Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
www.michigan.gov/ems
517-335-8150 (Phone)

EMAIL application and all supporting documents to: **MDHHS-EMSED@michigan.gov**	**MDHHS-BETP USE ONLY** Date Received by Regional Coordinator: ____________________ Date Amendments Requested: ____________________________ Amendments Received: _________________________________ Date to MDHHS: _____________________________________ Date Interim Review Notice to Sponsor: _____________________ Recommend Approval: ____Yes _____No Regional Coordinator Signature:

APPROVED EMS EDUCATION PROGRAM SPONSOR
APPLICATION FOR A SATELLITE LOCATION

This original notification must be received by the department <u>at least 60 days prior</u> to the start of the course. Failure to complete and submit this form as prescribed may result in the education program sponsor approval revocation. If changes are made to a previously approved course, this form must be submitted as soon as changes are known.

1.

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

2.

Level of course to be offered:

__________ MFR/EMR	________ EMT Matriculation
__________ EMT	________ EMT Refresher
__________ Specialist/AEMT	________ Specialist/AEMT Refresher
__________ Paramedic	________ Paramedic Refresher
__________ Instructor/Coordinator	________ Instructor/Coordinator Refresher

3.

Dates of Course:
Start ________________________ Ending _____________________________

Meeting Days: S M T W Th F S Class Hours: _________________________

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4.

Specific Course Location________________________________ (Building, Room Number)____________________________

Address______________________________________

____

5. **Satellite Course at New Location:**

a. IDENTIFY ANY AND ALL CHANGES RELATED TO THIS SATELLITE LOCATION THAT ARE DIFFERENT THAN THE ORIGINAL CRITERIA FROM THE INITIAL PROGRAM SPONSOR APPLICATION:
(e.g., change of program director, physician director, additional faculty, additional clinical contracts, etc.)

b. Attach required documentation:

1. Dates satellite location to be active.
2. Sponsor representative at satellite location.
3. Satellite lead instructor (IC) and credentials if different than primary site lead instructor.
4. Satellite location physician director. Include credentials if different the primary site physician director.
5. Provide action plan that documents how sponsor will provide oversight to satellite location to ensure state requirements are met.
6. Provide written agreement between sponsor and satellite site identifying responsibilities of each.
7. Provide written plan to promote communication and evaluate progress among sponsor representative, satellite location representative, and satellite program director.
8. Provide documentation to ensure curricula, exams, evaluation tools, policies and procedures used must be consistent among all sponsor locations.
9. Provide equipment inventory and A/V resource list. If program is running concurrently with primary site program, must have enough equipment for both sites.
10. Ensure students have written contact information for contacting sponsor representative during course and after course completion.
11. Provide documentation that sponsor has approved all IC's, subject matter experts, and qualified instructors. Attach documentation if different from primary site.
12. Identify clinical sites to be used by satellite program and provide copies of contracts if different from sponsor's primary clinical sites.
13. Document provisions for satellite program students to have access to resources equivalent to those at the primary site, including library, assessment, tutoring and financial aid.
14. Identify location where program records will be kept during course and where they will be kept after course completion.
15. Provide documentation that Sponsor is providing financial support for the satellite program.
16. Documentation that the satellite program has a representative on the sponsor's advisory committee.
17. Adhere to all other primary site responsibilities.

c. ATTACH COURSE SCHEDULE (UTILIZE THE ATTACHED FORMAT).

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6. **REQUIRED SIGNATURES**

Program Director:
I affirm my commitment to serve as Program Director and to comply with all MDHHS-BETP requirements for education program Program Directors.

Program Course Coordinator Name	Title	Telephone Number
Signature - Program Course Coordinator	Date	Email:

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's Representative	Title	Telephone Number)
Signature – Authorized Program Sponsor's Representative	Date	Email:

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.

Printed Name of Physician Director	Title	Telephone Number
Signature – Physician Director (Please indicate M.D. or D.O.)	Date	Email:

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COURSE SCHEDULE

Program Sponsor: ______________________________ **Course Level:** ______________________________ **# Clinical Hours:** _________

Course Coordinator: ____________________________ **Course Location:** __________________________ **Hospital:** _________

Pre-Hospital: _________

Attach course schedule(s) to application. Schedule must include topics and hours required in MDHHS-BETP Education Program Requirements.

Lesson Number	Date & Time	Didactic Hours	Practical Hours	Topic	Instructor(s)

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