Serving as chair of the AARC Transport Section over the last two years has been a personal and professional accomplishment for me. During my tenure, our section was in the forefront of homepage development through the AARC’s Internet site, AARC Online. As each new chair comes along, I’m sure our site will continue to evolve. The 1996 convention in San Diego was a big success for the Transport Section, as well. We had a tremendous showing at our lectures, and I would like to thank everyone who participated in our effort to ensure continued success at the 1997 Respiratory Congress in New Orleans in December. Our section chair-elect, Kathleen Adams, and I provided topics that should be of interest, not only to transport RCPs, but to a wide variety of respiratory care professionals. Bill Galvin, the Program Committee liaison for the Transport Section, worked closely with us to develop a strong presentation. I would like to thank him for his dedication to our profession.

One of my goals as chair has been to increase awareness of the RCP’s role in the air medical community. The Association of Air Medical Services (AAMS) has been very gracious and accommodating in our efforts to become more visible to all facets of transport services. In October, the Air Medical Transport Conference will be held in Cincinnati, and AAMS has agreed to set up an RCP meeting room on October 6 from 5-7 p.m. following the AAMS board meetings. Angela Johnson at the AAMS office has contacted the AARC office to arrange for CRCE credit to be provided for RCP participants.

As a profession, we need to make a strong showing not only at AAMS, but also within the AARC organization. As someone once said, there truly is strength in numbers. I have been working with the AARC and AAMS to develop an alliance between the two organizations, and I hope that I have been able to lay the groundwork for Kathleen to continue the crusade for professional recognition of our section.

Cathy Peterson (section chair from 1992-93) told me at the beginning of my term that every chair had left the transport field by the end of their term. She and Jamie Taylor (1994-95) had both taken jobs outside of transport by the time they left office. I thought, no way I would leave transport — I love this job. I have been a transport therapist for 13 years. Well, as the story goes, I too have succumbed. I have taken a management position at Shands Hospital at the University of Florida. Although I will miss transporting, I have new challenges to conquer. Well, Kathleen, will you break the cycle?

We, as a section, have accomplished a great deal this year. Kay Lockhart, our outgoing chair, has worked very hard and deserves a big pat on the back. She mentions in her “Notes” that she has been working to form an alliance between the AARC and AAMS. However, she greatly understates the amount of hard work that is going into this effort and will continue to go into it if we are to be successful. Why is it so difficult for us to gain the recognition we deserve from our colleagues in the transport community? One reason may be the current lack of cohesiveness among transport RCPs nationwide.

I receive a lot of calls from people all over the country, and on occasion, people ask me if I think we should have a national group for flight therapists. I tell them we already do — and actually we have it one better because this group represents all therapists who do transport, ground and air. It’s called the Transport Section of the AARC. As Kay also states in her “Notes,” strength comes from numbers. What is a stronger number — 37,000 (the current membership of the AARC as a whole) or 700 (the current number of transport therapists)? This would be the approximate difference in numbers if a splinter group were to develop a separate organization for flight or transport RCPs.

We need to stay where we are wanted and supported, and that is within the AARC organization. Through the AARC we have strength, support, access to Washington, DC, and people who understand what it means to be an RCP. Should we be able to come to an agreement with AAMS on an alliance, we will only be stronger.

My challenge to each of you for the upcoming year is to spread the word out there. I was surprised at how many

Visit AARC on the Internet—
http://www.aarc.org
RCPs involved in transport do not even know that the Transport Section exists. Talk to your fellow therapists about the advantages of belonging to the AARC and the Transport Section. If every one of you got just one other therapist to join the section, our numbers would double. Let’s all get involved in our section and our organization. Both are something you can be very proud of, and you can be proud of yourselves for being members.

**FAA Grants Extension for IFR**

The FAA has agreed to grant an extension of Exemption 6175 until September 1999. This will permit part 135 certificate holders that conduct helicopter EMS operations and are members of both HAI and AAMS to conduct EMS departures under IFR minimums. These operations are permitted from airports or heliports that have available weather reports from the National Weather Service. (Source: AAMS News and Views, Vol. 1 Issue 3, July 1997.)

