

Air Ambulance Service Initial Application  
Effective: September 11, 2022

Air Ambulance Service Initial Application Checklist

Refer to OSDH EMS Regulation (OAC 310:641-2-3) for complete requirements

**(Department use only)**

Date Application Received: \_\_\_\_\_

Date Application Completed: \_\_\_\_\_

Agency Name: \_\_\_\_\_

**Applicant Checklist**

Fee: \$600.00 initial fee (non- refundable)	\$600.00
# Of aircraft _____ (Add \$20.00 for each air ambulance over 2) (non-refundable)	\$ _____
# Of substations _____ (add \$150.00 for each substation (non-refundable)	\$ _____
Total enclosed fee:	\$ _____
Completed Application: _____	

Separate sections within application

Business Information	EMS District Board	Business Plan
Level of Care	Other Ownership or Controlling Interests	Aircraft Insurance Verification
Type of Owner	Felony Statement	General Liability Insurance Verification
Type of Operation	Owner Signature	Workers Compensation Insurance Verification
Dispatch and Communication Information	Personnel Roster	Medical Director Consent Letter
Aircraft List	Substation List	Medical Director Medical License
Medical Director	Equipment List	Medical Director OBNDD and DEA Registrations
Type of Ownership	Protocol Application	Medical Director Curriculum Vitae, or Resume
Indirect Ownership	Communication Policy	Contracts for personnel, equipment, or services
Mortgage	Response Plan	
Corporate Officers / Directors	Confidentiality Policy	

All sections complete, signed and notarized: \_\_\_\_\_

Initial EMS Air Agency Application Instructions:

Fees: (OAC 310:2-3 (v) (Non-refundable)

Initial application fee: \$600.00

Add \$20.00 for each unit over 2 units

Add \$150.00 for each substation

**Section 1- Business Information**

- Enter the name of your agency.
- Enter the mailing address of your agency including city, state, and zip code.
- Enter the physical address of your agency including city, state, and zip code.
- Enter the records retention address (address of where the agency records will be kept) including city, state, and zip code.
- Enter the business telephone number and an emergency telephone number.
- Enter the name of the person who will be a point of contact for the Department.
- Enter an email that the point of contact will be able to access to receive correspondence for the Department.
- Enter the days and times of the agencies operations. Please include the days and times that records will be available for an unannounced inspection review.
- Additional points of contact may be included with the application

**Section 2 – Level of Care (310:641-1-7 Air ambulance service) (Staffing requirements are detailed in OAC 310:641-3-15)**

- Paramedic

**Section 3 – Type of owner (OAC 310:641-2-3 (f) – (g)**

Enter the type of ownership for the agency. Essentially, what type of organization will own the license?

Examples include:

- Will an ambulance Service District (522 District or a Title 19) District own the license?
- Will a Fire Protection District (Title 18 or Title 19 District) own the license?
- Will a different type of board or trust own the license?

**Section 4 - Type of Operation (OAC 310:641-2-3 (f) – (g)**

Enter the type of operation for the agency. These are examples of type of owner and type of operation combinations:

- A city (or county) owns the license, and the service is based in the city fire department, then governmental city (or county) and fire-based would be marked.
- A city (or county) owns the license, and the service is based in the police department (or county sheriff's office), then governmental city (or county) and law enforcement would be marked.
- A city (or county) owns a hospital, and the service is based in the hospital, then governmental city (or county) and hospital would be marked.

## Air Ambulance Service Initial Application

Effective: September 11, 2022

- A city or county owns a hospital, and then appoints a board for the hospital. The city still owns the hospital.
- If a board owns the hospital, then it will be a board or trust that is marked with hospital.
- If the license will be owned by an ambulance Service District (522 District or Title 19) or a Fire District (Title 18 or Title 19), then mark either Fire Based or other type of operation.
- Third service means the agency is not fire or law enforcement based but is governmental owned.

