ADIRONDACK-APPALACHIAN REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL, INC.
Regional Medical Advisory Committee

APPLICATION FOR APPROVAL OF SERVICE TO PROVIDE ALS LEVEL CARE

ALS LEVEL APPLYING FOR: ☐ AEMT ☐ Critical Care

☐ Paramedic

Agency Name _____ Agency Code _____

Address _____

Town/City _____ County _____ Zip _____

Business Telephone (___)_____
Emergency Telephone (___) □Dispatched by _____

- Type of Agency: □Ambulance □First Responder
  □All volunteer □Some paid personnel □All paid personnel

☐ CERTIFIED ☐ REGISTERED

For consideration as a new ALS agency, the regional council requires that the agency either be certified or in the bonafide process of completing application for certification. If the agency is in the process of certification, the application for certification should be attached to this application. This application may be tentatively approved, pending successful certification of the agency by NYS DOH

- Current Agency Personnel

#CFR ___ #EMT ___
#AEMT ___ #AEMT-CC ___ #EMT-P ___

- Primary Operating Territory (As listed on your certification or registration):

_____

- Do any other BLS/ALS agencies serve all or part of your operating territory? □Yes □No If yes, please list them:

_____

- Do you have a mutual aid agreement/s with any other EMS agency/agencies? □Yes □No If yes, please list them

_____

- Please describe your response vehicle(s) and the location at which each response vehicle is based:

- What is your primary (nearest) receiving hospital?

  _____

- To what other hospitals do you transport patients?

_____

  _____

- Do you have a medical control agreement with a medical control facility? ☐ Yes ☐ No

(Please attach a copy of all agreements)

- Does your agency have a physician medical director?
  □Yes □No If yes, who is your medical director?
  Name _____
  Address _____
  Telephone _____

(Attach letter of support and agreement for ALS level practice signed by your medical director. This letter should state the ALS level that the medical director is recommending)

- Does your agency have current malpractice insurance?
  □Yes □No (*Please provide a certificate of insurance along with this application.)*

- Does your agency have two-way communication capability with the nearest receiving hospital from all areas of your primary operating territory? □Yes □No
  If no, what method of communication do you use from "dead spots" to contact medical control? _____
  _____

- Is your agency available 24-hours per day, seven days per week?
  □Yes □No If no, what arrangements are made to provide coverage to your territory when your agency is not available? _____
_____

- Is your agency able to provide at least one EMT on every call?
  □Yes □No If no, what percentage of your calls last year did <u>not</u> have an EMT on board? _____%

- If you are unable to provide an EMT on every call, what percentage of calls last year had a certified first responder on board? _____%

- Please estimate the percentage of calls in the next year that will be covered by an AEMT at the level for which you are applying _____ %

- What was your average call volume for the past three years?
  _____ calls per year

- Do you submit PCRs *monthly* to the regional EMS program office?
  □Yes □No *If no, please explain how PCRs are submitted*____
_____

- Does your agency have its own or participate regularly in a hospital based, county, or regional level QI committee?
  □Yes □No
  Briefly describe your QA and evaluation mechanism:

- Do you have (or plan to have) a defibrillator and other ALS equipment appropriate for the level for which you are applying for each of your emergency response vehicles? □Yes □No

PLEASE ATTACH ALL OF THE FOLLOWING TO THIS APPLICATION:

- Name; address; telephone number; certification level, number, and expiration dates of all of your certified members/employees. Indicate by * all members who are currently certified as an AEMT, CC, P.

- Name and level of training and responsibilities (patient care, motor vehicle operator, dispatcher, etc.) of all other non-certified agency personnel.

- All standard operating procedures and policies of the agency.

- List of agency officers with name, address, telephone (day and evening).

- Contact person for ALS level service (This person must be, at a minimum, certified at the highest ALS level for which you are applying).

- Copy of the ambulance operating certificate. (If certification is pending, attach application for certification)

- Certificate of malpractice/liability insurance.

- Copies of all mutual aid agreements.

- Copy of your application to DOH for a controlled substances license.

- **Letter of support/agreement from your agency medical director**

FOR FIRST RESPONDER AGENCIES ONLY:

- List of ambulance agencies that transport patients cared for by your agency, and a copy of your agreement with each of these ambulance agencies. Each mutual aid agreement must address the issue of the AEMT from the first responder agency remaining in charge of patient care throughout transport if no AEMT is on the ambulance.

We, the _____ hereby apply for approval to operate at the _____ ALS level. We agree to adhere to all operating standards, protocols, procedures, and standards of emergency medical care defined by the New York State Department of Health and the

Adirondack - Appalachian Regional Emergency Medical Services Council and its Medical Advisory Committee (Including automatic ALS dispatch in those circumstances covered by the protocol, if appropriate level ALS is not available from our agency) We further agree to participate as a member of the Regional Quality Improvement Committee, and to submit copies of all PCR forms completed to the appropriate regional office on a monthly basis, or in the case of ePCRs, to upload them appropriately to the State Bridge. We agree that we will attempt to foster mutual aid agreements with surrounding agencies to assure prompt ALS response and to call for ALS intercept in all situations which, according to protocol or EMTs judgment would benefit from ALS care, when an appropriate level of ALS is not available from our agency.

We further understand that failure to comply with the above stated terms may result in suspension or revocation of our agency's permission to provide ALS level services.

Agency Chief Executive Officer Signature _____ **Date** _____

Agency ALS Contact Person _____ **Date** _____

Agency Medical Director Signature _____ **Date** _____