

<p style="text-align: center;">Michigan Department of Community Health Bureau of Health Policy, Planning & Access EMS & Trauma Systems Section</p> <p style="text-align: center;">201 Townsend Street Lansing, Michigan 48913</p>	<p style="text-align: center;">MDCH USE ONLY</p> <p>Date Received: _____</p> <p>Date Reviewed: _____</p> <p>Date Interim Approval Notice to Sponsor: _____</p> <p>Change Approved <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Approval Signature _____</p>
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NOTIFICATION OF CHANGE

APPROVED EMS EDUCATION PROGRAM SPONSOR

For all changes that occur within an approved Education Program Sponsor, the sponsor must submit this form with required documentation to the Department as soon as changes are known.

When requesting approval for additional course offerings, or courses with changes, within the approval period, the sponsor must submit this form with required documentation to the Department at least thirty (30) days prior to the course start date. **This original notification must be received by the Regional Coordinator at least thirty (30) days prior to the start of the course.** Receipt less than 30 days prior will result in automatic denial of the application. Failure to complete and submit this form as prescribed may result in the education program sponsor approval revocation. If changes are made to an approved course, a Notice of Change form must be submitted as soon as changes are known.

1.

Education Program Sponsor			
Address			
City	State	Zip	County
Sponsor Contact Person	Title	Telephone Number	Email Address
Program Sponsor Approval #:		Approval Valid Through:	

2. Location Change Shall Occur

Specific Course Location _____ (Building, Room Number) _____ Address _____ _____

3. If this is an application for **Changes to Program Sponsor Information:**

IDENTIFY ANY AND ALL CHANGES MADE SINCE APPROVAL OF PROGRAM SPONSOR APPLICATION (e.g., change of sponsor representative, change of course coordinator, change of faculty, change of clinical site, etc.) and **attach required documentation.**

- Change in Sponsor Representative
- Change in Program Course Coordinator
- Notification of Additional Instructors
- Change of clinical site (attach copy of contract)
- Other: (Please specify) _____

4. If this is an application for a **Course That Includes Changes:**

a. **ATTACH COURSE SCHEDULE and SUMMARY of CHANGE (UTILIZE THE ATTACHED FORMAT).**

Level of course to be offered:		
<input type="checkbox"/> MFR	<input type="checkbox"/> MFR Refresher	
<input type="checkbox"/> Basic EMT	<input type="checkbox"/> Basic EMT Refresher	<input type="checkbox"/> EMT Matriculation
<input type="checkbox"/> EMT-Specialist	<input type="checkbox"/> EMT-Specialist Refresher	
<input type="checkbox"/> Paramedic	<input type="checkbox"/> Paramedic Refresher	
<input type="checkbox"/> Instructor/Coordinator	<input type="checkbox"/> Instructor/Coordinator Refresher	

Dates of Course: (Includes cognitive, psychomotor, clinical, and field internship)			
Start _____	Ending _____		
Classroom completed on: _____	Class Hours: _____	Clinical Hours: _____	Internship Hours: _____

Specific Course Location _____
(Building, Room Number) _____
Address _____

5. **REQUIRED SIGNATURES**

Course Coordinator:

I affirm my commitment to serve as Course Coordinator and to comply with all MDCH requirements for education program Course Coordinators, as described in the program approval packet.

Printed Name of Authorized Program Course Coordinator	Title	Telephone Number	Email Address
		()	
Original Signature – Program Course Coordinator			Date

Program Sponsor Representative:

I affirm that all information submitted with this form is true and that the Program Sponsor continues to comply with all requirements upon which the program sponsor approval was based. The Sponsor assumes full responsibility for this course and will provide necessary oversight of the course.

Printed Name of Authorized Program Sponsor Representative	Title	Telephone Number	Email Address
		()	
Original Signature – Program Sponsor Representative			Date

Physician Director :

I affirm that all information submitted with this form is true and that the Program continues to comply with all requirements upon which the program sponsor approval was based. I assure responsibility for medical direction of this course and will provide necessary oversight of the course.

Print Name of Physician Director (Please indicate M.D. or D.O.)	Telephone Number	Email Address
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Original Signature - Physician Director		Date

