APPLICATION FOR SUPERVISING HOSPITAL CERTIFICATION

State Form 46604 (R / 4-14)

EMS COMMISSION
302 W. Washington St., Room E239
Indianapolis, IN 46204
Telephone: (800) 666-7784

INSTRUCTIONS:
1. *Type or print carefully.*
2. *Complete all items and questions, attach additional pages as necessary.*
3. *Submit this form with all attachments, listing number and title of each item, to the above address.*
4. *Upon receipt, this form will be treated as a public record.*

Type of certification ☐ New ☐ Renewal ☐ Upgrade / Additional	Level of hospital ☐ Advanced ☐ EMT-Intermediate ☐ Paramedic	
Common operating name of organization		Certification number
Legal name of organization *(as filed with the Indiana Secretary of State)*		County
Address *(number and street, city, state, and ZIP code)*		Telephone number of organization ( )
Mailing Address *(number and street, city, state, and ZIP code)(if different)*		Fax number of organization ( )
Name of Chief Executive Officer	Title	Daytime telephone number ( )
Name of Chief of Medical Staff	Title	Daytime telephone number ( )
Signature of Chief of Medical Staff		Date signed *(month, day, year)*
Name of EMS Coordinator	Title	Daytime telephone number ( )
Fax number ( )	E-mail address	
Signature of EMS Coordinator		Date signed *(month, day, year)*

INSTRUCTIONS (Address each of the following in narrative form.)

A. Describe your communication system, licensed per FCC rules and regulations, which is available twenty-four (24) hours a day, and any other means of communication with EMS certified Advanced, EMT-Intermediate, or paramedic vehicles.
B. Attach a copy of current FCC license. If affiliated providers use cellular telephones for UHF communications, describe you facility's arrangements for a dedicated telephone line with ring-down capability.
C. Describe procedures to supervise the advanced life support procedures and/or IV administration performed by Advanced, EMT-Intermediate, and /or paramedic personnel via voice communication.
D. Describe the procedures for audit and review of cases transported by Advanced, EMT-Intermediate, or paramedic provider. Include the membership of the medical control committee, listed by job title.
E. Attach written approval from the administrative and medical staff to supervise the procedures performed by the Advanced, EMT-Intermediates, and/or paramedic personnel.
F. Attach a copy of your contractual agreement, or inter-departmental memo if hospital based, with Advanced, EMT-Intermediate, and/or paramedic provider organization(s) whereby the administrative and medical staff have agreed to provide the following in accordance with IAC 836 2-4.1-2:
   a) Continuing education organizations including length and frequency of training, attendance policy, and policy for acceptance of training from outside sources.
   b) Audit and review.
   c) Medical control and direction.
   d) Describe procedure to allow Advanced, EMT-Intermediate, and/or paramedic personnel to function within the appropriate hospital department to maintain continuing education for the Advanced, EMT-Intermediate, and/or paramedic personnel skills as defined in 836 IAC. Include a list of hospital departments involved and supervisory personnel.
G. Do you keep a copy of protocols of all providers you affiliate?
H. Do you co-sponsor an Advanced, EMT-Intermediate, and/or paramedic provider organization with another hospital? (If yes, submit name of the hospital and a copy of the agreement to coordinate medical control.)
I. Describe the procedures for reviewing the competency of the clinical personnel of the emergency medical services provider organizations that you supervise.
J. Attach a list of EMS personnel whose only affiliation is with the Supervising Hospital.
K. Attach a list of EMS personnel whose only affiliated with provider organizations sponsored by the Supervising Hospital.

Disclosure of this informaiton is mandatory. Failure to provide any information may prevent this application from being approved. Misrepresentation of information, failure to comply and maintain compliance with, and/or violation of any 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 that I have read and do understand the State of Indiana official rules and regulations regarding Supervising Hospitals in 836 IAC 2-4.1-1 and agree to strictly adhere to them.

Signature of Chief Executive Officer	Date signed *(month, day, year)*
Name of Hospital	Certification number