Volume Eight

DIRECTOR'S WORDS

I want to take this opportunity to thank all of you (EMS services) who have worked so hard to meet the data submittal requirements. I know that this has been a big project, requiring a great deal of effort. Those of you who are committed to excellence have stepped up to the challenge.

I've frequently been asked what we're going to do with this data. My answer is that there are a number of uses and benefits. On the provider level, each service will have access to its own data to run needed reports. At the state level, OEMST will review run report data every day to identify unusual occurrences or procedures. We'll use the data to review everything from drugs to response times to education needs. The data will also be used to assist with grant opportunities for the EMS community. Timely data also ensures that the Department has good data to conduct surveillance activities, from pandemic indications to emergency calls to nursing home or family planning centers. Nearly every unit within the Alabama Department of Public Health will have access to this data for any public health concern.

For the first time in history, the EMS Program will be driven by real data. This is not Big Brother looking over the EMS providers' shoulders, but a partner standing next to the EMS community, creating a "culture of excellence."

EMS in Alabama is in a period of defining who we are and where we want to go. I have had the privilege of attending national meetings with EMS officials from every state in the nation. I always come home from these meetings with new and greater appreciation for our EMS system. While I will not deny we have problems, we are 10 plus years ahead of most states.

One of my goals as the Director of the OEMST is to create a culture in EMS. This "culture of excellence" has to be displayed in how we dress, talk, think, train, provide patient care, maintain our vehicles, maintain our records, and on and on. We can create this "culture" if we all are doing what is best for the patient and the system. The "system" is made up of all EMTs and providers, not just a few individuals. Too many times, we lose sight of what is best for the system as a whole. EMS is part of the "Allied Health Care System." EMS isn't a trade or a hobby. It's a licensed profession of saving people's lives through the practice of pre-hospital medical intervention.

I know that the EMS provider salaries are not as high as they should be, but I hope, in time that this will change. I know from talking with many of you, that we are on the right track. Other states have told me personally that they are watching Alabama and see us on the cutting edge of EMS. It's only because of so many of you who are providing the leadership in your services that we can be an example to the rest of the EMS community in this country.

Dennis Blair, Director
Office of EMS & Trauma

EMS SERVICE INSPECTIONS

It's the middle of the summer and you work for an ambulance service in Alabama. The average high temperature this time of year is somewhere in the low 90s with the occasional "pop-up" variety of thundershowers ever present. Are you thinking, "What does working on an ambulance and a synopsis of summertime weather in Alabama have to do with this newsletter?"

Over the past couple of months, our OEMST inspectors have found numerous ambulances with inadequate air conditioning and units running with severely worn tires. These conditions affect both patient and ambulance crew safety and well being. State EMS Rule 420-2-1-.03 Ground Ambulances (18) page 11 states the State Board of Health shall have the authority to remove from service ambulances which, in the opinion of the inspecting officer, significantly fail to meet the minimum requirements to be operated on the public streets and highways of Alabama and thereby present a threat to public health or safety. In such instances, inspectors have grounded units until repairs or replacements have been made.

Another deficiency found with many services is the lack of VHF (HEAR SYSTEM) radio communication. In times of disaster, the Hospital Emergency Administrative Radio System has proven to be invaluable as a communication link when other systems have failed. Be on the lookout for further notices from the OEMST concerning HEAR Radio Systems.

Coming up in the next issue of our newsletter we will recognize our services found to be compliant with State EMS Rules. Kudos to services who have already met compliance standards. We look forward to listing your service after your next inspection. As Director Dennis Blair stated in his article, EMS is the "profession of saving people's lives" and one of the steps in reaching the "culture of excellence" in Alabama EMS is providing our EMTs and public with safe and well-equipped ambulances.

EMTs and Service Providers…..it is your responsibility to make sure all personnel are properly licensed by the State Board of Health!!! Upon vehicle inspections, inspectors will verify EMT licensure for those crew members assigned to the inspected vehicle. Violations are reported to 3rd party reimbursement agencies (see Compliance and Investigations).

The State Medical Control Committee has tasked the Protocol Subcommittee to update the Alabama Patient Care Protocols yearly and bring the suggested updates to the SEMCC meeting in June. On June 25, 2008, the Alabama State Board of Health accepted the following changes to the protocols (only the paramedic protocol changes are listed below). The updated protocols (EMT-Basic, EMT-Intermediate, EMT-Paramedic) will be placed on the EMS&T web site during the week of July 21-25. An educational DVD of the protocol changes will be made available to all services by late July. All EMTs will have until October 1, 2008, to have Protocol Update Training. The reports of training should be sent to the regional EMS office, not to the office of EMS&T. When every member of a service has had the protocol update training, the service will be allowed to use the updated protocols.

