

# Genesee County Medical Control Authority

## Letter of Compliance

Agency Name: \_\_\_\_\_ Applicable Year: \_\_\_\_\_

1. Current license by Michigan Department of Consumer and Industry Services (MDCH):  
\_\_ ALS      \_\_ LALS      \_\_ BLS      \_\_ MFR
2. Agency personnel shall be trained and licensed in accordance with appropriate statutes and rules (i.e. MDCH and GCMCA).
3. Agency will maintain medical supplies, communication equipment, procedures and protocols consistent with the MDCH and GCMCA.
4. Agency will ensure minimum staffing requirements for vehicle level of service and base dispatch consistent with MDCH and GCMCA.
5. Agency agrees to ensure timely and complete monthly submission of records and reports to the GCMCA for EMS Quality Assurance Committee review as is set by GCMCA protocol; and to respond timely (as set by GCMCA QA Committee) to peer review case, trend, and/or protocol concern inquiries which may include submission of run records, reports, explanation, corrective action plans, and/or presentation of agency personnel to the committee.
6. Agency agrees to respond collegially and timely to GCMCA QA Committee recommendations for improvement in accordance with the GCMCA protocols for review and corrective actions.
7. The agency has a system based upon GCMCA protocols to ensure the appropriate dispatching of life support vehicles based on medical need and capability of the Genesee County Emergency Medical Services System and consistent with the Genesee County mutual aid and efficiencies of the ALS intercept system.
8. Agency will ensure 75% attendance to GCMCA Committee and Subcommittee meetings in which it has an assigned representative member.
9. Any agency that does not comply with the above could be subject to the sanctions outlined in the current GCMCA protocols.

We acknowledge that each criteria and verification are subject to inspection by a GCMCA representative at any time. Should cause exist, the GCMCA and or GCMCA Project Medical Director of designee may request formal verification.

Authorized Agency Representative (Printed Name) \_\_\_\_\_

Authorized Agency Representative (Signature) \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

GCMCA Medical Director (Signature) \_\_\_\_\_

Date of Receipt \_\_\_\_\_