**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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# INSTRUCTIONS FOR THE COMPLETION OF OKLAHOMA'S GROUND AMBULANCE SERVICE INITIAL APPLICATION FORM

O.A.C. 310:641
Effective: September 1, 2016

Oklahoma State Department of Health
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OKLAHOMA State Department of Health

# Ground Ambulance Agency Initial Application Checklist

Refer to OSDH EMS Rules and Regulations **310:641-3-10** for complete Agency Application Regulations

Date Application Received: _____ Date Application Complete: _____

Agency Name: _____

CHECKLIST

| | |
|---|---|
| ____Fee: $600 Initial Fee. | $600.00 |
| # of Ambulances____(add $20 for each ambulance over 2) | $_____ |
| # of Substations_____(add $150 for each substation) | $_____ |
| TOTAL FEE: | $_____ |

____Completed Ground Ambulance Service Application – All sections complete and signed by Director and Notary.

SEPARATE FORMS (included with this packet)
____Protocols Application
____Personnel Roster
____Substation List
____Equipment List

ADDITIONAL REQUIRED DOCUMENTATION
____Communication Policy
____Response Plan
____Confidentiality Policy
____Business Plan
____Letter of Governmental Support
____Coverage Area Map
____Contracts (if applicable)
____Insurance Proofs
☐General Liability,
☐Auto Liability,
☐Worker's Comp

MEDICAL DIRECTOR DOCUMENTATION
____Consent Letter
____Copy of Medical License
____Copy of OBNDD or DEA certificate
____Curriculum Vitae
____Lapse in Medical Director Plan

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# Initial EMS Ground Agency Application Instructions

For a Ground Agency License Renewal: https://www.ok.gov/health2/documents/Ambulance%20Service%20Renewal.pdf
For a Ground Agency License Amendment: https://www.ok.gov/health2/documents/Agency%20amendment.pdf

FEES OAC 310:641-3-10(g)(13):

Initial Application Fee: $600.00 (Non Refundable)
+ $20.00 for each unit after two units for transport (Non Refundable)
+ $150.00 for each Substation (Non Refundable)

APPLICATION:

**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 (310:641-3-11 (b (1) to (4))**

Select the level of care that will be provided.

- Basic life support
- Advanced life support
- Paramedic life support

**Section 3 – 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 4 – Type of Operation**

Enter the type of operation for the agency. For Section 4 and 5 – 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.

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<Type of Operation Continued>

- 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 not fire or law enforcement based but is governmental owned.

**Section 5 –Dispatch Information (310:641-3-10 (g) (10) (A) – (B))**

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.

(NOTE: 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 – Additional Documentation**

- These additional documents that are to be submitted with the application.
- Applications without these documents are incomplete.
- Contracts for equipment and services are to be submitted, if applicable.
- See “Additional Required Information” below.

**Section 7 – Ambulance List**

- Enter the make, model and VIN for each ambulance you conduct transports with. This can be done on a separate page.

**Section 8 – Medical Director**

- Enter the name, address, email and phone number of your Medical Director
- See “Additional Required Documentation” below for required Medical Director documentation.

**Section 9 – Type of Ownership (310:641-3-10 (g) (1) (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 (310:641-3-10 (g) (1) (A) - (C))**

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.

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**Section 11 – Mortgage (310:641-3-10 (g) (1) (A) - (C))**
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 (310:641-3-10 (g) (1) (A) - (C))**
If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

**Section 13 - EMS District Board (310:641-3-10 (g) (1) (A) - (C))**
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 14 – Other Ownership or Controlling Interests (310:641-3-10 (g) (1) (A) - (C))**
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 15 – 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 16– Owner Signature (310:641- 3-10 (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 310:641-3-10(g)(10)) –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 310:641-3-10(g)(11)) – must include:
   ☐ How you provide and receive mutual aid with all surrounding, contiguous, or overlapping, licensed service areas,

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<Additional Required Information continued>