**HCFA Publishes Proposed Rule on Ambulance Services**

HCFA has issued a proposed policy on coverage of ambulance services (62 FR 32715). The proposal bases coverage and reimbursement for ground ambulance services on the level of care needed to treat and transport the patient. In order to decrease the amount of times HCFA pays for ALS transfers when only BLS was required, the payments would be based on the ICD-9 diagnostic code assigned to the patient. Because of the trickle down effect (or, in this case, trickle up), AAMS is keeping a close eye on these developments. (Source: AAMS News and Views Vol. 1 Issue 3, July 1997.)

**Association of Air Medical Services Has New Address**

As many of you may be aware, AAMS has moved. Their new address and contact information is —

Association of Air Medical Services
110 North Royal Street, Suite 307
Alexandria, VA 22314
Phone: (703) 836-8732
Fax: (703) 836-8920
E-mail: aams@erols.com
Website: www.aams.org

**Educational Corner**

Management of children with epiglottitis during transport: Analysis of a survey

Physicians who attended the 1990 Pediatric Critical Care Transport Leadership Conference were asked to complete a 22-item questionnaire on management of children with epiglottitis during transport. The survey addressed issues such as demographics, availability and composition of the transport team, methods of airway management, use of sedation, and monitoring techniques. Forty-three of 49 attendees responded, and the following results were noted:

- 83% of centers had transport teams

For transport of a child with epiglottitis from a doctor’s office:
- 64% recommended transfer by ambulance to nearest facility
- 36% recommended transfer by ambulance to tertiary center

For interfacility transports:
- 49% recommended intubation prior to transport in all cases
- 49% considered intubation by individual case
- A majority preferred nasal intubation
- 71% used paralytics
- 37% reported complications during transport
- When compared to groups without designated teams, groups with designated teams had significantly fewer complications

The authors conclude that while there is no universal protocol for the transport of the child with epiglottitis, the use of trained transport personnel appears to reduce the risk of complications. (Source: Waisman et al; Pediatric Emergency Care, Vol 9 (4), August 1993.)

**Lights and Siren in Pediatric 911 Ambulance Transports: Are They Being Misused?**

The department of pediatrics at the University of Cincinnati College of Medicine performed a study to evaluate the appropriate use of lights and siren by ambulance personnel when transporting pediatric patients.

Audio tapes covering a seven-month period were reviewed. Data collected included use of lights and siren, time of day, patient age, chief complaint, mental status, vital signs, and findings on physical exam. The corresponding ED charts were reviewed to obtain the final disposition of the patient. Also noted was the level of training of the EMS personnel conducting the transport (basic versus paramedic), and any voluntary comments made about the patient or his/her comfort with the situation.

Of 504 calls which met inclusion criteria, 312 used lights
and siren (62%). Of the 312 cases, 123 were considered to have used lights and siren inappropriately (with a stable patient). It was noted that basic units were more likely to use lights and siren inappropriately than were paramedic units.

Inappropriate use was not linked to patient age or time of day. It was also noted that patients with primary complaints of a respiratory or cardiovascular nature were more likely to be transported with appropriate use of lights and siren than were patients whose chief complaints were of a central nervous system or a general medical nature. (Source: Lacher ME, Bausher JC; Annals of Emergency Medicine, 29:2 February 1997)

CAMTS Program Update

Editor’s Note: The following list contains all of the programs that were CAMTS accredited as of the end of April. If your program has met CAMTS since that time we would like to honor you as well. Please contact me at the address/numbers listed on the back page of this issue and I’ll add your program to the list.

