

Instructions: Address each of the following in narrative form.

A. ORGANIZATION AND ADMINISTRATION

1. Describe your organizational structure including:
 - a. Type of Organization
 - b. Hours of Operation
 - c. Corporations—Attach a copy of your Certificate of Existence for domestic Corporations as filed with the office of the Secretary of State.
 - d. Non-Corporations—Attach authority to operate from Secretary of State
2. Provide a detailed description of your proposed service area. Include:
 - a. A map depicting the proposed area to be serviced,
OR
 - b. Listing of all counties, townships, cities, and owns to be serviced— including territorial boundaries.

B. TRANSPORTATION

1. List all of your vehicles by year, make, model and vehicle identification number.
2. List all locations where vehicles will be stationed.
3. Submit a certificate of insurance provided by the insurance company listing the vehicle identification number for each vehicle insured, the effective date, expiration date, and amount of coverage. Organizations operating vehicles owned by a governmental entity as defined in IC16-31-3-2, are not required to submit proof of insurance.
4. Submit a vehicle certification application form for each ambulance to be certified.

C. MANPOWER

1. Describe staffing patterns to be utilized by your organization.
2. Submit a completed personnel roster (*enclosed*).

D. PERSONNEL TRAINING AND CONTINUING EDUCATION

1. Describe the organization's continuing education program. Include:
 - a. Continuing education record keeping
 - b. Hours of continuing education offered through the organization.

E. COMMUNICATIONS

1. Describe the organization's communication system. Include:
 - a. Tactical frequencies,
 - b. Dispatch procedures, and
 - c. Location of dispatch center.
2. Attach a copy of your tactical FCC license.

***If functioning under another provider's license, submit a copy of the license AND a letter from the license holder granting authorization to transmit under that license.**

3. Describe the UHF Communication system.

Instructions: Address each of the following in narrative form.

F. DATA COLLECTION

1. Describe the organization's method for collecting and reporting data to the Indiana EMS Registry, and include where records are kept.

G. RECORD KEEPING

1. Describe the organization's record keeping system AND attach copies of all forms for the following areas:
 - a. Patient Care
 - b. Continuing Education
 - c. Audit and Review
 - d. Maintenance
 - i. Vehicle
 - ii. Equipment
 - e. Equipment Checklist

H. AUDIT and REVIEW

In accordance with EMS Commission Rule 836 1-2-3 (o), and 836 1-11-3 (k), each ambulance service, BLS Non-Transport, and EMT Basic-Advanced provider organization must provide a program for audit and review.

1. Describe the approved Audit and Review method being utilized by your organization.
 - a. How are forms chosen for the audit process?
 - b. List by title and name those who participate in your audit and review process.
 - c. Who is responsible for conducting your audit and review process?
 - d. How often is your audit and review conducted?

I. VEHICLE and EQUIPMENT CHECK

1. Describe the organization's procedures for checking emergency care equipment and supplies.
2. Describe how the organization maintains the mechanical integrity of its equipment.
3. Describe the organization's rigid sanitation procedures for the equipment.
4. Describe the organization's procedures for maintaining vehicle integrity.

J. MEDICAL CONTROL

1. Submit a completed medical director approval form. (*enclosed*)
2. Submit a copy of protocols that have been **approved, signed** and **dated** by the medical director.

K. MEDICATIONS

1. Describe the method of distribution, replacement, storage, and security of medications and solutions approved to be carried on board your emergency response vehicles.
2. Attach a list of medications to be carried on board your emergency response vehicles, that have been **approved, signed, and dated** by the medical director. Please include minimum quantity and dosages.

EMT BASIC-ADVANCED ORGANIZATIONS ONLY

1. Attach a list of medications and intravenous solutions to be carried on board your emergency response vehicles, that have been **approved, signed, and dated** by the medical director.
2. Describe the method of distribution, replacement, storage, and security of medications and solutions approved to be carried on board your emergency response vehicles.

L. SUPERVISING HOSPITAL APPROVAL

1. Submit a copy of the contract with the supervising hospital, or interdepartmental memo, if hospital based. If more than one hospital supervises the service, submit a copy of the agreement between hospitals that ensures consistency in medical control.
2. Submit a letter from the supervising hospital stating the acceptance of advanced life support personnel.

Disclosure of this information is mandatory. Failure to provide any information may prevent this application from approved. Misrepresentation of information, failure to comply and maintain compliance with, and/or violation provisions, standards, or requirements may be cause for suspension or revocation

This is to affirm that all statements contained in this application are true to the best of my knowledge. I hereby affirm have read and do understand the State of Indiana official rules and regulations for operations and administration of eme medical services and/or advanced life support, and agree to strictly adhere to them.

Signature of Chief Executive Officer

Date

EMERGENCY MEDICAL SERVICE PROVIDER *BLS and ALS - MEDICAL DIRECTOR APPROVAL*

The duties and responsibilities of the medical director shall include, but not be limited to:

1. Provide liaison between physicians, the medical community and the emergency medical service provider.
2. Assure that the appropriate equipment and supplies are available to the emergency medical service provider:
 - a. Basic EMT
 - b. EMT Basic Advanced
 - c. EMT Intermediate
 - d. EMT Paramedic
3. Monitor and evaluate the day-to-day medical operations of the emergency medical service provider organization.
4. Assist in the provision and coordination of continuing education programs of the emergency medical service provider organization.
5. Provide information concerning the operation of the emergency medical service provider organization.
6. Provide individual consultation to the emergency medical personnel affiliated with the emergency medical service provider organization.
7. Participate on the assessment committee for audit and review of cases treated by the emergency medical personnel of the emergency medical service provider organization.
8. Attest to the competency of the advanced emergency medical personnel affiliated with the advanced life support emergency medical service organization to perform skills required of the organization.
9. Establish protocols for automatic defibrillation, airway management, patient assisted medications and emergency medical technician-administered medications as approved by the commission for the emergency medical service provider organization.
10. Establish protocols for advanced life support.
11. Establish and publish a list of medication, including minimum quantities and dosages to be carried on vehicle.

(Check all levels that apply)

BASIC EMT **EMT BASIC ADVANCED** **EMT INTERMEDIATE** **PARAMEDIC**

This is to affirm that as Medical Director, I have reviewed and agree to accept the duties and responsibilities as described and approve the medical operations of the emergency medical service provider, as described in this application.

Signature of Medical Director *(Must be original signature)*

Date

Print or Typed name of Medical Director

License Number

Daytime Telephone Number

Address

City

State

Zip Code

Print or Type name of Provider

Certification Number

Roster of Personnel for:

Certification Number:

List All Names Of Driver And EMS Personnel	EMS Certification Number	CHECK ONE		CHECK ONE		CHECK IF APPLICABLE					
		NIMS Trained	Haz-Mat Trained	Paid	Vol	Driver	1 st Resp	EMT	EMT Basic Adv	EMT I	Para
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