

BOARD OF MEDICAL EXAMINERS

1500 SW 1st Ave, Suite 620
Portland, Oregon 97201

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, September 17, 2004, 9:00 AM

MEMBERS PRESENT

Gregory Lorts, M.D., Chair
John J. Herbold, EMT-I
Dave Lapof, EMT-B
Paul S. Rostykus, M.D.
Jon Tardiff, EMT-P

STAFF PRESENT:

Kathleen Haley, Executive Director
Diana Dolstra, Licensing Administrator

GUESTS

Peggy Andrews, Chemeketa Community College
Shawn Baird, Woodburn Ambulance Service, Oregon Ambulance Association
Chris Benson, OFMAA, Lane County Fire District #1
Paul Bollinger, Department of Human Services-EMS
Dan Christy, King Systems Corporation
Jon P. Cloutier
Denise Giard, OFMAA/Albany Fire
Cindy Halaas, AMR
Cameron Helikson, EMT-I, Newberg Fire District
Tim Hennigan, Department of Human Services-EMS
Randy Jackson, Keizer Fire District
Gregg Lander, Chemeketa Community College
Taneka Means, AMR
Gary McLean, EMT-P, OSPA
Shane Moore, Portland Community College/Hooper Detox
Elizabeth E. Morgan, Department of Human Services-EMS
John Praggastis, OSPA
Jon Shields, AMR
Donna Wilson, Department of Human Services-EMS
Paula Wilson, Portland Community College

AGENDA

Welcome new EMT Advisory Committee member Dave Lapof, EMT-B (Keizer)

Approve minutes of the September 17, 2004 EMT Advisory Committee meeting.

Process for selecting Advisory Committee chairperson

Administration of epinephrine by First Responders for anaphylaxis

Update on the EMT-Intermediate curriculum development – Paul Bollinger, DHS EMS

DHS-EMS administration of the CombiTube program – Paul Bollinger, DHS EMS

King LT Oropharygeal airway

Discussion items for scope of practice – Paul Rostykus, MD

Further discussion of EMT proficiency in the use of the bag-valve mask
– Jon Tardiff, EMT-P

Future meeting date

Gregory Lorts, M.D., Chair, called the meeting to order at 9:00 AM.

Dr. Lorts welcomed Dave Lapof, EMT-B as the new member on the EMT Advisory Committee.

APPROVE MINUTES OF THE JUNE 11, 2004 EMT ADVISORY COMMITTEE MEETING

On page 4 there is a mis-spelling of anaphylaxis, and in the fourth paragraph there is a reference to the use of epinephrine by EMTs and it should be First Responders.

It was moved and seconded

**THE MINUTES OF THE JUNE 11, 2004 EMT ADVISORY COMMITTEE MEETING
BE ACCEPTED WITH THE ABOVE CHANGES.**

Motion carried.

PROCESS FOR SELECTING ADVISORY COMMITTEE CHAIRPERSON

Ms Dolstra, Licensing Administrator, described the process of selecting a chairperson for the Acupuncture Committee and the Board. The EMT Advisory Committee decided on a yearly rotation of the chair, and then discussed at which committee meeting to make the change. It was determined it would be the June meeting, and the Committee should not select someone whose term is going to end June 30th. The person selected in June will chair the September meeting for the next four meetings, and then the selection process starts again.

By unanimous Committee approval, Dr. Lorts was voted to chair the committee for the next year. At the June 2005 meeting, another chair will be selected.

ADMINISTRATION OF EPINEPHRINE BY FIRST RESPONDERS FOR ANAPHYLAXIS

The agenda contains two case reports of the administration of epinephrine to patients by EMTs in the field. Mary Ann Vaughan who was going to present to the Committee today is not able to make the meeting, but she mailed some articles she obtained from the Internet on the administration of epinephrine, and a list of additional articles.

Dave Lapof said that there is not very good training and not really good follow-up as to whether it is used effectively and there has been a positive outcome or not. First Responders as a group are in limbo as to whether they are a civilian based response and they can do it under those guidelines or as an EMS agency provider and they have to follow their scope of practice. From the information we have been given there does not seem to be adverse effects to their being trained to use epinephrine. He does not see why it would be a bad thing.

Dr. Rostykus said there are no statistics showing that it does work or it does not work. There is no information; there are no records. It will probably work, we just don't know.

Jon Tardiff asked if there is a way we could add it to the rules for a certain period of time and then take a look to see whether it is effective. In the meantime collect data and find out if there are any adverse effects, and whether First Responders can administer epinephrine effectively.

