2012-2014
NORTH DAKOTA LICENSE APPLICATION FOR ADVANCED LIFE SUPPORT GROUND AMBULANCE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 53887
8/2012

Name of ALS Ground Ambulance Service	County

Where as, the above-named ambulance service provides emergency medical care and uses publicly or privately owned vehicles upon the streets or highways of this state for the transportation of persons who are sick, injured, wounded, or otherwise incapacitated or helpless, and holds itself to the public, or to its employees, for such a service or regularly provides such a service.

Where as, the above-named ambulance service will provide services which meet the standards of Chapter 23-27 of the North Dakota Century Code, and regulations promulgated by the State Health Council governing advanced life support ground ambulance service.

Application is hereby made to operate as a advanced life support ground ambulance service until midnight October thirty-first of the year 2014.

This license is nontransferable and substation ambulances may not operate independently outside the primary license holder. Substation ambulances must display the name of the headquarter ambulance on all vehicles. A licensing fee is required for each substation licensure.

The license fee of $50.00 and $50.00 for each substation is enclosed and made payable to:

North Dakota Department of Health.

Signature	Date

DEMST OFFICE USE ONLY
License Number
Date Issued
Substations
Amount Due
Approved by

STATE USE ONLY
Date Received
Amount Received
Cash MO Check Number _____

VEHICLE INFORMATION: ALS GROUND AMBULANCE

Name of ALS Ground Ambulance Service

☐ Check here if you have updated your vehicle roster online. If so you may leave this page blank.

PLEASE LIST AND DESCRIBE YOUR AMBULANCE VEHICLE(S)

1

Unit Number (Radio)					Year	Make
VIN Number						Mileage
Ambulance Cell Phone Number						Type of Vehicle ☐ Type I ☐ Type II ☐ Type III

2

Unit Number (Radio)					Year	Make
VIN Number						Mileage
Ambulance Cell Phone Number						Type of Vehicle ☐ Type I ☐ Type II ☐ Type III

3

Unit Number (Radio)					Year	Make
VIN Number						Mileage
Ambulance Cell Phone Number						Type of Vehicle ☐ Type I ☐ Type II ☐ Type III

4

Unit Number (Radio)					Year	Make
VIN Number						Mileage
Ambulance Cell Phone Number						Type of Vehicle ☐ Type I ☐ Type II ☐ Type III

OFFICERS: ALS GROUND AMBULANCE

Name of ALS Ground Ambulance Service

Please name the individual and the mailing address to be used for official mailings to your ambulance service from DEMST.

SQUAD LEADER

Name			
Title			
Mailing Address			
UPS Address			
City		State	ZIP Code
Home Telephone Number	Work Telephone Number	Cell Phone Number	
Squad Leader E-mail Address		Fax Number	
Service E-mail Address			

MEDICAL DIRECTOR

Name			
Address		City	
State	ZIP Code	E-mail Address	
Home Telephone Number		Work Telephone Number	

I hereby affirm that all information entered on this license application is true and correct to the best of my knowledge. I understand that any fraudulent entries may be sufficient cause for rejection or revocation of agency licensure.

I further agree to notify the North Dakota Department of Health Division of EMS and Trauma immediately if any changes in status occur. I agree that this ground ambulance service completes a trip ticket for each call and submits the required data to the Division of EMS and Trauma within 30 days of the call.

Signature	Date

ALS GROUND AMBULANCE

Name of ALS Ground Ambulance Service		
Physical Address of Service		
City	State	ZIP Code
Mailing Address of Service		
City	State	ZIP Code

OWNERSHIP

Name of Exact Ownership of Service				
Please check one:	☐ Hospital Based	☐ Fire Based	☐ Private / Independent	☐ Government / Non-Fire Entity

TYPE OF CONTROL

Governmental	☐ County	☐ Municipal	☐ County and City	☐ Tribal	☐ Federal
Non-profit	☐ Corporation		☐ Association		
For-profit	☐ Individual		☐ Partnership		☐ Corporation
Is your corporation / partnership / association listed as "In Good Standing" with the North Dakota Secretary of State?				☐ Yes	☐ No

