OKLAHOMA
State Department
of Health

OSDH Emergency Systems
p. (405) 426-8480 esystems@health.ok.gov

AGENCY APPLICATION GUIDANCE

February 2, 2026

Dear Applicant,

This guidance letter is intended to assist you in preparing and submitting an Agency application for licensure.

Application Review Process
Once your completed application is submitted, it will be reviewed by Department staff to ensure that all required information is accurate, complete, and legible. If any documentation is missing or further clarification is needed, you will be contacted directly.

Upon confirmation that your application is complete, an EMS Administrator will be assigned to conduct an initial inspection of your records, equipment, and facility. The following documents are required for all agency types for the initial inspection.

Documents required for all Agency's:
☐ Confidentiality Policy
☐ Quality Assurance Policy
☐ Communication/Dispatch Policy
☐ Response Plan Policy
☐ Equipment list
☐ Contracts for vehicles, equipment and/or personnel (if applicable)
☐ Sole Source (if applicable)

The following additional documents are required by Agency type for the initial inspection.

Documents for: Ground Ambulance Service
☐ Protocol Application
☐ Policy for Lapse of Medical Director
☐ Governmental Letter of Support for proposed area
☐ Map of proposed response area
☐ Destination Protocols

Documents for: Air Ambulance Service
☐ Protocol Application
☐ Policy for Lapse of Medical Director
☐ Destination Protocols

Documents for: Specialty Care Ambulance Service
☐ Protocol Application
☐ Policy for Lapse of Medical Director
☐ Transport request screening policy
☐ Type or types of specialty care and patients that will be transported above the Paramedic scope of practice

Documents for: Emergency Medical Response Agency
☐ Protocol Application
☐ Policy for Lapse of Medical Director
☐ Map of proposed response area
☐ Governmental Letter of Support for proposed area
☐ Letter of support from licensed ambulance service

Documents for: Stretcher Van Service
☐ Governmental letter of support for proposed area
☐ Map of proposed response area
☐ Evidence proposed service area has population of greater than 500,000
☐ Transport request screening policy

Certificate Issuance
Following the inspection and upon receipt of the EMS Administrator's report, your Agency Certificate will be issued via the email address listed in your application.

If you have any questions during the application process, please contact us at **(405) 426-8480** or via email at **esystems@health.ok.gov.**

Professionally,

Lori Strider

Lori Strider
Interim EMS Coordinator – EMS Division
OSDH – Emergency Systems

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Agency Application

Initial	**Renewal: License #:** _____
☐ Ground Ambulance Service ☐ Air Ambulance Service ☐ Specialty Care Ambulance Service ☐ Stretcher Van Service Initial Application Fee: $600.00 Vehicle Fees if more than 2: $20.00 per vehicle Substation(s) Fee: $150.00 per substation ☐ Emergency Medical Response Agency ☐ Pre-Hospital EMRA ☐ Event Standby EMRA Application Fee: $50.00	☐ Ground Ambulance Service ☐ Air Ambulance Service ☐ Specialty Care Ambulance Service ☐ Stretcher Van Service Renewal Application Fee: $100.00 Vehicle Fees if more than 2: $20.00 per vehicle Substation(s) Fee: $50.00 per substation ☐ Emergency Medical Response Agency Application Fee: $20.00 Insurance verification: Vehicle Liability, Professional Liability, & Workers Compensation insurance

Section 1: Business Information

Agency Name: _____ Date: _____

Agency Business Phone Number: _____ Alternate Phone Number: _____

Agency Director: _____ Director Email Address: _____

Alternate Email Address (if applicable): _____

Physical Address: _____
Address City State Zip Code County

Mailing Address: ☐ same as physical: _____
Adress City State Zip Code County

Record Retention Address: ☐ same as physical: _____
Adress City State Zip Code County

Volunteer Staff: ☐ Yes or ☐ No

Section 2: Ownership

Name of owner: _____ Phone #: _____

Address: _____

Select all that apply:

☐ Governmental ☐ City ☐ County ☐ State ☐ Federal ☐ Tribal ☐ Private (for profit) ☐ Private (not for profit)

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Owners that have 5% or more, attach the name, address of any other ambulance service in which any partner or stockholder holds an interest shall also be included.