Gary McLean asked the Committee whether they were trying to make this part of the First Responder scope of practice, because they can be trained to give it now as a citizen on the scene.

Dr. Lorts said that that was the issue discussed at the last meeting; that the First Responder should not administer epinephrine on the scene if he/she has been trained to use it, but it is not in his/her scope of practice because it gives the impression that it is in his/her scope.

Dr. Rostykus said you cannot administer epinephrine while advertising yourself as a First Responder and it is awkward to disassociate yourself from being a First Responder when administering epinephrine and then go back into the role of First Responder to continue treating the patient.

Dr. Lorts, said there was discussion of should it only be for those First Responders who have supervising physicians and only the auto-injector, and the cost of adding the training to the First Responder level.

Dr. Rostykus said there was also discussion of having all First Responders have a supervising physician.

In response to the question of how many certified First Responders there are, Paul Bollinger from DHS-EMS said that DHS-EMS does not know as they are not tracked by DHS. Certification is through the educational institutions.

It was determined that if epinephrine is added to the First Responder scope of practice, it would be agency specific, and Paul Bollinger could request tracking by each agency that signed up to allow their First Responders to train to administer epinephrine for anaphylaxis.

It was moved, and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS APPROVE THE ADDITION TO THE FIRST RESPONDER SCOPE OF PRACTICE THE ADMINISTRATION OF EPINEPHRINE FOR ANAPHYLAXIS BY AUTO-INJECTOR (OAR 847-035-0030 (8) (e) (*Exhibit A*).

Motion passed unanimously.

Agencies would sign up for epinephrine as they are doing now for the Combitude and they would be required to submit reports of administration to DHS-EMS.

There was discussion of the expense of buying auto-injectors versus buying epinephrine in vials and filling the injectors, but as Dr. Rostykus said the First Responder would have to deal with syringes, needles, biohazards and making sure they injected it subcutaneously; and there are several educational steps that are different.

UPDATE ON THE EMT-INTERMEDIATE CURRICULUM DEVELOPMENT

Donna Wilson, DHS-EMS, presented an update to the EMT Advisory Committee and said that the Intermediate curriculum committee met just this week. The committee is about half-way through writing the declarative. The committee will meet again the first of October. The physician group has not met yet, but will soon. The committee chair is Jon Jui, M.D., and he is off with Hurricane Ivan. The target end date for completion of the EMT-Intermediate curriculum revision is to have it ready to bring to the EMT Advisory Committee at the December meeting.

Jon Tardiff discussed the new concept of the Intermediate being provided training in a broad class of drugs but not in specific drugs, which the supervising physician will provide when the Intermediate is working for an EMS agency. Mr. Tardiff wanted to be sure that the Intermediate was as well trained as possible in the drugs to be used, so that he/she would be confident once leaving the training program and able to function well at his level of certification. The supervising physician will provide the training on the specific drugs the Intermediate will use in the field.

Donna Wilson said that was the intent of the new Intermediate curriculum.

DEPARTMENT OF HUMAN SERVICES-EMS ADMINISTRATION OF THE COMBITUBE PROGRAM

Back in November 2003, DHS-EMS made the Combitude an agency specific program. As of yesterday, there are 25 current agency providers that are providing airway care using the Combitude throughout the state. It is now included in the current EMT-Basic curriculum. Once everyone has had the training, it will disappear as an agency specific program.

Dr. Rostykus asked whether the EMT supervising physician or a physician designee must conduct the practical test for EMT-Basics who wish to use the Combitude, as he finds it difficult to schedule all the testing himself or find another physician to help him with the testing. Most physicians do not know anything about the use of the Combitude. Paul Bollinger asked that if he changed the memo to allow a designee of the supervising physician to be an EMT-Paramedic under

the supervision of the supervising physician who could do the practical test of the Combitube, would that help? Dr. Rostykus said that it would.

There was a question about the agency specific program. When does training of all the EMTs in the agency have to be complete? The response from DHS-EMS is “within a reasonable period of time.”

Liz Morgan said that the supervising physician can limit the scope of practice of an EMT in an agency if that person does not get the training required.

Paul Bollinger restated, by saying that the training for the agency should be obtained within a reasonable period of time. Obviously not everyone is going to be trained in the Combitube right away, but the agency can go ahead and start using the Combitube when the supervising physician feels a high enough percentage of the EMTs in the agency have obtained the training. The remaining EMTs who have not been trained must receive their training within the target date set by the agency, which they felt was within a reasonable period of time.