### **Section 5 – Dispatch and communication information (OAC 310:641-2-3 (r))**

The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. See "Additional Required Information" below.

### **Section 6 – Aircraft list**

- Enter the manufacturer and serial number for each air ambulance you conduct transports with. This can be done on a separate page.

### **Section 7 – Medical Director OAC 310:641-2-3 (h)**

- Enter the name, address, email, and phone number of your Medical Director
- See application checklist and protocol application for required medical director documentation.

### **Section 8 – Type of Ownership (OAC 310:641-2-3 (f) – (g))**

- Enter the name of the agency owner (You must also complete and submit the ownership supplementary form)
- A business plan is also required. The plan must include a financial disclosure statement showing evidence of the ability to sustain the operation for at least one (1) year.

### **Section 9 – Indirect ownership (OAC 310:641-2-3 (f) – (g))**

List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

### **Section 10 - Mortgage (OAC 310:641-2-3 (f) – (g))**

List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

### **Section 11 - Corporation Officers/ Directors (OAC 310:641-2-3 (f) – (g))**

If the disclosing entity is a CORPORATION, list the names, titles, and addresses of the officers and directors.

### **Section 12 - EMS District Board (OAC 310:641-2-3 (f) – (g))**

If the disclosing entity is a '522' District Board, or received money from a '522' District Board, list the names, titles, and addresses of the officers and directors.

**Section 13 - Other Ownership or Controlling Interests (OAC 310:641-2-3 (f) – (g)**

If the disclosing entity is an Ambulance District Board established by Title 19, a city, a county, a council, or any other entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times, and other pertinent information.

**Section 14 - Felony Statement (310:641-3-13 (a) (1))**

Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

**Section 15- Owner Signature (OAC 310:641-2-3 (e)**

- Print the license owner's name in the space provided.
- Print the license owner's title in the space provided.
- Enter the date in the space provided.
- The license owner must sign in the space provided.
- The signature must be verified by a notary public.

**SEPARATE FORMS - forms included with this application**

- Personnel Roster- List all personnel for your agency who provide patient care.
- Substations - Check "yes" if your agency will maintain substations. Complete and submit the ambulance substation form with your application.
- Equipment List - initial or check the box next to each required list item to indicate it is in your agency's possession.
- Protocols Application - work with your Medical Director to complete this application to ensure your agency meets all EMS Protocol requirements.

**ADDITIONAL REQUIRED INFORMATION:**

1. Communication Policy (OAC 310:641-2-3 (r) -a written policy addressing how you receive and dispatch emergency and non-emergency calls, and stating that you will ensure compliance with State and Local EMS Communication Plans.
2. Response Plan (OAC 310:641- 2-3(t) - must include:
  - How you provide and receive mutual aid with all surrounding, contiguous, or overlapping, licensed service areas,
  - How you provide and receive disaster assistance in accordance with local and regional plans and command structures such as an incident command structure using national incident management support models.
3. Confidentiality Policy (OAC 310:641-2-3 (u)) -A policy ensuring confidentiality of all documents and communications regarding protected patient health information.
4. Business Plan (OAC 310:641-2-3 (x)

Air Ambulance Service Initial Application  
Effective: September 11, 2022

5. Insurance Proofs (OAC 310:641 2-3 (g) (2) – (4)

- General Liability
- Aircraft Liability
- Worker's Comp

6. Protocol Application (OAC 310:641-2-3 (j)) - in addition to the included Protocols Application, the following must be provided:

- Quality Assurance Policy (Section 6 of the Protocols Application) - a written policy that outlines your QA review policy.

7. Contracts for equipment, vehicles, or personnel are to be submitted, if applicable.

Department Application Procedures:

After submitting your application, it will be reviewed by Department staff for completeness, accuracy, and legibility. You will be contacted if the package is incomplete or additional information is required. Once the application is complete, an EMS Administrator will be assigned to conduct an initial inspection of your files, equipment, and facility. Upon receipt of the EMS Administrator's inspection report, your EMS Agency Certificate will be mailed to the address on record. Information regarding your Air ambulance application package may be obtained by calling (405) 426-8480.

Air Ambulance Service Initial Application

Effective: September 11, 2022

**Section 1 – Business Information**

Service Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street

City

State

Zip code

Physical Address: \_\_\_\_\_

Street

City

State

Zip code

Record Retention Address: \_\_\_\_\_

Street

City

State

Zip code

\*If record retention location is out of state, describe how will the records be available at the physical address:

---

---

Business Telephone: \_\_\_\_\_ Emergency Telephone: \_\_\_\_\_

Agency Director: \_\_\_\_\_ Telephone: \_\_\_\_\_

Director email: \_\_\_\_\_

Additional point of contact \_\_\_\_\_ Telephone: \_\_\_\_\_

PoC email: \_\_\_\_\_

Business hours (Days and times your office accepts business calls): \_\_\_\_\_

**Section 2 - Level of Care**

Paramedic life support :

**Section 3 – Type of Owner**

Governmental: City \_\_\_\_\_

Governmental: County \_\_\_\_\_

Governmental: Federal \_\_\_\_\_

Governmental: Tribal \_\_\_\_\_

Private (For Profit) \_\_\_\_\_

Private (Not for Profit) \_\_\_\_\_

522, Title 18 or Title 19 Board \_\_\_\_\_

Other \_\_\_\_\_

**Section 4 – Type of Operation**

Fire-Based \_\_\_\_\_

Law Enforcement \_\_\_\_\_

Hospital \_\_\_\_\_

3rd Service \_\_\_\_\_  
(Government Owned)

Private \_\_\_\_\_

Other \_\_\_\_\_

**Section 5 – Dispatch and communication information**

Dispatch phone number where calls are received: \_\_\_\_\_

Calls are received by: \_\_\_\_\_

Air Ambulance Service Initial Application  
Effective: September 11, 2022

**SECTION 6 –Air Ambulances** List all vehicles that will be used for patient transport. Use a separate sheet if necessary.

Manufacturer: \_\_\_\_\_ Serial No. \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Serial No. \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Serial No. \_\_\_\_\_

**SECTION 7 – Medical Director** - See "Additional Required Documentation"

Medical Director Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Email address: \_\_\_\_\_

**SECTION 8 – Type of ownership**

**Government Ownership (City, County, State or Federal) Describe:** \_\_\_\_\_

**Sole Proprietorship. List name of owner:** \_\_\_\_\_

**Partnership. List partners on a separate sheet if necessary:** \_\_\_\_\_

**Corporation. List name of Corporation:** \_\_\_\_\_

**Disclosing entity that receives money from or contracts with a 522 District.**

**Give 522 District name:** \_\_\_\_\_

**Disclosing entity that receives money from or contracts with an Ambulance service District (Title 19)**

**Give Ambulance Service District name:** \_\_\_\_\_

**Other (Specify):** \_\_\_\_\_

**SECTION 9 -Indirect Ownership (If Applicable)**

If disclosing entity is indirectly owned by another individual, agency or other entity with a controlling interest, separately, or in combination amounting to an ownership interest of 5% or more, provide a list of names and addresses of each individual or entity: \_\_\_\_\_

If disclosing entity has no indirect ownership, check here: \_\_\_\_\_

**SECTION 10 -Mortgage (If Applicable)**

If disclosing entity has individuals, organizations, or other entities with an interest in the form of the mortgage or other obligation, provide a list of names and addresses of each individual or entity: \_\_\_\_\_

If disclosing entity has no such other entities, check here: \_\_\_\_\_

**SECTION 11 -Corporation Officers/Directors (If Applicable)**

If the disclosing entity is a CORPORATION, provide a list the names, addresses and titles of the corporation's officers and directors: \_\_\_\_\_

If disclosing entity is not a corporation, check here: \_\_\_\_\_

**SECTION 12 -EMS District Board (If Applicable)**

If disclosing entity is a 522 District Board, or receives money from a 522 District Board, provide a list the names, addresses and titles of the board's officers and directors:

If disclosing entity is not a 522 District Board, check here:

**SECTION 13 - Other Ownership or Controlling Interests (If Applicable)**

If disclosing entity is an established Ambulance District Board established by Title 19 District Board, a city, county, council, or other entity, provide a list the names, addresses and titles of the officers, directors, commissioners, council members, etc. Provide meeting times, dates, and other pertinent information:

If disclosing entity is not an established Ambulance District Board established by Title 19 District Board, a city, county, council, or other entity, check here:

**SECTION 14 - Felony Statement**

Have any of the owners, principals, officers, or directors of the disclosing entity ever been convicted of a felony?

YES:  NO:

If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

**SECTION 15- Owner Signature**

This application form must be signed by the party or parties who shall be considered the owner agency (certificate holder) and who are responsible for compliance of the act and rules. The signature must be witnessed by a commissioned Notary Public.

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge.

Print name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

Signed before this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Notary Signature \_\_\_\_\_

My commission expires \_\_\_\_\_

**310:641-13-10. Air ambulance equipment**

The following medical equipment shall be required to be on board every aircraft certified by the Department for air medical services:

- readily available IV supplies and fluids, readily available;
- hangers or hooks to secure IV solutions in place and equipment to provide high flow fluids if needed. Glass IV containers shall not be used unless required by specific medications and properly secured;
- a minimum of three (3) IV infusion pumps immediately available for critical care transports;
- accessible medications, consistent with the service's medical protocols;
- a cardiac monitor, defibrillator and external pacemaker shall be secured and positioned so that displays are visible. Two (2) extra batteries or a power source shall be available for cardiac monitor / defibrillator or external pacemaker (adult and pediatric);
- laryngoscope and tracheal intubation supplies, to include laryngoscope blades, bag-valve-mask, and oxygen supplies, including PEEP valves; appropriate for ages and potential needs of patient transported;
- a mechanical ventilator appropriate for critical care transports;
- two (2) suction units, one of which is portable and both of which are capable of delivering adequate suction to clear the airway with wide bore (1/4") tubing and rigid and soft suction catheters for adults, children, and infants;
- pulse oximetry with adult and pediatric capability;
- continuous waveform capnography monitoring capabilities and equipment;
- automatic blood pressure device;
- devices for decompressing a pneumothorax and performing an emergency cricothyroidotomy;
- doppler stethoscope;
- continuous/bi level positive airway pressure device as allowed by protocol; and
- arterial line blood pressure monitoring as allowed by protocol.
- All medical equipment (including specialized equipment) and supplies shall be secured according to FAR's.

Air Ambulance Service Initial Application

Effective: September 11, 2022

**Air ambulance agency personnel roster (OAC 310:641-3-15)**

Instructions: List all certified and licensed personnel associated with the application/agency. Please list the names in alphabetical order. Please type or print only.

Volunteer means a person that does not receive compensation or is compensated at less than minimum wage.

Agency Name \_\_\_\_\_ Date \_\_\_\_\_

Name (last, first, and MI)

Certification/License level

SSN

Address

Certification/license number

Full/Part time/volunteer

1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16		

Air Ambulance Service Initial Application

Effective: September 11, 2022

**Air Ambulance Service List of Substations**

**Do you have units positioned at locations other than  
the business office or main station?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes, list the address and physical location, if different from the address of the units.**

**Make additional copies of this page if necessary.**

Substation Name or Number	Address	City, Zip	Phone number at Substation

# AGENCY PROTOCOL APPLICATION

## INTRODUCTORY INFORMATION

This protocol application packet applies to the following types of agencies:

- Ground Ambulance Service (310:641 - Subchapter 3)
- Air Ambulance Service (310:641 - Subchapter 13)
- Emergency Medical Response Agency (310:641 - Subchapter 15)

## SECTION 1 - TYPE OF APPLICATION

- Initial License Application (An agency not yet licensed)
- Amending or modifying existing protocols (OSDH Certified or Licensed Agency with Department approved protocols.)
- Change in Medical Director (When a new medical director is authorizing care.)

