Reset Form

RENEWAL APPLICATION FOR EMERGENCY MEDICAL SERVICE PROVIDER ORGANIZATION CERTIFICATION

State Form 55593 (R2 / 5-18)

INDIANA DEPARTMENT OF HOMELAND SECURITY
EMERGENCY MEDICAL SERVICES COMMISSION
302 West Washington Street, Room E239
Indianapolis, IN 46204
Telephone: 1-800-666-7784

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.*

Level of provider *(Please check all that apply)*

☐ Rescue Squad	☐ Advanced Emergency Medical Technician (AEMT)	☐ Basic Life Support (BLS) Non-Transport
☐ Paramedic	☐ Basic Emergency Medical Technician (EMT)	☐ Advanced Life Support (ALS) Non-Transport
☐ Intermediate	☐ Tactical Emergency Medical Services (TEMS)	☐ Ambulance Service Provider (Transporting)

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	Certification number

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
( )	

A. COMMUNICATION

1. List the FCC License expiration dates *(month, day, year)* for all that apply for the following:
(If operating on frequencies licensed by other organizations, attach letter of authorization from the licensed organization.)

☐ Tactical ____/____/____ ☐ Indiana Hospital Emergency Radio Network (IHERN) ____/____/____

☐ Ultra High Frequency (UHF) *(If applicable)* ____/____/____ ☐ Other ____/____/____

2. Ultra High Frequency (UHF) Method:

Dispatch	Hospital / Med Control
☐ Very High Frequency (VHF)	☐ Very High Frequency (VHF)
☐ Ultra High Frequency (UHF)	☐ Ultra High Frequency (UHF)
☐ 800 MHz	☐ 800 MHz
☐ Cellular	☐ Cellular

B. OPERATIONAL INFORMATION

(Attach additional pages if necessary.)

1. Does your organization provide emergency medical service twenty-four (24) hours, seven (7) days a week?
   ☐ Yes ☐ No *(If no, explain.)* _____

2. Describe your organization's staffing pattern to include number of vehicles, operated by what personnel, and during which hours.

3. Has service area changed since last application?
   ☐ Yes ☐ No (*If yes, attach narrative and map describing new service area.)*

4. List location where organization's records are kept.

5. List any waivers granted to the provider by the Emergency Medical Services Commission.

Emergency Medical Service (EMS) Data Registry Reports are due by the 15th of each month.

6. List what software you are currently using to collect and report data.

C. TRAINING

1. How often are training sessions held?
   ☐ Daily ☐ Monthly ☐ Quarterly ☐ Other *(Explain)* _____

2. Where are training sessions held?

D. AUDIT AND REVIEW

1. Who is responsible for conducting the audit?
   ☐ Medical Director ☐ Hospital Committee ☐ Provider Organization Committee

2. How often are audit sessions conducted?
   ☐ Monthly ☐ Quarterly ☐ Other *(Explain)* _____

3. Who is responsible for keeping audit records?

Name of provider	Certification number

E. VEHICLES

Attach additional page if necessary.

	CERTIFICATION NUMBER	LAST 4 DIGITS OF VEHICLE IDENTIFICATION NUMBER	LOCATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

1. How often are vehicles checked for equipment inventory?
   ☐ Daily ☐ Monthly ☐ Quarterly ☐ Other *(Explain)* _____

2. Describe the organization's equipment maintenance procedures.

The following questions do not apply to Basic Life Support (BLS) Non-Transport Organizations.

1. How often are vehicles checked for vehicle integrity?
   ☐ Daily ☐ Monthly ☐ Quarterly ☐ Other *(Explain)* _____

3. Describe the organization's vehicle maintenance procedures.

F. ATTACHMENTS

Only original signatures will be accepted.

1. All Organizations
   - PROTOCOLS – Submit copy of current protocols, signed and dated by the Medical Director or a letter signed and dated by the Medical Director stating that there have been no changes in the protocols since the previous application.
   - MEDICAL DIRECTOR APPROVAL FORM – Submit form, signed and dated by the Medical Director.
   - PERSONNEL ROSTER – Submit roster, signed and dated by organization CEO and Medical Director.
   - MEDICATIONS – Submit a list of any and all medications and solutions, including amounts, and dosages approved and signed by the Medical Director.
   - MEDICATION STORAGE – Describe method of storage for all medications including double locked system for all scheduled medications.
   - AGREEMENT – (If a Non-Transport Provider Organization only) Submit a copy of the agreement with an ambulance service which guarantees transportation of patients to a hospital or a letter from the transporting service stating the agreement is still in effect.

2. If a Tactical Emergency Medical Service (EMS) Provider

Submit all written approvals, authorities, protocols, and acknowledgements must be signed and dated.

- Submit a narrative explanation that defines the activities of tactical medical support as a function of the provider organization.
- 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.
- 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.
- Submit medical director's written approval of the tactical medical support activity and approval of the individual personnel involved.
- 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 proactive of the provider's and the individual's certification or license.
- 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.
- Submit medical director's written authority defining when and under what circumstances any advanced life support devices or medication or both may be used.
- Submit medical director's written authority defining how the security of any controlled substances will be ensured.
- Submit medical director's written protocol for emergency medical services procedures performed by the advanced life support personnel while performing as tactical medical support.
- 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.
- 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.

3. If an Advanced Life Support Provider Organization
   - CONTRACT – Submit a copy of the contract with the supervising hospital, or interdepartmental memo, if hospital based; or a letter signed and dated by the Administrator of the supervising hospital stating that the existing contract is still in effect. If more that one hospital supervises the service, submit a copy of the agreement between the hospitals, which ensures consistency in medical control, or a letter from the hospitals stating that the contract is still in place.
   - ACCEPTANCE OF PERSONNEL –Submit a letter from the supervising hospital stating the acceptance of paramedic, and Advanced EMT's.

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 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 have read and do understand the State of Indiana official rules and regulations for operations and administration of emergency medical services and/or advanced life support, and agree to strictly adhere to them.

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