

GENERAL INSTRUCTIONS

Attached is a copy of the application for use by out-of-hospital ground emergency medical services. This application can be used for either initial certification or recertification as well as expanded scope application.

The application must be used by the following ground EMS agencies seeking initial certification or recertification under 7 AAC 26.210 – 7 AAC 26.999:¹

- Basic Life Support (BLS) Services;
- Advanced Life Support (ALS) Services; and
- BLS services that sometimes provide ALS.

This application is not to be used for the certification of air medical services under 7 AAC 26.310 7 26.999 AAC

Returning the application:

For timely service, the application should be returned 45 days prior to expiration:

Mail to: EMS Ground Ambulance Certification
Department of Health and Social Services
Division of Public Health
Section of Emergency Programs
P.O. Box 110616
Juneau, AK 99811-0616

Deadlines

By statute, a “person, organization, or government agency that provides, offers, or advertises to provide an emergency medical service may not provide advanced life support services unless authorized under AS 18.08.082.”² Consequently, an applicant for initial certification as an out of hospital emergency medical service which intends to perform advanced life support must become certified before doing so.

Please include a copy of your current protocols(Offline Standing Orders) via weblink or included in mailing when sending in this application. Paste link into form directly below if online.

Weblink:

Questions

For answers to questions regarding the application or the application process, contact the Section of Emergency programs: EMS unit

Telephone: (907) 465-8741

Email: emsambulancecert@alaska.gov

¹ The regulations can be downloaded from the Section’s web site at: <http://www.chems.alaska.gov>

² AS 18.08.084

EMS OFFICE USE ONLY
Received: _____
Issued: _____
Expires: _____
Cert. #: _____

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL"
EMERGENCY MEDICAL SERVICE
GROUND AMBULANCE

Our organization is applying for:

Initial Certification
 Recertification as a/an:

Basic Life Support (BLS) Service
 BLS Service with ALS Available Some of the Time
 Advanced Life Support Service (ALS)

1. Legal Name of Organization/Agency: _____

2. National Provider Identifier (NPI): _____

3.

Address	
Mailing	Geographic/Physical (stations)

4. Head of Organization/Agency: _____ JobTitle: _____

5. Telephone of Head of Organization/Agency: _____ Business: _____
 Home: _____
 Fax (Business): _____
 e-mail contact: _____
 Web site: _____
 24-hour Dispatch number: _____ 911 E-911

6. Type of 'outside hospitals' emergency medical service (check one):

- | | |
|------------------------------|-------------------------------|
| Independent Vol. Service | Commercial |
| Hospital Based | Military |
| Fire Dept. Service | Industrial _____ |
| Volunteer Fire Dept. Service | Other (please specify): _____ |
| Police Dept. Service | |

7. Name of Designated Infection Control Officer for purposes of Ryan White activities (in the absence of service personnel trained in infectious disease issues and reporting, we recommend that the service's physician medical director serve as the Designated Officer):

Print _____ (Phone #) _____

8. Date physician-signed standing orders were last reviewed by physician: _____ Date _____ Revised by _____

9. List all physician medical directors: I verify that I will fulfill the requirements in state regulations 7 AAC 26.610 7 AAC 26.690, including annual review of treatment protocols (standing orders):

Medical Control Physician Contact Number: _____ Email: _____

#	Name	Alaska License #	Signature
1.			
2.			
3.			

Note: The physician medical director must sign before submitting application. (If the physician medical director is affiliated with the Indian Health Service or the military, please indicate state(s) of license and license number(s).

10. Name of person(s) responsible for continuing medical education program:

#	Name	Level (EMT1, 2,3 or MICP)	Certification #	Contact Telephone
1.				
2.				
3.				
4.				

11. Verify that you have all of the necessary equipment to perform medical procedures (basic and advanced) within the skill levels of available certified personnel. Use Appendix I "Inventory of Ambulance Supplies and Equipment," pages 5-9.

12. Check the appropriate box about enclosure of your EMS report form:

Enclosed Own Report Form Using Alaska EMS Prehospital Report (handwritten)	Using Aurora Database for EMS Report (Expanded Scope not permitted unless using Aurora)
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Enclosure of a copy of your EMS report form is required in regulations 7 AAC 26.245. If you do not have an EMS report form which meets state requirements, the Alaska Pre-Hospital Report Form (#06-1368) may be obtained from the Section of Emergency Programs, EMS Unit, Division of Public Health, Department of Health & Social Services, P.O. Box 110616, Juneau, Alaska, 99811-0616.

