EMS TRAINING INSTITUTION LICENSURE APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 60909 (8/2015)

PLEASE PRINT CLEARLY.
NOTE: All information must be completed before this form is submitted. Applications will be returned if any required information is missing.
Application must include payment of $75 payable to: ND Department of Health.

Date		
Facility	Business Telephone Number	
Address	City	ZIP Code
Program Director	Home Telephone Number	
Address	City	ZIP Code
E-Mail Address	ND EMS Number	
Medical Director	Telephone Number	
Address	City	ZIP Code
E-Mail Address	ND License Number	
Contact Person	Telephone Number	
Address	City	ZIP Code
E-Mail Address	ND License Number	

STATEMENT OF ACCURACY

I hereby affirm and declare that the information in this document is true and correct and that any fraudulent entry may be considered sufficient cause for rejection and revocation. I further agree to notify the ND State Department of Health - Division of EMS and Trauma immediately if any changes occur.

Signature	Date

Application checklist:
☐ Completed application form
☐ Copy of Institution's Student Policy Book
☐ Copy of Institution's Instructor Policy Book
☐ Student Application Form
☐ $75 Fee payable to: ND Department of Health

When all completed application materials are received, you will be contacted to set up a verification visit by DEMST. Prior to this visit please review the EMS Training Institution Guidebook an make all necessary preparations.

Sign and mail with payment and all required documents to the address below.

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

DEMST OFFICE USE ONLY
License Number
Date Application Received
Site Visit Date
Date License issued

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

Training Institution License Number			
OWNERSHIP OF TRAINING INSTITUTION			
Name	Telephone Number		
Address	City	State	ZIP Code
Name	Phone		
Address	City	State	ZIP Code
Name	Telephone Number		
Address	City	State	ZIP Code
OFFICERS			
Name	Title		
Name	Title		
Name	Title		
Name	Title		

INSTRUCTORS
List only the instructors that are currently licensed as a ND Instructor/Coordinator or Continuing Education Coordinator (CEC) and affiliated with the institutions at the time of application.

Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number

Training Institution License Number

MEDICAL DIRECTOR AGREEMENT: EMS TRAINING INSTITUTION

INSTRUCTIONS: This form must be completed with each training institution licensure renewal application or at any time a change or addition of medical directors is made. A current medical director agreement must be on file for each training institution at all times.

PHYSICIAN MEDICAL DIRECTOR

First Name		Last Name	MI
Street Address / PO Box		City	
State	Zip Code	Telephone Number	
ND License Number		Expiration Date	
Name of Training Institution			
Training Institution License Number			

I, the above-named physician, agree to function as Physician Medical Director for the above-named EMS Training Institution. As Medical Director I agree that I will be directly involved in the development of course curricula and evaluate and approve all courses offered by this Training Institution. I also agree to oversee the Quality Improvement / Quality Assurance program developed by the Training Institution.

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

☐ Remove previous medical director.	
☐ Add as an additional medical director.	
Printed Medical Director Name	
Medical Director Signature	Date

Training Institution License Number

HOSPITAL ADMINISTRATION SUPPORT AGREEMENT: EMS TRAINING INSTITUTION

Facility	Telephone Number	
Address	City	ZIP Code
Name of Training Institution		
Training Institution License Number		

As administrator of the above named hospital I support the above named EMS Training Institution and agree that the students enrolled in the EMS programs at this facility may do their clinical training skills required at this hospital. The nursing unit supervisor will assign a preceptor to directly supervise and advise each student. I reserve the right to terminate this agreement by submitting a written notice to the Division of Emergency Medical Services and Trauma as well as to the named EMS Training Institution.

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

Printed Administrator Name	
Hospital Administrator Signature	Date

Training Institution License Number

AMBULANCE SERVICE SUPPORT AGREEMENT: EMS TRAINING INSTITUTION

Ambulance Service	License Number	
Address	City	ZIP Code
Ambulance Service Medical Director		
Name of Training Institution		
Training Institution License Number		

As director of the above named ambulance service I agree to provide a clinical setting for EMS programs conducted by the above named EMS Training Institution. I understand that the EMS programs conducted by the Training Institution will involve students observing and participating in all aspects of patient care as carried out by this service while under supervision. The ambulance clinical experience will be under direct supervision of a field preceptor assigned by this ambulance service with overall coordination by the Training Institution Program Director and the medical director of stated institution. I reserve the right to terminate this agreement by submitting a written notice to the Division of Emergency Medical Services and Trauma as well as to the named EMS Training Institution.

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

Printed Service Director Name	
Service Director Signature	Date