



**CENTRAL NEW YORK EMERGENCY MEDICAL SERVICES REGIONAL COUNCIL, INC.**

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**Collaborative Agreement  
for Possession and Use of Epinephrine Auto-Injector**

It is the intent of *[Name of Agency]* \_\_\_\_\_ to possess and use an Epinephrine Auto-Injector for patients in anaphylaxis. This service is being offered in cooperation with *[Name of Operational Medical Director or REMAC Physician]* \_\_\_\_\_.

In accordance with the provisions of Chapter 578 of the Laws of 1999, our organization has:

1. Identified a physician, hospital or REMAC Physician to serve as our Emergency Health Care Provider (EHCP).
2. Selected an approved Epinephrine Auto-Injector training course.
3. Provided written notice to 911 and/or community equivalent ambulance dispatch entity of the availability of Epinephrine Auto-Injectors at our organization's location.
4. Filed with the Regional Emergency Medical Services Council (REMSCO) serving the area a copy of the Notice of Intent to Possess and Use Epinephrine Auto-Injector Form DOH 4188, along with a signed copy of this agreement.
5. Agreed to file a new Collaborative Agreement with the REMSCO if the EHCP changes.
6. Agreed to participate in the required Quality Improvement Program, mailing the requested information CNYEMS each time the Epinephrine Auto-Injector is used.

**Policies:**

It is the policy of our organization that any personnel using the Epinephrine Auto-Injector be properly trained, therefore all persons providing treatment with the Auto-Injector shall be certified in its use by: *[Name and Title]* \_\_\_\_\_

All personnel will be retrained in accordance with the certifying agency's standards. An annual review of the Epinephrine Auto-Injector and its use will be presented to each member.

**(The following sections should be completed only for applicable types of organizations.)**

**Camps:**

It is the policy of our organization to ensure the rapid arrival of EMS. Therefore, 911 and/or the community equivalent dispatch entity will be called immediately when the Epinephrine Auto-Injector is used. *[Initial]* \_\_\_\_\_

**Rescue Units:**

Our primary responding ambulance is: \_\_\_\_\_

We will notify both the primary responding ambulance agency and the area 911 dispatch center of this availability in writing. *[Initial]* \_\_\_\_\_

**Ambulance Services:**

Our organization provides:  Basic Life Support  
 Intermediate or Advanced Life Support

If BLS, our primary ALS service provider is: \_\_\_\_\_

We will notify both the primary responding ALS ambulance service or ALS rescue unit and the area 911 center of this availability in writing. *[Initial]* \_\_\_\_\_

It is the policy of our organization to obtain the Epinephrine Auto-Injectors through *[Supplier or Distributor]* \_\_\_\_\_. The Epinephrine Auto-Injectors will be stored *[Location]* \_\_\_\_\_ to be protected from exposure to light and extreme changes in temperature. After use, the Epinephrine Auto-Injectors will be disposed of in a sharps container in accordance with OSHA regulation 29CFR1910.1030.

It is the policy of our organization to ensure the Epinephrine Auto-Injectors are in a state of readiness for use at all times, and that each unit is accounted for; therefore, all regular maintenance, expiration date tracking, and supply accounting of the Epinephrine Auto-Injectors will be performed by: *[Name of Individual and his/ her Initial]* \_\_\_\_\_.

The individual listed above will ensure that *[quantity]* \_\_\_\_\_ adult doses and *[quantity]* \_\_\_\_\_ pediatric doses will be carried on each ambulance/rescue unit, and also that *[quantity]* \_\_\_\_\_ adult doses and *[quantity]* \_\_\_\_\_ pediatric doses will be stored in facility as backup stock.

It is the policy of this organization to ensure appropriateness in using the Epinephrine Auto-Injectors; therefore, we will participate in the Quality Improvement program as determined by CNYEMS.

Signed in agreement:

\_\_\_\_\_  
*Organization designee*

\_\_\_\_\_  
*Operational Medical Director or REMAC Physician*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date signed*

\_\_\_\_\_  
*Date signed*

Please attach the following (The application is not complete without these items):

1. Completed and signed Notice of Intent to Possess and Use Epinephrine Auto-Injector form (DOH-4188)
2. Copy of 911 Center Notification
3. Copy of Primary ALS Service Notification