

Oklahoma State Department of Health

Protective Health Services

Financial Management

Emergency Systems/EMS Division

Oklahoma State Department of Health

PO Box 268823 Oklahoma City, OK 73126-8823

123 Robert S. Kerr Ave, suite 1702

Oklahoma City, OK 73102-6406



OKLAHOMA
State Department
of Health

**INSTRUCTIONS
FOR THE
COMPLETION
OF
OKLAHOMA'S
AIR AMBULANCE SERVICE
INITIAL AND AMENDMENT
APPLICATION FORMS**

Oklahoma State Department of Health

Protective Health Services
Financial Management
Emergency Systems/EMS Division
PO Box 268823 Oklahoma City, OK 73126-8823
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Oklahoma City, OK 73102-6406
Telephone: (405) 426-8480
Fax: (405) 900-7560



APPLICATION: Please type or print all information, except where a signature is required.

License Fees

Type of Fee	Reg	Fee for Initial License	Initial Vehicles	Substation
Fee for license	O.A.C. 310:641-13-2 (b)	\$600.00 (non-refundable)	\$20.00 for each unit after two units for transport (non-refundable)	\$150.00 each (Non-refundable)
Renewal of license	310:64113-4	\$100.00	\$20.00 for each after two units	\$50.00
Amendment	310:641-13-7	\$100.00		\$100.00

Section 1 – Type of Application

- Enter the date of the application.
- Enter the application purpose.
- Enter the agency license number if submitting an application amendment.

When amending the current license, complete section one, then complete the sections that will be changing within the application.

An amendment to the license is not required when changing protocols. When changing protocols, review and complete the protocol packet.

Section 2 – 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 can be provided with the application.

Section 3 – Level of Care (310:641-13-3 (d))

If your air service will be at the Paramedic level, select "Paramedic Life Support". If your service will operate at a level of care higher than or outside of the Paramedic scope of practice, please

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complete the OSDH Specialty Care Service application from the EMS Website instead of the Air Ambulance Application. If the applicant plans to offer both levels of care, then both applications are required.

Section 4 – Type of Owner

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

- 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 5 – Type of Operation

Enter the type of operation for the agency. For Section 5 and 6 – 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.
- 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 Government owned, but not operated as part of the fire or law enforcement departments.

Section 6 –Communication Plan (310:641-13-2 (a) (5) (M) – (N))

Agency Dispatch

- Enter the agency phone number to be used by dispatch to contact by phone.
- Enter who will receive the call (i.e. crew members, agency dispatcher).

Other Dispatch

- Enter the agency that is providing dispatch to the agency.
- Enter the phone number of the agency providing dispatch for the agency.

Radio System

- Enter the type of two-way radio communication maintained by the agency (UHF/VHF/800 MHz)
- Enter the frequency being used for dispatch if applicable.

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(NOTE: The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. The communication plan must be compliant with Local, State and Federal communication plans. The agency must complete and submit a statement stating the agency has a communication policy as part of this application.)
(NOTE: see 310:641-13-12 and 13-13 for specific communication requirements)

Section 7– Medical Director – Quality Assurance – Protocols (310:641-13-2 (a) (5) (G) and 13-11)

See Protocol Application Directions and forms.

Section 8 – Additional Documentation

- These additional documents that are to be submitted with the application.
- Applications without these documents are incomplete.
- Include contracts for equipment or services, if applicable.

Section 9 – Type of Owner (310:641-13-2 (a) (5) (A)- (C))

- 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 10 – Indirect Ownership (310:641-13-2 (a) (5) (A) - (C)) (if applicable)

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 11 – Mortgage (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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 12 – Corporation Officers / Directors (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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

Section 13 – Felony Statement (310:641-13-5 (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 14 - EMS District Board (310:641-13-2 (a) (5) (A) - (C)) (if applicable)

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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 16 – Other Ownership or Controlling Interests (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board ("522 or "Title 19"), a city, a county , a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Section 16 – Owner Signature (310:641-13-2 (a) (3) - (4)

- 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.

Additional Forms

- **Personnel Roster** – List all personnel for your agency who provide patient care.
- **Inspection Forms** – This form is used by the Department for inspections. Complete the form to provide us with your ambulance's information as well as an equipment checklist. Complete this form for each of your agency's ambulances. The Record Review checklist detail records to be maintained at the agency.
- **Medical Director** – See the attached Medical Director Checklist to ensure you are sending all of the required information.
- **Approved Procedures List** – Check each box to indicate the procedures used at your agency—including procedures at scopes of practice above your agency's level of care. **Include** a signed letter from the medical director and agency director stating acceptance of the Oklahoma State Protocols either "as-is" or "with changes", to include or attach an outline of the changes.
- **Substations** – Check "yes" if your agency will maintain substations. Complete and submit the Air Ambulance Substation form with your application.
- **Air ambulance communications** – Review requirements to ensure compliance.