CareFlight — Dayton, Ohio
INOVA AirCare — Falls Church, Virginia
CareFlite Dallas — Dallas, Texas
West Michigan AirCare — Kalamazoo, Michigan
CAREFLIGHT — Lexington, Kentucky
ST. Joseph’s Health Systems — Tampa, Florida
Butterworth AeroMed — Grand Rapids, Michigan
San Juan Air Care — Farmington, New Mexico
STAT MedEvac — Pittsburgh, Pennsylvania
Mercy Air Services, Inc. — Fontano, California
North Flight, Inc. — Traverse City, Michigan
LIFELITE Medical Air Transport — Mesa, Arizona
University MedEvac — Allentown, Pennsylvania
Mayo One — Rochester, Minnesota
Air Med Team — Modesto, California
AeroCare — Lubbock, Texas
Guardian Air Transport — Flagstaff, Arizona
Eagle Rescue of Arizona — Phoenix, Arizona
Life Air Rescue — Shreveport, Louisiana
AirLife of Greeley — Greeley, Colorado
Flight for Life — Milwaukee, Wisconsin
Texas AirLife — San Antonio, Texas
Shriners Burns Institute Transport Team — Cincinnati, Ohio
University Air Care — Cincinnati, Ohio
NorthWest MedStar — Spokane, Washington
Angel Flight — Little Rock, Arkansas
Native American Air Ambulance, Inc. — Mesa, Arizona
Topeka Air Ambulance, Inc. — Topeka, Kansas
Conemaugh Med Star — Johnstown, Pennsylvania
Allegheny Life Flight — Pittsburgh, Pennsylvania
Medical Express International, Inc. — Show Low, Arizona
Critical Air Medicine — San Diego, California
LifeFlight MeritCare — Fargo, North Dakota
LifeGuard — Albuquerque, New Mexico
UCDMC Life Flight — Sacramento, California

ARCF Silent Auction Offers Unparalleled Opportunity for RC Managers

Attention RCPs! If you’re planning to attend the AARC’s 43rd International Respiratory Congress this December 6-9 in New Orleans there’s a new attraction you won’t want to miss. In an effort to raise funds for important projects aimed at improving quality of care for patients and positioning the RCP for success in our changing health care system, the American Respiratory Care Foundation is sponsoring the profession’s first-ever Silent Auction.

Thanks to the generous support of the respiratory care industry and others in the respiratory community, the auction will feature items ranging from Las Vegas casino/hotel nights and ski lift passes to Disneyland vacations. Medical equipment to be auctioned off includes items such as capnographs, ventilators, and an oxygen system. You may also want to take advantage of the many New Orleans packages available, including fine dining, cruises, and voodoo tours. Since opening bids on all items have been set at just 25% of estimated retail value, it’s a great way to take advantage of a good deal for yourself and/or your department while supporting your profession at the same time.

The auction will run throughout the four-day meeting and all AARC members and officially registered attendees at the meeting are invited to come by Auction Headquarters as often as they like to place and/or raise bids. A preliminary catalog of items published in the October issue of AARC Times tells how the bidding process works, and a final catalog with an updated items list will be available onsite. So take a minute to see what’s available, then come and join in the fun.

DATES TO REMEMBER

AARC International Respiratory Congress
December 6-9, 1997
New Orleans, LA
Contact AARC
(972) 243-2272
Fax/Snail Mail Survey

Editor's Note: After reviewing the two articles summarized in the “Education Corner,” I wondered what current practices are among our section membership. The following survey is designed to answer that question. Please take a few minutes to fill it out and fax your responses to Kathleen Adams, RCP, RRT at (909) 824-4165, or snail mail your responses to me at 11234 Anderson Street Room 6432, Loma Linda, CA 92354. Thanks for your help. Results will follow in a later Bulletin.

Name of Participant: _________________________________________ City & State of Residence: _________________________________________
Name of Program / Hospital ________________________________________________

Part 1—Epiglottitis / Difficult Airway
1. Is a specialized team used by your program? ____ Yes ____ No
2. What team configuration do you use for a Child with a Difficult Airway (CDA)?
   ____ RN/RN/RCP ____ RN/RCP/Resident ____ RN/RCP/ Attending or Fellow
   ____ RN/RCP ____ RN / EMT-P ____ RN/ RCP/ EMT-P
   ____ Other (specify) _______________________________________
3. Does the above configuration differ from your normal team configuration? ____ Yes ____ No
4. If yes, briefly explain how. ___________________________________________________________
5. Does your team routinely intubate CDA prior to transport? ____ Yes ____ No
6. When you do intubate the CDA patient, is the procedure performed by the team? ____ Yes ____ No
7. If no, who performs the procedure? ________________________________________________
8. If yes, who performs the procedure? ________________________________________________
9. If the team performs the procedure, where is it performed?
   ____ In the Emergency Department ____ At the patients bedside ____ In the OR
   ____ Other (specify) ____________________________________________
10. What method of intubation is used most often?
    ____ Endotracheal route ____ Nasotracheal Route ____ Cricothyrotomy
    ____ Retrograde Intubation ____ Emergency Tracheotomy
    ____ Other (specify) ____________________________________________

