SCOPE OF PRACTICE DOCUMENTATION – INTERMEDIATE RED DOT SKILLS

This letter serves as specific written authorization of the EMS provider listed below for use of the procedures and medications as described when operating on behalf of the agency and physician signing.

PROVIDER____

CERTIFICATION LEVEL / NUMBER ____

Procedure / Medication	Authorized	Date of Training
Patient restraint, Medication	YES / NO	
Anesthetics/Sedatives: Maintenance Intubated Patient	YES / NO	
Mechanical Ventilation: Initiate / Manage	YES / NO	
Non-Invasive Positive Pressure Ventilation	YES / NO	

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Agency OMD Date

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Agency Representative / Agency Date