Reset Form

INITIAL APPLICATION FOR BASIC LIFE SUPPORT AND EMERGENCY MEDICAL SERVICE PROVIDER ORGANIZATION CERTIFICATION

State Form 55594 (R / 2-19)

INDIANA DEPARTMENT OF HOMELAND SECURITY
EMERGENCY MEDICAL SERVICES COMMISSION
302 West Washington Street, Room E241
Indianapolis, IN 46204
Telephone: 1-800-666-7784
E-mail: dhscertifications@dhs.in.gov

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

Type of application *(check one)*
☐ New Service ☐ Upgrade / Additional

Level of provider *(Please check one)*
☐ Basic Non-Transporting Provider Organization ☐ Emergency Medical Technician (EMT) Basic Transporting Provider Organization

Type of provider *(Check one box in each column that applies.)*
☐ Government ☐ Paid ☐ Ambulance ☐ Governmental ☐ Industrial
☐ Private ☐ Volunteer ☐ Fire Department ☐ Hospital ☐ Other _____

Common operating name of organization	County

Legal name of organization *(As filed with the Indiana Secretary of State.)*

Address *(number and street, city, state, and ZIP code)*

Mailing address *(if different) (number and street, city, state, and ZIP code)*

Business telephone number	24-hour contact telephone number	Business fax number
( )	( )	( )

Name of Medical Director	Title

Daytime telephone number	E-mail address
( )	

Name of Chief Executive Officer	Title

Daytime telephone number	E-mail address
( )	

Name of Day to Day Operations Manager	Title

Daytime telephone number	E-mail address
( )	

Name of Training Officer	Title

Daytime telephone number	E-mail address
( )	

Name of Pediatric Emergency Care Coordinator	Title

Daytime telephone number	E-mail address
( )	

Name of Data Collection Manager	Title

Daytime telephone number	E-mail address
( )	

INSTRUCTIONS: Address each of the following in a 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 Indiana 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 towns 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. Basic Life Support Non-Transport Provider only: Submit a copy of a valid agreement with a transporting ambulance service.

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 and IHERN 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.

F. DATA COLLECTION

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

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 1-1-6, each ambulance service and BLS Non-Transport provider organizations shall conduct audit and review at least quarterly.

1. Describe the approved Audit and Review method being utilized by your organization.
   a. How are run 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?

Name of provider	Certification number

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

I. EQUIPMENT CHECK

1. How often does your organization check its emergency care equipment and supplies?
2. Describe how your organization maintains the mechanical integrity of its equipment.
3. Describe the organization's rigid sanitation procedures for the equipment.

J. MEDICAL CONTROL

1. Submit a completed medical director approval form.
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.

L. TACTICAL EMS

If your organization is conducting tactical EMS the following must be submitted. All written approvals, authorities, protocols, and acknowledgements shall be signed and dated.

1. Submit a narrative explanation that defines the activities of tactical medical support as a function of the provider organization.
2. Submit written documentation authorizing all involved advanced life support personnel to function in the capacity of tactical medical support personnel within the scope of practice of the provider's and the individual's certification.
3. Submit documentation that ensures the continuation, during patient transport, of advanced life support procedures that are initiated by the tactical medical support personnel transport for all jurisdictions to which the tactical medical support personnel can be reasonably expected to respond.
4. Submit medical director's written approval of the tactical medical support activity and approval of the individual personnel involved.
5. Submit medical director's written authority for any advanced life support devices or medications or both that are carried by the advanced life support personnel within the scope of practice of the provider's and the individual's certification or license.
6. Submit medical director's written authority defining when and under what circumstances the advanced life support personnel may carry the advanced life support devices or medications or both.
7. Submit medical director's written authority defining when and under what circumstances any advanced life support devices or medication or both may be used.
8. Submit medical director's written authority defining how the security of any controlled substances will be ensured.
9. Submit medical director's written protocol for emergency medical services procedures performed by the advanced life support personnel while performing as tactical medical support.
10. Submit from the chief officer of the participating law enforcement agency written acknowledgement that the provider organization's advanced life support medical personnel are functioning as tactical medical support for the law enforcement agency.
11. Submit a statement agreeing that all medical care rendered by the tactical medical personnel will be documented on the organization's standard patient care record.

Name of provider	Certification number

Disclosure of this information 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 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 emergency medical services and agree to strictly adhere to them.

Signature of Chief Executive Officer	Date signed *(month, day, year)*