STAFFING

Please check one:	☐ Volunteer	☐ Paid	☐ Combination
Number of staff members on a scheduled shift			
What type of shifts are service personnel scheduled?			
☐ 8 hours ☐ 12 hours ☐ 16 hours ☐ 24 hours ☐ 1 week ☐ 2 weeks ☐ Other Please explain			
Are substations staffed in the same manner?	☐ Yes	☐ No	☐ Not Applicable

VEHICLE AND LIABILITY INSURANCE CARRIERS

Name of Vehicle Insurance Company		
Agent Name	Agent Address	
City	State	ZIP Code
Name of Medical Liability Insurance Company		
Agent Name	Agent Address	
City	State	ZIP Code

MILL LEVY

Does the service have a mill levy in place?	☐ Yes	☐ No
If yes: Number of mills	Amount Received	

AMBULANCE PERSONNEL ROSTER: ALS GROUND AMBULANCE

☐ Check here if you have updated your vehicle roster online. If so you may leave this page blank.

NOTE: State ID numbers are required. Application will be rejected if this information is not provided. If this is a new or an initial application include EMS registration forms or ALS licensure forms.

First Name	Last Name	State ID Number	Provider Level

AMBULANCE PERSONNEL ROSTER, CON'T: ALS GROUND AMBULANCE

First Name	Last Name	State ID Number	Provider Level

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Name of ALS Ground Ambulance Service		Date
Name of Person Completing Application		Title
Telephone Number	Total Number of Ambulances in Service	

Please make copies if additional pages are needed.

Item **Please place an "X" in boxes if stocked.**

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Mounted ambulance cot with retaining straps				
Stretchers with retaining straps. Vehicle design dictates quantity.				
Piped oxygen system - with appropriate regulator and flow meter, or two "E" size bottles for minimum oxygen supply with regulator and flow meter				
Portable oxygen unit with carrying case. To include one "D" size bottle with another "D" bottle in reserve				
Three nasal cannula, three non-rebreather oxygen masks in adult sizes, and three sets of oxygen supply tubing				
Suction wall mounted and portable capable of achieving 400 mm/hg 4 seconds or less, w/catheters in adult sizes, rigid and soft				
Bag valve mask resuscitation units in infant, child and adult sizes with appropriate sized face masks or pocket masks with oxygen inlet in infant, child and adult sizes				
Spine boards - one full size and one half size - with retaining straps				
Head to board immobilization device				
Commercial fracture splints usable for open and closed fractures or padded boards usable for pediatric and adult patients				
Hot packs - four minimum				
Cold packs - four minimum				
Activated Charcoal				
Obstetrical Kit - disposable or sterile				
Soft roller self adhering bandages - five yards (4.75 meters) long - twelve minimum				
Sterile burn sheets - two minimum				
Triangular bandages - three minimum				
Sterile gauze pads - four inches (10.16 centimeters) by four inches - twenty five minimum				
Trauma dressing - approximately 10 inches by thirty six inches - two minimum				
Nasopharyngeal airways in adult and child sizes - one set minimum				
Oral airways in adult and child sizes - one set minimum				
Sterile occlusive dressings - approximately three inches by nine inches				
Tape - assorted sizes - four rolls minimum				
Blunt Shears - two minimum				
Lower extremity traction splint				
Disposable gloves - small, medium and large - one box each min.				

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Please make copies if additional pages are needed.

Please place an "X" in boxes if stocked.

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Bedpan, emesis basin and urinal - single use or sterilizable; one each minimum				
Distilled water or saline solution - one gallon minimum				
Flashlights - two minimum				
Reflectorized flares for securing scene - three sets minimum				
Red biohazard bags - three minimum				
Cervical collars - small, medium and large one each minimum				
Two blankets, two pillows, four sheets and four towels.				
Tubiculcidal disinfectant product				
Fire extinguisher - dry chemical, mounted, five pound (2.27 Kg) minimum				
Intravenous fluid holder - cot mounted or ceiling hook				
Stethoscope with adult and pediatric capabilities				
Blood pressure manometer with cuff size in large adult, adult, child and infant				
Endotracheal airway equipment - pediatric and adult				
Manual cardiac monitor defibrillator with pediatric capabilities				
IV therapy equipment - catheters, tubing, solution - pediatric and adult				
Syringes and needles - assorted sizes				
Glucose measuring device				
Nebulizer with tubing				
Pediatric weight and length based drug chart or tape				
Twenty-five triage tags				
Pulse oximeter				
Reflectorized flares for securing scene - 3 sets minimum				
Twenty-five triage tags				
VHF radio with capabilities of meeting EMS standards as determined by the department				
Portable radio capable of reaching law enforcement & hospitals				
Personal protection equipment, such as mask, non-absorbant gown, protective eyewear - four each minimum				
Biological fluid cleanup kit				
Reflective vest - minimum of two				
Pediatric backboard				
Pediatric traction splint				
Appropriate pediatric reference material				
Pulse oximeter				
Written treatment protocols				
Narcotic				
Antidysrhythmic				

