

**Iowa Department of Public Health
Bureau of Emergency Medical Services
EMS Physician Medical Director Statement of Affirmation**

I hereby affirm and declare I have read Iowa Code Chapter 147A and Iowa Administrative Code 641--Chapter 132. The below named Iowa authorized service program(s) will comply with all applicable requirements set forth.

I understand I am responsible for providing appropriate medical direction and overall supervision of the medical aspects of the service program and shall ensure that those duties and responsibilities are not relinquished before a new or temporary replacement is functioning in that capacity.

I understand that, unless previously attended, I must attend an *Iowa EMS Physician Medical Director Workshop* sponsored by the department within one year of assuming duties.

I understand that failure to comply may result in denial, citation and warning, suspension, revocation or probation of the service program's authorization.

Service program(s) name:

Medical Director signature and date:

Medical Director Contact Information

print name first last MD or DO

mailing address

street address

city state zip

Iowa License # daytime phone evening phone

fax number email address

I have attended an Iowa EMS Physician Medical Director Workshop: yes no.