

Medical Advisor Manual

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1. Introduction

This manual is designed to assist Local EMS Medical Advisors (LEMA's) and EMS Coordinators (EMS-C's) by delineating and describing the duties and responsibilities of a LEMA. It describes the levels of NPS EMS providers and their scopes of practice (SOP), provides advice on how training, continuing education (CE), quality improvement (QI), and operational issues can be addressed and provides references for more detailed information and resources available to the LEMA. It should ideally be reviewed in conjunction with a copy of Directors Order 51 (DO-51) and Reference Manual 51 (RM-51). RM-51 includes the NPS EMS Field Manual, containing the Protocols, Procedures and Drugs approved for use at the EMT and Parkmedic levels. (see sections 3 and 4 below and Appendix #1, the Table of Contents from the NPS EMS Field Manual). These documents can be obtained through your park EMS Coordinator.

Section 1 of this manual references resources for those physician that have limited EMS Medical Direction experience. The remainder of the handbook focuses on the more unique aspects of providing EMS Medical Direction within the NPS. This handbook is neither definitive nor exhaustive, but designed as a resource and as such, is not intended to restrict LEMA's in how they operate. Several appendices are included for reference purposes:

- NPS EMS Manual Table of Contents
- Sample Continuing Education (CE) Schedule
- National Park Service Hierarchy
- EMS Coordinator Job Description

2. General EMS Medical Direction

Familiarity with the basics of EMS Medical Direction is key to successfully fulfilling the role of a LEMA. If needed, information on general EMS Medical Direction can be obtained through the following resources. It is recommended that new LEMA's review at least one of the Medical Direction publications listed below if they are not already familiar with this information.

American College of Emergency Physicians (ACEP)

Web site.....www.acep.org

Publications.....Medical Direction of Prehospital Emergency Medical Services, (also see the joint publication listed below)

National Association of EMS Physicians (NAEMSP)

Web site.....www.naemsp.org

Publication.....see the joint publication listed below

Courses.....Medical Direction: National Standard Curriculum

National Highway Transportation and Safety Authority (NHTSA)

Web site.....www.nhtsa.dot.gov

Publications..... 1. Guide for Preparing Medical Directors

This is the recommended resource if you are new to the role of EMS Medical Direction. It is a joint publication of NHTSA, ACEP, NAEMSP and Health Resources and Services Administration (HRSA) and can be ordered or downloaded through NHTSA at:

www.nhtsa.dot.gov/people/injury/ems/2001guidemedical.pdf

2. A Leadership Guide to Quality Improvement for EMS Systems Courses.....Several are sponsored by NHTSA and are usually offered through state or local EMS Authorities. Specific courses and dates are listed on their web site. Some you might consider are those on EMS Medical Direction, CQI in EMS Systems and Data Management

3. Terminology and Definitions

Park EMS Medical Advisor (LEMA): Within the Federal Government, “Directors” are employees. As the vast majority of Medical Advisors are working as volunteers in unpaid positions, this term is more accurate. Additionally, and perhaps more importantly, designation as a Medical Advisor allows Volunteer in the Park (VIP) status to be extended to the Medical Advisor, thus giving him/her significant tort claim protection.

EMS-Coordinator (EMS-C): This position is held by a Park Ranger who has been tasked with managing the EMS system within a park or sometimes multiple small parks/park areas. He/She is the primary link between the park and the LEMA. The assignment as an EMS-C is most often a collateral duty designated a percentage of the Rangers time, typically 10 to 20%. (See Appendix #4)

*More detailed descriptions of these positions, as well as additional related positions, can be found in RM51, Chapter 3, and Section 3. Also the unique Parkmedic (Level V) designation is detailed in section 4 below.

4. Levels of EMS provider in the NPS

Level 1: CPR AED Provider

Level 2: Basic First Aid Provider

Level 3: Emergency Medical Responder (EMR)

Level 4: EMT

Level 5: Parkmedic (AEMT)

Level 6: Paramedic

*Detailed descriptions of each of these positions can be found in RM-51, Chapter 6, Section three.

5. Training, Continuing Education and Scope of Practice (SOP)

Whenever possible the NPS strives to adopt nationally recognized certification standards at each level. RM-51 outlines the specific course of training and certifying organizations that the NPS has approved for each level of care. The NPS utilizes the National Registry for medic certification testing at the EMT level and above (www.nremt.org). Refreshers, as defined below, need to conform to the NREMT curricular outlines. However, other CE can be tailored to specific park needs, ideally identified through the CQI process.

