Required Agency Information (please print)

Agency Name: _____ **Agency Phone Number:** _____

Agency Mailing Address: _____ **City:** _____ **Zip**_____

1. Designated representative responsible for the BLS Naloxone Administration Program:

Name: _____

Daytime #: _____

Email (if applicable): _____

2. Agency Designated Administrator:

Name: _____

Daytime #: _____

Email (if applicable): _____

3. Agency Medical Advisor:

Name: _____

Daytime #: _____

Email (if applicable): _____

4. Agency QI Coordinator:

Name: _____

Daytime #: _____

Email (if applicable): _____

5. We will receive Overdose Prevention Rescue Kits from: _____

_____

_____

6. Naloxone will be stored in the Agency's station in the following manner:

_____

_____

7. Naloxone will be carried and secured on the ambulance(s) in the following manner:

_____

_____

8. The following ALS agencies will be called for intercepts:

_____

_____

Must Be Completed By BLS Non-transporting Agencies ONLY:

9. Primary transporting ambulance service:

Name: _____