



# Scope of Practice

Approved by

**State Board of Emergency Medical, Fire and Transportation Services and  
the Ohio Department of Public Safety, Division of EMS**

**February 19, 2026**

This document offers an “at-a-glance” view of the Scope of Practice for Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics as formally written in Ohio Revised Code and Ohio Administrative Code and approved by the State Board of Emergency Medical, Fire, and Transportation Services (EMFTS Board). The authorized services can be found in sections 4765.35 (FR/EMR), 4765.37 (EMT-B/EMT), 4765.38 (EMT- I/AEMT), and 4765.39 (EMT-P/Paramedic) of the Revised Code. The scopes of practice can be found in rules 4765-12-04 (EMR), 4765-15-04 (EMT), 4765-16-04 (AEMT), and 4765-17-03 (Paramedic) of the Administrative Code. The Ohio EMS scope of practice authorized by the EMFTS Board applies to emergency and non-emergency settings.

All services provided by certified Ohio EMS providers must be approved by the EMFTS Board. Following Board approval, all services that are provided must be authorized by a physician who meets the qualifications to serve as the medical director of an Ohio EMS agency as cited in Ohio Administrative Code 4765-3-05. In addition to authorization, the medical director must provide a written protocol, training, continuing education, and a quality assurance program for the services provided. The medical director of an Ohio EMS agency retains the authority to restrict the performances of services that have been approved by the EMFTS Board. However, regardless of the amount of training provided, the medical director is not permitted to exceed the scope of practice that has been approved by the EMFTS Board.

Within the Ohio EMS scope of practice that has been approved by the EMFTS Board, there are two categories of authorized services, “core competencies” and “added competencies.” Core competencies are services that are required to be taught and are included in the statewide approved initial training curricula of Ohio EMS education institutions for EMRs, EMTs, AEMTs, and Paramedics. Added competencies are elective services that are not required to be taught and are not included in the statewide approved initial training curricula for EMRs, EMTs, AEMTs, and Paramedics. For services classified as added competencies, the medical director is responsible for providing the education for each specific service he or she elects to authorize. Analogous to core competencies, the medical director must also provide training, a written protocol, continuing education, and a quality assurance program for each added competency.

Performance of services outlined in this document and in the aforementioned code sections shall only be performed if the EMR, EMT, AEMT, and Paramedic have received training as part of an initial certification course or through subsequent training approved by the EMFTS Board. If specific training has not been specified by the EMFTS Board, the EMR, EMT, AEMT, and Paramedic must have received training regarding such services approved by the local medical director before performing those services.

The individual medical director of each EMS agency may limit or ask that providers obtain approval from medical direction for certain treatments. Each medical director may need to tailor and revise their protocol to meet their community's needs and to fit their region and individual practice, but they must ensure that all protocols remain within the approved scope of practice. EMS medical directors are reminded that they are not permitted to expand or exceed the scope of practice for EMS providers which has been authorized by the EMFTS Board; however, they may provide clarifications or limitations on services that are permitted.

EMS medical directors and EMS providers are strongly encouraged to review the EMFTS Board's policy statement "Regarding EMS Provider Prehospital Transport of Patients with Pre-Existing Medical Devices or Drug Administrations" dated June 2023 (located at: [State Board Policies and Position Papers](#)). This statement clarifies how EMS providers, in the prehospital setting, should deal with medical devices and medication administrations that are outside their scope of practice.

Pursuant to rule 4765-6-04 of the Administrative Code, the EMFTS Board may allow EMRs, EMTs, AEMTs, and Paramedics to perform services beyond their respective scopes of practices as part of a board-approved research study. An entity must submit a research proposal to the EMFTS Board in accordance with the requirements of rule 4765-6-04 of the Administrative Code. The EMFTS Board is not obligated to approve the proposed research study nor accept any recommendation to permanently amend the scope of practice.