CHANGES IN 4TH EDITION EMT-PARAMEDIC PROTOCOLS

UPDATE, JUNE 25, 2008

1. Updated Table of Contents
   - Safe Transportation of Pediatric Patients added to Section 6
   - Helicopter protocols added to Section 7
   - Devices to perform needle decompression of the chest added to Section 9
   - Request to be taken to a hospital on diversion added to Section 10
2. Section II, Patient Rights
   Updated #5
   - The protocol has been rewritten to emphasize that a patient who is conscious and alert has the right to be taken to the hospital of his/her choice, even if the hospital is on diversion.
3. Section 3.2
   Updated section on Medical Direction Hospitals
   - It has been added that if a service's off-line medical director has a medical control physician identification (MCPI) number and is board certified in emergency medicine or is current in ATLS and ACLS, he/she may give on-line medical direction (OLMD) for the service.
4. Section 3.4
   Updated lists of Category A and B medications
5. Updated 4.7 Burns
   - It has been added that cyanide poisoning can cause dyspnea and cerebral anoxia the same as carbon monoxide. Also added indications for entering a burn patient into the trauma system and transporting directly to a ready burn center. Also added that the pulse oximeter is unreliable in cyanide poisoning and if a patient is unconscious from smoke inhalation the EMT should give 100% oxygen as well as consider use of Cyanokit (if available - Cyanokit is an optional drug).
6. Updated 4.10 Cardiac Symptoms/Acute Coronary Syndrome
   - Added that if equipment is available to record and transmit a 12-lead ECG, the EMT is required to do so (provided the hospital has the ability to receive). If the hospital lacks the equipment to receive the 12-lead ECG, the EMT is to run the ECG and deliver it to the hospital with the patient.
7. Updated 4.21 Hypoglycemia
   - We have had multiple complaints from medical direction physicians about hypoglycemic patients being drilled with an intraosseous needle in order to give D50W (often without even trying to start an IV). We added a note that IO is not indicated for hypoglycemia except in extreme circumstances and use of IO for this would be reviewed in each case. Our new electronic patient care report allows us to monitor use of such procedures on a daily basis.
8. Updated 4.29 Stroke
   - The giving of aspirin to every patient with stroke symptoms was part of the original stroke protocol in the mid 90s at the suggestion of Dr. Gomez when he was head of the UAB Stroke service. This has always been controversial because of the possibility of increased intracranial bleeding if the patient was having a hemorrhagic stroke. There was also the danger of aspiration of the aspirin if the stroke had affected the patient's ability to swallow. We now have national guidelines for emergency stroke care. The 2007 stroke association guidelines suggest keeping patients NPO until their swallowing can be adequately tested. The guidelines also recommend aspirin only for ischemic stroke and then it can be given any time within 48 hours. The change is to remove the prehospital use of aspirin for patients with stroke symptoms and to keep the patient NPO.
9. Updated 5.5 Aspirin
   - The use of aspirin for patients with stroke symptoms has been deleted.
10. Updated 5.13 Glucagon
    - The protocol subcommittee had received a request that use of glucagon be changed from CAT B to CAT A. Upon investigation we found reports of it being used as a first-line drug for hypoglycemia without bothering to try to start an IV and give D50W. We decided it would be prudent to leave it as CAT B and add a note that it was not a first-line drug for hypoglycemia.
11. Added 5.27 Hydroxocobalamin (Cyanokit) as an optional medication for known cyanide poisoning or for smoke inhalation victims who are comatose, in shock, or in cardiac arrest.
12. Updated 6.1 Endotracheal Intubation
    - This protocol has been rewritten to correct errors (such as esophageal disease being a contraindication for ET intubation), to add use of the bougie for difficult adult intubations, and to add a procedure for use of nasotracheal intubation (not indicated for services that can perform RSI). It stresses that either qualitative or quantitative CO2 monitoring must be done. We also added that pediatric patients very rarely need endotracheal intubation and are usually better ventilated by bag-mask.
13. Updated 6.5 Intraosseous Infusion
    - We have had multiple complaints from medical direction physicians about inappropriate use of the intraosseous route of drug administration since the IO drill became available. For this reason we changed the procedure to CAT B except for:
      1. Cardiac arrest or shock with altered mental status in children
      2. Cardiac arrest or shock with BP <90 in adults.
    - We also changed the protocols to reflect indications, contraindications, and precautions of the procedure

Continued on page 3

Continued from page 2

rather than listing specific details of performing the procedure (which vary depending on the device used). Also changed the wording to make it clear that the proximal tibia is the only acceptable site for IO (except for the sternum if using the FAST-1).