☐ 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 310:641-3-10(g)(12)) –A policy ensuring confidentiality of all documents and communications regarding protected patient health information.
4. **Business Plan** (OAC 310:641-3-10
5. **Letter of Governmental Support** (OAC 310:641-3-10(g)(8) -Documents that support agency licensure from the governmental authority(ies) having jurisdiction over the proposed emergency response area. If the emergency response area encompasses multiple jurisdictions, a written endorsement shall be presented from each; and will be consistent with the County EMS plan as required in 19 O.S. Section 1-1203. Each endorsement shall contain the following:
   ☐ name(s) and title(s) of the person(s) providing approval,
   ☐ any expiration date
   ☐ name of the service receiving the endorsement.
6. **Coverage Area Description** (OAC 310:641-3-10(g)(9) – must include:
   ☐ a map defining the licensed service area including location(s) of base station, substations, and posts
   ☐ a description of the level of care to be provided, describing variations in care within the proposed service area
7. **Contracts** (if applicable) (OAC 310:641-3-10(g)(6))
8. **Insurance Proofs**
   ☐General Liability (OAC 310:641-3-10(g)(3))
   ☐Auto Liability (OAC 310:641-3-10(g)(2))
   ☐Worker's Comp (OAC 310:641-3-10(g)(4))
9. **Medical Director/Protocols**(OAC 310:641-3-10(g)(5, 7)) – in addition to the included Protocols Application, the following must be provided:
   ☐ Letter from an Oklahoma licensed Physician agreeing to be your Medical Director
   ☐ Copy of the Medical Director's State Medical License
   ☐ Copy of the Medical Director's OBNDD or DEA Certificate
   ☐ Copy of the Medical Director's Curriculum Vitae
   ☐ Documentation of steps that will be taken in case of a lapse in medical direction – such as the name or names of a back-up or reserve Medical Director.
   ☐ **Quality Assurance Policy** (Section 6 of the Protocols Application) – a written policy that outlines your QA review policy.

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 Ground Ambulance application package may be obtained by calling (405) 271-4027.

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# Ground Ambulance Agency Initial Application

SECTION 1 – BUSINESS INFORMATION

Service Name: _____

Mailing Address: _____
Address City ST Zip

Physical Address: _____
Address City ST Zip

Record Retention Address: _____
Address City ST Zip

Business Telephone: _____ Emergency Telephone: _____

Agency Director: _____ Phone: _____

Director Email:_____

Point of Contact: _____ Phone: _____

POC Email:_____

Business Hours – Days and times that your office accepts business calls: _____

SECTION 2 – LEVEL OF CARE

☐ Basic Life Support
☐ Intermediate Life Support
☐ Advanced Life Support
☐ 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 INFORMATION

**Agency Dispatch**

Agency Phone number where calls are received: _____ Calls are received by: _____

**Other Dispatch**

Other Agency providing Dispatch: _____ Other Agency Phone: _____

Radio System (How are you dispatched?):

☐Cell Phone ☐VHF ☐UHF ☐700 MHz ☐800 MHz What Frequency? _____

SECTION 6 – Additional Documentation Checklist – See "Additional Required Documentation" in instructions.

☐Communication Policy ☐Response Plan ☐Business Plan
☐Confidentiality Policy ☐Letter of Governmental Support ☐Coverage Area Map
☐Contracts (If Applicable) ☐Insurance Proofs(General Liability, Auto Liability, Worker's Comp

SECTION 7 – Ambulance List – list all vehicles that will be used by this agency for patient transport. Use a separate sheet if necessary.

Make_____Model_____VIN_____

Make_____Model_____VIN_____

Make_____Model_____VIN_____

Make_____Model_____VIN_____

SECTION 8 – Medical Director – Also, See "Additional Required Documentation" for required Medical Director documentation

Medical Director Name: _____ Phone: _____

Address: _____
Address City ST Zip

Email Address: _____

SECTION 9 – Type of Ownership (310:641-3-10 (g) (1) (A) - (C))

___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 (Article X) 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 10 – Indirect Ownership (310:641-3-10 (g) (1) (A) - (C)) (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 11 – Mortgage(310:641-3-10 (g) (1) (A) - (C)) (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 12 – Corporation Officers/Directors (310:641-3-10 (g) (1) (A) - (C)) (If Applicable)

If the disclosing entity is a CORPORATION, list the names, addresses and titles of the corporation's officers and directors. If disclosing entity is not a corporation, check here: ☐

SECTION 14 – EMS District Board (310:641-3-10 (g) (1) (A) - (C)) (If Applicable)

If disclosing entity is a 522 District Board, or receives money from a 522 District Board, 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 15 – Other Ownership or Controlling Interests (310:641-3-10 (g) (1) (A) - (C)) (If Applicable)