Updated 11/19/03; 5/17/05; 10/26/05; 10/17/07; 3/8/12; 8/22/13, 10/16/13, 12/18/13, 4/16/2014, 10/19/16, 2/15/17, 10/18/17, 6/20/18, 4/1/20, 1/1/21, 4/21/22, 1/1/24, 4/18/24, 6/26/24, 4/16/25, 8/12/2025, 8/20/25, 12/17/2025, 2/19/2026



**State Board Emergency Medical, Fire and Transportation Services**  
**Ohio Department of Public Safety, Division of EMS**

**CORE COMPETENCIES**

	<b>Airway Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Open and maintain the airway	X	X	X	X
2	Oropharyngeal airway adjunct	X	X	X	X
3	Nasopharyngeal airway adjunct	X	X	X	X
4	Manual removal of obstructed airway	X	X	X	X
5	Laryngoscopy for removal of airway obstruction			X	X
6	Oral suctioning	X	X	X	X
7	Endotracheal (ET) tube suctioning through a previously established airway or a stoma		X	X	X
8	Tracheostomy tube replacement <sup>A</sup>			X	X
9	Cricothyrotomy, surgical <sup>A</sup>				X
10	Cricothyrotomy, needle <sup>A</sup>				X
11	Apply and obtain readings of pulse oximeter, CO-oximeter, and capnography or capnometry equipment	X	X	X	X
12	Oxygen administration				
	a. Nasal cannula	X	X	X	X
	b. Simple face mask	X	X	X	X
	c. Non-rebreather mask	X	X	X	X
	d. Mouth-to-barrier devices, mask, mouth, nose, or stoma	X	X	X	X
	e. Partial rebreather mask		X	X	X
	f. Venturi mask		X	X	X
13	Ventilation management				
	a. Bag valve mask	X	X	X	X
	b. Ventilation with a flow-restricted oxygen-powered device	X	X	X	X
	c. Positive pressure ventilation devices (manually triggered or automatic ventilators)		X	X	X
14	Ventilator management of patients with invasive airway devices - 16 years of age or older <sup>A, B</sup>				X

15	Non-emergent ambulance transport of a stable patient less than 16 years of age who has a chronic condition requiring a tracheostomy tube and a ventilator provided the patient's caregiver accompanies the patient during transport. The caregiver must have received appropriate training in use of the patient's ventilator. A caregiver is not required to accompany the patient if the patient is accompanied by an Ohio licensed registered nurse or respiratory therapist, or other appropriately trained and licensed Ohio healthcare provider. <sup>A</sup>				X
16	Orotracheal intubation <sup>A</sup>				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients			X	X
17	Nasotracheal intubation <sup>A</sup>				X
18	Dual lumen airway <sup>A</sup>				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
19	Extraglottic airways <sup>A</sup>				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
20	CPAP administration and management		X	X	X
21	BiPAP administration and management				X
22	High flow nasal cannula				X
23	Positive end-expiratory pressure (PEEP)				X
24	End tidal CO <sub>2</sub> monitoring and detecting		X	X	X
25	Oxygen humidifier equipment application and monitoring		X	X	X
26	Chest tube placement – assist only				X
27	Chest tube monitoring and management				X
28	Nasogastric (NG) tube placement				X
29	Orogastric (OG) tube placement				X
<sup>A</sup> The utilization of waveform capnography is mandatory for all patients requiring invasive airway devices with the exception of stable patients with no cardiac or pulmonary complaints or symptoms unless ordered by the transferring physician. An invasive airway device is any airway device inserted or pre-positioned into a patient's airway by means of the mouth, directly into the trachea, or into the trachea by means of a tracheostomy tube, cricothyrotomy or nasotracheal intubation. Dual lumen and extraglottic airways, even though they are blindly inserted into the hypopharynx or the esophagus, are considered invasive airway devices.					
<sup>B</sup> Traditional ventilators solely perform mechanical ventilation; however, multi-function ventilators are capable of performing mechanical ventilation as well as positive end expiratory pressure (PEEP), bilevel positive air pressure (BiPAP),					