14. Updated 6.10 Needle Decompression · The protocol was changed to allow decompression to be CAT A for the patient in traumatic cardiac arrest. Decompression will remain CAT B for all other uses. Also added that it is acceptable to perform a precautionary chest decompression on patients with a flail chest so severe that they have to be intubated because of persistent hypoxia. Also added that decompression needle should be at least 2.5 inches in length (6-7cm) and at least 14 gauge.
15. Added new protocol 6.13 Safe Transport of Pediatric Patients.
16. Added new protocol 7.9 Early Activation of Helicopter EMS.
17. Added new protocol 7.10 Guidelines for Helicopter Transport of Trauma System Patients.
18. Added new protocol 7.11 Guidelines for Helicopter Utilization for Scene Response Other than Trauma System.
19. Updated 8.5 Trauma System Protocol.
20. Updated 9.2 Hemostatic Agents by adding WoundStat.
21. Updated 9.4 Continuous Positive Airway Pressure Devices by adding O2-RESQ single use system by Pulmodyne.
22. Added 9.5 Devices to Perform Chest Decompression
23. Added 10.4 Request to be Taken to a Hospital on Diversion (Optional form)

John Campbell, M.D.
State EMS Medical Director

DO YOU HAVE QUESTIONS FOR OEMST STAFF?

This is another reminder to those of you calling our Office:

Complaints, Investigations - Call Mark Jackson

Service Inspections or Service Licenses - Call Hugh Hollon or Kem Thomas

Individual Training, Testing or Individual Licenses - Call Gary Mackey

COMPLIANCE & INVESTIGATIONS | May, June, and mid-July, 2008

Name	Violation/Complaint	EMS Rule	Action Taken
John Doe EMT-Basic/Driver	Impairment	420-2-1.21	Rehab Facility / Evaluation
Christopher Mathis EMT-Paramedic	Medication Administration	420-2-1.05	EMS Rules Review
Mobile County EMS	Pt Care Issues	No EMS Violation	No Action Taken
Dothan Amb Service	Pt Care Issues	No EMS Violation	No Action Taken
John Doe II EMT-Paramedic	Impairment	420-2-1-.21	Voluntary Suspension
Bryan Avery EMT-Basic	Scene Cancellation	No EMS Violation	No Action Taken
Haynes Ambulance Montgomery	Professionalism	420-2-1-.25	Internal Training Issues
John Doe III EMT-Paramedic	Impairment	420-2-1-.21	Rehab Facility / Evaluation
Charles Tilton EMT-Paramedic	Professionalism	420-2-1.25	Internal Suspension w/ Probation
Med Call Ambulance	EVOC	No EMS Violation	No Action Taken
Athens Limestone Hospital Ambulance	Pt Care Issues	No EMS Violation	No Action Taken
John Doe IV EMT-Paramedic	Impairment	420-2-1-.21	Rehab Facility / Evaluation
Angel Ambulance Service	Unlicensed Amb. Driver	420-2-1-.03 420-2-1-.04	Turned over to 3rd Party Payors
Care Ambulance Service	Unlicensed Amb. Driver	420-2-1-.03 420-2-1-.04	Turned over to 3rd Party Payors

INDIVIDUAL LICENSURE ISSUES

AHA and ARC require that CPR cards be typed. Any card that is handwritten will not be accepted by the Office of EMS and Trauma.

Please review the revised EMS rules that were officially approved on January 21, 2008. The OEMST has experienced a number of calls from people who do not know how to renew their license or what their renewal requirements are. The revised rules were mailed to every licensed provider and can also be found at http://www.adph.org/ems.

Electronic-PCR (e-PCR) Update

As of July 18, 2008, over 145,000 electronic patient care reports have been submitted since January 1, 2008. We appreciate the effort that everyone has made. We continue to expect great things once we get everyone reporting.