Due to the unique environments often faced by NPS EMS Providers, some specific Scope of Practice expansions have been authorized for the EMT, Parkmedic, and Paramedic levels. These are briefly summarized below:

A. EMT

When approved by the LEMA and after successful completion of the appropriate training modules (see training below). EMT providers are allowed to use or perform the following procedures, as delineated in the NPS EMS Field Manual:

- Epinephrine – Auto-injectors
- Dislocation reductions
- Gamow Bag - (Portable hyperbaric chamber)
- NAAK/Mark I (Atropine/2PAM Auto-injector)

Some individual parks have authorized an expanded SOP for EMT , including IVF and/or a Drug module, typically (Nitroglycerine, Aspirin, Albuterol, Glucose). These are not uniform and do not currently fall under the approved NPS SOP. Parks that have chosen these expanded SOP items are doing so under the local or state SOP in their areas or under the medical license of their LEMA. Parks needing expanded SOP's are encouraged to consider moving to the Parkmedic level.

Training: EMT obtain training at a variety of sites and need state and/or National Registry certification to function within the NPS EMS System (check with your park EMS-C regarding the specifics in your park).

The specific EMT training modules, bulleted above, are taught and approved at the local park level as per the park medical Advisor.

Continuing Education: EMT must obtain adequate hours of CE to maintain their certification. National Registry requires 72 hours every 2 years (a 24 hour refresher plus 48 hours additional CE). This is most often provided by a combination of periodic practice and lecture sessions, led by the LEMA and coordinated by the EMS-Coordinator plus a 24-hour refresher. These refreshers are often provided by the larger parks and attended by EMT from neighboring smaller parks. Additionally, at the EMT level, CE is often obtained through local EMS Agencies.

B. Parkmedic

When approved by the LEMA and after successful completion of the appropriate training modules, Parkmedic level providers are allowed to do all the expanded SOP items listed in the EMT SOP. Additionally they have an expanded drug module and procedural skill set, uniquely tailored to NPS needs. This can be found in the NPS EMS Field Manual.

Training: Parkmedics are trained to this unique level at a biannual training and certification course provided at Community Regional Medical Center in Fresno California. This "January Course," is attended by Park Rangers from national parks all over the United States. Lectures, small group sessions, and clinical rounds are provided by Faculty and Residents as well as other staff. The course includes 4 weeks of didactics and additional clinical time. RN precepted, (ED time) and Prehospital, Paramedic precepted, (Ride along) time. The course teaches from the NPS EMS Field Manual and graduates obtain a certification at the NPS Parkmedic level and the AEMT level. They subsequently need to obtain authorization to practice in their designated park under the license of the LEMA.

Continuing Education: Parkmedics must obtain adequate hours of CE to maintain their certification. Although the National Registry does not specifically recognize the Parkmedic level of training, currently they are certified at the AEMT level. Thus they are required to obtain 72 hours of CE every 2 years (a 36 hour refresher plus 36 hours additional CE). This is most often provided by a combination of periodic practice and lecture sessions, led by the LEMA and coordinated by the EMS-Coordinator plus a 36-hour refresher every 2 years. These refreshers are often provided by the larger parks and attended by Parkmedics from neighboring smaller parks. See appendix # 2 for a sample CE schedule for a park with Parkmedic and EMT Providers. Although the Parkmedic SOP is somewhat unique, it is tailored specifically for the needs of the NPS and is standardized through the NPS EMS Field Manual. Some specific suggestions regarding CE sessions:

- Keep the sessions 3-4 hours each (1 hour didactics, 1 hour procedural practice, 1 hour QI and Q &A)
- The EMS Coordinator does most/all of the logistics
- Protocol based case scenarios are well received and more interactive
- Include procedural review and practice sessions, i.e. King Tube placement in mannequins, IV practice
- Mandate attendance and use testing for absentees
- Limit formal lecture format when possible
- Include a segment for QI – Feedback from their PCR review. Hand out sample PCR's and critique the care and documentation using EMS Charts.
- Use local field experience and CQI to focus emphasis and topic selection

C. Refreshers

Both the EMT and Parkmedic refreshers are multi-day training sessions that are designed to cover the entire SOP for the level of the provider. Parkmedics are often able to provide much of the instruction for the EMT Refresher. Additionally, local EMS Systems can often be tapped for instruction and training equipment for the Parkmedics. Format for these refreshers is highly variable, but often morning didactics and afternoon hands on practice sessions work well. National Registry Curriculum requirements provide an excellent framework, modified and tailored to the specific needs of your park/providers.