If disclosing entity is an established Ambulance District Board established by Title 19 District Board, or receives money from 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 13 – Felony Statement (310:641-3-13 (a) (1))

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 14 – Owner Signature (310:641- 3-10 (e))

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: _____ Date: _____

Signed before this _____ day of _____, _____. _____
Day Month Year Notary Signature

My commission expires: _____

**EMS Ground Agency Required Equipment List**
**(OSDH EMS Statutes and Regulations 310:641-3-23)**



Each ground ambulance service vehicle shall carry:

**Airway and breathing equipment and supplies, to include:**

| | |
|---|---|
| | A pulse oximetry device with pediatric and adult capability. |
| | A functioning portable suction apparatus with wide-bore tubing (1/4"), and rigid and soft suction catheters for adults, children, and infants, as detailed by agency protocols in addition to the vehicle mounted suction unit. |
| | One (1) bulb syringe, with saline drops, sterile, in addition to any bulb syringes in obstetric kits. |
| | A minimum of two (2) each, single use adult, pediatric, and infant bag-valve mask resuscitators with an adult, child, and infant clear masks. |
| | Oropharyngeal airways set or a minimum of two (2) of each size for adult, child, and infant individually wrapped for sanitation purposes. Nasopharyngeal airways are optional. |
| | A portable ventilator as directed by the agency medical director and approved protocols. |
| | Wall mounted oxygen set with variable flow regulators and adequate tubing. |
| | Portable oxygen cylinder and regulator with a spare oxygen cylinder appropriately secured. |
| | A minimum of two (2) each adult, child, and infant sized oxygen masks. |
| | A minimum of two (2) adult nasal cannulas. |
| | A nebulizer; adult and pediatric, sizes per local protocols. |

**Bandaging materials to include:**

| | |
|---|---|
| | Two (2) burn sheets; clean, wrapped, and marked in a plastic bag. |
| | Fifty (50) sterile 4"x4" dressings. |
| | Six (6) sterile 6"x8" or 8"x10" dressings. |
| | Ten (10) roller bandages, 2" or larger, such as kerlix, kling, or equivalent. |
| | Four (4) rolls of tape (minimum of one (1) inch width). |
| | Four (4) sterile occlusive dressings, 3" x 8" or larger. |
| | Four (4) triangular bandages. |
| | One (1) pair of bandage scissors must be on the ambulance or on the on-duty personnel. |

**Fracture immobilization devices, to include:**

| | |
|---|---|
| | One (1) adult and one (1) pediatric traction splint or equivalent device capable of adult and pediatric application. |
| | Two (2) upper and two (2) lower extremity splints in adult and pediatric sizes. |
| | Short spine board or vest type immobilizer, including straps and accessories as described within agency protocols. |
| | Two (2)adult and one (1) pediatric size long spine board including straps and head immobilization devices(s), as described within the agency protocols. |
| | Two (2) rigid or adjustable extrication collars in large, medium, small adult sizes, and pediatric sizes for children ages 2 years or older, and one (1) infant collar, as described within the agency protocols. Collars shall not be foam or fiber filled. |

**Miscellaneous medical equipment, to include:**

| | |
|---|---|
| | One (1) infant, one (1) child, two (2) adult, and one (1) extra-large blood pressure cuffs. |
| | Stethoscope, one (1) adult and one (1) pediatric size. |
| | Obstetrical kit, with towels, 4"x4" dressing, umbilical tape, bulb syringe, cord cutting device, clamps, sterile gloves, aluminum foil, and blanket. |
| | Universal communicable disease precaution equipment including gloves, mask, goggles, gown, and other universal precautions. |
| | Blood-glucose measurement equipment per medical direction. |
| | CPAP per medical direction. |
| | Semi-automatic advisory defibrillator (SAAD) with adult and pediatric capability. |

**Other mandatory equipment, to include:**

| | |
|---|---|
| | Two (2) appropriately labeled or designated waste receptacles for:<br>* waste that is contaminated by bodily fluids or potentially hazardous or infectious waste, and,<br>* waste that does not present a biological hazard, such as plastic and paper products that are not contaminated. |
| | One (1) flexible, portable, soft stretcher for confined space and extrication as approved by medical direction. |
| | Two way radio communication equipment as detailed in this Chapter and through the Statewide Interoperability Governing Body utilizing VHF frequency 155.3400. |
| | One (1) sturdy, lightweight, all-level cot for the primary patient and mounting cot fastener and/or anchorage assembly that is compliant with the vehicle manufacturing standards in place at the time of purchase. |
| | At least three (3) strap type restraining devices (chest, hip, and knee), and compliant shoulder harness shall be provided per stretcher, cot, and litter (not less than two (2") inches wide, nylon, easily removable for cleaning, two (2) piece assembly with quick release buckles). |