A letter was recently sent to every licensed EMS agency in Alabama outlining the modified reporting timeframes. Reporting is now required to be completed no later than 168 hours after the response was completed. We feel this will allow agencies ample time to overcome the learning curve for reporting as well as addressing any managerial or equipment needs. It will always be the goal to eventually return to 24 hour reporting sometime in the future. We will monitor closely the new compliance period and appreciate every person and agency that was able to comply with the original 24 hour reporting request.

Our e-PCR tech support staff is on duty every day 8-5 to answer your questions or assist you with technical issues. Contact Chris Lochte or Craig Dowell at 334-206-5383.

Resource tools, validation, and procedures for becoming compliant are listed at http://emsis.net/alabama. Please refer your IT people or vendor representatives to this site.

TRAUMA SYSTEM UPDATE

The North Alabama Trauma System (EMS Region 1) and the Central Trauma System (EMS Region 3) continue to operate well. There were a total of 521 patients entered into the systems in June (324 in BREMSS and 197 in North). About 75% of these are taken to Level I Trauma Centers and about 25% are spread among the Level II and Level III hospitals. The town hall meetings to kick off the trauma region planning have already occurred in the East Trauma Region (EMS Region 2), the Southeast Trauma Region (EMS Region 5), and the Gulf Trauma Region (EMS Region 6). These regions are in the process of having their regional trauma councils appointed. The prehospital trauma education for these regions will begin in late August or early September. The initial meeting in the West Trauma Region (EMS Region 4) will probably be in August or September. Our goal continues to be to have all of the regional trauma systems operational by the end of this year or early 2009.

The trauma system works like this:

1. The Alabama Trauma Communications Center (ATCC) constantly monitors, by computer, the resources and ready status of every trauma hospital.

2. Using the trauma patient criteria protocol (8.5) the first responding EMS service evaluates the patient and determines whether the patient meets trauma system criteria. If so, the senior EMT calls the ATCC and enters the patient into the system.

3. The EMT will be given a unique identifying number to go on the ePCR to flag this patient as being a trauma system patient. Together the EMT and the TCC will decide which of the ready trauma centers would be most appropriate for the patient.

4. If the patient is handed off to another service to transport, this identifying number must be put on that service's ePCR as well. This is how the system is able to pull together all the PCRs that pertain to a single patient.

5. The ATCC will then fax a written report to the receiving hospital and in some cases link the EMT with the ED of the receiving hospital for a verbal report as well.

6. Level I and Level II trauma centers will, after evaluating and treating the patient, send (within 24-48 hours) written Patient Care Feedback to the ATCC, stating what was found when the patient was evaluated, and what was done for the patient. This is sent to the EMTs who cared for the patient so they get feedback about the patient.

In the first four months of operation of the North Trauma Region, we initially, through the QI process, identified that there was confusion about who should put a trauma patient into the system. While the first responding EMS service is encouraged to do this, it is the absolute responsibility of the transporting service to do this if it is not already done. If the patient is not entered into the system, the charts cannot be retrieved for QI, the patient may not be taken to the best hospital for trauma care, and the EMS service will get no feedback on the patient. After some education and some encouragement from the office of EMS & T, the number of patients entered into the system in the North region went from 73 in April to 178 in May and to 197 in June. The Region 1 EMS staff and all of the Region 1 EMTs deserve a pat on the back and a big "THANKS" for making the QI process work.

For further information and updates on the trauma system, see the trauma system web site: www.adph.org/ats.

NEWS FROM THE PEDIATRIC FRONT | Courtesy of Ann Klasner, MD, MPH and EMS-C Grant

aklasner@peds.uab.edu

EMS-C News

- Check out our webpage: http://www.adph.org/emsc.
- We would love for you to check out our new web page. It should serve as a source for pediatric information in the State of Alabama. Please send your thoughts to Verla Thomas (VerlaThomas@adph.state.al.us).
- Pediatric Equipment Surveys: If you didn't fill them out the first time, here is your chance. These surveys will help us identify pediatric equipment needs in the state, so your input is important. To date we have required 60% of the surveys, but we need yours to reach our goal of 90%. One need already identified and addressed is the lack of pediatric backboards. As you know, we have secured pediatric backboards for all services and each of you should now have yours in place. If you have questions about whether you have completed your survey or the status of your backboard, please contact Verla Thomas.
- EMS-C Advisory Board: Our last meeting was May 21, 2008. This was an invigorating and thought-provoking meeting. We even had guests from the national level to help guide our discussions. From this meeting several excellent ideas were brought forward including the development of a State EMS Conference (set for October 17, 2008-stay tuned for further details) and development of pocket reference materials for pediatric protocols. We look forward to future work on our grant performance measures, and thank everyone who participated. If you would like to be involved please contact Dr. Ann Klasner or Verla Thomas.