continuous positive airway pressure (CPAP), and/or high-flow oxygen generation. When providing airway management with a multi-function ventilator, the administration of PEEP, BiPAP, CPAP, and high-flow oxygen is permitted for patients of all ages per the written protocol provided by the EMS medical director. When a multi-function ventilator is used during the provision of mechanical ventilation to patients with invasive airway devices, the patient must be 16 years of age or older. An invasive airway device is any airway device inserted or pre-positioned into a patient's airway by means of the mouth, directly into the trachea, or into the trachea by means of a tracheostomy tube, cricothyrotomy, or nasotracheal intubation. Dual lumen and extraglottic airways, even though they are blindly inserted into the hypopharynx or the esophagus, are considered invasive airway devices.

	<b>Cardiac Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Cardiopulmonary resuscitation (CPR)	X	X	X	X
2	Chest compression assist devices	X	X	X	X
3	Automated external defibrillator (use of an AED)	X	X	X	X
4	Manual defibrillation			X	X
5	Negative impedance threshold devices		X	X	X
6	Administration of cardiac medication				X
7	Set up cardiac monitor in the presence of an AEMT or Paramedic		X		
8	Cardiac monitor strip interpretation			X	X
9	Cardioversion				X
10	Transcutaneous cardiac pacing				X
11	Transvenous cardiac pacing – monitoring and maintenance				X
12	Diagnostic EKG performance and interpretation				X
13	Diagnostic EKG application assisting a Paramedic who is present		X	X	
14	Diagnostic EKG set up and application for electronic transmission <sup>Ⓔ</sup>		X	X	X

<sup>Ⓔ</sup>An EMT or AEMT may set up and apply a diagnostic electrocardiogram when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met: 1) performed in accordance with written protocol; 2) EMT or AEMT shall not interpret the electrocardiogram; 3) delay in patient transport is minimized; and 4) EKG is used in conjunction with destination protocols approved by the local medical director.

	<b>Medical Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Epinephrine administration via auto-injector	X	X	X	X
2	Epinephrine administration via SQ or IM routes			X	X
3	Epinephrine administration via IV or IO route				X
4	Aspirin administration		X	X	X
5	Oral glucose administration		X	X	X
6	Oral over-the-counter (OTC) analgesics for pain or fever		X	X	X
7	Nitroglycerin administration (patient assisted) <sup>Ⓕ</sup>		X	X	X

8	Nitroglycerin administration (non-patient assisted)			X	X
9	Aerosolized or nebulized medications administration (patient assisted) <sup>E</sup>		X	X	X
10	Administration of aerosolized or nebulized medications (non-patient assisted)			X	X
11	Naloxone administration via auto-injector	X	X	X	X
12	Naloxone administration via intranasal route	X	X	X	X
13	Naloxone administration via ETT, IM, IV, IO, or SQ routes			X	X
14	Medication administration (protocol-approved) <sup>E</sup>			X	X
15	Medication administration via the intradermal route				X
16	Administration of intranasal medications (in addition to naloxone) <sup>E</sup>			X	X
17	Immunizations for influenza to firefighters, EMTs, AEMTs, or Paramedics (ORC 4765.391)				X
18	Set up of IV administration kit in the presence of an AEMT or Paramedic		X		
19	Transport of central/peripheral IV without an infusion		X	X	X
20	Intravenous access and peripheral initiation			X	X
21	Access indwelling catheters and implanted central IV ports				X
22	IV maintenance and fluid administration			X	X
23	Maintenance of medicated IV fluids				X
24	Central line monitoring				X
25	IV infusion pump				X
26	Intraosseous needle insertion			X	X
27	Saline lock initiation			X	X
28	Peripheral IV blood specimens			X	X
29	Maintenance of blood administration				X
30	Thrombolytic therapy initiation and monitoring				X
31	Administration of immunizations <sup>E</sup>	X	X	X	X

<sup>D</sup> Patient Assisted Definition: May assist with 1) patient's prescription upon patient request and with written protocol – OR – 2) EMS-provided medications with verbal medical direction.