Updated CE requirements and curricula are available at www.nremt.org

Current Hours:

EMT Refresher (24 hours) plus 48 hours additional CE every 2 years

Parkmedic (AEMT) Refresher (36 hours) plus 36 hours additional CE every 2 years

D. MCI Drill

The NPS EMS Field Manual includes a procedure using START/Jump START for triaging patients in disaster or Multi Casualty Incidents (MCI). See the NPS EMS MCI Drill link on the LEMA homepage should you wish to practice for an MCI in a drill format.

E. Paramedics

Some parks have National Registry (NREMT) Paramedics and others utilize Paramedics through contracted personnel or mutual aid agreements with local EMS Systems. Hence, these parks (often in urban settings) may have frequent calls run within their boundaries as part of a larger EMS system. Contract agreements are usually seasonal or designated to cover a specific region within a park, typically those areas with high visitation or population density. These medics are usually not NPS personnel and the typical LEMA has minimal interaction with them as they often function within their local protocols and/or medical control. If your park utilizes Paramedics, contact your EMS-C for specifics on how they fit into the parks EMS System. If you would like more general information on how these providers fit into the NPS EMS System, contact the WASO office.

6. Continuous Quality Improvement (CQI)

Compared to most urban EMS Systems, the typical NPS EMS Provider has a low number of patient contacts. Many will go through an entire season with less than 10. Thus PCR, (run sheet) review with/without the EMS Coordinator, is critical to CQI. In many parks 100% review is feasible, as the total EMS contacts for the year is in the 100-300 range. Weighted sampling of PCR's for review, with the emphasis on ALS calls, can be accomplished with the assistance of the EMS-C. For example, all ALS airway, IV fluid, AED uses plus a percentage of the remainder might be a first query.

Feedback should be separated into two major categories, individual and group. Feedback to specific providers should have the goal of remediation and education of that individual. Group feedback is designed to cover educational points uncovered during investigations of specific incidents or via CQI data trends.

This is often accomplished as part of regularly scheduled continuing education sessions and can be augmented with electronic bullet point feedback via the EMS-Coordinator and the park bulletin board. For continuity the EMS-C needs to be included in all types of feedback. Regardless, due to medico-legal concerns, patient and to a lesser extent provider, identities need to remain confidential✳.

Most parks require a significant amount of data collection by the EMS-C and review of what they already collect is often a pleasant surprise to a new LEMA. Much of this is accomplished through EMS Charts. Additionally, the NPS maintains an EMS/Search and Rescue database that allows better decision-making, needs assessments and resource allocation, as well as national and local research opportunities.

✳Note: Typically the CQI process is shielded from legal inquiry. However, CQI requires a level of protection and confidentiality that complies with both federal and your state legislation. Be sure to maintain patient confidentiality and use communication forms that remain protected from discoverability, eg. email is often discoverable, while written communications with the local state statutes cited on the forms remain undiscoverable in most circumstances. Often the practices followed by your local urban EMS system(s) are a good resource for the best way for this to be accomplished.

7. Operations

Operational issues are predominantly the responsibility of the EMS-C. However, to understand the Medical Advisor and EMS System issues faced, this section is included to address some of the unusual circumstances that arise. What follows is a list of some relevant issues:

- The typical Park Ranger wears many hats. These may include fire, law enforcement, interpretive duties, Administration and EMS. This comes into play with CE issues as it is often difficult to free up large numbers of staff to attend multiple sessions. This also affects transport decisions as the prolonged transport of medical patients may leave large areas of the park uncovered for medical responses, but also for fire and law enforcement. Therefore, air evacuations or rendezvous are often the norm as opposed to the exception.
- Patient contacts are often few and far between, but may be significant in length (occasionally running into days). Thus the protocols and SOP decisions are designed to allow for this eventuality.
- Patients are often park employees, their families and concessionaires. Thus the providers often know their patients personally. This, along with the EMS providers potential law enforcement role, can result in some controversial, occasionally difficult situations for all parties involved.
- With the increasing mobility of the elderly, terminal and disabled, there have been several incidences of NPS EMS Providers needing to deal with advance directives. Often patients have stated they simply wish to die in a beautiful place. Having a policy and contingency plan for such situations can avoid numerous headaches.
- Park Rangers are often temporarily assigned to a specific area or transferred after a single year or season in a specific park. Thus the training, CQI and CE components are key to keeping a handle on what's happening within the park.
- Communications are usually well developed and highly professional, often incorporated within the fire and law enforcement systems. However, due to terrain and remote locations, there are often large communication failure areas mandating protocol and SOP decisions that allow operations to continue without base contact. This also illustrates the need for a thorough CQI process. Additionally a variety of communication devices may be in use within the same park. Familiarity with the capabilities and limitations of communications within your park(s) is key to good medical oversight.

- Some parks are geographically large enough to have more than one base hospital, while others have no on line medical control. Both of these situations may affect communications, SOP, CQI processes, transport and treatment decisions. Familiarity with the jurisdiction, mutual aid agreements, if any, base hospitals, park policy and geography are often key to smooth functioning of the NPS EMS System.
- The NPS EMS Field manual standardizes Parkmedic SOP, and documentation is done using EMS Charts. There is also an approved paper NPS Patient Care Report (PCR). This has been designed and updated to address the backcountry needs as well as the data collection requirements needed on a regional and/or national level. EMS Charts should be used to for all documentation unless the local situation mandates differently, when this standardized paper PCR form should be used.
- The NPS holds EMS conferences on a periodic basis. Attendees are NPS LEMA's and EMS-C's. Agenda items include issues germane to NPS EMS and discussion is focused on what future direction should be taken. Past conferences have been heavily focused on standardizing SOP, Policy, Protocols, Procedures, Drugs, and Documentation when and wherever possible. This handbook is one example of an attempt to have a standardized reference for LEMA'S and EMS-C's.
- One very useful relationship to develop, outside of the EMS-C, is that with your local EMS System. Good relations in this arena can be beneficial to both sides from nearly every aspect of EMS. This is particularly true with training, drills, equipment, transport and communications.

8. Administration

As a LEMA there is a minimum of administrative work as these duties primarily fall to the EMS Coordinator. Periodically the EMS-C will need a physician signature on recertification paperwork. In some unique settings there may be a call for a specific protocol or policy to be developed. Interagency relationships may also involve the LEMA from time to time, usually in the form of advice to the EMS-C. Although infrequent, some examples of how a LEMA might be involved include:

- Review of the Park EMS Plan
- National vs State vs Park – Jurisdiction issues
- Mutual Aid agreements*
- WASO (Washington DC) – LEMA interface
- Local EMS interface*
- National EMS-MA – LEMA interface
- State EMS interface*
- LEMA – EMS-C interface
- Hospital interface*
- Trauma/Burn center destination designation
- Billing/Reimbursement – mostly in the form of an occasional letter to an insurance carrier
- Medico-legal advice

*These items often involve a Memorandum of Agreement (MOA) or Understanding (MOU). These should be reviewed in conjunction with your EMS-C. Your input is predominantly from the medical content perspective and theirs from the operational. The actual document writing is done mostly by the park and agency attorneys.

NPS Hierarchy

Appendix # 3 shows the chain of command from the President on down to the typical EMS – Coordinator in a National Park. As a LEMA you serve as an advisor and consultant to the EMS-C and the vast majority of the typical interactions will be through this individual. EMS-C's rarely, if ever, have this as their only assigned duty. EMS is most often a small percentage “collateral duty.” Typically this is 10 to 20 % of their assigned time. Appendix #4 is the DO51 and RM51 description of the EMS Coordinator position and required duties.

9. Resources/Information

- Directors Order-51
- ReferenceManual-51
- NPS EMS Field Manual-Appendix #3 is the Table of Contents from this document to give you an idea of the Parkmedic SOP.
- EMS Coordinator
- WASO – EMS/SAR office in Washington DC
- National EMS-MA's*
- Fellow/Neighbor Parks/LEMA's*
- NPS EMS Leadership Committee* – This is a group of LEMA's who have met several times over the last 8 years to discuss and advise the NPS via the WASO Branch Chief for EMS/SAR.