**EMS Ground Agency Required Equipment List**
**(OSDH EMS Statutes and Regulations 310:641-3-23)**



**Other mandatory equipment, continued:**

| | |
|---|---|
| | Electronic or paper patient care reports. |
| | Two (2) fire extinguishers one (1) in the cab of the unit, and one (1) in the patient compartment of the vehicle. Each mounted in a manner that allows for quick release and is compliant with the ambulance manufactures standards. Each extinguisher is to be dry powder, ABC, and a minimum of five (5#) pounds. |
| | Two (2) operable flashlights. |
| | Digital or strip type thermometer and single use probes. |
| | Six (6) instant cold packs. |
| | One (1) length/weight based drug dose chart or tape. |
| | A minimum of two (2) DOT approved reflective vests. |
| | One (1) pair of binoculars. |
| | A current copy of the emergency response guide, electronic or paper format. |
| | As approved by local medical direction, a child restraint system or equipment for transporting pediatric patients. |
| | Three (3) reflectors (triangular) or battery powered warning lights; |
| | Two (2) OSHA approved hard hats, with goggles or face shield; |
| | Two (2) pair of heavy work gloves; and |
| | One (1) spring-loaded window punch or other tool that may be used to access a patient through a window. |
| | All ambulance services shall have sufficient and appropriate rescue equipment to gain access to patients either on board the ambulance or provided through an extrication agreement with a rescue department or team. |

**Intermediate equipment, in addition to the basic equipment, intermediate licensed service ambulance vehicles shall carry:**

| | |
|---|---|
| | Intravenous administration equipment in a sufficient quantity to treat multiple patients requiring this level of care, including intravenous catheters 14 to 24 gauge, six (6) each. |
| | Interosseous needles, two (2) each for adult and pediatric patients, and associated administration equipment if approved by local medical control. |
| | Appropriate quantities of sterile fluid as approved by local medical control. |

**Adequate advanced airway equipment per medical control:**

| | |
|---|---|
| | Endotracheal tubes, two (2) sets of cuffed 2.5 to 8.0, as permitted and approved by local medical control. Uncuffed endotracheal tubes are optional, based on medical director approval. |
| | Supraglottic airway devices to be used as a primary or secondary airway intervention, as approved by medical control. |
| | Laryngoscope handle with extra batteries and bulbs with blade sizes and styles as approved by local medical control. |
| | Blood sampling equipment if approved by medical control. |
| | One (1) Occupational Safety and Health Administration (OSHA) approved sharps container. |
| | Magill forceps one (1) pediatric and one (1) adult size, individually wrapped. |
| | Continuous waveform capnography required for use in endotracheal intubation and specific supraglottic airway devices. |

**Advanced Emergency Medical Technician equipment, in addition to the required equipment for the EMT and the Intermediate, will carry:**

| | |
|---|---|
| | Medication that is permitted within the AEMT scope of practice and as approved by the medical control physician; |
| | Equipment and supplies that are permitted within the AEMT scope of practice and approved by the medical control physician. |

**Paramedic equipment, in addition to the required EMT, Intermediate, and AEMT equipment, the Paramedic level ambulance will carry:**

| | |
|---|---|
| | Cardiac monitor/defibrillator with printout, and appropriate pads, paddles, leads and/or electrodes (adult and pediatric). Telemetry capability is optional. |
| | Medication with quantities to be carried on each ambulance as detailed in the formulary of agency approved protocols. |
| | Nasogastric tubes; two (2) each 8 french to 16 french, in accordance with medical control authorization. |

All assessment and medical equipment utilized for patient care will be maintained in accordance with the manufacturer's guidelines. Documentation will be maintained at the agency showing that periodic tests, maintenance, and calibration are being conducted in accordance with the manufactures requirements. These types of equipment include, but are not limited to, suction devices, pulse oximetry, glucometers, capnography monitors, end-tidal co2 monitors, CPAP/BiPAP devices, ventilators, and blood pressure monitors.