☐ Title 19 Ambulance Service District ☐ 522 District

☐ Other (Specify): _____

☐ Have any of the owners or officers of the disclosing entity ever been convicted of a felony? Yes ☐ No ☐

If yes, please attach a list of names and a brief description of the felony convictions.

Section 3: Business Hours

Time: _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Section 4: License Level (Select one)

☐ EMS Basic Life Support ☐ EMS Intermediate Life Support ☐ EMS Advanced Life Support ☐ EMS Paramedic Life Support

*If providing Basic Life Support, OBNDD and DEA proof of Registration may be substituted with evidence the Medical Director is not restricted from obtaining or maintaining OBNDD and DEA registrations**

Section 5: Vehicle Information

How many of these units will be utilized by the applicant for service related to the license: _____

Ground ambulances _____ Specialty Care Ambulances _____ Air Ambulances _____ Stretcher Vans _____

Section 6: Substations

How many substations will be utilized by the applicant for service related to the license: _____

Substation Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Substation Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Substation Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Section 7: Medical Director Information

Name of Medical Director: _____ Medical Director Phone Number: _____

Medical Director Business Address: _____
Street City State Zip Code

Medical Director Email: _____

63 O.S. §§ 1-2506: Performance of Medical Procedures

I, _____, attest that all medical procedures performed under my direction comply with the standards established by Oklahoma Statute, Title 63, Chapter 1, Article 25, Section 1-2506, which are as follows:"

1. All medical procedures are performed by qualified personnel in accordance with Oklahoma's state and facility-specific guidelines.
2. Procedures adhere to standards of care to ensure patient safety, effectiveness, and ethical conduct.
3. The Medical Director is responsible for overseeing and ensuring the competence of all personnel authorized to perform these procedures.

Required Documents (N/A for Business Plan on renewal application)

- ☐ Business Plan (must include a financial disclosure statement)
- ☐ Professional Liability Insurance Verification
- ☐ Workers' Compensation Insurance Verification
- ☐ Vehicle Liability Insurance Verification
- ☐ Medical Director Letter of Agreement (Stretcher Van exempt)
- ☐ Medical Director curriculum vitae
- ☐ Copy of Medical Director's Oklahoma Medical License
- ☐ Copy of OBNDD Registration
- ☐ Copy of DEA Registration

Section 8: Signature of Applicant

This application form must be signed by an authorized applicant. Signature on the license application indicates an understanding that the signee is a responsible party for compliance with rule and law. I attest that the foregoing is true and correct to the best of my knowledge.

Print name: _____ Title: _____

Signature: _____ Date: _____

Please mail the application, supporting documents, and fee to: OSDH Emergency Systems
Attn: Financial Management
P.O. Box 268823
Oklahoma City, OK 73126-8823
Make a check or money order payable to: OSDH Emergency Systems

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PROTOCOL APPLICATION CHECKLIST

Documents for: Initial Agency Application
☐ 2-month clock starts application complete and sent on _____
☐ Application complete • Section 1 - 8
☐ On Agency Application • Medical Director Letter of Agreement • Copy of Medical Director State License, OBNDD License, and DEA License, Curriculum Vitae or Resume • Plan for Lapse of Medical Director
☐ Copy of Agency Patient Care Protocols (Section 4 - Option 3)
☐ Agency Authorized Procedure List (APL)
☐ Acknowledgment Page

Documents for: Protocol Amendment
☐ Internal Timeline for completion reviewers schedule determines
☐ Protocol Amendment Application complete • Section 1 - 8
☐ Copy of Agency Patient Care Protocols (Section 4 – Option 3)
☐ Section 5 – List of each protocol modification
☐ Section 6 – Agency Authorized Procedure List (APL)
☐ Acknowledgment Page

Documents for: Medical Director Update
☐ Internal Timeline for completion reviewers schedule determines
☐ Medical Director Update Application complete • Section 1-3
☐ Required Supporting Documents • Medical Director Letter of Agreement • Copy of Medical Director State License, OBNDD License, and DEA License, Curriculum Vitae or Resume • Plan for Lapse of Medical Director • Quality Assurance Policy
☐ Protocol Application
☐ Copy of Agency Patient Care Protocols (Section 4 - Option 3)
☐ Agency Authorized Procedure List (APL)
☐ Acknowledgment Page