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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) 271-4027.



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Air Ambulance Agency Application Checklist

Date application received: _____ Date complete application received: _____

Reason for package: Initial _____ Amended _____ Update _____ Other _____

Agency Name: _____

Level of Care: Paramedic _____ Specialty Care: _____

(Complete Specialty Care Application)

Scheduled for Inspection: _____ Date: _____ (or attach Aspen Report)

Please check each item:

1. Amount \$ _____ Fee Paid (310:641-13-2 (b))

Section	Content	Regulation (O.A.C)	Complete (Yes/No)
1	Type of Application		
2	Business Information		
3	Level of Care		
4	Type of Owner		
5	Type of Operation		
6	Public Access & Dispatch	310:641-13-2 (a) (5) (M and N)	
7	Medical Director- Quality Assurance- Protocols	310:641-13-11 (See protocol application packet)	
8	Insurances:	310:641-13-2 (a) (5) (D)	
	Contracts	310:641-13-2 (a) (5) (H)	
	Response Plan	310:641-13-2 (a) (6)	
	Confidentiality Policy	310:641-13-2 (a) (7)	
	Business Plan	310:641-13-2 (d)	
	Personnel roster	310:641-13-8	
	Vehicle checklist	310:641-13-10	
	Communication checklist	310:641-13-12 and 13	
9	Type of Ownership	310:641-13-2 (a) (5) (A) – (C)	
10	Indirect ownership	310:641-13-2 (a) (5) (A) – (C)	
11	Mortgagee	310:641-13-2 (a) (5) (A) – (C)	
12	Corp. officers/directors	310:641-13-2 (a) (5) (A) – (C)	
13	Felony Statement	310:641-13-2 (a) (5) (A) – (C)	
14	EMS District Board	310:641-13-2 (a) (5) (A) – (C)	
15	Other Ownership	310:641-13-2 (a) (5) (A) – (C)	
16	Owner signature	310:641-13-2 (a) (5) (A) – (C)	
Separate form	Personnel Roster	310:641-13-8	
Separate form	Inspection forms	310:641-13-10	
Separate form	Protocol Application/forms		
Separate form	Substation list		
Separate form	Communication checklist		

Medical Director Checklist



Agency Name: _____

Medical Director _____

Please provide these items or copies of these items:

If you change your Medical Director, a new Medical Director Checklist will be needed.

- Letter from the physician agreeing to be your Medical Director
- Copy of Medical Director's State Medical License
- Copy of Medical Director's OBNDD or DEA certificate
- Medical Director's Curriculum Vitae
- Medical Director's Primary Practice Address
- Medical Director's Email Address
- Name of Hospital where Medical Director is On Staff
- Medical Director's Specialty
- Medical Director's Approval of Protocols – include whether you are accepting the State protocols "as-is" or "with changes", including a list of any proposed changes. This letter should be signed by the EMS director and Medical Director.
- Provide documentation showing what steps will be taken in the event of a Lapse in Medical Direction – such as a back-up or reserve Medical Director.
- Completed Authorized Procedure List (included), signed by the EMS director and Medical Director

Air Ambulance Communication Requirements and Checklist

☐ **310:641-13-12. Operational protocols**

- Air ambulances shall operate within a statewide emergency medical response system coordinating pre- hospital and interfacility responses with the appropriate local emergency resources through:
- the use of the state designated resource status reporting and communication tool to show near real- time availability by using global positioning satellite systems to show where aircraft are located at the time of the request, and
- coordination with ground personnel to ensure the timeliest response to the patient via radio or telephone contact.

☐ **310:641-13-13. Communications**

All air ambulance aircraft shall have radio capability to communicate

- air to ground, air to air, and ground to air.
- The aircraft communication system will include two-way communications:
- with physician(s) who are responsible for directing patient care in transit, and
- with ground personnel who coordinate the transfer of the patient by surface transportation.

☐ The aircraft shall:

- have the capability to communicate between the medical attendant and pilot, and
- be in compliance with the Oklahoma State Interoperability Governing Body, and provide documentation that the aircraft can communicate with hospitals utilizing VHF frequency 155.3400.

☐ All communications equipment used for transmitting patient care information shall be maintained in full operating condition and in good repair. Ambulance communications equipment shall be capable of transmitting and receiving clear and understandable voice communications to and from the base station at a reasonable distance. Radios on aircraft shall be capable of transmitting and receiving the following traffic:

- Medical direction.
- Communication Center.
- EMS and law enforcement agencies.