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OKLAHOMA State Department of Health

## GROUND AMBULANCE AGENCY PERSONNEL ROSTER *(O.A.C. 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:_____/_____/_____

Person Providing the Information:_____Title: _____

| Name (Last, First and Middle Initial)<br>Address | Level of License<br>OK License Number and expiration date | SSN<br>Full/Part Time or Volunteer |
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| Name (Last, First and Middle Initial) | Level of License | SSN |
|---|---|---|
| Address | OK License Number and expiration date | Full/Part Time or Volunteer |
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_____ _____/_____/_____

Signature Date

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## Ground 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 |
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# Agency Protocol Application

## PLEASE TYPE OR PRINT ALL INFORMATION

**INTRODUCTORY INFORMATION**
**This protocol application packet is to be used by 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)**

**1. TYPE OF APPLICATION**

- **Initial License Application (An agency not yet licensed)**
- **Amending or modifying existing protocols**
  **(Agency has approved protocols, and is submitting a change or modification.**
- **Change in Medical Director (When a new medical director is authorizing care)**

**2. BUSINESS INFORMATION**

NAME of AGENCY:

MAILING ADDRESS: (where the agency receives mail)

PHYSICAL ADDRESS (the address where the main business office is located, to include city/state/zip)

BUSINESS TELEPHONE:

FAX NUMBER:

NAME OF AGENCY DIRECTOR:

SECONDARY POINT OF CONTACT: (the name of the person who is administratively responsible for all communications in regards to the protocols)

**3. 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) (310:641-3-11 (b) (1)):
Means that the ambulance services 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 that 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 that 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) and
Means that the ambulance service vehicles are equipped with the minimum paramedic equipment and staffed with at least one 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 that 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 requests and interfacility transfers.

**4. MEDICAL DIRECTOR (Do not complete if amending or modifying existing protocols)**

The information regarding the physician licensed in the State of Oklahoma providing Medical Direction for you service. If your medical director has changed and you have not notified the Department, please submit documents from the medical director checklist.

**Please provide the plan or policy for addressing a sudden lapse in medical direction.**

**5. Destination Protocols: See Page Three**

**6. QUALITY ASSURANCE PLAN**
**(Do not complete if amending or modifying existing protocols)**

**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 educational 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:**

Protect the confidentiality of the information;
Review patient refusals;
Review air ambulance utilization;
Review airway management;
Review cardiac arrest interventions;
Review 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.

## 7. DECLARE PROTOCOL OPTION

Option #1:

The Agency is adopting the state protocols updates **as written**.

Option #2

The Agency is adopting the state protocols with **alterations/deletions.** Must supply an electronic copy of the changes made.

Additionally, Option 2 is to be used when an agency has approved protocols and is requesting a change to their existing protocols. The information that is required is the:

- license level authorized;
- treatment protocol; and
- indication, contraindications, administration route, and dose.

Option #3

The Agency is **rejecting** the state protocols and will use their own protocols. The agency must submit an electronic copy of their current protocols.

## 8. LIST EACH PROTOCOL ALTERATION / DELETION

## 9. SIGNATURES:

EMS Director and Medical Director

REMINDER: See Example one below.

## 10. ATTACH A COMPLETED COPY OF THE SUMMARY OF AGENCY PROTOCOLS

**(Return this document to the Department)**

This form is a summary of your agency protocols. Please complete each scope of practice field that your medical director has authorized to perform each medication, technique, or intervention. (See enclosed example)

## 11. Individual List of Authorized procedures (also known as Authorized Procedure List or APL)

**Do not return the individuals list of authorized procedures document to the Department.**

This form is an example of a credentialing document or list of authorized procedures detailed in the regulations to show what an individual crew member has been authorized by the Medical Director to perform. These forms need to be available for inspection by EMS Administrators.

AGENCY PROTOCOL APPLICATION

PLEASE TYPE OR PRINT ALL INFORMATION

The enclosed copies of the Summary of Agency Protocols and the Individual List of Authorized Procedures list the same medications, techniques, and interventions. However, based on the authorizations of the medical director, an individual may not have all the agency protocols provided to them.

The individual form is an example. You will not need to return this document to the Department. Your agency may use your specific method for tracking the list of authorized procedures. However, the list will need to be retained in the credential file for each staff member. (See example Two)

**EXAMPLE ONE**

Option 1- When accepting the protocols as written; all of the equipment and supplies are required.

Example – Mechanical CPR Devices are in the 2018 protocols. If your agency does not have these devices, then alter that protocol.

