



**NORTH DAKOTA APPLICATION FOR
LIGHT RESCUE SERVICE CERTIFICATION**
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
SFN (0604)

CERTIFICATION PERIOD:

Certification shall expire midnight on June 30 of the last year of issuance. Certification renewal shall be on a biennial basis

CERTIFICATION APPLICATION:

Application for certification shall be made on application forms available from the Division of Emergency Medical Services. (DEMS)

AVAILABILITY OF RESCUE SERVICE:

The rescue Service must be available for call seven days a week, 24 hours a day, and shall respond to all emergencies when called. The Rescue Service must demonstrate the existence of an established dispatch system, which is compatible to the area served.

TRAINING STANDARDS FOR THE LIGHT RESCUE SERVICE:

Five (5) rescue service personnel must be currently certified in CPR to the Heart Saver Certification or its equivalent, a standard 8 hour first aid course and the North Dakota Automobile Extrication (12 hour) Certification. ***Medical and extrication personnel should conduct ongoing cross-training so both roles can be shared in times where there is limited availability of either resource.***

OTHER REQUIREMENTS:

1. The name, address, level of certification, and telephone numbers of the rescue service squad leader must be kept on file with DEMS. In addition to other appropriate duties, the squad leader shall:
 - a. Coordinate efforts with other local EMS services.
 - b. Inspect and maintain equipment.
 - c. Establish and maintain a personnel roster.
 - d. Maintain attendance records for the replacement of inactive members.
 - e. Establish a recruiting and retention program.
 - f. Provide general record-keeping for the rescue service.
 - g. Be responsible for making sure each member is outfitted with NFPA approved personal protective equipment to include: fire or rescue helmet, eyewear (safety glasses or goggles), bunker gear or extrication coveralls, hand protection (extrication or fire gloves), foot protection with steel toes, hearing protection and respiratory protection.
2. The rescue service shall utilize a standardized run reporting system. (Copies available at DEMS)
3. The DEMS may periodically inspect the equipment and vehicle utilized by the rescue service.

Complete the attached checklist For the Light Rescue Service minimum equipment.

Complete the attached Light Rescue Service personnel roster.

**LIGHT RESCUE SERVICE NORTH DAKOTA APPLICATION FOR
CERTIFICATION**

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES

Name & location of Rescue Service:

Name of unit: _____

City, State, Zip: _____

Will the Rescue Service utilize a standardized run reporting system? (A copy of the state's Emergency Medical Services Rescue Trip Ticket is available)

Will the Rescue Service be available for calls seven days per week, 24 hours per day, and will the Rescue Service respond to all emergencies when called?

Describe the Rescue Service's dispatch system:

Describe the storage that will be utilized for the Rescue Service equipment:

Complete the attached checklist For the Light Rescue Service minimum equipment.

Complete the attached Light Rescue Service personnel roster.

Name of Light Rescue Service

Signature

Title

Date

DEMS OFFICE USE ONLY

Certification #

Date Issued

CHECKLIST FOR

(Name of Light Rescue Service)

LIGHT RESCUE SERVICE RESCUE AND VEHICLE EQUIPMENT

RESCUE QUALITY AIR GUN SYSTEM TO INCLUDE THE FOLLOWING:

1 – air gun with spare quick-connect couplings for hose to gun

1 – T-bar chisel

1 – Long flat chisel

1 – Short flat chisel

1 – Pressure regulator

3 – 30 minute or greater compressed air bottles that are currently tested, connecting hoses

FIREMENS AXE

4 X 8 FIRE RETARDANT RESCUE BLANKETS – 2 EACH. (FOR PATIENT PROTECTION

ALUMINIZED RESCUE BLANKET

LONG AND SHORT HARD PROTECTION (long and short boards)

FORCIBLE ENTRY BAR

36 INCH BOLT CUTTER

HEAVY DUTY BATTERY CABLE CUTTERS

4000 LB CABLE COME-ALONG – 2 EACH

ALLOY STEEL CHAINS, DESIGNED FOR USE WITH COME-ALONG (call rescue company for sizes)

6 LB SLEDGE HAMMER

CRIBBING : 8 - 2 X 4 X 18 INCH, 8 - 4 X 4 X 18 INCH, 4 – STOP CHOCKS, 4 – 4 X 4 WEDGES

4 – QUALITY HACKSAWS WITH SPARE BLADES

HIGH LIFT JACK (farmer jack)

SPRING LOADED CENTER PUNCH

SOCKET WRENCH SET AND ASSORTED SCREW DRIVERS

VEHICLE EQUIPMENT

20 LB ABC DRY CHEMICAL EXTINGUISHER, OR PUMPER WITH FOAM CAPABILITIES

4 HIGH OUTPUT BATTERY POWERED LIGHTS

TWO-WAY MOBILE RADIO CONFIGURED TO DEMS SPECIFICATIONS

D-HANDLED SPADES - 2

100 FEET OF HIGH STRENGTH ROPE

DOT EMERGENCY RESPONSE GUIDE

**CHECKLIST
FOR**

(Name of Light Rescue Service)

LIGHT RESCUE SERVICE MEDICAL EQUIPMENT

	GLOVES – MEDICAL / NON LATEX - SIZE SMALL, MEDIUM, AND LARGE
	POCKET MASK WITH ONE-WAY VALVE
	GOGGLES FOR EYE PROTECTION
	COMMERCIAL SPLINTS – 1 SET LONG, 2 SETS SHORT
	ONE BLUNT BANDAGE SHEARS
	TWO STERILE BURN SHEETS OR EQUIVALENT
	SOFT ROLLER SELF-ADHERING BANDAGES, STERILE - DOZEN
	BANDAIDS – 1 BOX OF 100
	MEDICAL TAPE – 3 ROLLS
	STERILE GAUZE PADS – 24 EACH
	MULTI-TRAUMA DRESSINGS, APPROXIMATELY 30" X 10" – 2 EACH
	BLANKETS – 2 EACH
	TRIANGULAR BANDAGES – 3 EACH
	HOT PACKS – 4 EACH
	COLD PACKS – 4 EACH
	EQUIPMENT CASE

LIST OF OFFICERS FOR

(Name of Light Rescue Service)

PLEASE PRINT and complete the following information:

SQUAD LEADER:

Name:
Address:
Home Phone #:
Work Phone #:

TRAINING OFFICER:

Name:
Address:
Home Phone #:
Work Phone #:

PHYSICIAN MEDICAL DIRECTOR:

Name:
Address:
Home Phone #:
Work Phone #:

PHARMACY:

Name:
Address:
Work Phone #:

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

CONTACT PERSON:

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

I hereby attest the Light Rescue Service is minimally equipped as indicated on the equipment checklist provided, and attest to the certifications and expirations listed on the squad roster as completed in this application.

SIGNATURE _____ TITLE _____