☐ The medical team shall be able to communicate with each other during flight.

☐ A communication specialist shall be assigned to receive and coordinate all requests for the medical transport service. Training of the designated person shall be commensurate with the scope of responsibility and include:

- EMT certification, or the equivalent in knowledge or experience which minimally includes:
- medical terminology,
- knowledge of EMS - roles and responsibilities of the various levels of training,
- state and local regulations regarding EMS,
- familiarization with equipment used in the field setting,
- knowledge of Oklahoma State EMS Rules,

- types of radio frequency bands used in EMS systems,
 - a knowledge of the hazardous materials response and recognition procedure using appropriate reference materials, and
 - stress recognition and management.
- ☐ Aircraft shall communicate, when possible, with ground units securing unprepared landing sites prior to landing.
- ☐ A record of contact shall include, but not be limited to:
- time of call;
 - name and phone number of requesting agency;
 - age, diagnosis or mechanism of injury;
 - referring and receiving physician and facilities (for interfacility requests); as per policy of the medical transport service.
 - verification of acceptance of patient and verification of bed availability by referring physician and facility.
 - destination airport, refueling stops (if necessary) location of transportation exchange and hours of operation;
 - ground transportation coordination at sending and receiving areas;
 - time of dispatch (time crew notified flight is a go approved, post pilot OK's flight approval);
 - time depart base (time of lift-off or other site);
 - number and names of persons on board;
 - amount of fuel on board;
 - estimated time of arrival (ETA);
 - pertinent landing zone information;
 - time arrive location;
 - time helicopter arrives at landing zone or helipad;
 - time depart location;
 - time helicopter lifts off from landing zone or helipad;
 - time arrive destination;
 - time depart destination;
 - time arrive base; and
 - time aborted.
- ☐ The communication center shall contain the following:
- At least one dedicated phone line for the medical transport service;
 - A system for recording all incoming and outgoing telephone and radio transmissions regarding patient care with time recording and playback capabilities. Recordings are to be kept for three (3) years.
 - capability to immediately notify the medical transport team and on-line medical direction (through radio, pager, telephone, etc.);
 - a status board with information about pre-scheduled flights/patient transports, the medical transport team on duty, weather, and maintenance status;
 - aircraft service area maps and navigation charts shall be readily available.

- ☐ Each air ambulance service shall have in place a protocol to insure no delay in aircraft response.
 - The air ambulance service shall provide to the caller a point of origin and an accurate ETA.
 - In such cases where a delay is anticipated, the air ambulance service called has a responsibility to notify the caller and assist in referral to another licensed ambulance service.
- ☐ The air ambulance service shall be integrated with and communicate with other public safety agencies, including ground emergency service providers. This shall include participation in regional quality improvement reviews, regional disaster planning, and mass casualty incident drills to include an integrated response to terrorist events.
- ☐ Air ambulances will provide to ground agencies and receiving facilities post event reviews, feedback, or information for the purposes of improving performance or safety.



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Air Ambulance Service Application

License fees:

Type of Fee	Reg	Fee for Initial License	Initial Vehicles	
Fee for license	O.A.C. 310:641-13-2 (b)	\$600.00 (non-refundable)	\$20.00 for each unit after two units for transport (non-refundable)	
Renewal of license	310:64113-4	\$100.00	\$20.00 for each after two units	
Amendment	310:641-13-7	\$100.00		

SECTION 1 – TYPE OF APPLICATION (Print or Type) To Renew, use the Agency Renewal form on our website.

Date of Application _____ Purpose: Initial _____ Amended _____ Update _____

SECTION 2 – BUSINESS INFORMATION

Service Name: _____

Mailing Address: _____

City State Zip Code

Physical Address: _____

City State Zip Code

Record Retention Address: _____

City State Zip Code

Business Telephone: _____ Emergency Telephone: _____

Director / Administrator / Coordinator / CEO Name: _____

(additional points of contact may be included with the application)

Email Address: _____

Hours of Business Operation (Include days and times): _____

SECTION 3 – LEVEL OF CARE

Paramedic Life Support _____

Specialty Care _____

(If providing Specialty Care, as defined in 63 O.S. 1-2503, please complete Specialty Care Application

SECTION 4 – TYPE OF OWNER

Governmental City _____

Governmental County _____

Governmental Federal _____

Governmental Tribal _____

Private (Not For Profit) _____

Private (For Profit) _____

Board or Trust (Other) _____

522, Title 18 or 19 Board _____

SECTION 5 – TYPE OF OPERATION

Fire Based _____

Law Enforcement _____

Hospital _____

3rd Service (government _____

owned)

Private _____

Other: _____

SECTION 6 – PUBLIC ACCESS AND DISPATCH (Communication Plan) (O.A.C. 310:641-13-2 (a) (5) (M and N))

Agency Dispatch

Agency phone number where calls are received: (____) ____ - ____ The call is received by: _____

Other Dispatch

Agency providing dispatch: _____ Phone number for agency providing dispatch: (____) ____ - ____

Radio System (How are you dispatched?)

