Oklahoma State Department of Health
Protective Health Services
Financial Management
Emergency Systems/EMS Division
Oklahoma State Health Department
PO Box 268823
Oklahoma City, OK 73126-8823

INSTRUCTIONS FOR THE COMPLETION OF OKLAHOMA'S PRE- HOSPITAL EMERGENCY MEDICAL RESPONSE AGENCY INITIAL APPLICATION FORMS

Oklahoma State Department of Health
Protective Health Services
Financial Management
Emergency Systems/EMS Division
Oklahoma State Health Department
PO Box 268823
Oklahoma City, OK 73126-8823

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

Type of Fee	Reg	Fee for Initial Certification
Fee for certification	O.A.C. 310:641-15-2 (h) (11)	$50.00 (non- refundable)
Renewal of certification	310:641-15-6 (a) (2)	$20.00 (non-refundable)

Section 1 – Type of Application

- Enter the date of the application.
- Enter the application purpose.

When amending the current license, use the OSDH EMRA Amendment form found in the Forms section of the Emergency Systems website.

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 may be included with the application

Section 3 – Level of Care (310:641-15-2 (k) (2)
Select the level of care that will be provided.

- Emergency Medical Responder
- Basic life support
- Intermediate life support
- Advanced life support
- Paramedic life support

Section 4 – Type of Owner (O.A.C. 310:641-15-2 (h) (1) (A) - (B))
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?

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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 not fire or law enforcement based but is governmental owned.

Section 6 –Communication Policy (O.A.C. 310:641-15-2 (h) (8) (A and 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. 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.)

Section 7 – Quality Assurance Plan and Protocols (310:641-15-2 (H) (7) (A) – (C))
See Protocol Application Forms

Section 8 – 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.

- For each unit the applicant owns, complete a vehicle checklist and submit with the application

Section 9 – Proposed Level of Service in Proposed Response Area
(O.A.C. 310:641-15-2 (k) (1) – (3)
Enclose a description of the proposed level of service in the response area and include:
1) a map defining the primary emergency response area including base station, substations, posts, and consistent with local or regional emergency communication plans (e.g. 911 center);
2) a description of the level of care to be provided and describing any variations in care within the area; and
3) Emergency Medical Response Agency applicants will provide documentation that reflects compliance with existing sole-source ordinances.

Section 10 – Type of Owner (O.A.C. 310:641-15-2 (h) (1) (A)- (B))
- 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 11 – Indirect Ownership (O.A.C. 310:641-15-2 (h) (1) (A)- (B))
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 12 – Mortgage (O.A.C. 310:641-15-2 (h) (1) (A) - (B))
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 13 – Corporation Officers / Directors (O.A.C. 310:641-15-2 (h) (1) (A) - (B))
If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

Section 14 – Felony Statement (O.A.C. 310:641-15-7 (a) (1))
Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the felony conviction.

Section 15 - EMS District Board (O.A.C. 310:641-15-2 (h) (1) (A) - (B))
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
(O.A.C. 310:641-15-2 (h) (1) (A) - (B))

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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 17– Owner Signature (O.A.C. 310:641-15-2 (f))

- 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** – Part of Protocol Application forms

- **Substations** – Check "yes" if your agency will maintain substations. Complete and submit the Ambulance Substation form with your application.

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) 426-8480

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of Health

Pre Hospital Emergency Medical Response Agency Application Checklist

Date application received: _____ Date complete application received: _____

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

Agency Name: _____

Level of Care: EMR _____ EMT _____ Intermediate _____ AEMT_____ Paramedic _____

Please check each item:

1. Amount $ _____ _____ Fee Paid (O.A.C. 310:641-15-2 (h) (11) and 15-6 (a) (2))

Section	Content	Regulation (O.A.C)	Complete (Yes/No)
1	Type of Application		
2	Business Information		
3	Level of Care	310:641-15-2 (k) (2)	
4	Type of Owner		
5	Type of Operation		
6	Communication Policy	310:641-15-2 (h) (8) (A and B)	
7	Quality Assurance Plan and Protocols	310:641-15-2 (h) (7) (A) – (C)	
8	Proposed Level of Service in proposed Area	*(O.A.C. 310:641-15-2 (k) (1) – (3)*	
9	Additional Documents		
	Insurances:	310:641-15-2 (h) (2) - (4)	
	Contracts:	310:641-15-2 (h) (7)	
	Medical Director:	310:641-15-2 (h) (5) and 15-13	
	Confidentiality Policy:	310:641-15-2 (h) (10)	
	Personnel roster:	310:641-15-10	
	Response Plan:	310:641-15-2 (h) (9) (A) – (B)	
	Type of Ownership	310:641-15-2 (H) (1) (A) – (B)	
	Indirect ownership	310:641-15-2 (H) (1) (A) – (B)	
11	Mortgage	310:641-15-2 (H) (1) (A) – (B)	
12	Corp. officers/directors	310:641-15-2 (H) (1) (A) – (B)	
13	Felony Statement	310:641-15-8 (a) (2)	
14	EMS District Board	310:641-15-2 (H) (1) (A) – (B)	
15	Other Ownership	310:641-15-2 (H) (1) (A) – (B)	
16	Owner signature	310:641-15-2 (f)	
Separate form	Substation list		
Separate form	Medical Director Checklist		
Separate form	Protocols Application Packet		
Separate form	Equipment Checklists		

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
- 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 EMS Protocols Application. This can be found on our website.