13. List all certified or licensed personnel, such as emergency medical technicians (EMTs) I, II, or III, mobile intensive care paramedics (MICPs), or other certified or licensed medical personnel, involved in the transportation and care of patients. (Indicate name, level of certification, certification/license number, and expiration date.)

#	NAME	LEVEL OF CERTIFICATE	STATE CERTIFICATE/ LICENSE NUMBER	EXPIRATION DATE
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Page 15 continues the list of personnel if needed

AFFIRMATION:

I hereby affirm that _____ (Name of Service) will comply with all rules and regulations of the Department of Health & Social Services 7 AAC 26.210 – 7 AAC 26.290, to include:

- 1a) **(For BLS services)** Having an Emergency Medical Technician I, and one other person to act as driver when using a surface transportation vehicle, available to respond to emergencies 24 hours a day.
- 1b) **(For ALS services)** Having an Emergency Medical Technician II or III, mobile intensive care paramedic, or other medical personnel certified or licensed to provide advanced life support (e.g., registered nurse, physician's assistant, or physician), and at least one other person trained to at least the basic emergency medical technician I level when using a surface transportation vehicle, available to respond to emergency calls 24 hours a day.
- 2) Providing a continuing medical education program that will enable certified emergency medical personnel to meet state recertification requirements;
- 3) Maintaining a direct communications capability with a physician, hospital, or mid-level practitioner, unless the Department grants a waiver due to technical communications problems. (If a waiver is requested, please submit and explain on a signed affidavit.)
- 4) Completing an approved EMS report form for each patient treated. The report form must document vital signs and medical treatment given the patient. A copy of the completed EMS form must:
 - a) accompany the patient to the treatment facility;
 - b) be sent to the physician medical director; and
 - c) be kept by the EMS service as a permanent record.

 (Printed Name of Head of Agency/Organization)

(Title): _____

(Signature): _____

(Date): _____

NOTARIZED STATEMENT:

In the presence of a notary public, postmaster, clerk of court, judge, magistrate, state trooper, or authorized state employee, if such official is available, applicant must sign here. **I certify under penalty of perjury that the foregoing is true and accurate.**

 (Signature of Applicant) (Date)

THIS IS TO CERTIFY that on this ____ day of _____, 20 ____, before me appeared _____, to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

 (Notary Public, Postmaster, Clerk of Court, or Judge, Magistrate, State Trooper, or authorized State employee)

My Commission Expires _____
 or
 My Badge Number is _____

APPENDIX I

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT

Please verify with a **check mark** that the following minimum Basic Life Support (BLS) equipment will be carried on board all ambulances at all times. An agency applying for certification or recertification as a BLS service needs only to complete the BLS equipment section of Appendix I. Agencies applying for certification as a BLS service providing Advanced Life Support (ALS) some of the time or as a full-time ALS service must complete the sections of this Appendix which relate to the skills used by the EMS agency's providers listed on page 3 of this application. If you are an EMT-III service, fill out the EMT-II and EMT-I sections, also. If you are a mobile intensive care paramedic service, complete the EMT-I, EMT II, EMT-III and MICP sections.

Basic Life Support (BLS) EQUIPMENT/SUPPLIES

VENTILATION AND AIRWAY EQUIPMENT:

- Oxygen, permanent - tank shall have a minimum capacity of 3,000 liters with reduction gauge & flowmeter
- Portable oxygen tank with regulator
- Adult bag-valve-mask with reservoir and mask
- Pediatric bag-valve-mask with reservoir and pediatric mask
- Infant bag-valve-mask with reservoir and infant mask
- Oxygen connection tubing
- Non-rebreathing masks, adult and pediatric sizes
- Oxygen masks, infant
- Oxygen cannulas, adult and pediatric
- Portable suction unit
- Suction catheters (6F-14F)
- Rigid suction tip (e.g., Yankaur)
- Pediatric bulb syringe
- Suction rinsing water bottle
- Oropharyngeal airways (00-5), adult, pediatric, and infant
- Nasopharyngeal airways, sizes 18F-34F or 4.5 - 8.5 mm
- Water-soluble lubricant

IMMOBILIZATION EQUIPMENT:

- Stretcher, main - shall be four-wheeled elevating cot for primary patient with appropriate patient restraining device
- Stretcher, portable - with appropriate patient restraining device
- Cervical collars, adult and pediatric
- Cervical immobilization device, adult and pediatric (sandbags may not be used)
- Long spine board
- Short backboard, KED, or equivalent
- Pediatric backboard, or equivalent
- Traction splint, adult and pediatric
- Extremity splints, adult and pediatric (e.g. vacuum, air, padded board, etc.)
- Infant car seat (desirable but not required)
- Restraints, patient

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT – continued

Advanced Life Support (ALS) EQUIPMENT/SUPPLIES

EMT-II EQUIPMENT/SUPPLIES:

Advanced Airway Device (Type: _____) and associated administration equipment

Naloxone HCl

50% Dextrose in Water

Balanced Salt Solution (e.g., normal saline)

Syringes of various sizes

Needles of various sizes

Three-way Stopcocks (desirable but not required)

Tubes for Blood Samples

Pediatric Medication Dosage Chart or Broselow Tape

IV Catheters (14-24 Gauge)

Intraosseous Needles

Mini (60 gtts/cc) and Macro (10, 12, or 15 gtts/cc) IV Drip Sets

Other EMT-II medications carried:

EMT-III EQUIPMENT/SUPPLIES:

Monitor/Defibrillator

Pediatric paddles/patches for defibrillator

Monitoring electrodes - adult and pediatric sizes

Defibrillator Gel/Pads

Lidocaine 1% or 2%

Lidocaine 20% or pre-mixed bag for drip

Morphine Sulphate

Epinephrine 1:1,000

Epinephrine 1:10,000

Atropine

Other EMT-III medications carried:

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued

PARAMEDIC EQUIPMENT/SUPPLIES: (Please indicate which paramedic medications you carry)

- Adenosine
- Albuterol
- Adenosine
- Aminophylline
- Amiodarone
- Diazepam
- Diphenhydramine
- Dopamine
- Furosemide
- Glucagon
- Metoprolol
- Midazolam
- Phenytoin
- Propranolol
- Thiamine
- Laryngoscope with blades, adult and pediatric sizes
- ET Tubes (uncuffed sizes 2.5 - 6.0; cuffed sizes 6.0 - 8.0)
- End tidal CO₂ detection device
- Magill Forceps – adult and pediatric sizes
- ET tube stylet - adult and pediatric sizes

Other MICP medications carried:

2. Equipment/supplies needed or missing (specify):

3. Please place a check mark next to the following optional equipment used by your service:

- Blood glucose monitoring system
- Automated external defibrillator
- Nebulizer system
- Nasogastric tubes

5. Please list other optional equipment or supplies you carry which you wish to have listed in your records (on attached sheet):

INVENTORY OF AMBULANCE SUPPLIES & EQUIPMENT - continued

6. Do you have sufficient equipment, supplies and medications to provide advanced life support procedures that are outlined in the standing orders signed by your physician medical director?

Yes No

7. Do you have equipment and supplies which enable you to comply with the OSHA/State bloodborne pathogen requirements (18 AAC 61.17)? Yes No Examples would be TB masks, redbags, sharps containers,, gloves and gowns. If "No," please explain:

8. List vehicles operated by the Service which require licenses:

#	MAKE (Chevy, Ford, etc.)	MODEL & YEAR	VEHICLE LICENSE NUMBER	FUNCTION (Ambulance, Fire, Rescue)
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Attach additional pages as necessary to provide information on each vehicle.

Additional Questions:

1. Do you have a narcotics storage policy? Yes No
2. Do you have an Orange Emergency Response Guide or hazmat guidebook in the ambulance?
Yes No
3. Do you have an adequate locking system for medication storage? Yes No
4. What is your primary resource hospital or clinic?
5. Who is the owner or administrative authority for your agency?
6. Is Emergency Medical Dispatch (EMD) provided to your EMS Agency's service area?

No (1213001)
Yes, 100% of the EMS Agency's Service Area (1213003)
Yes, Less than 100% of the EMS Agency's Service Area (1213005)

7. Does your EMS agency provide special training or services to your EMS service area/community?
Please select services provided or none if not applicable.