Focus on Pediatric Summertime Safety Tips:

- Summer is a time of vacations, swimming and endless fun, but it also brings its own unique safety concerns. Some of these concerns are reviewed below:
  - Boating Safety: Children should wear life jackets at all times when on a boat or near bodies of water. Make sure the life jacket is the correct size. Blow-up water-wings, toys, and rafts should never be used as life jackets or life preservers. Adults should wear life jackets for their own protection.
  - Lawn Mower Safety: Children < 16 years should not be allowed to use ride-on mowers and those < 12 years should not use walk-behind models. Sturdy shoes should be worn while operating any type of lawn mower and the user should never be barefooted.
  - ATV Safety: Children who are not licensed to drive a car should not be allowed to operate off-road vehicles. All riders should wear helmets, eye protection and protective reflective clothing. Do not ride double. Passengers are frequently injured when riding ATV's.
  - Playground Safety: Playgrounds should be housed on safety mats or loose materials, and should be at least 9" deep, and have a border of 6' around the equipment. Anything with strings/straps should not be allowed on playgrounds, as children have been strangled by these when caught in the playground parts.

Free Personal Protection Equipment and Personal Preparedness Training

The Alabama Department of Public Health (ADPH), Center for Emergency Preparedness (CEP), is offering free personal protection equipment (PPE) and personal preparedness training (PPT) so your organization can respond effectively to pandemic influenza (PI). The personal preparedness education will ensure your staff has thought through the tough questions and will be more likely to respond when called during an emergency.

ADPH will provide a free limited supply of PPE:

- N95 masks
- Surgical masks
- Face shields
- Hand gel
- Gloves
- General cleaning supplies

To receive the free PPE for PI, your organization must provide:

- A PI operational plan
- Education for all staff on PI and personal preparedness
- Secure storage location for PPE.

The PI operational plan must contain the specific names, resources, supplies, and descriptions on how your organization will continue to operate during a pandemic.

Key elements of an operational plan include, but are not limited to:

- Delegation of authority
- Order of succession
- Essential functions
- Essential staff
- Alternate operating facility
- Communications
- Vital records and databases
- Human capital
- Health and safety of employees
- Supply chain and other resources
- Recovery

Upon request, your Public Health Area (PHA) Emergency Preparedness (EP) Teams will provide reference material and advice for your operational plan.

If your organization is interested, please contact your local county health department and ask for your EP Coordinator.

For more information about pandemic influenza, go to www.adph.org/pandemicflu or www.pandemicflu.gov

SERVICE TYPE	ALS Transport	ALS Non-Transport	BLS Transport	BLS Non-Transport	Total	ALS/T	ALS/NT	BLS/T
County	10	1	0	0	11	5.32%	0.90%	0.00%
Educational Institutions	1	1	0	0	2	0.53%	0.90%	0.00%
Hospital	13	0	0	0	13	6.91%	0.00%	0.00%
Industrial	3	5	1	0	9	1.60%	4.50%	7.14%
Military	2	1	0	0	3	1.06%	0.90%	0.00%
Municiple Ambulance	3	0	0	0	3	1.60%	0.00%	0.00%
Municiple Fire	27	41	0	0	68	14.36%	36.94%	0.00%
Police	0	2	1	0	3	0.00%	1.80%	7.14%
Private	79	0	2	0	81	42.02%	0.00%	14.29%
Rescue	31	4	9	0	44	16.49%	3.60%	64.29%
Volunteer Ambulance	1	0	0	0	1	0.53%	0.00%	0.00%
Volunteer Fire	5	55	1	0	61	2.66%	49.55%	7.14%
Other	13	1	0	0	14	6.91%	0.90%	0.00%
TOTAL	**188**	**111**	**14**	**0**	**313**	**100.00%**	**100.00%**	**100.00%**