Open Forum Comments:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Part 2—Use of Lights and Siren
1. Does your program have it’s own vehicles? ____ Yes ____ No
2. What training do the operators of the ambulance have?
   ____ EMT ____ EMT-P ____ No medical certification required
   ____ Other (specify) ____________________________________________
3. Do you ever use lights and siren? ____ Yes ____ No
4. If yes, under what criteria? check all that apply.
   ____ Improve response time to referring facility ____ Patient intubated
   ____ Patient status deteriorating ____ Patient coding / may code
   ____ Other (specify) ____________________________________________
5. Who determines the use of lights and siren?
   ____ Ambulance driver ____ Team jointly ____ Team physician
   ____ Medical control physician ____ Team leader
6. Does your state, county, or local EMS agency have specific criteria for the use of lights and siren? ____ Yes ____ No

Open Forum Comments:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Research & Information Corner

End-tidal CO₂ levels after 20 minutes of ACLS predict survival rates in heart attack victims

Measuring end-tidal CO₂ levels 20 minutes after the initiation of ACLS can predict which cardiac arrest victims who present with electrical activity but no pulse will survive to hospital admission and which will die.

In a study involving 150 consecutive heart attack patients with electrical activity but no pulse who were treated by paramedics, researchers from Bellingham, WA, and Houston, TX, found marked differences in CO₂ levels 20 minutes after beginning ACLS in survivors to admission and nonsurvivors. While CO₂ levels measured at the beginning of ACLS were about the same for all 150 patients, mean end-tidal CO₂ after 20 minutes was 32.8 mm Hg in the 35 who survived to admission and 4.4 mm Hg in the 115 who died. A CO₂ level of less than 10 mm Hg after 20 minutes of ACLS proved to be predictive of nonsurvival in 100% of the cases, leading the study's authors to conclude that changes calling for the discontinuation of ACLS based on the CO₂ marker could be made to current American Heart Association protocols if further studies bear out their results.

Researchers note, however, that among those patients who survived to admission, end-tidal CO₂ levels during resuscitation were not predictive of survival to discharge. The study was published in the July 31 issue of the New England Journal of Medicine. (Source: Reuters Medical News, 7/31/97)

AAHP Battles “Prudent Layperson” Standard in Emergency Situations

“Pain” is too nebulous a term to justify a trip to the emergency room, or so says an industry group representing the nation’s managed care organizations. The American Association of Health Plans (AAHP) went on the offensive last summer to battle provisions in legislation under consideration in Congress that would apply the “prudent layperson” standard in determining when severe pain is a symptom of an emergency medical situation.

According to the AAHP, “pain is a highly subjective term and has vast differences in meaning among consumers.” Saying that the provisions would allow people to receive emergency medical care for conditions that could easily be treated in another, less costly setting, the group circulated a set of “talking points” to Washington insiders detailing its objections to the provisions. Arguments against the provisions included the fact that—

• Incorrect medications are prescribed and conditions are misdiagnosed more often in emergency rooms because ER physicians do not have access to patients’ medical records.

(Source: Reuters Medical News, 6/26/97)

Intubation in the Field Reduces Mortality Rate for Severe Head Injury Victims

Endotracheal intubation in the field results in lower mortality rates in patients with severe head injury from blunt trauma, say researchers from the University of California, San Diego, who conducted a retrospective study of 1,092 such patients. All had either a Glasgow Coma Score at the scene of eight or less or an Abbreviated Injury Score of four or greater and were transported to a trauma center by ground ambulance.

The mortality rate for patients who were intubated by paramedics in the field was 26%, compared with 36% for those not intubated in the field. An even greater drop in mortality rate was seen in a subgroup of patients with more severe head injuries who were intubated in the field, from 57% to 36%. Patients with isolated severe head injury who were intubated in the field had a mortality rate of 23% compared with 50% for those not intubated in the field.