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Agency Protocol Guidance

63 O.S. 1-2506 – Performance of Medical Procedures.

Licensed and certified emergency medical personnel, while a duty to act is in effect, shall perform medical procedures to assist patients to the best of their abilities under the direction of a medical director or in accordance with written protocols, which may include standing orders, authorized and developed by the medical director and approved by the State Department of Health when not in conflict with standards approved by the State Board of Health, giving consideration to the recommendations of the Trauma and Emergency Response Advisory Council created in Section 44 of this act. Licensure, certification and authorization for emergency medical personnel to perform medical procedures must be consistent with provisions of this act, and rules adopted by the Board. Medical control and medical directors shall meet such requirements as prescribed through rules adopted by the Board.

PROTOCOL AMENDEMENT APPLICATION
PLEASE TYPE OR PRINT ALL INFORMATION

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

- Ground Ambulance Service (310-641 - Subchapter 3)
- Specialty Care Ambulance Service (310-641 - Subchapter 11)
- Air Ambulance Service (310-641 - Subchapter 13)
- Emergency Medical Response Agency (310-641 - Subchapter 15)

SECTION 1 - TYPE OF APPLICATION

- Protocol Amendment Application (An agency already licensed)

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- LEVEL OF CARE

- Emergency Medical Responder (EMR) Allows for the use of Emergency Medical Responders as their level of care.
- Basic Life Support (BLS) means the 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 means the 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 means the 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 means the 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.
- Air Ambulance 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.

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SECTION 4 - 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 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 submi**t an electronic copy of the agency protocols.

SECTION 5 - LIST OF EACH PROTOCOL ALTERATION/ DELETION (Use form provided)

SECTION 6 - 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. We **do not need** with the application.

SECTION 7 – AGENCY DIRECTOR and MEDICAL DIRECTOR SIGNATURE

SECTION 8 – ACKNOWLEDGMENT

Medical Director and Agency Director (Include dates)
The Signature also includes an acknowledgment that the protocol that is submitted meets one or more the following Criteria:

- 63 O.S. 1-2506 Performance of Medical Procedures.
- 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, 11, 13, and 15)

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AGENCY PROTOCOL APPLICATION

SECTION 1 – Type of Application (Print or Type)

Date of Application: _____ **Agency Number:** _____

SECTION 2 – BUSINESS INFORMATION

AGENCY NAME: _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS: _____

BUSINESS TELEPHONE: _____ **FAX NUMBER:** _____

AGENCY DIRECTOR / ADMINISTRATOR NAME: _____

SECONDARY CONTACT: _____ **PHONE NUMBER:** _____

SECTION 3: LEVEL OF CARE (check the certification or license level of agency or agency application)

EMR ☐ **EMT** ☐ **Intermediate** ☐ **AEMT** ☐ **Paramedic** ☐ **Ground Agency** ☐ **Air Agency** ☐

SECTION 4 – 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 Section 5)**

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

SECTION 5 – 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 6 – SUMMARY OF AGENCY PROTOCOLS or LIST OF AUTHORIZED PROCEDURES
(SEE INSTRUCTIONS)

SECTION 7 – AGENCY AND MEDICAL DIRECTOR SIGNATURE:
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:** _____

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SECTION 5 – PROTOCOL MODIFICATIONS
(e.g., additions, deletions, or alterations)

Protocol Name	Protocol page #	Modified item	Supporting evidence provided

SECTION 6: AUTHORIZED PROCEDURE LIST

APL Must Match Protocols **Blackout Boxes Completely For Items Not in the Protocols.**

