2010-2012
NORTH DAKOTA LICENSE APPLICATION FOR ADVANCED LIFE SUPPORT GROUND AMBULANCE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
600 E BOULEVARD AVE DEPT 301
BISMARCK ND 58505-0200
SFN 53888 (1-08, 8-10)

Whereas, the _____ ,
(Name of Ground Ambulance Service)

in the City of _____, County of _____

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.

Whereas, the _____ ,
(Name of Ground 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 2012.

This license is nontransferable and substation ambulances may not operate independently outside the primary license holder. Substation ambulances must display name of headquartered ambulance service and a 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**

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

Please return completed application to:
ND Department of Health
Division of Accounting
600 E. Boulevard Ave Dept 301
Bismarck, ND 58505-0200

FOR STATE USE ONLY
Date Received: _____
Amount Received: $_____
Cash MO or CK#_____

GROUND AMBULANCE VEHICLE INFORMATION

☐ Check Here if Completed Online (if so nothing more is required on this page)

PLEASE LIST AND DESCRIBE YOUR AMBULANCE VEHICLE(S) INCLUDING ANY VEHICLES LOCATED AT SERVICE SUBSTATION(S):

1

Unit Number (Radio)				Year	Make	
VIN#					Mileage	
☐ Primary Vehicle	☐ Backup Vehicle			☐ Type I	☐ Type II	☐ Type III
Is this a substation vehicle? ☐ Yes ☐ No			Ambulance Cell Phone Number			

2

Unit Number (Radio)				Year	Make	
VIN#					Mileage	
☐ Primary Vehicle	☐ Backup Vehicle			☐ Type I	☐ Type II	☐ Type III
Is this a substation vehicle? ☐ Yes ☐ No			Ambulance Cell Phone Number			

3

Unit Number (Radio)				Year	Make	
VIN#					Mileage	
☐ Primary Vehicle	☐ Backup Vehicle			☐ Type I	☐ Type II	☐ Type III
Is this a substation vehicle? ☐ Yes ☐ No			Ambulance Cell Phone Number			

4

Unit Number (Radio)				Year	Make	
VIN#					Mileage	
☐ Primary Vehicle	☐ Backup Vehicle			☐ Type I	☐ Type II	☐ Type III
Is this a substation vehicle? ☐ Yes ☐ No			Ambulance Cell Phone Number			

LIST OFFICERS FOR

_____
(Name of Ground Ambulance Service)

SQUAD LEADER:

Name:			
Address:			City:
State:	Zip:	E-mail Address:	
Home Phone #		Work Phone #	

MEDICAL DIRECTOR:

Name:			
Address:			City:
State:	Zip:	E-mail Address:	
Home Phone #		Work Phone #	

Please name the individual and the mailing address you wish this office to use when making official mailings to your ambulance service.

CONTACT PERSON:

Name:			
Title:			
Mailing Address:			
UPS Address:			
City:		State:	Zip:
Home Phone #	Work Phone #	Cell Phone #	
E-mail Address:			

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.

I FURTHER AGREE TO NOTIFY THE NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF EMERGENCY MEDICAL SERVICES & 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 EMERGENCY MEDICAL SERVICES WITHIN 30 DAYS OF THE CALL.

_____ _____
Signature Date

GROUND AMBULANCE OWNERSHIP

Name of Exact Ownership of Service:		
Address:		
City:	State:	Zip Code:
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

Governmental	☐ County ☐ Municipal ☐ County and City ☐ Tribal ☐ Federal
Non Profit	☐ Corporation ☐ Association
For Profit	☐ Individual ☐ Partnership ☐ Corporation

STAFFING

☐ Volunteer ☐ Paid ☐ Combination

Do you schedule personnel to cover on certain shifts?	☐ Yes	☐ No

If you answered "no" no further information is needed on this section. If answered "yes" please complete the following

How many staff members do you have on a scheduled shift?	