* These can all be accessed through the WASO office

NPS EMS FIELD MANUAL

General

- 0010 How to Use this Manual.
- 0020 Terms, Acronyms, & Abbreviations

Procedures

- 1010 Automated External Defibrillator (AED).
- 1020 Base Hospital Contact Criteria.
- 1030 Blood Glucose Determination.
- 1040 CPAP
- 1041 Electronic Control Device (ECD).
- 1042 Endotracheal Intubation.
- 1043 Epinephrine Ampule.
- 1045 Epinephrine Auto-Injector.
- 1050 Fracture/Dislocation Management.
- 1060 Gamow Bag.
- 1070 Intraosseous (IO) Access.
- 1080 IV Access and IV Fluid Administration.
- 1085 King Tube.
- 1095 Mucosal Atomizer Device.
- 1100 Multi-Casualty Reporting & Triage.
- 1105 NAAK/Mark I (Nerve Agent Antidote).
- 1110 Nasogastric/Orogastric Tube Insertion.
- 1120 Needle Thoracostomy.
- 1130 Oxygen Administration.
- 1135 Pelvic Stabilization.
- 1140 Rectal Drug Administration.
- 1150 Spine Immobilization.
- 1160 Standard Reporting Format.
- 1170 Transtracheal Jet Insufflation.
- 1180 When to Initiate a PCR.
- 1190 Wound Care.

Protocols

- 2005 Abdominal Pain.
- 2010 Allergic Reactions.
- 2020 Altered Mental Status/Altered Level of Consciousness (ALOC).
- 2030 Altitude Illness.
- 2035 Altitude Illness Prophylaxis.
- 2040 Bites and Stings.
- 2050 Burns.

- 2060 Cardiac Arrest With AED (Adult Medical).
- 2065 Cardiac Arrest Without AED (Adult Medical).
- 2070 Chest Pain (Cardiac).
- 2080 Childbirth.
- 2090 Electrical and Lightning Injuries.
- 2100 Eye Trauma.
- 2110 Frostbite.
- 2115 General Medical Illness – Adult.
- 2120 Heat Illness.
- 2130 Hypothermia.
- 2140 Ingestion/Poisoning.
- 2150 Major Trauma (Adult).
- 2160 Minor and Isolated Extremity Trauma.
- 2180 Pediatric – Major Trauma.
- 2190 Pediatric – Medical Arrest With AED.
- 2195 Pediatric – Medical Arrest Without AED.
- 2200 Pediatric – Medical Illness/Fever.
- 2210 Pediatric – Newborn Resuscitation.
- 2220 Pediatric Parameters.
- 2230 Respiratory Distress.
- 2235 SCUBA/Dive Injury.
- 2240 Seizures.
- 2250 Shock Without Trauma.
- 2255 Submersion/Near Drowning
- 2260 Trauma Arrest (Adult and Pediatric).
- 2270 Vaginal Bleeding.

Drugs

- 3005 Acetaminophen (Tylenol).
- 3010 Acetazolamide (Diamox).
- 3020 Activated Charcoal.
- 3030 Albuterol or Metaproterenol Sulfate.
- 3035 Amiodarone.
- 3040 Aspirin (Acetylsalicylic Acid).
- 3050 Atropine Sulfate.
- 3055 Bacitracin Ointment.
- 3060 Cefazolin Sodium (Ancef).
- 3070 Dexamethasone (Decadron).
- 3080 Dextrose 50% (D50).
- 3090 Diphenhydramine (Benadryl).

3100 Epinephrine.
3105 Erythromycin Ophthalmic Ointment.
3107 Fentanyl (Sublimaze).
3120 Glucagon.
3130 Glucose Paste or Gel (Glucose).
3133 Hydromorphone (Dilaudid)
3135 Ibuprofen (Motrin, Advil).
3145 Ipratropium (Atrovent).
3148 Ketamine
3150 Lidocaine
3155 Magnesium Sulfate 50%.
3160 Midazolam (Versed).
3170 Morphine Sulfate.
3180 Naloxone (Narcan).
3190 Nifedipine (Adalat, Procardia).
3200 Nitroglycerin.
3205 Ondansetron (Zofran).
3210 Oxytocin (Pitocin).
3215 Pralidoxime Chloride (2PAM).
3220 Sodium Bicarbonate.