If some supervising physicians are not going to allow their EMT-Basics to use the Combitube, there will be Basics who are trained to use it and Basics who won't be trained to use it. The newly graduating Basics will all have training in it, but there will be two levels of Basics; those with the training and those without the training.

Liz Morgan said that it is reasonable to say that it is going to be the standard of care in Oregon for all EMT-Basics to be trained on the Combitube, aspirin and epinephrine. She knows that in the metropolitan area there are EMTs that are not allowed to give aspirin. They are all trained in it, but it is not in the EMT's protocol. Combitube is an agency specific procedure. Eventually that will go away, and then every EMT should have the training.

KING LT OROPHARNGEAL AIRWAY

Dr. Lorts said he talked to two physicians about the King LT oropharyngeal airway. One anesthesiologist was aware of the device but had had some problems with, although he wasn't specific. The trauma anesthesiologist said he hasn't seen it used enough, and didn't have enough information.

Dr. Rostykus said he talked to an anesthesiologist who is involved in the military who knew someone in California who would come up and talk to the Committee about it, for a fee. He didn't pursue that offer.

Dan Christy, the King LT representative, brought the disposable device and the monometer device, which fine-tunes the pressure in the cuff.

The Committee discussed the King oropharyngeal device and where it belongs in the scope of practice and does language in the scope cover it already or does language need to be drafted? Dr. Rostykus wanted to come up with the most generic terms that can allow some variation without having to change the rules.

Mr. Christy said that boards and other people are calling it the oropharyngeal obturator. A number of fire departments and EMS people want to use the device. He would like to bring it back in a year with some clinical studies and see if it can be added to the scope.

In response to a question, Mr. Christy said that the FDA has approved the device to be called and marketed as an oropharyngeal airway. Dr. Rostykus asked what is the intent of the administrative rules and the intent of the company that does the labeling and are they the same? He doesn't feel the King LT is appropriate to be used by First Responders.

The question was: would that limit the LMA, and what about calling it a cuffed pharyngeal airway device?

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE WORDING IN OAR 847-035-0030 (10)(h) "CUFFED PHARYNGEAL AIRWAY" BE SUBSTITUTED FOR "DUAL LUMEN AIRWAY."

Dr. Rostykus hesitated to approve the new airway because the Combitube is still being taught to all EMT-Basics through the colleges and training programs. If everyone was trained in Combitube he would feel better about adding it, but it's almost changing in mid-stream by adding another airway when the last one the Committee added hasn't even been completely taught yet.

Dr. Lorts said it will take up to a year before this is added to the scope.

Dr. Rostykus said he would like to see more evidence-based studies on how well the King LT works in the field.

Dan Christy said King LT has been gathering evidence for FDA approval for five years.

John Praggastis suggested leaving dual lumen in and adding "or cuffed pharyngeal airway", so that EMTs who know that the dual lumen airway is the Combitube won't get confused with the term cuffed pharyngeal airway. It allows them the option of one device or the other, and the LMA remains in as an airway as well.

The motion was amended to read

THE EMT ADVISORY COMMITTEE RECOMMENDS ADDING IN OAR 847-035-0030 (10)(h) "INSERT A DUAL LUMEN AIRWAY OR A CUFFED PHARYNGEAL AIRWAY OR A LARYNGEAL AIRWAY (LMA) DEVICE IN THE PRACTICE OF AIRWAY MAINTENANCE."

Gary McLean, EMT-P asked whether hours of training needed to be added with this new airway.

The general consensus was that no additional training was needed.

Administrative rules will be written and brought back to the Committee at its December meeting.

Motion carried unanimously.

John Praggastis said that the comment has come up that the Board, by adopting these other airway options, is trying to get rid of endotracheal (ET) tubes at all certification levels that have ET tubes.

Dr. Lorts restated what John Praggastis said by saying that it appears that by investigating and promoting or allowing these alternative devices there is an underling desire from this Committee to diminish the utilization of endotracheal tubes.

John Herbold said he never heard of that and Jon Tardiff said it was an untrue rumor and it was wrong, wrong, wrong!

DISCUSSION ITEMS FOR SCOPE OF PRACTICE – PAUL ROSTYKUS, MD

The first suggestion regarding a generic term for “dual lumen airway device” has been discussed. Dr. Rostykus’ second idea is to change the wording in OAR 847-035-0030 (9)(f)(A) from anaphylactic shock to anaphylaxis because there are people who have severe anaphylaxis without having low blood pressure; without having shock.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE WORDING IN THE EMT-BASIC SCOPE OF PRACTICE (OAR 847-035-0030 (9)(f)(B)) BE CHANGED TO “ADMINISTER EPINEPHRINE BY SUBCUTANEOUS OR AUTOMATIC INJECTION DEVICE FOR ANAPHYLAXIS.” (Exhibit A)

Motion carried unanimously.