Regardless of the protocols that are approved, the agency is required to ensure that the equipment and supplies

**EXAMPLE TWO**

Agency protocols include specific details of who can do what to patients exhibiting specific symptoms, signs, and diagnosis's

Example: The Intubation protocol provides all of the details for providing care for patients in respiratory arrest, and who can provide what care based on scope of practice.

The Summary of the Agency protocols details what can be done at an agency and by whom within the agency.

Example: OPA can be performed by all personnel, but ETI can only be performed by ALS Personnel

The Individual List of Authorized Procedures takes the summary and defines what a specific employee can do within the protocol

Example: Employee 1 is a Paramedic and can perform ETI. However, Rapid Sequence Induction (RSI) has not be approved for Employee 1.

Oklahoma State Department of Health
Financial Management
Emergency Systems/EMS Division
PO Box 268823 Oklahoma City, OK 73126-8823
123 Robert S. Kerr Ave, Suite 1702 Oklahoma City, OK 73102-6406
Telephone: (405) 426-8480
Fax: (405) 900-7560

# Agency Protocol Application

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

Date of Application:_____ License No: _____

Purpose:

☐ Initial license application ☐ Amending existing protocols ☐ Medical Director change

## SECTION 2 – BUSINESS INFORMATION

Agency Name: _____

Mailing Address: _____

Physical Address : _____

Business Telephone: _____ Fax Number: _____

Agency Director / Administrator Name: _____

Secondary point of contact: _____ Phone number: _____

## Section 3 – Level of Care (check the certification or license level of agency or agency application)

☐ Emergency Medical Responder ☐ Basic Life Support ☐ Intermediate Life Support

☐ Advanced (EMT) Life Support ☐ Paramedic Life Support (ground) ☐ (Air)

## Section 4 - Medical Director

Name: _____ MD ☐ DO ☐ Specialty: _____

Address: _____

Phone Number: _____ email address: _____

State License Number: _____ OBNDD Number: _____

**(If your medical director has changed, submit the documents required on the medical director 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.)

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Section 5 – Destination Protocols: *See Page Three*

**SECTION 6 – QUALITY ASSURANCE PLAN**

(Attach a copy of the Quality Assurance Plan with this application)

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

- Protect the confidentiality of the information;
- Review patient refusals;
- Review air ambulance utilization;
- Review airway management;
- Review cardiac arrest interventions;
- Review 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**

(The agency must make one of the options below)

☐ Option 1:
The agency is adopting the 2018 state protocol updates as written.

☐ Option 2:
The agency is adopting the 2018 state protocols with additions, deletions, or alterations.

☐ Option 3:
The agency is not adopting the 2018 state protocols and will use their own protocols.

## Section 8 – Define each protocol addition, deletion, or alteration

(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 – Signatures

Medical Director's Signature: _____ Date: _____

Agency Director/ Administrator: _____ Date: _____

**Section 10 and 11** – Summary of Agency Protocols and List of Authorized Procedures
(See Instructions)

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OKLAHOMA State Department of Health

# Section 5 - Destination Protocols (See O.A.C. 310:641-3-61)

| Regulation | Facilities within a reasonable range (Please list) |
|---|---|
| 3-61 (c) or 13-20 (f) | |
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|---|---|
| 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) emergency, non-injury related, non-life threating 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 |

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## Section 8 – Protocol addition, deletion, or alteration

| Protocol Name | Protocol page # | Item being added, deleted, or altered | Evidence or explanation provided |
|---|---|---|---|
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# Authorized Procedure List

☐ AGENCY ☐ INDIVIDUAL

| | | | |
|---|---|---|---|
| **Agency Name:** | | | |
| **Agency Director Signature:** | | **DATE:** | |
| **Medical Director Signature:** | | **DATE:** | |
| **Employee Name:** | **Level:** | **Signature:** | **DATE:** |