## SECTION 2- BUSINESS INFORMATION

- Name of Agency:
- Mailing Address: (Where the agency receives mail)
- Physical Address: (The address of the business office)
- Business Telephone:
- Fax Number:
- Name of Agency Director: (Include phone number and email address.)
- Name of Protocol Contact or Secondary Contact: (The name of the person who is administratively responsible for all communications regarding protocols. Include cell phone number and email address.)

## SECTION 3- TYPE OF AGENCY AND LEVEL OF CARE

- Emergency Medical Responder (EMR) (310:641-15-2(k)(2)): Allows for the use of Emergency Medical Responders as their level of care.
- Basic Life Support (BLS) (310:642-3-11(b)(1)): Means the ambulance service vehicles are equipped with the minimum basic equipment, and staffed with at least one EMT-Basic Attendant on each request for emergency medical service
- Intermediate Life Support (310:641-3-11(b)(2)): Means the ambulance service vehicles are equipped with the minimum intermediate equipment, and staffed with at least one EMT-Intermediate Attendant on each request for emergency medical service.
- Advanced Life Support (310:641-3-11(b)(3)): Means the ambulance service vehicles are equipped with the minimum advanced EMT equipment and staffed with at least one Advanced EMT Attendant on each request for service, except as permitted in this subchapter.



- Paramedic Life Support (310:641-3-11(b)(4)): Means the ambulance service vehicles are equipped with the minimum paramedic equipment and staffed with at least one EMT-Paramedic Attendant on each request for emergency medical service, or
- Air Ambulance Paramedic Life Support (310:641-13-8(a)(1)-(3)): Paramedic life support means the air ambulance vehicles are equipped with the minimum Paramedic equipment and staffed with at least one Paramedic on each request for service and may respond to both pre-hospital request and interfacility transfers.

#### **SECTION 4 - MEDICAL DIRECTOR**

The information regarding the physician licensed in the State of Oklahoma, providing medical direction for the agency. The Department must be notified by the next business day of any change in medical direction has occurred.

#### **SECTION 5 - DESTINATION PROTOCOLS - Complete Enclosed Table (O.A.C.310:641-3-61 or 13-20 Transfer Protocols)**

#### **SECTION 6 - QUALITY ASSURANCE PLAN**

The **Medical Director shall** be accessible, knowledgeable, and actively involved in quality assurance and the educational activities of the agency's personnel and supervise a quality assurance (QA) program. The appointment of a designee to assist in QA and education activities does not absolve the medical director of their responsibility for providing oversight.

**The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceeds the following requirements:**

Medical Director's Active Involvement in the review of:

- Patient refusals;
- Air Ambulance Utilization;
- Airway Management;
- Cardiac Arrest interventions;
- Time sensitive medical and trauma cases;
- Review other selected patient care reports not specifically included;
- Provide internal and external feedback of findings determined through reviews;
- Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years.

#### **SECTION 7 - DECLARE PROTOCOL OPTION**

- **Option #1:** The Agency is adopting the state protocol updates as written. Units must carry all equipment listed at the level of care selected when in service.



- **Option #2:** The agency is adopting state protocols with modifications. The agency must supply the an electronic copy of the modifications. Additionally, Option 2 is to be used when an agency has Department approved protocols and is requesting a change to the existing protocols.
- **Option #3:** The Agency is **rejecting** the state protocols and will use their own medical treatment protocols. The agency must submit an electronic copy of the agency protocols.