Dr. Rostykus said that there is redundancy of language in that the dual lumen airway device is in the EMT-Basic scope of practice and then is repeated for the Intermediate scope of practice. He proposed the dual airway device be deleted from OAR 847-035-0030 (10)(h).

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE WORDS “DUAL LUMEN AIRWAY OR” BE DELETED FROM OAR 847-035-0030(10)(h), WHICH WILL NOW READ “INSERT A LARYNGEAL AIRWAY DEVICE (LMA) IN THE PRACTICE OF AIRWAY MAINTENANCE.”

Administrative rules will be written and brought back to the Committee at its December meeting.

Motion carried unanimously.

FURTHER DISCUSSION OF EMT PROFICIENCY IN THE USE OF THE BAG-VALVE MASK

Mr. Tardiff did not have time to work with the Department of Human Services-EMS on this project, and he would like to bring it back to the next Committee meeting in December.

OTHER BUSINESS

Dave Lapof asked about the process of adding discussion items to the agenda, and is the Committee going to have an annual scope of practice meeting?

Dr. Lorts said years ago when the Committee meetings weren't held on such a regular basis, the January meeting was the annual scope of practice meeting. The Committee would receive a lot of requests, many of them for the same change, and it would take a while for the Committee to sort through changes, decide which changes to make, and write the administrative rules. It seems more efficient to have requests come in and have the Committee discuss them at each meeting.

Dr. Lorts described the process of what the Board is responsible for versus the Department of Human Resources-EMS, and one is not in charge of the other, but each drives the other. The rewrite of the EMT-Intermediate curriculum will require a change in the scope of practice, and changes in the scope require the Department of Human Services-EMS to add training to the curriculum or develop agency-specific training programs. A better awareness of how each agency works makes the process work better.

Recommendations made from the Committee to the Board are reviewed by the Board with Dr. Lorts' input. The Board's decision is made based on the minutes, discussion by the Board members, and input from Dr. Lorts who attends the Board meetings upon request.

Gregg Lander mentioned that at the national level there is a national scope of practice being worked on, consistent across the country, with four levels of certification: First Responder, EMT, Paramedic Associate degree level, and then an advanced level Paramedic with a bachelors degree. Liz Morgan, said that they are accepting comments on it through January 2005, and she gave the web site. It is perhaps twenty years away from implementation.

NEXT MEETING

Friday, December 10, 2004, 9:00 AM

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 11:00 AM.

OREGON ADMINISTRATIVE RULES
CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS
PROPOSED RULES CHANGES – OCTOBER 2004
FIRST REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Board of Medical Examiners has established a scope of practice for emergency and nonemergency care for First Responders and EMTs. First Responders and EMTs may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001 (5).

(2) The scope of practice for First Responders and EMTs is not intended as statewide standing orders or protocols. The scope of practice is the maximum functions which may be assigned to a First Responder or EMT by a Board-approved supervising physician.

(3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.

(4) Standing orders for an individual EMT may be requested by the Board or Section and shall be furnished upon request.

(5) No EMT may function without assigned standing orders issued by Board-approved supervising physician.

(6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician or a nurse

practitioner, if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

(7) The scope of practice for emergency and nonemergency care established by the Board for First Responders is intended as authorization for performance of procedures by First Responders without direction from a Board-approved supervising physician, except as limited by subsection (2) of this rule. A First Responder may perform the following emergency care procedures without having signed standing orders from a supervising physician:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for soft tissue injuries;
- (g) Provide care for suspected fractures;
- (h) Assist with prehospital childbirth; and
- (i) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a copy of that report to the senior EMT with the transporting ambulance.

(8) A First Responder may perform the following procedures only when the First Responder is providing emergency care as part of an agency which has a Board-approved supervising physician who has issued written standing orders to that First Responder authorizing the following:

- (a) Administration of medical oxygen;
- (b) Open and maintain an airway through the use of an oropharyngeal and nasopharyngeal airway and pharyngeal suctioning devices;

(c) Operate a bag mask ventilation device with reservoir;

(d) Provision of care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia; and

(e) Administer epinephrine by automatic injection device for anaphylaxis;

[(e)] **(f)** Perform cardiac defibrillation with an automatic or semi-automatic defibrillator, only when the First Responder:

(A) Has successfully completed a Section-approved course of instruction in the use of the automatic or semi-automatic defibrillator; and

(B) Complies with the periodic requalification requirements for automatic or semi-automatic defibrillator as established by the Section.