| ***APL MUST MATCH PROTOCOLS*** | SCOPE OF PRACTICE | | | | |
|---|---|---|---|---|---|
| **AIRWAY** | **EMR** | **EMT** | **I/85** | **AEMT** | **NRP** |
| Airway Assessment | | | | | |
| Oxygen Therapy--Nasal Cannula | | | | | |
| Oxygen Therapy--Non Rebreather Mask | | | | | |
| Oxygen Therapy-Partial Rebreather Mask | | | | | |
| Oxygen Therapy-Simple Face Mask | | | | | |
| Oxygen Therapy-Venturi Mask | | | | | |
| Oxygen therapy-Humidifiers | | | | | |
| Airway Obstruction Management | | | | | |
| Head Tilt-Chin lift | | | | | |
| Jaw Thrust | | | | | |
| Modified Jaw Thrust | | | | | |
| BLS Artificial Ventilation | | | | | |
| Pulse Oximetry | | | | | |
| BVM | | | | | |
| Airway-Nasal | | | | | |
| Airway-Oral | | | | | |
| Airway-Laryngeal Mask | | | | | |
| Intubation-Orotrachael | | | | | |
| Intubation-Nasal Trachael | | | | | |
| Airway Dual Lumen | | | | | |
| Airway Supraglottic | | | | | |
| Suctioning-Upper Airway | | | | | |
| Suctioning-Tracheobronchial | | | | | |
| Obstruction-Direct laryngoscopy | | | | | |
| Non-Invasive Positive Pressure Ventilation | | | | | |
| End Tidal-Co2 Monitoring | | | | | |
| Wave-Form Capnography | | | | | |
| Impedance Threshold Device | | | | | |
| Automated Transport Ventilator (ATV) | | | | | |
| Chest decompression--Needle | | | | | |
| Cricothyrotomy--Percutaneous | | | | | |
| Cricothyrotomy--Surgical | | | | | |
| Gastric Decompression--NG Tube | | | | | |
| Gastric Decompression--OG Tube | | | | | |
| Stoma/Tracheostomy Management | | | | | |
| **MEDICATION ADMINISTRATION ROUTES** | **EMR** | **EMT** | **I/85** | **AEMT** | **NRP** |
| Inhalation | | | | | |
| Oral | | | | | |
| Sublingual | | | | | |
| Nasogastric | | | | | |
| Intranasal | | | | | |
| Intramuscular | | | | | |

| ***APL MUST MATCH PROTOCOLS*** | SCOPE OF PRACTICE | | | | |
|---|---|---|---|---|---|
| **CARDIAC - CIRCULATION** | **EMR** | **EMT** | **I/85** | **AEMT** | **NRP** |
| CPR | | | | | |
| AED | | | | | |
| Mechanical CPR Device | | | | | |
| 12-Lead Cardiac Monitor Application | | | | | |
| 12-Lead Cardiac Monitor Transmission | | | | | |
| 12-Lead Cardiac Monitor Interpretive | | | | | |
| Single Lead Cardiac Monitor Interpretive | | | | | |
| Manual Defibrillation | | | | | |
| Cardioversion-Electrical | | | | | |
| Carotid Massage | | | | | |
| Transcutaneous Pacing-Manual | | | | | |
| Internal pacing-monitor ONLY | | | | | |
| Ventricular assist device | | | | | |
| Induced Hypothermia Therapy | | | | | |
| **IMMOBILIZATION / LIFTING** | **EMR** | **EMT** | **I/85** | **AEMT** | **NRP** |
| C-Collar | | | | | |
| CID (Cervical Immobilization) | | | | | |
| Pedi Board | | | | | |
| Long Spine Board | | | | | |
| Scoop | | | | | |
| Rapid Manual Extrication | | | | | |
| Extremity Stabilization | | | | | |
| Vest Type Extrication Device | | | | | |
| Traction Splint | | | | | |
| Mechanical Patient Restraint | | | | | |
| Urgent Maneuvers Endangered Patient | | | | | |
| Pelvic Splint | | | | | |
| Portable Pt. Transport Device (Megamover) | | | | | |
| **MEDICATION ADMINISTRATION ROUTES** | **EMR** | **EMT** | **I/85** | **AEMT** | **NRP** |
| Intraosseous | | | | | |
| Auto-injector | | | | | |
| IV Push | | | | | |
| IV Bolus | | | | | |
| IV Piggyback | | | | | |
| Indwelling Catheters | | | | | |
| Implanted Central IV Ports | | | | | |
| Rectal | | | | | |
| Ophthalmic | | | | | |
| Topical | | | | | |
| Transdermal | | | | | |
| Buccal | | | | | |
| Subcutaneous | | | | | |