Agency Name:											
Agency Director Signature:						Date:					
Medical Director Signature:						Date:					
Employee Name:						Level:					
Employee Signature:						Date:					
Skill or Intervention	**Scope of Practice**					**Skill or Intervention**	**Scope of Practice**				
Airway	**EMR**	**EMT**	**I/85**	**AEMT**	**Para**	**Medication Administration Routes (continued)**	**EMR**	**EMT**	**I-85**	**AEMT**	**Para**
Oxygen- Nasal Cannula						Intraosseous					
Oxygen- Non Rebreather Mask						Auto-Injector					
Oxygen- Partial Rebreather Mask						IV Push					
Oxygen-Simple Mask						IV Bolus					
Oxygen- Venturi Mask						IV Piggyback					
Oxygen-Humidifier						Indwelling Catheters					
Airway Obstruction Management						Implanted Central IV Ports					
Head-Tilt/Chin Lift						Rectal					
Jaw Thrust						Ophthalmic					
Modified Jaw Thrust						Topical					
BLS Artificial Ventilation						Transdermal					
Pulse Oximetry						Bucal					
Bag-Valve- Mask						Subcutaneous					
Airway-Nasal						Cardiac – Circulation	EMR	EMT	I/85	AEMT	Para
Airway-Oral						CPR					
Airway-Laryngeal Mask						AED					
Intubation-Oral Trachael						Mechanical CPR Device					
Intubation-Nasal Trachael						12- Lead (Multi-lead) Cardiac Monitor Application					
Airway-Dual Lumen						12- Lead (Multi-Lead) Cardiac Monitor Transmit					
Airway-Supraglottic						12- Lead (Multi-Lead) Cardiac Monitor Interpret					
Suctioning-Upper Airway						Single Lead Cardiac Monitor Interpret					
Suctioning- Tracheobronchial						Manual Defibrillation					
Obstruction-Direct Laryngoscopy						Cardioversions – Electrical					
Non-Invasive Positive Pressure Ventilation						Carotid Massage					
End Tidal-Co2 Monitoring						Transcutaneous Pacing – Manual					
Waveform Capnography						Ventricular Assist Device					
Impedance Threshold Device						Induced Hypothermia Therapy					
Automated Transport Ventilator						**Immobilization/Lifting**	**EMR**	**EMT**	**I/85**	**AEMT**	**Para**
Chest Decompression – Needle						C-Collar					
Cricothyrotomy- Percutaneous						Cervical Immobilization Device (CID)					
Gastric Decompression – NG Tube						Pedi-Board					
Gastric Decompression – OG Tube						Long Spine Board					
Stoma/Tracheostomy Management						Scoop					
Medication Administration Routes	**EMR**	**EMT**	**I-85**	**AEMT**	**Para**	Rapid Manual Extrication					
Inhalation						Extremity Stabilization					
Oral						Vest Type Extrication Device					
Sublingual						Traction Splint					
Nasogastric						Mechanical Patient Restraint					
Intranasal						Urgent Maneuvers- Endangered Patient					
Intramuscular						Pelvic Splint					

SECTION 6: AUTHORIZED PROCEDURE LIST

APL Must Match Protocols **Blackout Boxes Completely For Items Not in the Protocols.**

