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
517-335-8150 (Phone)

EMAIL application and all supporting documents to:	MDHHS-BETP USE ONLY
MDHHS-EMSED@michigan.gov	Date Received by Education Coordinator: Date Amendments Requested: Amendments Received: Date to MDHHS: Recommend Approval: ☐ Yes ☐ No Education Coordinator Signature:

APPLICATION FOR A SATELLITE LOCATION FOR INITIAL EDUCATION

This satellite application must be received by the department at least **30** days prior to the start of the course. If applying during initial application or renewal, this satellite application and all required documents must be included with the initial application at least **60** days prior to the course start date or expiration date of program. Failure to complete and submit this form and all required documents as prescribed may result in the education program sponsor approval revocation.

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

Level of course to be offered:

- ☐ MFR/EMR
- ☐ EMT
- ☐ Specialist/AEMT
- ☐ Paramedic
- ☐ Instructor/Coordinator
- ☐ RN to EMT
- ☐ RN to Paramedic
- ☐ MFR/EMR to EMT Matriculation
- ☐ EMT Refresher
- ☐ Specialist/AEMT Refresher
- ☐ Paramedic Refresher
- ☐ Instructor/Coordinator Refresher

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Dates of Course:

Start Date: End Date:

Class Hours: _____

Specific Course Location_____ (Building, Room Number)_____

Address_____

_____

Documentation required with satellite application:

- ☐ Course syllabus for level of program being taught.
- ☐ Course schedule if the course is scheduled to begin within 30 days of application.
- ☐ Provide action plan that documents how sponsor will provide oversight to satellite location to ensure state requirements are met.
- ☐ Provide written agreement between sponsor and satellite site identifying responsibilities of each.
- ☐ Provide documentation to ensure curricula, exams, evaluation tools, policies and procedures used must be consistent among all sponsor locations.
- ☐ 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.
- ☐ Provide documentation that Sponsor is providing financial support for the satellite program.

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.)

Attach required documentation:

- ☐ Sponsor representative at satellite location.
- ☐ Satellite program director and credentials if different than primary site program director.
- ☐ Satellite location physician director, as needed for EMT, Specialist/AEMT, Paramedic levels.
- ☐ Include credentials if different the primary site physician director.

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☐ Provide written plan to promote communication and evaluate progress among sponsor representative, satellite location representative, and satellite program director.
Provide equipment inventory and A/V resource list. If program is running concurrently with primary site program, must have enough equipment for both sites.

☐ Identify clinical sites to be used by satellite program if not on file with MDHHS-BETP and provide copies of those contracts.

☐ Identify location where program records will be kept during course and where they will be kept after course completion.

☐ Adhere to all other primary site responsibilities.

It is recommended that the satellite program have a representative on the sponsor's advisory committee.

ATTACH COURSE SCHEDULE HERE

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 Director, as described in the program approval packet.

Program Director Name		Telephone Number
Signature - Program Director	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 Representative	Title	Telephone Number
Signature – Authorized Program Sponsor Representative	Date	Email:

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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: