

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)  
REFERENCE NO. 621

SUBJECT: **NOTIFICATION OF PERSONNEL CHANGE**

**PURPOSE:** To inform the EMS Agency of all pertinent staffing, address and telephone changes within the EMS community in order to facilitate the flow of information between organizations.

**POLICY:** All EMS related organizations shall complete and forward Reference No. 621.1, Notification of Personnel Change Form, whenever there is an address, telephone or personnel staffing change of one of the following positions:

- Hospitals:
1. Chief Executive Officer
  2. Emergency Department Medical Director
  3. Emergency Department Nurse Manager
  4. Base Hospital Medical Director
  5. Prehospital Care Coordinator
  6. Trauma Medical Director
  7. Trauma Program Manager
  8. EDAP Medical Director
  9. Pediatric Liaison Nurse
  10. PMC/PTC Medical Director
  11. PMC/PTC Liaison Nurse
  12. Disaster Coordinator
  13. ASC Medical Director
  14. ASC Program Coordinator
  15. SRC Medical Director
  16. SRC Clinical Director
- Provider Agency:
17. Fire Chief/Chief Executive Officer
  18. Paramedic Coordinator
  19. Medical Director/Drug Authorizing Physician
  20. EMS Educator
  21. Nursing Coordinator - (Nurse Staffed Ambulance)
  22. AED Program Coordinator
  23. Quality Improvement Coordinator
  24. General Manager/Operations Manager or Equivalent

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

25. Medical Director - (Paramedic only)
26. Program Director
27. Clinical Director/Coordinator
28. Principal Instructor - (EMT only)

Forward to: Los Angeles County Emergency Medical Services Agency  
10100 Pioneer Boulevard, Suite 200  
Santa Fe Springs, CA 90670  
Attn: Prehospital Care Programs

EFFECTIVE DATE: 7-1-93  
REVISED: 02-01-13  
SUPERSEDES: 3-15-10

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APPROVED:   
Director, EMS Agency

  
Medical Director, EMS Agency

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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Chief Executive Officer (CEO)      | <input type="checkbox"/> PMC/PTC Medical Director |
| <input type="checkbox"/> ED Medical Director                | <input type="checkbox"/> PMC/PTC Liaison Nurse    |
| <input type="checkbox"/> ED Nurse Manager/Director          | <input type="checkbox"/> Disaster Coordinator     |
| <input type="checkbox"/> Base Hospital Medical Director     | <input type="checkbox"/> ASC Medical Director     |
| <input type="checkbox"/> Prehospital Care Coordinator (PCC) | <input type="checkbox"/> ASC Program Coordinator  |
| <input type="checkbox"/> Trauma Medical Director            | <input type="checkbox"/> SRC Medical Director     |
| <input type="checkbox"/> Trauma Program Manager             | <input type="checkbox"/> SRC Clinical Director    |
| <input type="checkbox"/> EDAP Medical Director              | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Pediatric Liaison Nurse (PdLN)     |   |

**Provider Agency:**

- |  |  |
|--|--|
| <input type="checkbox"/> Fire Chief/CEO                              | <input type="checkbox"/> Paramedic Coordinator   |
| <input type="checkbox"/> Medical Director/Drug Authorizing Physician | <input type="checkbox"/> EMS Educator  |
| <input type="checkbox"/> Nursing Coordinator (Nurse Staffed Amb.)    | <input type="checkbox"/> AED Program Coordinator   |
| <input type="checkbox"/> Quality Improvement Coordinator             | <input type="checkbox"/> General Manager/Operations Manager<br>or equivalent (attach copy of resume) |
| <input type="checkbox"/> Other: _____                                |  |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Director (Paramedic/MICN) | <input type="checkbox"/> Program Director                |
| <input type="checkbox"/> Clinical Director/Coordinator     | <input type="checkbox"/> Principal Instructor (EMT only) |
| <input type="checkbox"/> Other: _____                      |  |

**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

Reviewed 2-1-13