Appendices

- A. Topics Removed from 2007 Manual.
- B. NPS EMS First Responder Manual.
- C. List of LEMA Approved ESOP
Items.
- D. Tactical Medic Protocols (Pending).

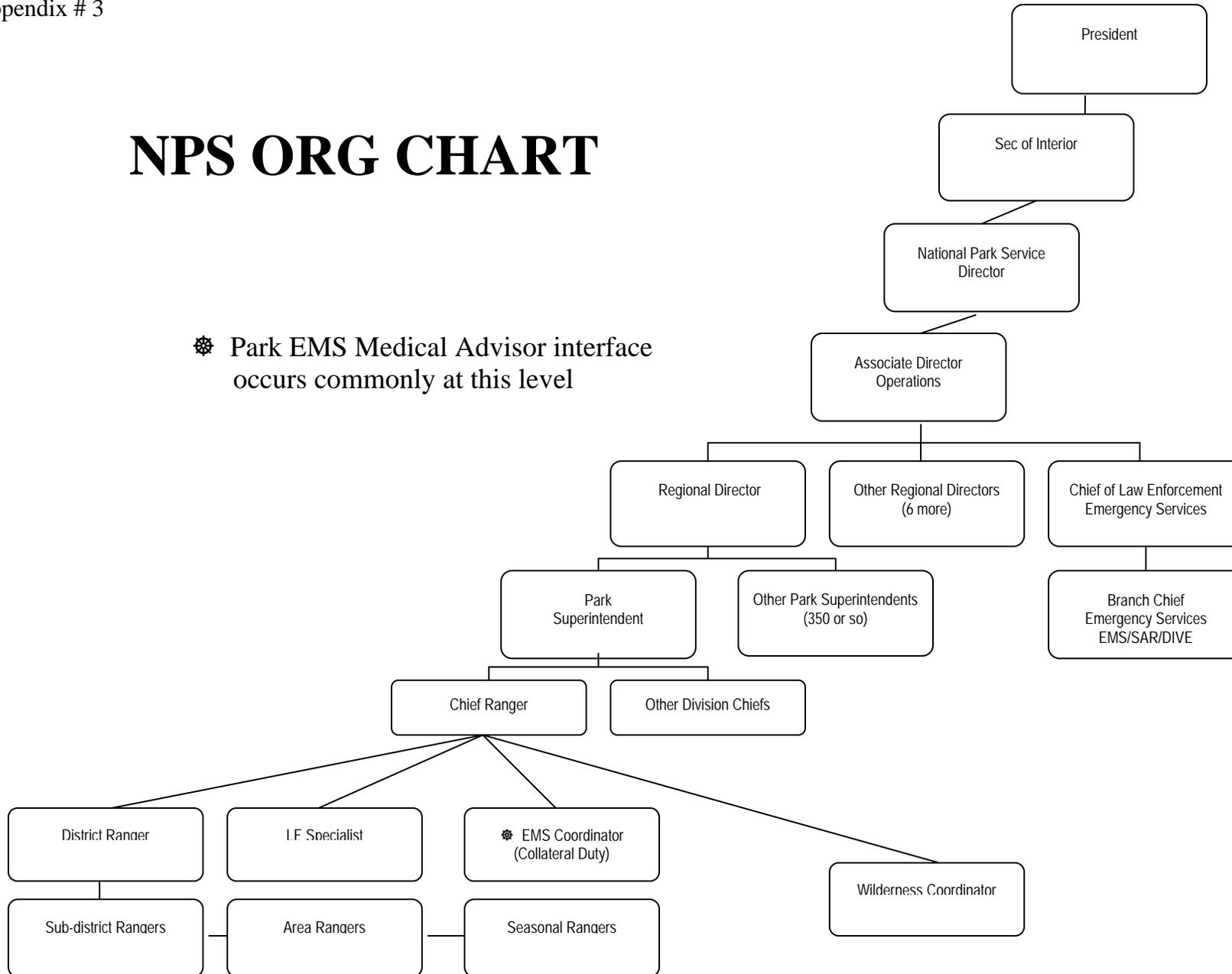
Appendix # 2

Sample Parkmedic Yearly CE Calendar

| Date | Topics/ Procedures/ Medications |
|-----------------|--|
| Sept 9, 2013 | Topics: Pediatrics, Ingestions, poisoning Procedures: IO access, rectal drug administration Medications: Narcan, childrens Tylenol, Tylenol, ibuprofen, charcoal |
| Oct 7, 2013 | Topic: Cardiac Arrest, abdominal pain Procedures: AED, IV access, O2 administration, King Tube Medications: Atropine, Epinephrine, Bicarbonate, amiodarone |
| Nov 4, 2013 | Topic: Chest pain, burns, lightning/electrical Procedures: King Tube, Medications: aspirin, nitroglycerin, fentanyl, morphine |
| Dec 2, 2013 | Topics: Trauma: minor and major, frostbite, hypothermia Procedures: wound care, Spine immobilization, needle thoracostomy, dislocation reduction, tourniquet, pelvic stabilization Medications: Fentanyl, Morphine, ancef, ondansetron |
| January 6, 2014 | Topic: Respiratory Distress, allergic reactions Procedures: Transtracheal Jet Insufflation Medications: Albuterol, Atrovent, Dexamethasone, Lasix, epi, diphenhydramine |
| Feb 2-7, 2014 | PARKMEDIC REFRESHER |
| March 3, 2014 | Topic: Environmental—altitude illness, heat illness, near drowning, bites and stings, eye trauma, general adult medical illness Procedures: Gamow bag, IV fluid, Medications: Nifedipine, acetazolamide, dexamethasone |
| April 7, 2014 | Topics: General Adult Medical Illness, Abdominal pain, Cardiac Arrest Procedures: AED, IV access, O2 administration, Combitube Medications: Atropine, Epinephrine, Bicarbonate |
| May 5, 2014 | Topics: ALOC, Seizures Procedures: Blood glucose determination, MAD, restraints Medications: D50, glucagons, glucose paste, midazolam |
| June 2014 | Tentative EMT refresher |
| July 2014 | Tentative MCI Drill vs. Summer Break, TBA |
| Aug 2014 | Tentative MCI Drill vs. Summer Break, TBA |

NPS ORG CHART

⚙️ Park EMS Medical Advisor interface occurs commonly at this level



Appendix #4

From Director's Order – 51 (DO-51)

Park EMS Coordinator

