NALOXONE ADMINISTRATION TRAINING REQUEST

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 61051 (4/2016)

INSTRUCTIONS: This form must be completed and signed by a medical director prior to requesting naloxone administration training materials for an ambulance service. Once completed please print, sign and mail, email or fax it to the address listed below.

PHYSICIAN MEDICAL DIRECTOR

First Name	Last Name	MI
ND License Number		
Name of Ambulance Service		

I, the above-named physician, have evaluated the need for naloxone administration and I believe it to be a desired and essential skill for members of the above-named Ambulance Service, its associated substation units and/or Quick Response Unit(s). As Medical Director I understand that I am responsible for either conducting the training or delegating qualified personnel to conduct the mandatory training. I have also approved and signed a written protocol to be put in place prior to carrying or administering naloxone.

☐ I will be conducting this training myself.	
☐ I have delegated the below named qualifying personnel to conduct the training.	
Name of delegated trainer	
☐ I have approved and signed a written protocol.	
Medical Director Signature	Date

Mail Training Materials To:

First Name	Last Name	
Address		
City	State	Zip Code
Telephone Number	Email	

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