What type of shifts are your personnel scheduled?	☐ 8 Hours	☐ 12 Hours	☐ 16 hours	☐ 24 Hours	☐ 1 week	☐ 2 weeks
	☐ Other (please explain)					

Do you staff your substation in the same manner? ☐ Yes ☐ No ☐ Not Applicable

VEHICLE AND LIABILITY INSURANCE CARRIERS

Name of **Vehicle** Insurance Company		
Agent's Name	Address of Agent	
City	State	Zip Code
Name of **Medical Liability** Insurance Company		
Agent's Name	Address of Agent	
City	State	Zip Code

MILL LEVY

Does your service have a mill levy in place? ☐ **YES** ☐ **NO**

If yes please list the following: Number of Mills _____ Amount Received _____

AMBULANCE PERSONNEL ROSTER

☐ Check Here if Completed Online (If so, nothing more is required on this page)

NOTE: State ID Numbers are Required!

First Name	Last Name	State ID Number (6 digit)	Provider Level

AMBULANCE PERSONNEL ROSTER CONT.

First Name	Last Name	State ID Number (6 digit)	Provider Level

Checklist of Required Equipment

North Dakota Licensed Advanced Life Support Ground Ambulance

Name of EMS Agency	Date
Name of Person Completing Report	Title
Phone Number	Total # 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 #	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 pediatric and 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 and pediatric 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 3 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.					
Sharps container - two w/one less than half full					

Bedpan, emesis basin and urinal - single use or sterilizable one each minimum					
Distilled water or saline solution - one gallon minimum					
Intravenous fluid holder - cot mounted or ceiling hook					
Flashlights - two minimum					
Reflectorized flares for securing scene -3 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					
Stethoscope w/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					
VHF radio with capabilities of meeting EMS standards as determined by the department					
Portable radio capable of reaching Law Enforcement and Hospitals					
IV Therapy equipment - catheters, tubing, solution. pediatric & adult					
Syringes and needles - Assorted sizes					
Personal protection equipment, such as mask, non-absorbant gown, protective eyewear - four each minimum					
Biological fluid cleanup kit					
Glucose measuring device					
Nebulizer w/tubing					
Pediatric weight and length based drug chart or tape					
Pediatric traction splint (required by July 1, 2011)					
Pediatric backboard (required by July 1, 2011)					
Reflective vest - minimum of 2					
Narcotic					
Antidysrhythmic					
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 DEMS)					
Infant/Child car seat					

Medical Director Agreement

Physician Medical Director

Name: _____

Mailing Address:_____

City:_____

State:_____

Zip Code:_____

ND License #_____

I, Dr. _____agree to function as Physician Medical Director for _____Ambulance Service, its 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.

This agreement expires at midnight on October thirty-first of the year 2012, or it may be terminated by me or the ambulance service upon written notice to Division of Emergency Medical Services & Trauma.

_____ _____

Signature Date

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)

Substation License Please Note: Leave this area below blank if your service does not have substations. If the ambulance station is located within the city limits already served by a headquartered ambulance service, substation licensure is not required. Substations must display the name of the headquarters ambulance service on all units. All substation personnel must be on the roster of the headquarters ambulance service. The contact person must be a certified or licensed EMS provider in North Dakota.

Substation 1

Location of Substation (city)	
Physical address	Zip Code
Unit Number(s)	Contact Person of Ambulance

Substation 2

Location of Substation (city)	
Physical address	Zip Code
Unit Number(s)	Contact Person of Ambulance

Substation 3

Location of Substation (city)	
Physical address	Zip Code
Unit Number(s)	Contact Person of Ambulance

Substation 4

Location of Substation (city)	
Physical address	Zip Code
Unit Number(s)	Contact Person of Ambulance

Please contact the Division of Emergency Medical Services if you license more than four substations

Please list ambulance services that you have a formal written agreement with for mutual aid. If you do not have any agreements, please leave blank.

Service	City
Service	City
Service	City
Service	City
Service	City
Service	City
Service	City
Service	City
Service	City

Please list any Quick Response Units that you have agreements or respond to emergency calls with.

Service	City
Service	City
Service	City
Service	City
Service	City

Please return completed application to:

ND Department of Health
Division of Accounting
600 E. Boulevard Ave Dept 301
Bismarck, ND 58505-0200