

EMERGENCY EPINEPHRINE CERTIFICATE HOLDER APPLICATION

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-MDH ext. 8417

I. YOUTH CAMP OPERATOR			
CAMP OPERATOR NAME		CAMP NAME	
OPERATOR'S MAILING ADDRESS		CAMP LICENSE NUMBER	
OPERATOR'S MAILING ADDRESS		OPERATOR'S WORK PHONE	
CITY	STATE	ZIP CODE	OPERATOR'S CELL PHONE
OPERATOR'S EMAIL			
II. AGE			
ARE YOU AT LEAST 18 YEARS OLD? <input type="checkbox"/> YES <input type="checkbox"/> NO			
III. TRAINING COURSE			
A) HAVE YOU SUCCESSFULLY COMPLETED AN EMERGENCY EPINEPHRINE EDUCATIONAL TRAINING PROGRAM APPROVED BY THE DEPARTMENT?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
B) NAME OF APPROVED TRAINING COURSE			
C) HAVE YOU ATTACHED A COPY OF YOUR TRAINING CERTIFICATE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IV. WRITTEN POLICY			
DOES THE ATTACHED COPY OF YOUR WRITTEN POLICY INCLUDE THE FOLLOWING:			
A) Your Designated Agents?			
B) The Name of the Approved Training Program?			
C) Procedures to:			
1) Store emergency auto-injectable epinephrine?			
2) Notify parent or guardian that emergency auto-injectable epinephrine is available at camp?			
3) Maintain the emergency auto-injectable epinephrine in a secure manner?			
4) Report the use of emergency auto-injectable epinephrine according to COMAR 10.16.07.06?			
5) Train the emergency epinephrine certificate holder and agent(s) annually?			
6) Maintain documentation of training for emergency epinephrine certificate holder and agent(s) for 3 years?			
V. OPERATOR'S SIGNATURE			
I have carefully examined and read this application and when operating, agree to comply with all applicable laws and COMAR 10.16.06 and 10.16.07 of the State of Maryland regarding youth camps. I understand that providing false information on this application or violating the Maryland Youth Camp Act, Maryland Health-General Code Annotated Title 14, Subtitle 4, or any regulation adopted by the Department under this subtitle may result in suspension or revocation of my certificate. <i>If you have questions, please call MDH, Center for Healthy Homes and Community Services at (410) 767-8417 or 1-877-4MD-DHMH ext. 78417.</i>			
X _____		DATE _____	
APPLICANT'S SIGNATURE			
FOR INTERNAL USE ONLY (Do Not Write Below This Line)			
<input type="checkbox"/> APPROVED		<input type="checkbox"/> DENIED Reason: _____	
		TRACKING #: _____	
X _____		DATE _____	
CHHCS CHIEF'S SIGNATURE			