The authors conclude that “broadening indications for intubation by paramedical personnel has great potential to improve outcome in patients with severe head injury.” The study was published in the Archives of Surgery. (Source: Reuters Medical News, 6/26/97)

New BLS, ALS Pediatric Ambulance Equipment Lists Available

Many organizations and agencies have come up with lists of essential equipment for pediatric BLS and ALS ambulance equipment, but until late last year, a consensus on minimum needs in this area had yet to be reached. A joint effort between the Health Resources and Services Administration, the Maternal Child Health Bureau, and the National Highway Traffic Safety Administration, however, has now produced minimum pediatric equipment lists for BLS and ALS ambulances.

Published concurrently in the December 1996 issues of Annals of Emergency Medicine and Pediatric Emergency Care, both lists were developed with input from 14 related groups and organizations, including the American Academy of Pediatrics, The American College of Emergency Physicians, The Emergency Nurses Association, and the National Association of EMTs and Paramedics. The project was organized and overseen by James Seidel, MD, PhD, and Deborah Henderson, PhD, RN, at the National Emergency Medical
Services for Children Resource Alliance (NERA). In addition to including essential items (those considered necessary), each list also includes desirable items (those that may improve care but whose use depends on local policy, cost, and scope of practice of the providers). For a copy of the lists, contact Susan L. Tittle, MSN, NERA Outreach Specialist, (310) 328-0720. (Source: EMSC News, Spring 1997)

"YOU HAVE TO LAUGH OR YOU'LL CRY" CORNER
by Kathleen Adams RCP, RRT

All nurses go to heaven

Three nurses went to heaven, where they awaited their turn with St. Peter to plead their case to enter the pearly gates.

The first nurse said, "I worked in an operating room. We tried our best to help patients, but occasionally we would lose one. I think I deserve to go to heaven." St. Peter looked at her file and admitted her to heaven.

The second nurse said, "I was an operating room nurse. It's a very high stress environment and we would do everything we could for our patients. Sometimes the patient was just too sick and we would lose him, but, overall, we tried very hard and I think I should get to go to heaven." St. Peter looked at her file and admitted her to heaven.

The third nurse said, "I was a case manager for an HMO." St. Peter looked at her file. He pulled out a calculator and started punching away at it furiously, constantly referring back to the nurse's file. After a few minutes St. Peter looked up, smiled, and said, "Congratulations! You've been admitted to heaven...for five days!" (Submitted by K. Willis RRT, RN, Loma Linda University School of Allied Health.)

I have good news and bad news...

A resident came to the patient's bedside, and after telling him they had received all the test results back said, "I have good news and bad news for you. The good news is you only have 24-hours to live."

"That's terrible," said the patient. "What could possibly be the bad news?" The resident looked down at his feet and answered, "I was supposed to tell you this yesterday." (Submitted by K. May RCP, RRT, Loma Linda University Medical Center.)

Presence of mind...

A man who was involved in a work-related accident filled out his workman's compensation paperwork. The insurance company contacted him and requested more information in a particular section. This was his response:

"I am writing in response to your request for additional information for block number 3 of the accident reporting form. I put 'poor planning' as the cause of my accident. You said in your letter that I should explain the circumstances surrounding my bizarre injuries more fully, and I trust the following details will be sufficient.

"I am an amateur radio operator and on the day of the accident, I was working alone on the top section of my new 80-foot tower. When I had completed my work, I discovered that I had, over the course of several trips up the tower, brought up about 300 pounds of tools and spare hardware. Rather than carry the now unneeded tools and materials down by hand, I decided that I should be more efficient and attempt to save both time and effort. Therefore I would lower all the items down in a small barrel by using a pulley, which was attached to the gin pole at the top of the tower.

"Securing the rope at ground level, I went to the top of the tower and loaded the tools and materials into the barrel. Then, I went back to the ground and untied the rope, holding tightly to ensure a slow decent of the 300 pounds of supplies. You will note in block number 11 of the accident reporting form that I weigh only 155 pounds. Due to my surprise at being jerked off the ground so suddenly, I lost my presence of mind and forgot to let go of the rope. Needless to say, I proceeded at a rather rapid rate of speed up the side of the tower. In the vicinity of the 40-foot level, I met the barrel coming down. This explains my fractured skull and broken collarbone.