Cell Phone? _____ VHF? _____ UHF? _____ 700Mhz _____ 800Mhz _____ What Freq? _____

Does the agency applicant have a communication policy that addresses receiving and dispatching emergency and non-emergency calls that is State and Federal compliant? Yes _____ No _____ (You must include a policy statement)

SECTION 7 – MEDICAL DIRECTOR- QUALITY ASSURANCE - PROTOCOLS (O.A.C. 310:641-13-11))**See Protocol Application Packet and Medical Director Checklist****SECTION 8 – Additional documentation (Return with Application)**

Certificate of Aircraft Insurance (\$1,000,000.00) (O.A.C. 310:641- 13-2 (a) (5) (D))
Professional Liability Insurance (\$1,000,000.00) (O.A.C. 310:641- 13-2 (a) (5) (E))
Workers' Compensation Program Verification (O.A.C. 310:641- 13-2 (a) (5) (F))
Copies of Contacts for Equipment & Services (O.A.C. 310:641- 13-2 (a) (5) (H)) (if applicable)
Response plan (O.A.C. 310:641-13-2 (a) (6))
Confidentiality Policy (O.A.C. 310:641-13-2 (a) (7))
Business plan and financial disclosure (O.A.C. 310:641- 13-2 (d))
Personnel Roster (form enclosed) (O.A.C. 310:641-13-8)
Vehicle checklist for equipment (O.A.C. 310:641-13-10)
Air Ambulance Communication checklist (O.A.C. 310:641-13-12 and 13-13)

SECTION 9 – TYPE OF OWNERSHIP (310:641-13-2 (a) (5) (A)- (C))

____ Government Ownership (City, State or Federal) – Give Description: _____
____ Sole Proprietorship. List name of owner: _____
____ Partnership. List partners: _____
____ Corporation. Name of corporation: _____
____ Disclosing entity received money from, or contracts with , a '522' District (Article X);
Give '522' district name: _____
____ Disclosing entity received money from or contracts with, an 'Ambulance Service' District (Title 19);
Give 'Ambulance Service' district name: _____
____ Other (Specify): _____

SECTION 10 – INDIRECT OWNERSHIP (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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.

NAME

ADDRESS

SECTION 11 – MORTGAGE (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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).

NAME

ADDRESS

SECTION 12 – CORPORATION OFFICERS / DIRECTORS (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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

OFFICERS NAME

TITLE

ADDRESS

CORPORATION DIRECTORS

DIRECTORS NAME

TITLE

ADDRESS

SECTION 13 – FELONY STATEMENT (O.A.C. 310:641-13-5 (a) (1) (A))

Has any owner, principal, officer, or director 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 the felony conviction.

SECTION 14 – EMS DISTRICT BOARD (“522” or “Title 19” District) (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

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.

Name: _____ Position: _____

Address: _____ Contact Number: _____

Name: _____ Position: _____

Address: _____ Contact Number: _____

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contact or contracts to provide ambulance services with this form.

SECTION 15 – OTHER OWNERSHIP OR CONTROLLING INTERESTS (310:641-13-2 (a) (5) (A)- (C)) (if applicable)

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board (“522 or “Title 19”), a city, a county , a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Name: _____ Position: _____ Ownership %: _____

Address: _____ Contact Number: _____

Name: _____ Position: _____ Ownership %: _____

Address: _____ Contact Number: _____

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contract(s) to provide ambulance service to this form.

SECTION 16 - OWNER SIGNATURE 310:641-13-2 (a) (3) and (4))

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. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name _____ Title _____ Date _____ Signature _____

Signed before this _____ day of _____. My Commission Expires: ____/____/____



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AIR AMBULANCE AGENCY PERSONNEL ROSTER (O.A.C. 310:641-13-8)

Instructions: List all personnel associated with the agency that provides patient care. 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: ____/____/____

Person Providing the Information: _____ Title: _____

Name (Last, First and Middle Initial)	Level of License	SSN
Address	OK License Number and expiration date	Full/Part Time or Volunteer
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name (Last, First and Middle Initial)

Level of License

SSN

Address

OK License Number
and expiration date

Full/Part Time
or Volunteer

11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Signature

Date

Oklahoma State Department of Health
Protective Health Services / Emergency Systems

Form: Air Ambulance Personnel Roster
February 20 21
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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 Sub-station