Air Rescue (1211001)	CBRNE (1211003)	Community Health Medicine (1211005)
Disaster Medical Assistance Team (DMAT) 1211007	Disaster Mortuary (DMORT) (1211009)	Dive Rescue (1211011)
Farm Rescue (1211013)	High Angle Rescue (1211015)	Machinery Disentanglement (1211017)
None of these (1211019)	Ski / Snow Rescue (1211021)	Tactical EMS (1211023)
Trench Confined Space Rescue (1211025)	Urban Search and Rescue (USAR) (1211027)	Vehicle Extrication (1211029)
Veterinary Medical Assistance Team (VMAT) (1211031)	Water or Ice Related Rescue (Incl Swift Water) (1211033)	Wilderness Search and Rescue (1211035)

8. Organization Status currently:

Mixed (1016001)	
Non-Volunteer (1016003)	
Volunteer (1016005)	

9. EMS Agency Tax Status:

For Profit (1018001)	Other (ex: Government) (1018003)	Not For Profit (1018005)
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10. Billing Status:

Yes (9923003)	No 9923001
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11. Any future improvements or changes in ambulance response in the works? Yes No

Explain any answers if needed

Application for Use of Additional Medications or Procedures

(7 AAC 26.670)

Department of Health and Social Services, EMS Unit

PO Box 110616, Juneau, AK 99811-0616
(907) 465-8741 FAX: (907) 465-4101

Regulations

7 AAC 026.670. Approval and or Renewal of Additional Medications and Procedures.

(a) In order for a medical director to authorize a state-certified EMT-I, EMT-II, or EMT-III to use additional medications or procedures not covered under [7 AAC 26.040](#)(a), (b), or (c), the medical director shall

- (1) submit to the Department a request for approval; the request must include a plan for training and evaluation covering the additional skills; and
- (2) if the request is approved, following the training and evaluation, send the Department a list of individuals who are authorized to use the additional medications or procedures.
- (3) expanded scope goes into effect once EMS office receives roster of trained individuals

Procedure for Reapproval

- If you seeking approval for additional medications and procedures other than the previously-approved items listed on page 12 below, please submit a plan for training and evaluation of the additional items(s).
- Sign and mail or fax this form to the EMS Unit along with certification
- Submit a roster of personnel authorized to administer the additional medications or procedures.

Physician Medical Director's Request for Reapproval

1. I have reviewed the program for additional medications and procedures approved by the EMS office under 7 AAC 26.670, which is summarized on page 2 below.
2. I request extension of the expanded scope approval through the 2-year certification period of my ambulance service.
3. I will continue to use the training and evaluation program described in my application which was approved by the EMS training division.
I will notify the office in writing of the following: when I authorize new medical personnel to perform these procedures; if I withdraw my authorization of an individual to perform these procedures; or if I withdraw my sponsorship of an EMT or EMTs or am no longer affiliated with the service.

Signature of Physician Medical Director

Date

Name of Physician Medical Director: _____

Name of Service: _____

Certification Level	Alaska Standard Scope of Practice	Additional Medications	Additional Procedures
<u>EMT I</u>	AED Manual defibrillation (if certified as a manual defibrillation technician) Ipecac Glucose (Glucose) Activated charcoal Aspirin 162-325 mg Assist patient in taking their own: <ul style="list-style-type: none"> • Nitroglycerin; • Epi-pens; and • MDI Albuterol 		
<u>EMT II</u>	All EMT-I procedures and medications plus: Approved advanced airway devices IV access Obtain blood for labs Glucometry Pediatric IO access Manual defibrillation (if certified as a manual defibrillation technician) Administer: <ul style="list-style-type: none"> • Narcan • D-50W • IV solutions: NaCl; LR; D5W 		
<u>EMT III</u>	All EMT-II procedures and medications plus: Monitor cardiac activity (3 or 12 lead) Manual defibrillation Monitor cardiac activity Contershock VF and pulseless VT Administer: <ul style="list-style-type: none"> • Epinephrine 1:1000 • Epinephrine 1:10,000 • Atropine • Lidocaine • Morphine 		

13. List all certified or licensed personnel, such as emergency medical technicians (EMTs) I, II, or III, mobile intensive care paramedics (MICPs), or other certified or licensed medical personnel, involved in the transportation and care of patients. (Indicate name, level of certification, certification/license number, and expiration date.)

#	NAME	LEVEL OF CERTIFICATE	STATE CERTIFICATE/ LICENSE NUMBER	EXPIRATION DATE
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