<sup>E</sup> See “AEMT Medications Approved by the EMFTS Board.”

<sup>F</sup> So long as the route of administration is within the scope of practice and the certificate holder administers the immunization pursuant to medical direction and training on the specific immunization, which includes adherence to the recommendations and instructions of the Food and Drug Administration.

	<b>Trauma Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Long spine board	X	X	X	X
2	Short spine board	X	X	X	X
3	Splinting devices	X	X	X	X
4	Traction splint		X	X	X
5	Manual cervical immobilization	X	X	X	X
6	Cervical immobilization device (CID)	X	X	X	X
7	Helmet removal		X	X	X
8	Rapid extrication procedures		X	X	X
9	Needle decompression of the chest			X	X
10	Soft tissue management	X	X	X	X
11	Management of suspected fractures	X	X	X	X
12	Controlling of hemorrhage	X	X	X	X
13	Wound packing	X	X	X	X

	<b>Basic Performances</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Personal protective equipment (PPE) Selection/donning/doffing	X	X	X	X
2	Taking and recording of vital signs	X	X	X	X
3	Emergency moves for endangered patients	X	X	X	X
4	Patient Care Report (PCR) documentation	X	X	X	X
5	Trauma triage determination per OAC 4765-14-02	X	X	X	X

	<b>Additional Services</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Emergency childbirth management <sup>g</sup>	X	X	X	X
2	Glucose monitoring system use (with Clinical Laboratory Improvement Amendments (CLIA) waiver in place)		X	X	X
3	Blood analysis				X
4	Eye irrigation	X	X	X	X
5	Eye irrigation with Morgan lens				X
6	Maintenance of blood administration				X
7	Thrombolytic therapy initiation and monitoring				X
8	Mechanical patient restraints		X	X	X
9	Telemetric monitoring devices and transmission of clinical data, including video data		X	X	X

<sup>g</sup> An EMR may only assist with emergency childbirth management.

<b>Emergency Medical Services in Hospital</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
<p><i>June 30, 2021-October 1, 2022: A first responder, emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician-paramedic may perform emergency medical services in any setting, including in any area of a hospital, if the services performed under the direction and supervision of one of the following:</i></p> <p><i>(1) A physician;</i></p> <p><i>(2) A physician assistant designated by a physician;</i></p> <p><i>(3) An advanced practice registered nurse designated by a physician. <sup>‡</sup></i></p>	X	X	X	X
<p><u>Prior to June 30, 2021 and after October 1, 2022:</u> In a hospital, an EMT, AEMT or Paramedic may perform emergency medical services in accordance with the following conditions: only in the hospital's emergency department (ED) or while moving a patient between the ED and another part of the hospital; only under the direction and supervision of a physician, a physician assistant designated by a physician, or a RN designated by a physician (ORC 4765.36). The EMT, AEMT, or Paramedic cannot perform any service outside the scope of practice of his or her certificate to practice.</p>		X	X	X
<p><sup>‡</sup>House Bill 110</p>				

<b>Additional Services in a Declared Emergency</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
<p>In the event of an emergency declared by the governor that affects the public's health, an EMS provider may administer drugs or dangerous drugs, in relation to the emergency, provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such drugs or dangerous drugs (OAC 4765-6-03)</p>	X	X	X	X

<b>Nerve Agent or Organophosphate Release</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
An EMS provider may administer drugs or dangerous drugs contained within a nerve agent antidote auto-injector kit, including a MARK I® kit, in response to suspected or known exposure to a nerve or organophosphate agent provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such drugs within the nerve agent antidote auto-injector kit. (OAC 4765-6-05)	X	X	X	X

<b>COVID-19 Testing</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
Per the Ohio Revised Code 4765.53 which became effective on July 6, 2022, an EMT, AEMT, and Paramedic may administer a test for COVID-19 and may collect and label specimens from a test for COVID-19 if that individual has received proper training to engage in those activities.		X	X	X