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Please make copies if additional pages are needed.

Please place an "X" in boxes if stocked.

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Anticholinergen parasympatholic				
Opiod antagonist				
Coronary vasodialator, antiaginal				
Antianxiety				
Caloric				
Alkalinizer				
Broncodilator, adrenergic IV or SQ, also handheld or nebulized				
Anticonvulsant				

Additional Equipment (not required by DEMST)

Infant / child car seat				

MEDICAL DIRECTOR AGREEMENT: ALS GROUND AMBULANCE

INSTRUCTIONS: This form must be completed with each ambulance licensure application or at any time a change or addition of medical directors is made. All ALS personnel license applications, etc. must be signed by the medical director on record or they will be returned. A current medical director agreement must be on file for each service at all times.

PHYSICIAN MEDICAL DIRECTOR

First Name		Last Name	MI
Street Address / PO Box		City	
State	ZIP Code	Telephone Number	
ND License Number			
Name of ALS Ground Ambulance Service			

I, the above-named physician, agree to function as Physician Medical Director for the above-named Ambulance Service, it's associated substation units and/or Quick Response Unit(s). As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service and its associated substation(s) and/or Quick Response Unit(s). The emergency medical services personnel working either as volunteers or as compensated employees for these services are acting as my designated agents when providing patient care. It is my duty to assure that a system for quality improvement / quality assurance is developed and implemented. I will provide input on training issues and provide online medical direction when necessary.

The expiration date of this agreement will coincide with the expiration date of the ambulance or may be terminated upon written notification to the Division of Emergency Medical Service and Trauma.

☐ Remove previous medical director from service roster.	
☐ Add to service roster as additional medical director.	
Medical Director Signature	Date

DISPATCHING: ALS GROUND AMBULANCE

Who dispatches your service? (Check all that apply)	☐ County	☐ State Radio	☐ Hospital	☐ Nursing Home
	☐ Other (Please explain)			

Name of emergency dispatching agency	
Location (City)	Contact Phone Number

Is a 911 call center able to dispatch your service directly?	☐ Yes	☐ No
If no, who does the 911 call center contact in order to dispatch?		
List any numbers (other than *911) the service may be dispatched by		

How are your personnel notified?	☐ Pager	☐ Radio	☐ Telephone	☐ Other (Please explain)

Substation License

Please Note: Leave this area blank if your service does not have substations. If the substation ambulance is located within headquartered service area (city limits), substation licensure does not apply. Substations must display headquartered ambulance services name on all units. For each licensure only one roster is permissible. Contact person must be registered under service's personnel roster.

Substation 1

Location of Substation (city)	
Physical Address	ZIP Code
Unit Number(s)	Contact person of substation ambulance

Substation 2

Location of Substation (city)	
Physical Address	ZIP Code
Unit Number(s)	Contact person of substation ambulance

Substation 3

Location of Substation (city)	
Physical Address	ZIP Code
Unit Number(s)	Contact person of substation ambulance

Substation 4

Location of Substation (city)	
Physical Address	ZIP Code
Unit Number(s)	Contact person of substation ambulance

MUTUAL AID AGREEMENT: ALS GROUND AMBULANCE

List ambulance services that this service has formal written agreements with for mutual aid. If no agreements have been made, leave this area blank.

Service	City

Click here to print completed form.
Sign and mail with payment to the address below.

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF ACCOUNTING
600 E. BOULEVARD AVE. DEPT 301
BISMARCK, ND 58505-0200