The day-to-day management and funding of park EMS programs resides at the park level. It is the responsibility of each superintendent to ensure that the park EMS program is in compliance with DO-51 and RM-51. Superintendents will appoint Park EMS Coordinators to ensure that their programs are compliant with Service-wide policy and regulation, as well as applicable laws.

From Reference Manual – 51 (RM-51)

1. Overview

The day-to-day management and funding of park EMS programs resides at the park level. It is the responsibility of each park's superintendent to ensure that the park EMS program is in compliance with DO-51 and RM-51. Superintendents will appoint Park EMS Coordinators, who will work with Park EMS Medical Advisors to ensure that their programs are in compliance with Service-wide policy and regulation, as well as applicable laws. The Washington and Regional Offices will provide guidance and assistance to the parks.

3.4. Park EMS Coordinator (PEMS-C)

The day-to-day management of EMS programs in the individual units of the NPS resides at the park level, and it is the responsibility of park superintendents to ensure that their programs are in compliance with the Director's Order and this Reference Manual. Superintendents will appoint an EMS Coordinator to fulfill these obligations.

Duties of the PEMS-C may include:

- Liaison with the Local EMS Medical Advisor (LEMA).
- Evaluate the welfare and effectiveness of the EMS program and apprise park management and the LEMA.
- Ensure that the area EMS plans are consistent and in compliance with DO-51 and RM-51.
- Coordinate park EMS training and serve as EMS training officer.
- Coordinate the purchase of controlled substances, EMS supplies and equipment.
- Maintain necessary records such as personnel resources, and supply and equipment inventories.
- Issue White Cards (EMS Provider authorizations) and ensure that appropriate credentials are maintained.
- Prepare and submit a summary of park EMS activities and the number of Level III, IV, V and VI EMS Providers to the NEMS-MA and REMS-C at the end of each calendar year.
- Provide for as necessary, critical incident stress management (CISM) follow-up for all employees and supervisors who may be involved in emergency response and/or support. The specific details regarding Critical Incident Stress Management is to be published in Reference Manual 57 *Occupational Medical Standards and Health and Fitness Guidelines*.
- Conduct EMS Needs Assessment for the park every 3 years.