## SECTION 8 - LIST OF EACH PROTOCOL ALTERATION/ DELETION (Use form provided)

## SECTION 9 - AUTHORIZED PROCEDURE LIST (APL) (Attached)

Complete and accurate with Medical Director and EMS Director signatures.

- Agency authorized procedure list is a summary of all activities, skill, and medications being utilized at the agency. Mark each box with an "X" being authorized and black out any box being denied, deleted, or unauthorized.
- A copy of the individual's authorized procedure list, with signatures and dates will need to be filled out for any personnel authorized by the agency medical director operating at the agency and maintained within the individual's credentialing/training/licensure files.

## Section 10 – AGENCY DIRECTOR AND MEDICAL DIRECTOR SIGNATURES.

## SECTION 11 – ATTESTATION

Medical Director and Agency Director (Include dates)

The Signature also includes an attestation that the protocol that is submitted meets one or more the following Criteria:

- 310:641-5-20 Scope of Practice authorized by certification or licensure;
- 310:641 Scope of License for the Agency Certification or Licensure (See Subchapters 3, 9, 13, and 15)
- The 2011 EMR Oklahoma Instructor Guidelines;
- The 2011 EMT Oklahoma Instructor Guidelines;
- The Intermediate (I-85) Transitions Syllabus;
- The 2011 AEMT Oklahoma Instructor Guidelines; and/or
- The 2011 Paramedic Oklahoma Instructor Guidelines.

Return the application and any supporting documentation to:

**OSDH – EMS Division**  
**123 Robert S. Kerr – Suite 1702**  
**Oklahoma City, OK 73102-6460**

**Fax: 405-900-7560**  
**Email: [esystems@health.ok.gov](mailto:esystems@health.ok.gov)**



## AGENCY PROTOCOL APPLICATION

### SECTION 1 – TYPE OF APPLICATION (Print or Type)

Date of Application: \_\_\_\_\_ Agency Number: \_\_\_\_\_

Purpose:

Initial Application  Protocol Amendment  Change in Medical Director

### SECTION 2 – BUSINESS INFORMATION

Agency Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Agency Director / Administrator Name: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Email: \_\_\_\_\_

### SECTION 3: TYPE OF AGENCY

EMRA   
Ground Ambulance   
Air Ambulance

### LEVEL OF CARE (CHECK HIGHEST LEVEL PROVIDED)

EMR  AEMT   
EMT  PARAMEDIC   
Intermediate

### SECTION 4: MEDICAL DIRECTOR

Name: \_\_\_\_\_ MD DO SPECIALTY: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

State License No.: \_\_\_\_\_ OBNDD No.: \_\_\_\_\_

**If your medical director has changed, please submit the required documents from the checklist.**

Each agency or service will have a plan or policy that will address a sudden lapse of medical direction, such as a back-up or reserve medical director, which is used to ensure coverage when a medical director is not available. Include your policy or plan with this application.



## SECTION 5 – DESTINATION PROTOCOLS (See Page 3)

## SECTION 6 – QUALITY ASSURANCE PLAN

(If this is an initial application or if your plan has changed, please Attach a copy of the Quality Assurance Plan)

The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceeds the following requirements:

- o Review patient refusals;
- o Review air ambulance utilization;
- o Review airway management;
- o Review cardiac arrest interventions;
- o Review time sensitive medical and trauma cases;
- o Review other selected patient care reports not specifically included; and
- o Provide internal and external feedback of findings determined through reviews;

**Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years.**

## SECTION 7 – PROTOCOL OPTIONS (Select one of the three options)

Option 1: Agency is adopting the 2018 state protocol as written.

Option 2: Agency is modifying the 2018 state protocol  
(Detail modification or amendments on page 4)

Option 3: Agency is not adopting the 2018 state protocols and will submit  
their own agency specific protocols.