"Slowed only slightly, I continued my rapid ascent, not stopping until the fingers of my right hand were two knuckles deep into the pulley.

"Fortunately, by this time, I had regained my presence of mind and was able to hold onto the rope in spite of my pain. At approximately the same time, however, the barrel hit the ground and the bottom fell out. Devoid of the weight of the tools, the barrel now weighed about 20 pounds. I refer you again to block number 11.

"As you might imagine, I began a rapid decent down the side of the tower. In the vicinity of the 40-foot level, I met the barrel coming up. This accounts for the two fractured ankles and the lacerations of my legs and lower body. The force encountered by the barrel slowed me enough to lessen my injuries when I fell onto the pile of tools and, fortunately, only three vertebrae were cracked.

"I am sorry to report, however, that as I lay there on the tools, in pain, unable to stand or move and watching the empty barrel 80 feet above, I again lost my presence of mind. I let go of the rope..." (Safety Net. Wrks, Loma Linda University Medical Center.)

CALL FOR AUTHORS

Calling all authors: I am interested in hearing what you have to say and I am sure the rest of the membership is as well.

I would like to receive articles about your programs, why you like your job, and interesting and/or innovative things you have seen or are doing. The time commitment on your part is minimal—Bulletin articles are usually no more than one or two typed, double-spaced pages—and they are a great way to publicize your program and, more importantly,
the people who make it special. Remember, we also want to hear from those of you involved in ground transports. You are just as important as those who fly. Indeed, this membership section is for all RCPs involved in transport, no matter what role they play.

Let’s make this a Bulletin of the membership, by the membership, and for the membership. Anyone interested in contributing to the Bulletin should contact me at the address/numbers listed on the back page.

**RESOURCE PANEL UPDATE**

We would like to update our Resource Panel in an upcoming issue. If you are interested in being on the panel, or are on the panel now but have information to update, please fill out the following form and send it to Kathleen Adams at the address listed on the back page of this issue. Thank-you.

| Name: ____________________________________________ |
| __________________________________________________|
| Title: ____________________________________________ |
| __________________________________________________|
| Hospital/Program: _________________________________ |
| __________________________________________________|
| Address: __________________________________________|
| __________________________________________________|
| City/State/Zip: ________________________________    |
| __________________________________________________|
| Phone: ____________________ Fax: _________________   |
| __________________________________________________|
| e-mail: __________________________________________ |
| __________________________________________________|

**Area of transport knowledge:**

- [ ] Transport ventilators
- [ ] Transport equipment
- [ ] On-board oxygen systems
- [ ] Scene responses
- [ ] Expanded roles
- [ ] Flight physiology
- [ ] Team development
- [ ] IABP transports
- [ ] HFV/HFO transports
- [ ] Ground transport
- [ ] Rotor wing issues
- [ ] Fixed wing issues
- [ ] Neonatal transport
- [ ] Pediatric transport
- [ ] Adult transport

**Other: __________________________________________**

Call For Nominations for Section Chair-Elect

We are currently looking for a Transport Section member who would be interested in serving the section as chair-elect. This is a two-year term, followed by a two-year term as chair. The chair-elect acts as Transport Section Bulletin editor and back-up for the section chair. If you are interested in the job, please fill out the following form and return to Kathleen Adams at the address on the back of this issue. Appointment to the position must be approved by the AARC Board of Directors.

| Name of Nominee: ________________________________ |
| ________________________________________________|
| Address of Nominee: ______________________________|
| ________________________________________________|
| City/State/Zip: ________________________________ |
| ________________________________________________|
| Phone # Daytime: ________________________________ |
| Evening: ________________________________         |
| ________________________________________________|

Number of years as a section member ____________

In your own words, why do you want to be chair-elect. What strengths do you bring to the section?

- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
- ________________________________________________
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Deadlines for submitting copy for publication in the Bulletin—
Spring Issue: February 1
Summer Issue: May 1
Fall Issue: August 1
Winter Issue: October 1

Guidelines for the submission of educational conference information for the Bulletin:

WINTER ISSUE: Submit dates for Feb., Mar., and April.
SPRING ISSUE: Submit dates for May, June, and July.
FALL ISSUE: Submit dates for Nov., Dec., and Jan.

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Dallas, TX 75229-4593

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