(9) An Oregon-certified EMT-Basic may perform emergency and nonemergency procedures. Emergency care procedures shall be limited to the following basic life support procedures:

(a) Perform all procedures that an Oregon-certified First Responder can perform;

(b) Ventilate with a non-invasive positive pressure delivery device;

(c) Insert a dual lumen airway device in the practice of airway maintenance;

(d) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;

(e) Provide care for suspected shock, including the use of the pneumatic anti-shock garment;

(f) Provide care for suspected medical emergencies, including:

(A) Obtaining a peripheral blood specimen for blood glucose monitoring, obtained via fingerstick, heelstick, or earlobe puncture;

(B) Administer epinephrine by subcutaneous or automatic injection device for [~~anaphylactic shock~~] **anaphylaxis**;

(C) Administer activated charcoal for poisonings, following local written standing orders; and

(D) Administer aspirin for suspected myocardial infarction.

(g) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator;

(h) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(i) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician;

(j) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(k) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician and that are in the possession of the patient at the time the EMT-Basic is summoned to assist that patient; and

(l) In the event of a release of military chemical warfare agents from the Umatilla Army Depot, the EMT-Basic who is a member or employee of an EMS agency serving the DOD-designated Immediate Response Zone who has completed a Section-approved training program may administer atropine sulfate and pralidoxime chloride from a Section-approved pre-loaded auto-injector device, and perform endotracheal or pharyngoesophageal intubation, using protocols promulgated by the Section and adopted by the supervising physician. 100% of EMT-Basic actions taken pursuant to this section shall be reported to the Section via a copy of the prehospital emergency care report and shall be reviewed for appropriateness by Section staff and the Subcommittee on EMT Certification, Education and Discipline.

(m) In the event of a release of chemical agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, using protocols approved by the Section and adopted by the supervising physician, if:

(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or

(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.

(10) An Oregon-certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:

(a) Perform all procedures that an Oregon-certified EMT-Basic can perform;

(b) Initiate and maintain peripheral intravenous (I.V.) lines;

(c) Initiate and maintain an intraosseous infusion;

(d) Initiate saline or similar locks when specifically authorized by the physician;

(e) Infuse any physiologic isotonic crystalloid solution;

(f) Draw peripheral blood specimens;

(g) Initiate or administer the following medications:

(A) Epinephrine 1:10,000;

(B) Atropine sulfate;

(C) Lidocaine bolus for ventricular fibrillation, post ventricular fibrillation/ventricular tachycardia cardiac arrest, ventricular tachycardia, or wide complex tachycardia;

(D) Naxolone hydrochloride;

(E) Hypertonic glucose;

(F) Nitroglycerine for chest pain;

(G) Beta-2-specific nebulized bronchodilators;

(H) Morphine for pain management;

(h) Insert a [~~dual lumen airway or~~] laryngeal mask airway (LMA) device in the practice of airway maintenance;

(i) Insert an orogastric tube;

(j) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for such maintenance have been provided by the personnel at the sending medical facility.

(k) Perform cardiac defibrillation with a manual defibrillator if the EMT-Intermediate has satisfactorily completed a Section-approved training course in manual defibrillation, including written and practical examinations and the EMT-Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an “EMT-Intermediate Manual Defibrillation Waiver” by the Section.

(11) An Oregon-certified EMT-Paramedic may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to:

(a) Perform all procedures that an Oregon-certified EMT-Intermediate can perform;

(b) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Tracheal suctioning techniques;

(C) Needle cricothyrotomy; and

(D) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway.

(c) Initiate a nasogastric tube;

(d) Initiate electrocardiographic monitoring and interpret presenting rhythm;

(e) Provide advanced life support in the resuscitation of patients in cardiac arrest;

(f) Perform emergency cardioversion in the compromised patient;

(g) Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;

(h) Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;

(i) Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;

(j) Initiate placement of a urinary catheter for trauma patients in a prehospital setting who have received diuretics and where the transport time is greater than thirty minutes; and

(k) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician.

(12) The Board has delegated to the Section the following responsibilities for ensuring that these rules are adhered to:

(a) Designing the supervising physician and agent application;

(b) Approving a supervising physician or agent; and

(c) Investigating and disciplining any EMT or First Responder who violates their scope of practice.

(d) The Section shall provide copies of any supervising physician or agent applications and any EMT or First Responder disciplinary action reports to the Board upon their request.

(13) The Section shall immediately notify the Board when questions arise regarding the qualifications or responsibilities of the supervising physician or agent of the supervising physician.