DEPARTMENT OF HEALTH SERVICES-COUNTY OF LOS ANGELES

NOTIFICATION OF PERSONNEL CHANGE FORM

REFERENCE NO. 621.1

Organization's Name: _____

Effective Date: _____

CHANGE REQUESTED: (Check all that apply) **[ ] No Changes Necessary**

[ ] Personnel Change

Hospital:

[ ] Chief Executive Officer (CEO)
[ ] ED Medical Director
[ ] ED Nurse Manager/Director
[ ] Base Hospital Medical Director
[ ] Prehospital Care Coordinator (PCC)
[ ] Trauma Medical Director
[ ] Trauma Program Manager
[ ] EDAP Medical Director
[ ] Pediatric Liaison Nurse (PdLN)
[ ] PMC/PTC Medical Director
[ ] PMC/PTC Liaison Nurse
[ ] Disaster Coordinator
[ ] ASC Medical Director
[ ] ASC Program Coordinator
[ ] SRC Medical Director
[ ] SRC Clinical Director
[ ] Other: _____

Provider Agency:

[ ] Fire Chief/CEO
[ ] Medical Director/Drug Authorizing Physician
[ ] Nursing Coordinator (Nurse Staffed Amb.)
[ ] Quality Improvement Coordinator
[ ] Other: _____
[ ] Paramedic Coordinator
[ ] EMS Educator
[ ] AED Program Coordinator
[ ] General Manager/Operations Manager or equivalent **(attach copy of resume)**

Approved Training Programs: (EMT/Paramedic/MICN/Expanded Scope/Skills and CE)**

[ ] Medical Director (Paramedic/MICN)
[ ] Clinical Director/Coordinator
[ ] Other: _____
[ ] Program Director
[ ] Principal Instructor (EMT only)

Change Name From: _____

Change Name To/Add: _____

****Additional information required, contact the Office of Program Approvals**

[ ] Change Address/Contact Numbers

_____
Address/Street

_____
City/State/Zip

_____
Telephone

_____
Fax

_____
Telephone: Disaster Command Post

_____
Fax: Disaster Command Post

_____
Pager Number

_____
Cellular Telephone Number

_____
E-mail address

_____
Name of person completing form

_____
Title

_____
Date