoring Existing IVs			●	●	●	●
	Mechanical IV Pumps				●	●	●
Hemodynamic Monitoring							
	ECG acquisition		●	●	●	●	●
	ECG Interpretation					●	●
	Invasive Hemodynamic Monitoring						●
	Vagal Maneuvers/Carotid Massage					●	●
Obstetrics							
	Delivery of newborn		●	●	●	●	●
Other Techniques							
	Vital Signs		●	●	●	●	●
	Bleeding control		●	●	●	●	●
		Tourniquets	●	●	●	●	●
	Foreign body removal	Superficial without local anesthesia		●	●	●	●
		Imbedded with local anesthesia/exploration				●	●
	Incision/Drainage						●
	Intravenous therapy				●	●	●
	Medication administration			●	●	●	●
	Nasogastric tube			●	●	●	●
	Orogastric tube			●	●	●	●

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.



Virginia Office of Emergency Medical Services

Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Pericardiocentesis						●
	Pleural decompression					●	●
	Patient restraint physical			●	●	●	●
	Patient restraint chemical					●	●
	Sexual assault victim management			●	●	●	●
	Trephination of nails					●	●
	Wound closure techniques					●	●
	Wound management		●	●	●	●	●
	Pressure Bag for High altitude						●
	Treat and Release			●	●	●	●
	Vagal Maneuvers/Carotid Massage					●	●
	Intranasal medication administration	Fixed/unit dose medications		●	●	●	●
		Dose calculation/measurement			●	●	●
Resuscitation							
	Cardiopulmonary resuscitation (CPR) (all ages)		●	●	●	●	●
	Cardiac pacing					●	●
	Defibrillation/Cardioversion	AED	●	●	●	●	●
	Post resuscitative care			●	●	●	●
Skeletal Procedures							
	Care of the amputated part		●	●	●	●	●
	Fracture/Dislocation immobilization techniques		●	●	●	●	●
	Fracture/Dislocation reduction techniques	Manipulation of angulated/pulseless extremities		●	●	●	●
		Joint reduction techniques		●	●	●	●
	Spine immobilization techniques		●	●	●	●	●
Thoracic							
	Thoracostomy (refer to "Other Techniques")						●
Body Substance Isolation / PPE							
			●	●	●	●	●
Lifting and moving techniques							
			●	●	●	●	●

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.



Virginia Office of Emergency Medical Services Scope of Practice - Procedures for EMS Personnel

This SOP represents *practice maximums*.

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Gastro-Intestinal Techniques							
		Management of non-displaced gastrostomy tube					●
Ophthalmological							
		Morgan Lenses		●	●	●	●
		Corneal Exam with fluorescein				●	●
		Ocular irrigation	●	●	●	●	●

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.

Attachment D

Emergency Medical Services Training Funds Summary

As of October 9, 2013





EMS Training Funds Summary of Expenditures

	Obligated \$	Disbursed \$
Fiscal Year 2012		
40 BLS Initial Course Funding	\$784,836.00	\$416,408.42
43 BLS CE Course Funding	\$122,640.00	\$43,898.75
44 ALS CE Course Funding	\$273,840.00	\$85,776.25
45 BLS Auxiliary Program	\$94,000.00	\$15,200.00
46 ALS Auxiliary Program	\$332,000.00	\$182,910.00
49 ALS Initial Course Funding	\$1,342,350.00	\$693,266.51
Total	\$2,949,666.00	1,437,459.93

	Obligated \$	Disbursed \$
Fiscal Year 2013		
19 Emergency Ops	\$1,320.00	\$755.00
40 BLS Initial Course Funding	\$725,064.00	\$339,869.77
43 BLS CE Course Funding	\$120,960.00	\$47,136.21
44 ALS CE Course Funding	\$295,680.00	\$73,202.50
45 BLS Auxiliary Program	\$74,000.00	\$17,000.00
46 ALS Auxiliary Program	\$344,000.00	\$147,940.00
49 ALS Initial Course Funding	\$1,099,608.00	\$472,386.26
Total	\$2,660,632.00	\$1,098,289.74

	Obligated \$	Disbursed \$
Fiscal Year 2014		
19 Emergency Ops	\$200.00	\$0.00
40 BLS Initial Course Funding	\$504,900.00	\$66,070.50
43 BLS CE Course Funding	\$62,160.00	\$3,167.50
44 ALS CE Course Funding	\$188,800.00	\$4,112.50
45 BLS Auxiliary Program	\$98,000.00	\$7,360.00
46 ALS Auxiliary Program	\$214,000.00	\$7,920.00
49 ALS Initial Course Funding	\$1,026,324.00	\$192,612.00
Total	\$2,094,384.00	\$281,242.50