EMT RESOURCES	Basic	Driver	EMT-I	Para	Total	%		
Asia Male	28	3	1	4	36	0.3%		
Asia Female	6	4	0	0	10	0.1%		
Black Male	530	84	21	116	751	6.3%		
Black Female	80	35	6	23	144	1.2%		
Hispanic Male	72	17	1	19	109	0.9%		
Hispanic Female	13	6	0	0	19	0.2%		
Native American Male	32	9	2	29	72	0.6%		
Native American Female	15	4	1	6	26	0.2%		
White Male	4316	864	454	2871	8505	71.8%		

State Troopers Add Search-and-Rescue Helicopter to Fleet

New Aviation Asset to Aid Local, State and Federal Law Enforcement Operations

Law enforcement agencies in Alabama now have a new workhorse at their disposal: A Bell 407 search-and-rescue helicopter recently acquired by the Department of Public Safety. DPS rolled out the state's latest aerial law enforcement asset this spring, significantly expanding state trooper emergency air rescue and response services provided in support of local, state and federal law enforcement operations.

Trooper Pilot Lee Hamilton said the new craft can provide rescue services from Mt. Cheaha to Mobile Bay. "Helicopters are notoriously limited by air speed and weight of cargo," said Hamilton. "With the new helicopter, we can get people off roofs and transport a six-member tactical team. The new helicopter can fight fires and has a 180-gallon BAMBI bucket. We can put the water where we want it with precision and accuracy."

Law enforcement agencies may request emergency assistance from State Trooper Aviation during regular business hours by contacting the unit at 334-242-4055. After hours, during holidays and on weekends, requests may be forwarded to the Montgomery Trooper Post, 334-242-4128, or the nearest local state trooper post.

MEETINGS, EVENTS & NOTICES

State Emergency Medical Control Committee (SEMCC) Meeting has been scheduled for September 16, 2008, at 1:00 p.m. in Clanton at the Alabama Power Building. Keep an eye on our website www.adph.org/ems for further information.

ALERT: Federal Rules Will Soon Require Wearing High Visibility Vests Effective November 24, 2008, firefighters and all other responders will be required to wear ANSI approved High Visibility Vests. A new federal rule requires responders to wear the vests while conducting operations on roadways supported by federal dollars. It only makes sense; after all, wouldn't your family want you to be visible while operating on the roadway?

Condolences to the family and friends of Pat Still, Paramedic and Owner of Atmore Ambulance: Pat Still, Alabama EMT-P, passed away peacefully at her home in McCullough on May 2, 2008, after being diagnosed in February with a rare form of cancer. Pat was the first female Paramedic licensed in the State of Alabama. Pat started the Atmore Ambulance Service in 1976 and her commitment and contributions to the EMS system and community over the past 30 plus years are invaluable. She was very dedicated and passionate about her responsibilities as a service owner, Paramedic and an EMS educator. Her impact is greatly appreciated by all that knew her in this office and State. Her legacy will live on through everyone she touched.

Mark I Kits / Duo Dote Kits Notice: Mark I Kits distributed by the ADPH Center for Emergency Preparedness (CEP) are beginning to expire and are being replaced by Duo Dote Kits. The usage and indications remain the same, it's just that the two medications are combined into one auto-injector. In order to swap out the expired kits for the new kits you must document all personnel (names) Duo Dote training in writing and fax it the attention of Alice Floyd, RN (within the CEP) at 334-206-3819 or email it to her at alicefloyd@adph.state.al.us. No Mark I Kits will be replaced unless you follow these procedures. You may contact Alice by phone at 334-206-3898.

Alabama EMS Rule DNAR: Any questions regarding DNAR from the EMS (EMTs Only) community should be addressed to our office at 334-206-5383. If you are approached by any other healthcare provider (nursing homes, assisted living facility, etc..) with a DNAR question, they should be contact W. T. Geary, M.D., Medical Director of Health Provider Standards at 334-206-5366.

Regional Training Opportunities: Through contract, the regional EMS agencies have various continuing and primary education training opportunities available for EMTs of all levels. Please contact your regional EMS agency to see what may be available for you.

North – Contact Region 1 office at 256-428-2376

East - Contact Region 2 office at 205-763-8400
07.29. 2008 8:30 – 4:30 Medical Command and EMS Operations
09.05.2008 8:30 – 4:30 EAEMS Annual Conference (8 hours of CEUs)

Birmingham – Contact Region 3 at 205-934-2595

West - Contact Region 4 office at 205-348-4549

Southeast – Contact Region 5 office at 334-793-7789

Gulf – Contact Region 6 office at 251-431-6418