<b>Withdrawing of Blood for Evidence Collection</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
<p>Withdraw blood for the purpose of determining the alcohol, drug, controlled substance, metabolite of a controlled substance, or combination content of the whole blood, blood serum, or blood plasma only if the medical director provides authorization, a written protocol, and training. It may only be performed in the course of the provision of emergency medical treatment and at the request of a law enforcement officer, and only in response to a request for emergency medical treatment and transport to a health care facility. A clinically competent patient may refuse transport.</p> <p>Withdrawal of blood shall not be done:</p> <ol style="list-style-type: none"> <li>1. If the physical welfare of the patient, EMS provider, or other person would be endangered</li> <li>2. If it causes an unreasonable delay in treatment or transport of the patient or any other person</li> <li>3. Consent of the patient is not obtained (an unconscious person or a person with a condition rendering</li> </ol>			X	X

<p>the person incapable of refusal shall be deemed to have consented)</p> <p>4. From a pre-existing central venous access device</p> <p>5. Withdrawal of blood violates any rule in this chapter (OAC 4765-6)</p> <p>6. The person is deceased (OAC 4765-6-06)</p>				
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<b>AEMT Medication Administration Approved by the EMFTS Board</b>		
<b><i>A certified AEMT may administer medications from the following list, provided the AEMT is under physician medical direction and has received appropriate training regarding the administration of such medications. A medication that does not appear on the following list SHALL NOT be added to the department's AEMT protocol.</i></b>		
Benzodiazepines		Lidocaine for pain relief after intraosseous needle insertions
Bronchodilators		Nalbuphine
Buprenorphine		Naloxone
Dextrose in water		Narcotics or other analgesics for pain relief
Diphenhydramine		Nitrous oxide
Epinephrine 1 mg per 1 ml (subcutaneous or intramuscular)		Ondansetron <sup>1</sup>
Glucagon		Sublingual nitroglycerin
Ketamine		Tranexamic acid
<sup>1</sup> A certified AEMT may administer ondansetron for patients age 4 years or older.		
<b><i>The approved route of administration of any specific medication is stated in the respective EMT, AEMT, and Paramedic curriculum. The EMS provider shall administer medications only via the route addressed in each respective curriculum and consistent with their level of training.</i></b>		

As stated in the introduction of this Ohio EMS scope of practice matrix, all core competencies and added competencies must be approved by the EMFTS Board. Added competencies are elective services that are not required to be taught and are not included in the statewide approved initial training curricula for EMRs, EMTs, AEMTs, and Paramedics. For services classified as added competencies, the medical director is responsible for providing the education for each specific service he or she elects to authorize. Analogous to core competencies, the medical director must also provide training, a written protocol, continuing education, and a quality assurance program for each added competency.



**State Board Emergency Medical, Fire and Transportation Services  
Ohio Department of Public Safety, Division of EMS**

**ADDED COMPETENCIES**

	<b>Medical Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Epinephrine administration IM via syringe for anaphylaxis <sup>2301</sup>		X		
2	Metered-dose or nebulized bronchodilator administration <sup>2401</sup>		X		
3	Glucagon administration via intranasal or IM routes for hypoglycemia <sup>2401</sup>		X		
4	Initiation of blood or blood products <sup>2401</sup>				X
5	Sound doppler devices <sup>2501</sup>	X	X	X	X
6	Finger thoracostomy <sup>2501</sup>				X
7	Ultrasound device utilization to be performed only as authorized by the local medical director <sup>2501</sup>				X
8	Urinary catheter initiation and maintenance <sup>2502</sup>				X
9	Oral ondansetron for patients age 12 years and older <sup>2502</sup>		X		
10	Buprenorphine administration within an established substance use disorder bridge program <sup>2601</sup>		X		