Attachment E

Accredited Training Site Directory

As of October 8, 2013



Accredited Paramedic¹ Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
<i>Associates in Emergency Care</i>	15319	No	4	National – Probation	CoAEMSP
<i>Center for EMS Training¹</i>	74015		1	Rejected by CAAHEP	Expired
<i>Central Virginia Community College</i>	68006	Yes	--	National – Initial	CoAEMSP
<i>Historic Triangle EMS Institute</i>	83009	No	1	CoAEMSP – Initial	CoAEMSP
<i>J. Sargeant Reynolds Community College</i>	08709	No	5	National – Initial	CoAEMSP
<i>Jefferson College of Health Sciences</i>	77007	Yes	--	National – Continuing	CoAEMSP
<i>Lord Fairfax Community College</i>	06903	No	--	CoAEMSP - LOR	
<i>Loudoun County Fire & Rescue</i>	10704	No	--	National – Continuing	CoAEMSP
<i>American National University</i>	77512	No	--	National – Initial	CoAEMSP
<i>Northern Virginia Community College</i>	05906	No	1	National – Continuing	CoAEMSP
<i>Patrick Henry Community College</i>	08908	No	1	CoAEMSP – LOR	
<i>Piedmont Virginia Community College</i>	54006	Yes	--	National – Continuing	CoAEMSP
<i>Prince William County Dept of Fire and Rescue</i>	15312	Yes	-	CoAEMSP - LOR	
<i>Rappahannock EMS Council Program</i>	63007	No	--	CoAEMSP - LOR	
<i>Southwest Virginia Community College</i>	11709	Yes	4	National – Continuing	CoAEMSP
<i>Southside Virginia Community College</i>	18507	No	1	National – initial	CoAEMSP
<i>Tidewater Community College</i>	81016	Yes	3	National – Continuing	CoAEMSP
<i>VCU School of Medicine Paramedic Program</i>	76011	Yes	4	National – Continuing	CoAEMSP

Programs accredited at the Paramedic level may also offer instruction at EMT- I, AEMT, EMT, and EMR, as well as teach continuing education and auxiliary courses.

- ¹The Center for EMS site visit was conducted in December, 2012. CAAHEP has rejected their accreditation packet and their letter of review is no longer in effect and they are no longer accredited as an ALS training center
- Lord Fairfax Community College, Rappahannock EMS Council, Patrick Henry Community College and Prince William County have received their CoAEMSP Letter of Reviews and will have their accreditation visits scheduled within the next two years.
- Central Shenandoah EMS Council is in the process of accreditation at the paramedic level in Virginia which is described on the OEMS web page at: <http://www.vdh.virginia.gov/OEMS/Training/Paramedic.htm>

Accredited Intermediate¹ Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
<i>Central Shenandoah EMS Council</i>	79001	No	--	State – Full	May 31, 2015
<i>Danville Area Training Center</i>	69009	No	--	State – Full	July 31, 2014
<i>Dabney S. Lancaster Community College</i>	00502	No	--	State – Full	July 31, 2017
<i>Hampton Fire & EMS</i>	83002	Yes	--	State – Full	February 28, 2017
<i>James City County Fire Rescue</i>	83002	No	--	State – Full	February 28, 2014
<i>John Tyler Community College</i>	04115	No	--	State – Full	April 30, 2017
<i>Nicholas Klimenko and Associates</i>	83008	Yes	1	State – Full	July 31, 2015
<i>Norfolk Fire Department</i>	71008	No	--	State – Full	July 31, 2016
<i>Rappahannock Community College</i>	11903	Yes	2	State – Full	July 31, 2016
<i>Roanoke Regional Fire-EMS Training Center</i>	77505	No	--	State – Full	January 31, 2015
<i>UVA Prehospital Program</i>	54008	No	--	State – Full	July 31, 2014
<i>WVEMS – New River Valley Training Center</i>	75004	No	--	State – Full	June 30, 2017

Programs accredited at the Intermediate level may also offer instruction at AEMT, EMT, and EMR, as well as teach continuing education and auxiliary courses.

Accredited EMT Training Programs in the Commonwealth

Site Name	Site Number	# of Alternate Sites	Accreditation Status	Expiration Date
Navy Region Mid-Atlantic Fire EMS		--	State – Provisional	March 13, 2014
City of Virginia Beach Fire and EMS		--	State – Provisional	July 31, 2014

- * Self study has been received from: Physicians Transport Service however they cancelled their accreditation visit for August and we have had no further correspondence requesting the site be rescheduled.

Attachment F

Committee Motion: _____ Name: Training And Certification Committee

Individual Motion: _____ Name: _____

Motion:

The EMS Advisory Board recommends the following actions to address HB1856 that pertains to the section addressing that “The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel” develop a process to identify the need for and complete a program(s) with the intent of attracting and recruiting volunteers for EMT certification, utilizing various resources including but not limited to EMS Regional Councils, no later than the June 30, 2015. The details of such activity will be developed in association with the EMS Regional Councils as follows.

1. Present this proposal to TCC for action on October 9, 2013.
2. Present this proposal to EMS Advisory Board Executive Committee for action on October 10, 2013.
3. Present this proposal to the Commissioner of Health by October 16, 2013.
4. OEMS develop the program goal(s).
5. OEMS in association with the EMS Regional Councils identify in their respective council areas if and where a volunteer oriented program may be needed by February 15, 2014.
6. Based upon the goal, the Regional Councils shall develop guidelines and policies as they determine are necessary to achieve specified goals by May 2014.
7. Implement identified programs by September 15, 2014.

