

LOCAL EMERGENCY MEDICAL SERVICE TRAUMA TRANSPORTATION PLAN



INSTRUCTIONS

- ☐ Fill out the electronic form: <https://arcg.is/1mKbqq>
- ☐ When finished, save or print the form:
 - To save: click the print icon and choose "Save as PDF"
 - Or print the completed form directly
- ☐ Attach the completed electronic form to this signature page
- ☐ Gather all required signatures below
- ☐ Submit the completed packet with required documentation to:
Jamie Zilverberg, Trauma System Manager
Phone: 605-773-3308
E-mail: Jamie.Zilverberg@state.sd.us

TRAUMA TRANSPORTATION PLAN SIGNATURES

Ambulance Service Director or Chief Officer

Name: _____

Organization: _____

Signature: _____ Date: _____

Ambulance Service Medical Director

Name: _____

Organization: _____

Signature: _____ Date: _____

Trauma Coordinator of Primary Receiving Hospital

Name: _____

Organization: _____

Signature: _____ Date: _____

SD DOH TRAUMA PROGRAM OFFICE USE ONLY

Approved: _____ Date: _____ Follow-up _____ Date: _____

Notes: _____