<sup>2301</sup>EMFTS Board approval on 12/13/2023; effective January 1, 2024

<sup>2401</sup>EMFTS Board approval on 6/26/2024; effective June 26, 2024

<sup>2501</sup>EMFTS Board approval on 8/20/2025; effective August 20, 2025

<sup>2502</sup>EMFTS Board approval on 12/17/2025, effective December 17, 2025

<sup>2601</sup>EMFTS Board approval on 2/19/2026, effective February 19, 2026



Mark Marchetta, Sr., Chair  
Mark Resanovich, Vice Chair

Dr. Carol Cunningham, State Medical Director

The State Board of Emergency Medical, Fire, and Transportation Services (“EMFTS Board”) issues the following statement:

Regarding EMS Provider Prehospital Transport of Patients with  
Pre-Existing Medical Devices or Drug Administrations  
June 2023

*This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMFTS Board’s general position on the above issue, this statement in no way precludes the EMFTS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMFTS Board will be decided on a case-by-case basis.*

**Introduction:**

The State Board of Emergency Medical, Fire, and Transportation Services (EMFTS Board) and the Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMS providers. The scope of practice for each level of EMS providers is established in Ohio Administrative Code Chapters 4765-12, 4765-15, 4765-16, and 4765-17. An outline of the Ohio EMS scope of practice is available in matrix form and is posted on the Ohio Department of Public Safety, Division of EMS website as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMFTS Board. Updates to the scope of practice are made as necessary and after approval by the EMFTS Board.

From time to time, EMS providers are confronted on-scene with patients with preexisting medical situations not included or addressed in their respective EMFTS Board approved scope of practice. Specifically, patients with pre-existing medical devices and drug administrations that require prehospital EMS services are becoming more commonplace. The intent of this position paper is to address the EMS provider’s approach to that prehospital patient with a pre-existing physician-ordered medical device or drug administration (“MDDA”) not covered in the provider’s scope of practice.

**Discussion:**

In general, the EMS provider should maintain the pre-existing MDDA and transport the patient to the appropriate facility. There is no expectation that the EMS provider will initiate, adjust, or discontinue the pre-existing MDDA. This implies that the EMS provider will maintain and continue care so that the patient can be transported.

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The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of prehospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (prehospital or “911 scene response”). It implies that the most appropriate and available level of EMS provider will respond to the request for prehospital EMS service. It also implies that the patient requires the pre-existing MDDA and it is not feasible or appropriate to transport the patient without the pre-existing MDDA. For the rare circumstance when it is impossible to transport a MDDA with the patient, the EMS provider must receive authorization and formal training in the removal of the MDDA and subsequent patient management from the EMS medical director well in advance of the emergency response. As a last resort, the EMS provider shall contact medical direction and, if available, the customer service and/or resource department of the manufacturer of the device for information regarding appropriate patient and device management.

The number and type of pre-existing MDDAs currently or potentially encountered by the EMS provider in the community setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive list of pre-existing MDDAs. However, as a guideline for the EMS provider, current pre-existing MDDAs may include ventilatory adjuncts (CPAP, BiPAP), continuous or intermittent IV medication infusions (analgesics, antibiotics, chemotherapeutic agents, vasopressors, cardiac drugs), continuous gastric or parenteral infusion of nutrition, and nontraditional out-of-hospital drug infusion routes (subcutaneous infusions, central venous access lines, direct subcutaneous infusions, self-contained implanted pumps). An example of a pre-existing MDDA that is impossible to transport with the patient is a home dialysis machine.

**Conclusion:**

In conclusion, the EMS provider confronted with a prehospital patient with a pre-existing physician-ordered medical device or drug administration not covered in the EMS provider’s respective scope of practice should provide usual care and transportation while maintaining the pre-existing MDDA, if applicable. Concerns or questions regarding real-time events associated with a pre-existing MDDA should be directed to the relevant physician providing medical direction. Concerns or questions regarding previous, recurrent, or future prehospital transportations with a pre-existing MDDA should be directed to the appropriate EMS medical director and legal counsel.