Affidavit Acknowledging Utilization of RAC Regional Protocols Regarding Patient Destination and Transport

This form may be used by Regional Advisory Councils (RACs) and EMS Providers as an acknowledgement of the Provider’s adherence to RAC regional protocols regarding patient destination and transportation. Contact your RAC office prior to completing this acknowledgement form, as they may require a similar but specific form for their trauma service area (TSA). Submit your completed acknowledgement form to your RAC office. A separate acknowledgement form is required for each TSA in which you operate.

Link to RAC office contact information:  http://www.dshs.texas.gov/emstraumasystems/etrarac.shtm.

To be eligible for funding from the EMS Allotment/Allocation, an EMS provider must, as specified in Texas Administrative Code §157.130 (d)(2)(B) and §157.131 (d)(2)(B), “demonstrate utilization of the Regional Advisory Council (RAC) regional protocols regarding patient destination and transport in all TSAs in which they operate”.

Print Provider Name and dba Name: _____________________________________________________

DSHS issued Provider License #:____________ County of Licensure: _________________________

Level of care: ______________ List the county(ies) in which you provide EMS: __________________
___________________________________________________________________________________

Note: A separate affidavit form is required for each TSA in which you operate.

As the Administrator and Medical Director for the above named Provider, we acknowledge this provider’s utilization of the pre-hospital triage and bypass protocols as approved by the Department of State Health Services and adopted by the RAC for TSA ________.

We understand that incorporation of the RAC pre-hospital triage and bypass protocols into our EMS provider’s medical protocols and/or standard operating procedures and utilization of these protocols by field medical personnel are required actions to meet the terms of utilization.

______________________________________  ______________________________________
Print Administrator’s Name Print Medical Director’s Name

______________________________________  ______________________________________
Signature of Administrator Signature of Medical Director

______________________________________  ______________________________________
Date Date

Revised July 31, 2019