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Pre-Hospital EMRA Application

Certification fees

Type of Fee	Regulation	Fee for Initial Certification
Fee for certification	O.A.C. 310:641-15-2 (h) (11)	$50.00 (non- refundable)
Renewal of certification	310:641-15-6 (a) (2)	$20.00 (non-refundable)

SECTION 1 – TYPE OF APPLICATION (Print or Type)

Date of Application_____ Purpose: Initial____ Update____ Certification No:_____

SECTION 2 – BUSINESS INFORMATION

Agency 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 / Chief 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

Emergency Medical Responder ____
Basic Life Support ____
Intermediate Life Support ____
Advanced (EMT) Life Support ____
Paramedic Life Support ____

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 – Communication Policy *(O.A.C. 310:641-15-2 (h) (8) (A and B))*

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 ____ Frequency _____

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 – QUALITY ASSURANCE PLAN and Protocols *(O.A.C. 310:641-15-2 (h) (7) (A) – (C))*

See enclosed Protocol Application

SECTION 8 – Proposed Level of Service in Proposed Response Area *(O.A.C. 310:641-15-2 (k) (1) – (3)*

Enclose a description of the proposed level of service in the response area and include: 1) a map defining the primary emergency response area including base station, substations, posts, and consistent with local or regional emergency communication plans (e.g. 911 center); 2) a description of the level of care to be provided and describing any variations in care within the area; and 3) Emergency Medical Response Agency applicants will provide documentation that reflects compliance with existing sole-source ordinances.

SECTION 9 – Additional documentation (Return with Application)

Certificate of Vehicle Insurance ($1,000,000.00)	*(O.A.C. 310:641- 15-2 (h) (2))*
Professional Liability Insurance ($1,000,000.00)	*(O.A.C. 310:641- 15-2 (h) (3))*
Workers' Compensation Program Verification	*(O.A.C. 310:641- 15-2 (h) (4))*
Copies of Contacts for Equipment & Services	*(O.A.C. 310:641- 15-2 (h) (6)) (if applicable)*
Confidentiality Policy	*(O.A.C. 310:641-15-2 (h) (10))*
Personnel Roster (form enclosed)	*(O.A.C. 310:641- 15-10))*
Response plan	*(O.A.C. 310:641-15-2 (h) (9))*
Medical Director	*(O.A.C. 310:641-15-2 (h) (5) and 15-13)*
Letters of support (EMS and Governmental)	(O.A.C. 310:641-15-2 (i) - (j)

SECTION 10 – TYPE OF OWNERSHIP *(O.A.C. 310:641-15-2 (h) (1) (A)- (B))*

____ 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 11 – INDIRECT OWNERSHIP *(O.A.C. 310:641-15-2 (h) (1) (A)- (B))* *(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 12 – MORTGAGE *(O.A.C. 310:641-15-2 (h) (1) (A)- (B))* *(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 13 – CORPORATION OFFICERS / DIRECTORS *(O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (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 14 – FELONY STATEMENT *(O.A.C. 310:641-15-7 (a) (1)*

Has any owner, principal, officer, or director been convicted of a felony? Yes ____ No ____.
If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the felony conviction.

SECTION 15 – EMS DISTRICT BOARD ("522" or "Title 19" District) *(O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (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 16 – OTHER OWNERSHIP OR CONTROLLING INTERESTS *(O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (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 17 - OWNER SIGNATURE *(O.A.C. 310:641-15-2 (f))*

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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PRE-HOSPITAL EMERGENCY MEDICAL RESPONSE AGENCY PERSONNEL ROSTER *(O.A.C. 310:641-15-10)*

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

Name (Last, First and Middle Initial) Address	Level of License OK License Number and expiration date	SSN Full/Part Time or Volunteer
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Signature

_____/_____/_____
Date

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Minimum Required Prehospital EMRA Equipment List (OAC 310:641-15-11(d))

Check or initial below to indicate that these minimum required supplies and equipment are available to be present during each emergency medical response provided by your agency .

____one (1) each adult, pediatric, and infant size bag-valve-mask resuscitators,
____one (1) complete set of oropharyngeal airways, single wrapped for sanitation purposes,
____ (3) portable oxygen system with two (2)each oxygen masks in adult, pediatric, and infant sizes,
____two (2) adult nasal cannulas,
____portable suction device with age and size appropriate tubing and tips,
____one (1) bulb syringe with saline drops, sterile, in addition to any bulb syringes in an obstetric kit,
____instant cold packs,
Sterile dressing and bandages, to include:
____sterile burn sheets,
____sterile 4"x4" dressings,
____sterile 6"x8" or 8"x10" dressings,
____roller bandages, 2" or larger,
____rolls of tape (minimum of one (1) inch width),
____sterile occlusive dressings, 3" x 8" or larger,
____triangular bandages, and
____scissors.
____blood pressure cuff kit in adult, pediatric, and infant sizes.
____obstetrics kit,
____blankets,
____universal precaution kit for each person attending a patient,
____blood-glucose measurement equipment per medical direction and Department approval,
____AED with adult and pediatric capability,
____adult and pediatric upper and lower extremity splints,
____spinal immobilization equipment per medical control authorization,
____adult traction splint,
____patient care reports,
____digital thermometer.

Include a list of any additional equipment that will be available during each emergency medical response provided by your agency .

Person Providing information:_____

Signature:_____ Date:_____

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Pre-Hospital Emergency Medical Response Agency 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