2013 - 2015
NORTH DAKOTA LICENSE APPLICATION FOR QUICK RESPONSE UNIT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
600 E BOULEVARD AVE DEPT 301
BISMARCK ND 58505-0200
SFN 53888 (3-13)

Name of Quick Response Unit	
City	County

Whereas, the above-named Quick Response Unit, uses publicly or privately owned vehicles upon the streets or highways of this state for the response to 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.

Whereas, the above-named Quick Response Unit, 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 Quick Response Units.

Application is hereby made to operate as a Quick Response Unit until midnight June thirtieth of the year 2015.

Application must be returned in it's entirety in order to be considered for licensure in ND.

Signature	Date

DEMST OFFICE USE ONLY

License Number
Date Issued
Approved by

LIST OFFICERS FOR

Name of Quick Response Unit

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		

CONTACT PERSON: To receive official DEMST mailings. (If applicable other than squad leader)

Name:		
Address:		City:
State:	Zip:	E-mail Address:
Home Telephone Number:		Work Telephone Number:

SERVICE INFORMATION: Please list appropriate information for the service.

Mailing Address:		City:
Physical Address of Service:		City:
State:	Zip:	E-mail Address:
Telephone Number:		Fax 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 Quick Response Unit completes a trip ticket for each call and submits the required data to the affiliated ambulance service.

Signature	Date

QUICK RESPONSE UNIT OWNERSHIP

Owner of service:		
Address:		
City:	State:	Zip:
What best describes who owns the service, please check one:		
☐ Hospital Based	☐ Fire Based	☐ Private / Independent	☐ Government / Non-Fire Entity

TYPE OF CONTROL (Check one)

☐ Private	☐ County	☐ Municipal	☐ County and City	☐ Tribal	☐ Federal

STAFFING

☐ Volunteer	☐ Paid	☐ Combination	
Do you schedule personnel to cover shifts?	☐ Yes	☐ No	
What level of care does your service provide?	☐ BLS	☐ ALS	☐ Both

DISPATCHING

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?				
Other than *911 are there any other phone number(s) your service may be dispatched by? *(if so please list)*				
How are your personnel notified?	☐ Pager	☐ Radio	☐ Telephone	☐ Other (Please explain)

MILL LEVY

Does your service have a mill levy in place?	☐ **YES**	☐ **NO**
If yes please list the following:	Number of Mills _____	Amount Received _____

QUICK RESPONSE UNIT PERSONNEL ROSTER

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

QUICK RESPONSE UNIT CHECKLIST OF REQUIRED EQUIPMENT

Name of QRU:	Date:
Name of Person Completing Report:	Title:

QUICK RESPONSE UNIT MINIMUM EQUIPMENT

- ☐ 1 - Automatic External Defibrillator (AED)
- ☐ 1- Blood pressure manometer cuff in child, adult, and large adult sizes; and stethoscope
- ☐ 4 each - Disposable gloves - In size small, medium and large
- ☐ 1- Blunt shears
- ☐ 1 - Portable suction device with catheter
- ☐ 1 - Portable oxygen unit size "D" with variable flowmeter
- ☐ 2 each - Nasal cannula, non-rebreather mask, and supply tubing
- ☐ 1 each size - Nasopharyngeal airways (adult and child sizes)
- ☐ 1 each size - Oropharyngeal airways (adult, child and infant sizes)
- ☐ 2 - Cold packs
- ☐ 4 - Hot packs
- ☐ 2 - Space blankets
- ☐ 12 - 4 inch X 4 inch sterile gauze pads
- ☐ 3 - Sterile soft roller self adhering bandages
- ☐ 4 - Rolls of medical tape
- ☐ 2 - Sterile occlusive dressings
- ☐ 1 - Sterile multi-trauma dressing approximately 10 x 36 inches
- ☐ 1 - Sterile burn sheet or its equivalent
- ☐ Equipment case
- ☐ Equipment storage - readily accessible and safe from the elements

QRU / AMBULANCE SERVICE AFFILIATION AGREEMENT

AFFILIATED SERVICE INFORMATION: Please list appropriate information for the affiliated service.

Name of Ambulance Service:			License Number:
Name of Ambulance Squad Leader :			License Number:
Mailing Address:			City:
Physical Address of Service:			City:
State:	Zip:	E-mail Address:	
Telephone Number:		Fax Number:	

I, the current squad leader/manager for the above-named ambulance service agree to assume affiliation with Quick Response Unit(s) (QRU) listed within this application. As a licensed ambulance service representative, 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 QRU(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. This ambulance service will provide input on training issues and provide online medical direction when necessary.

This agreement expires at midnight on June thirtieth of the year 2015, or may be terminated by the QRU or the ambulance service upon written notice to Division of Emergency Medical Services and Trauma.

Signature	Date

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