2012-2014
NORTH DAKOTA LICENSE APPLICATION FOR CRITICAL CARE AIR AMBULANCE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 53889
8/2012

Name of Air Ambulance Service	County

Where as, the above-named ambulance service provides emergency medical care and uses publicly or privately owned aircraft in the airspace 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 critical care air ambulance service.

Application is hereby made to operate as a critical care air ambulance service until midnight October thirty-first of the year 2014.

This license is nontransferable and a licensing fee of $50.00 is required at time of submission and must be 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: AIR AMBULANCE

Name of Air 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 AIRCRAFT(S) USED AS CRITICAL CARE AIR AMBULANCE

1

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Registered Owner of Aircraft	☐ Multi Engine

2

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Registered Owner of Aircraft	☐ Multi Engine

3

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Registered Owner of Aircraft	☐ Multi Engine

4

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Registered Owner of Aircraft	☐ Multi Engine

OFFICERS: AIR AMBULANCE

Name of Air 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 air 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

AIR AMBULANCE

Name of Air 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

TYPE OF CONTROL

Non-profit	☐ Corporation	☐ Association	
For-profit	☐ Individual	☐ Partnership	☐ Corporation
Is your entity listed with the North Dakota Secretary of State? If no, list the state the entity is listed with.	☐ Yes ☐ No	State	

STAFFING

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 Explain					

AIRCRAFT AND LIABILITY INSURANCE CARRIERS

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

DISPATCHING

Who dispatches your service? (Check all that apply)	☐ County	☐ State Radio	☐ Hospital	☐ Nursing Home
	☐ Other	Explain		
City	State	ZIP Code		
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 Explain

AMBULANCE PERSONNEL ROSTER: AIR 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: AIR AMBULANCE

First Name	Last Name	State ID Number	Provider Level

CHECKLIST OF REQUIRED EQUIPMENT: AIR AMBULANCE

Name of Air 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.

Please place an "X" in boxes if stocked.

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Patient litter or stretcher				
Stethoscope				
Blood pressure cuff with aneroid gauge				
Manual suction with assorted rigid and soft catheters				
One set of oropharyngeal airways				
One set of nasopharyngeal airways				
Oxygen administration system, including a protective pressure gauge, a non-gravity dependent flowmeter, supply tubing, a non-rebreather mask and a nasal cannula. The unit must be capable of achieving an oxygen delivery flow rate of at least 15 liters per minute for one hour.				
Mouth-to-mask artificial ventilation device with supplemental oxygen inlet port such as a pocket mas, suitable for use on infant through adult patients. This may be replaced with bag valve mask devices with masks for infant, child and adult patients.				
A suction unit capable of providing free airflow of at least 20 liters per minute and achieving a minimum of 300 millimeters of mercury vacuum within four seconds. Must include an assortment of soft and rigid catheters in both pediatric and adult sizes.				
Intravenous equipment and supplies for both pediatric and adult patients.				
Two intravenous bag holders with straps				
Endotracheal intubation equipment and supplies for both pediatric and adult patients				
Cardiac monitor-defibrillator and supplies with pediatric and adult capabilities				
A drug box / bag that contains drugs that have been ordered by the medical director of the ambulance service				
Equipment and supplies necessary to provide level of care as ordered by medical director				
Transport ventilator				
Intravenous infusion pump				

MEDICAL DIRECTOR AGREEMENT: AIR 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 Air Ambulance Service			

I, the above-named physician, agree to function as Physician Medical Director for the above-named Ambulance Service. As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service. The emergency medical services personnel working as compensated employees for this service 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

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