EMS Plan Reference (include section number):

CHAPTER 429

An Act to require the State Board of Health to develop certain policies related to statewide emergency medical services.

[H 1856]

Approved March 16, 2013

Be it enacted by the General Assembly of Virginia:

1. § 1. That the Board of Health shall direct the State Emergency Medical Services Advisory Board to, by July 1, 2014, develop and facilitate the implementation of (i) a process whereby an emergency medical services provider who is certified by the Office of Emergency Medical Services pursuant to § 32.1-111.5 and who has received an adverse decision related to his authority to provide emergency medical care on behalf of an emergency medical services agency under the authority of an agency operational medical director shall be informed of the appeals process and (ii) a standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services provided by emergency medical services personnel. The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel. The Board shall report on

Attachment G

NR Results as of 9/26/13

Results sent to National Registry = 3,427

No test attempt to date = 612 of which 86% (527) have completed applications and 14% (85) have not completed their National Registry application. I have sent another reminder email this week.

Those who have tested:

	Attempted	Passed	%	Failed	%
First	2,815	1,752	62%	1063	38%
Second	427	181	42%	246	58%
Third	83	29	35%	54	65%
Fourth	13	5	38%	8	62%
Fifth	3	1	33%	2	67%
Sixth	0				

The above is reflective of the 'Under 18' test candidates that is not reflected when you pull our State report from National Registry. The statistics for the 'Under 18 group are as follows:

Results sent to National Registry = 293

No test attempt to date = 80 which is 27% of those eligible to test and should have pending applications with National Registry.

	Attempted	Passed	%	Failed	%
First	213	80	38%	133	62%
Second	31	13	42%	18	58%
Third	2	1	50%	1	50%
Fourth	0				
Fifth	0				
Sixth	0				

The National statistics for this same period are as follows:

GENERAL INFO
 CBT CANDIDATES
 MY CERTIFICATION
STATE EMS OFFICE
 PROGRAM DIRECTOR

Home
 State EMS News
 Check Registrant
 Status

▶ Manage Candidates

▼ Reports

- Cognitive Exam Results
- Pass/Fail Report
- Topic Area Performance
- Pencil/Paper Results
- Candidate Progress

Report Date: 9/26/2013 9:38:21 AM
 Report Type: National Report
 Registration Level: EMT-Basic / EMT
 Course Completion Date: 3rd Quarter 2012 to 3rd Quarter 2013
 Training Program: All

[View Legend](#) | [Printer-Friendly Version](#)

[Show All](#) | [Show Only Percentages](#) | [Show Only Numbers](#)

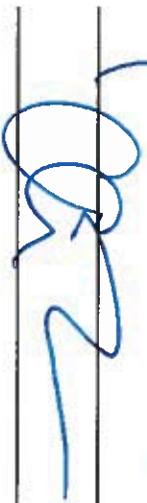
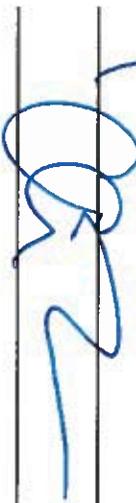
The results of your report request are as follows:

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
71036	72% (51268 / 71036)	80% (56979 / 71036)	80% (57106 / 71036)	0% (3 / 71036)	20% (13927 / 71036)	0% (0 / 71036)

Attachment H

MEDICAL DIRECTION COMMITTEE MEETING ROSTER
October 10, 2013

Please sign in next to your name.

Region	Representative	Signature
SWVEMS	PAUL PHILLIPS, D.O.	
WVEMS	CHARLES LANE, M.D.	
BREMS(CHAIR)	MARILYN MCLEOD, M. D.	
TJEMS (OEMS)	GEORGE LINDBECK, M. D.	
CSEMS	ASHER BRAND, M. D.	
LFEMS	CHRISTOPHER TURNBULL, M.D.	
REMS	NAEL HASAN, M. D.	
NVEMS	E. REED SMITH, M.D.	
ODEMSA	ALLEN YEE, M. D.	
PEMS	CHERYL LAWSON, M. D.	
TEMS	STEWART MARTIN, M. D.	
MAL	FORREST CALLAND, M.D.	
MAL	SCOTT WEIR, M.D.	
EMS CHILDREN	THERESA GUINS, M.D.	
VAGEMSA	CHIEF EDIE FERGUSON	

OEMS STAFF:

GARY BROWN		WARREN SHORT	
SCOTT WINSTON		DEBBIE AKERS	
MIKE BERG		GREG NEIMAN	
TIM PERKINS			

MEDICAL DIRECTION COMMITTEE MEETING ROSTER

October 10, 2013

OTHERS PRESENT: PLEASE PRINT YOUR NAME AND SIGN ON THE LINE NEXT TO YOUR NAME.

PRINT NAME

SIGNATURE

DAVID BURSAR



WYNNE PERCY



GARY CUTLER



Randy Feldreich



Bradley

Bearm



Cathy Cockerell



Garry R. Brown



John Sullivan



BARRY



Neva Purpala



LARRY A. OLIVER