***BLACK OUT BOX COMPLETELY FOR ITEMS **NOT** IN THE PROTOCOL***

# Authorized Procedure List

☐ AGENCY ☐ INDIVIDUAL

| ***APL MUST MATCH PROTOCOLS*** | SCOPE OF PRACTICE | | | | |
|---|---|---|---|---|---|
| | EMR | EMT | I/85 | AEMT | NRP |
| Hemorrhage control-direct pressure | | | | | |
| Hemorrhage control-tourniquet | | | | | |
| Shock Treatment | | | | | |
| Lifting and Moving Patients | | | | | |
| Helmet Removal (Sports) | | | | | |
| Helmet Removal (Motorcycle) | | | | | |
| Child-Birth / Complication | | | | | |
| Blood-glucose monitoring | | | | | |
| Automated BP | | | | | |
| Manual BP | | | | | |
| Respiratory Rate | | | | | |
| Manual Pulse | | | | | |
| Eye irrigation | | | | | |
| Urinary catheterization | | | | | |
| Venous Blood Sampling | | | | | |
| Central line-monitoring | | | | | |
| Intraosseous Initiation | | | | | |
| IV-maintain of non-medicated fluids | | | | | |
| IV-maintain of medicated fluids | | | | | |
| IV Initiation-Peripheral | | | | | |
| Thrombolytic therapy-monitoring | | | | | |
| Medication Assisted Intubation | | | | | |

| SCOPE OF PRACTICE | | | | | |
|---|---|---|---|---|---|
| **FORMULARY** | EMR | EMT | I/85 | AEMT | NRP |
| Albuterol-Proventil-Ventolin (pt. prescribed) | | | | | |
| Albuterol-Proventil-Ventolin (agency) | | | | | |
| Assist with Pt. Prescription Beta Agent | | | | | |
| Aspirin | | | | | |
| Activated Charcoal | | | | | |
| Adenosine | | | | | |
| Amiodarone | | | | | |
| Atropine Sulfate | | | | | |
| Calcium Chloride | | | | | |
| Dextrose 5%Water | | | | | |
| Dextrose (D50) | | | | | |
| Dextrose (D25) | | | | | |
| Diazepam | | | | | |
| Diltiazem | | | | | |
| Diphenhydramine | | | | | |
| Dopamine | | | | | |
| Duodote Auto Injector | | | | | |
| Epinephrine 1:1000 | | | | | |
| Epinephrine 1:10,000 | | | | | |
| Epinephrine Auto injector | | | | | |

| **APL MUST MATCH PROTOCOLS*** | SCOPE OF PRACTICE | | | | |
|---|---|---|---|---|---|
| **FORMULARY** | EMR | EMT | I/85 | AEMT | NRP |
| Etomidate | | | | | |
| Fentanyl | | | | | |
| Glucagon | | | | | |
| Glucose | | | | | |
| Haloperidol | | | | | |
| Hydralazine | | | | | |
| Hydroxocobalamin | | | | | |
| Ipratropium Bromide | | | | | |
| Lactated Ringers | | | | | |
| Labetalol | | | | | |
| Lidocaine | | | IO | IO | |
| Lidocaine 2% Intravascular | | | IO | IO | |
| Lidocaine Viscous Gel | | | | | |
| Lorazepam | | | | | |
| Magnesium Sulfate | | | | | |
| Methylprednisolone | | | | | |
| Midazolam | | | | | |
| Morphine Sulphate | | | | | |
| Hydromorphone | | | | | |
| Narcan (Naloxone) | Nasal | Nasal | | | |
| Nitroglycerin Metered Dose/Tablet-Patient's | | | | | |
| Nitroglycerin Metered Dose/Tablet agency supplied | | | | | |
| Nitroglycerin-IV Infusion | | | | | |
| Nitroglycerin-Ointment | | | | | |
| Norepinephrine | | | | | |
| Normal Saline - IV Infusion | | | | | |
| Ondansetron | | | | | |
| Oxygen | | | | | |
| Phenylephrine 2% | | | | | |
| Pralidoxime Chloride | | | | | |
| Sodium Bicarbonate | | | | | |
| Topical Hemostatic Agent | | | | | |

| FORMULARY MISCELLANEOUS SKILLS | EMR | EMT | I/85 | AEMT | NRP |
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| MISCELLANEOUS SKILLS ADDITIONS | EMR | EMT | I/85 | AEMT | NRP |
|---|---|---|---|---|---|
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***BLACK OUT BOX COMPLETELY FOR ITEMS **NOT** IN PROTOCOL***