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/emstraumasytems/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 30, 2018