## SECTION 8 – DEFINE EACH PROTOCOL MODIFICATION (Use additional pages if needed)

Agency must attach scientific data or evidence for protocol requests that are not within the state protocols or existing scope of practice. (See Page 4)

## SECTION 9 – SUMMARY OF AGENCY PROTOCOLS or LIST OF AUTHORIZED PROCEDURES (SEE PROTOCOL APPLICATION INSTRUCTIONS)

## SECTION 10 – AGENCY AND MEDICAL DIRECTOR SIGNATURES

By signing the application, the agency director and the medical director approve the protocols submitted to the Department for review and approval.

Agency Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SECTION 4 – CHANGE OF MEDICAL DIRECTOR CHECKLIST**

<b>Medical Director's Consent Letter</b>	
<b>Medical Director's State Medical License</b>	
<b>Medical Director's OBNDD or DEA Certificate</b>	
<b>Curriculum Vitae</b>	
<b>Completed Protocols Application with new medical director information, signature and attestation.</b>	



**SECTION 5 – DESTINATION PROTOCOLS**  
**(See OAC 310:641-3-61 (ground agencies) or 13-20 (air agencies)**

<b>Regulations</b>	<b>List facilities within a reasonable range</b>
3-61 (c) or 13-20 (f)	

3-61 (d) or 13-20 (g)	(1) medical and trauma non-emergency transports shall be transported to facility of patient's choice, if within reasonable service range (see list above)
3-61 (d) or 13-20 (g) (2)	(2) emergency, non-injury related, non-life threatening transports shall be transported to the facility of the patient's choice if within reasonable service range (see list above)
3-61 (d) or 13-20 (g)	(3) emergency, injury related transports shall adhere to the OK Triage, Transport, and Transfer Guidelines... and ensure that patients are delivered to the most appropriate hospital, either within their region or contiguous regions.
List facilities that your agency would transport to:	A. B. C.
3-61 (d) or 13-20 (g)	(4) severely injured patients as described in the OK Triage, Transport and Transfer Guidelines...shall be transported to a hospital classified at Level I or II...unless a Level III facility identified in a regional plan is capable of providing definitive care. If time and distance are detrimental to the patient, then transport to the closest appropriate hospital identified in the regional plan
List facilities that your agency would transport to:	A. B. C.
3-61 (d) or 13-20 (g)	(5) Stable patients at risk for severe injury or with minor to moderate injury as described in the OK Triage, Transport, and Transfer Guidelines shall be transported to the closest appropriate facility, or by patient choice consistent with regional guidelines.
List facilities that your agency would transport to:	A. B. C.



## **SECTION 8 – PROTOCOL MODIFICATIONS (e.g., additions, deletions, or alterations)**



## Section 11: Attestation

Agency Name: \_\_\_\_\_ Agency No.: \_\_\_\_\_  
Agency Director: \_\_\_\_\_  
Medical Director: \_\_\_\_\_

By completing and signing this attestation, the agency director and the medical director attests the contents of this application are in compliance with the following requirements:

Requirement	Agency Director Initials	Date	Medical Director Initials	Date
<b>Certified and Licensed Emergency Medical Personnel Scope of Practice (OAC 310:641-5-20)</b>				
<b>Certified and Licensed Emergency Medical Personnel Educational Guidelines (EMR, EMT, Intermediate, AEMT, and Paramedic)</b>				
<b>Certified and Licensed Agency Scope of Licensure (OAC 310:641 Subchapters 3, 11, 13, and 15)</b>				
<b>Patient Safety (OAC 310:641 Subchapters 3, 11, 13, and 15)</b>				
<b>Destination Protocols (OAC 310:641 – 3 – 61 and 13-20)</b>				
<b>Quality Assurance (OAC 310:641-3-10, 11-2, 13-2, 15-2, and 15-3)</b>				
<b>Medical Director Approval (63 O.S. 1-2506)</b>				

Agency Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

