Medical Control Physician

South Carolina Department of Health and Environmental Control
Division of EMS & Trauma
Medical Control Physician Update Form

1. Service Information

Service Name______________________________________ SC DHEC License #___________________

Service Mailing Address____

City/State/Zip code____

Telephone Number__________________________ Emergency Number__________________________

2. Medical Control Physician (MCP) Information

O Primary O Assistant

Name of MCP ____

SC BOME #________________________________ SC DHEC EMS# SC_______________________

Email Address__________________________________

Mailing Address________________________________

City/State/Zip__________________________________

Phone #_______________________________________

Emergency # __________________________________

Gender: O Male O Female

Race: (Select)
0 American Indian or Alaskan Native
0 Asian 0 Black or African American
0 Native Hawaiian or Pacific Islander
0 White 0 Other

Ethnicity: (Select)
0 Hispanic or Latino
0 Not Hispanic or Latino

Statement of Understanding & Authorized Signatures:
I have read and understood the duties & responsibilities of the Medical Control Physician as outlined in Regulation 61-7§ 402 (A through G) and § 44-61-130. Of the EMS law also included on this form. Further, if my EMS service has a State- Approved In-Service Training program, I accept full responsibility for the program and understand that I may not waive anyone from the State recertification examination until I have attended a State-Approved EMS Medical Control Workshop. If I have not already attended a Medical Control Physician Workshop, I understand that I must attend the next available workshop within the next twelve (12) months to remain as Medical Control Physician for the above EMS service.

O I have attended a Medical Control Workshop O I have not attended a Medical Control Workshop

Signature of Primary MCP & Date **Signature of Assistant MCP & Date**

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I understand that I must Notify the SCDHEC Division of EMS & Trauma of any change in Medical Control, Drug List, and/ or Standing Orders/Protocols within ten (10) days (Regulation 61-7 ,§ 402 E)

Signature of EMS Director & Date ____