



Georgia Office of EMS and Trauma Medical Director Agreement

EMS AGENCY NAME: _____

This form must be completed and uploaded for EACH Medical Director in order to submit an application.

MEDICAL DIRECTOR INFORMATION

Medical Director Name	Georgia Medical Board License Number	Phone number	
_____	_____	_____	
Address	City	State	Zip code
_____	_____	_____	_____
Medical Director Email Address	LMS Username		
_____	_____		

AGREEMENT

I am a physician licensed to practice medicine in Georgia and have agreed to serve as the Medical Director for the above-identified EMS Provider. **This contract is valid for a maximum of twenty five (25) months from the date of signing and must be renewed in conjunction with the license renewal.**

As Medical Director, I will provide medical direction and training in conformance with O.C.G.A. 31-11, Department Rules and Regulations, and Policies established by the Office of Emergency Medical Services and Trauma. I have read and do hereby affirm that I understand and will abide by all requirements contained therein.

If I should decide to relinquish my role as Medical Director, I will notify the Department of Public Health (DPH), Office of Emergency Medical Services and Trauma (address below), and the EMS Provider in writing not less than ten (10) calendar days prior to the termination of the agreement.

Office of EMS and Trauma
Georgia Department of Public Health
1680 Phoenix Boulevard, Suite 200
Atlanta, GA 30349

SIGNATURES - ALL SIGNATURES MUST BE HANDWRITTEN WET SIGNATURES

Printed Name of Authorized Agent	Signature of Authorized Agent	Date Signed
_____	_____	_____

Printed Name of EMS Medical Director	Signature of Medical Director	Date Signed
_____	_____	_____