

DEFIBRILLATOR MEDICAL AUTHORIZATION

Complete and return original form to:

Spokane County EMS & Trauma Care Council
44 W. Riverside Ave
Spokane, WA 99201

Date: _____

Customer/Company Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Contact Person: _____ Phone: _____

Specific Product(s) and Model(s) Ordered: _____

Authorizing Physician's Name and Address

James M. Nania, M.D., FACEP
Medical Program Director
Spokane County EMS & Trauma Care Council
44 W. Riverside Ave.
Spokane, WA 99201

Authorizing Physician Signature

Date

(Valid only on original letterhead with original signature)