

**CENTRAL NEW YORK REMAC**  
**BLS Agency Application to Perform Blood Glucose Monitoring**

Agency Name \_\_\_\_\_ Agency Code \_\_\_\_\_

Address \_\_\_\_\_  
Mailing address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Contact \_\_\_\_\_ Title \_\_\_\_\_ Limited Lab Reg # \_\_\_\_\_

Daytime phone number \_\_\_\_\_ Email \_\_\_\_\_

Agency Medical Director \_\_\_\_\_ # of trained providers \_\_\_\_\_

Representative responsible for BLS Glucometer Testing Care:

Name: \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Agency QA/QI Coordinator:

Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

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\_\_\_\_\_ requests authorization from REMAC to permit BLS providers to perform Blood Glucose testing in compliance with NYS BLS Protocol and CNY Policy Statement. Attached to this application are the following items:

- A letter from the Agency Medical Director supporting the request and indicating an understanding of their role in the Clinical Lab requirements and quality assurance process.
- A copy of the completed NYS Department of Health Clinical Laboratory Limited Laboratory Registration application for blood testing licensure (DOH-4081 Limited Service Laboratory Registration), along with the authorizations from the Clinical Laboratory.
- Copies of written Policies and Procedures for the operation of the glucometer that are consistent with local protocols, to include:
  - Training and documentation of authorized users
  - Defined QA program, including appropriateness review by the Agency Medical Director
  - Documentation of control testing process
  - Storage of glucometer and proper disposal of sharps

As CEO of the above agency, I agree to the requirements set forth in the CNY-REMAC Policy Statement on blood glucose monitoring and will be responsible to make sure that the providers in the agency follow those regional protocols. I also agree that all Blood Glucose monitor operators will successfully complete the required training with an approved instructor and that documentation of this training will be submitted to the Regional QA/QI Coordinator at least yearly.

Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Date of approval by REMAC \_\_\_\_\_