Skill or Intervention	Scope of Practice					Skill or Intervention	Scope of Practice				
Immobilization/Lifting (continued)	EMR	EMT	I/85	AEMT	Para	Formulary (Continued)	EMR	EMT	I/85	AEMT	Para
Portable Pt. Transport Device (megamover)						Fentanyl	[redacted]	[redacted]	[redacted]	[redacted]	
Lifting and moving patients						Glucagon	[redacted]	[redacted]			
Assessment/Breathing/Bleeding Control	EMR	EMT	I/85	AEMT	Para	Glucose					
Hemorrhage control –Direct Pressure						Haloperidol	[redacted]	[redacted]	[redacted]	[redacted]	
Hemorrhage control – Tourniquet						Hydralazine	[redacted]	[redacted]	[redacted]	[redacted]	
Shock Treatment						Hydroxocobalamin	[redacted]	[redacted]	[redacted]	[redacted]	
Helmet removal – sports						Ipatropium Bromide	[redacted]				
Helmet removal - motorcycle						Lactated Ringers	[redacted]	[redacted]			
Child-Birth / Complications						Labetalol	[redacted]	[redacted]	[redacted]	[redacted]	
Blood-Glucose Monitoring						Lidocaine	[redacted]	[redacted]	IO	IO	
Blood Pressure – Automated						Lidocaine 2% Intravascular	[redacted]	[redacted]	IO	IO	
Blood Pressure – Manual						Lidcaine Viscous Gel	[redacted]	[redacted]			
Respiratory Rate						Lorazepam	[redacted]	[redacted]	[redacted]	[redacted]	
Manual Pulse						Magnesium Sulphate (Sulfate)	[redacted]	[redacted]	[redacted]	[redacted]	
Eye Irrigation						Methylprednisolone	[redacted]	[redacted]	[redacted]	[redacted]	
Urinary Catheterization	[redacted]	[redacted]	[redacted]	[redacted]		Midozolam	[redacted]	[redacted]	[redacted]	[redacted]	
Venous Blood Sampling	[redacted]	[redacted]				Morphine Sulphate (Sulfate)	[redacted]	[redacted]	[redacted]	[redacted]	
Central Line Monitoring	[redacted]	[redacted]				Hydrmorphone	[redacted]	[redacted]	[redacted]	[redacted]	
Intraosseous Initiation	[redacted]	[redacted]				Narcan (Naloxone)	Nasal	Nasal			
IV-maintain of non-medicated fluids	[redacted]					Nitroglycerin-Metered Dose/tablet (pt. supplied)					
IV-maintain medicated fluids	[redacted]	[redacted]	[redacted]	[redacted]		Nitroglycerin-Metered Dose/tablet (agency supply)	[redacted]	[redacted]	[redacted]	[redacted]	
IV Initiation- Peripheral	[redacted]	[redacted]				Nitroglycerin – IV Infusion	[redacted]	[redacted]	[redacted]	[redacted]	
Thrombolytic Therapy- Monitoring	[redacted]	[redacted]	[redacted]	[redacted]		Nitroglycerin - Ointment	[redacted]	[redacted]	[redacted]	[redacted]	
Medication Assisted Intubation	[redacted]	[redacted]	[redacted]	[redacted]		Norepinephrine	[redacted]	[redacted]	[redacted]	[redacted]	
Formulary	EMR	EMT	I/85	AEMT	Para	Normal Saline- IV Infusion	[redacted]	[redacted]			
Albuterol-Proventil-Ventolin (pt. prescribed)						Ondansetron	[redacted]				
Albuterol-Proventil-Ventolin (agency supplied)	[redacted]					Oxygen					
Assist with Pt. Prescription – Beta Agent						Phenylephine 2%	[redacted]				
Aspirin						Pralidoxime Chloride	[redacted]	[redacted]	[redacted]	[redacted]	
Activated Charcoal						Sodium Bicarbonate	[redacted]	[redacted]	[redacted]	[redacted]	
Adenosine	[redacted]	[redacted]	[redacted]	[redacted]		Topical Hemostatic Agent					
Amiodarone	[redacted]	[redacted]	[redacted]	[redacted]		Miscellaneous Formulary /Skills	EMR	EMT	I/85	AEMT	Para
Atropine Sulphate (Sulfate)	[redacted]	[redacted]	[redacted]	[redacted]							
Calcium Chloride	[redacted]	[redacted]	[redacted]	[redacted]							
Dextrose 5%	[redacted]	[redacted]									
Dextrose (D50)	[redacted]	[redacted]									
Dextrose (D25)	[redacted]	[redacted]									
Diazepam	[redacted]	[redacted]	[redacted]	[redacted]							
Diltiazem	[redacted]	[redacted]	[redacted]	[redacted]							
Diphenhydramine	[redacted]	[redacted]	[redacted]	[redacted]		Miscellaneous Formulary /Skills	EMR	EMT	I/85	AEMT	Para
Dopamine	[redacted]	[redacted]	[redacted]	[redacted]							
Duodote Auto Injector											
Epinephrine 1:1000	[redacted]	[redacted]	[redacted]	[redacted]							
Epinephrine 1:10,000	[redacted]	[redacted]	[redacted]	[redacted]							
Epinephrine Auto Injector											
Etomidate	[redacted]	[redacted]	[redacted]	[redacted]							

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SECTION 8: ACKNOWLEDGMENT

Agency Name: _____ **Agency No.:** _____

Agency Director: _____

Medical Director: _____

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

Requirement	Agency Director Initials	Date	Medical Director Initials	Date
Medical Director Approval (63 O.S. 1-2506)				
Certified and Licensed Emergency Medical Personnel Scope of Practice (OAC 310:641-5-20)				
Certified and Licensed Agency Scope of Licensure (OAC 310:641)				
Patient Safety (OAC 310:641 Subchapters 3, 11, 13, and 15)				

Agency Director Signature: _____ **Date:** _____

Medical Director Signature: _____ **Date:** _____