2011 - 2013
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 (1-08)

Whereas, the _____,
(Name of Quick Response Unit)

in the City of _____, County of_____

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 _____,
(Name of 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 2013.

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

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 and cause for rejection or revocation. 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 run report for each call and submits the required data to the associated 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)

VEHICLE AND LIABILITY INSURANCE CARRIERS

Name of **Vehicle** 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 _____

QUICK RESPONSE UNIT 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

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- Stethoscope and blood pressure cuff
- ☐ 4 each - Gloves - In size small, medium and large
- ☐ 1- Blunt shears
- ☐ 1 - Portable suction device with catheter
- ☐ 1 - Portable oxygen unit size "D" with variable flow meter
- ☐ 2 each - Nasal cannula, non-rebreather mask, and supply tubing
- ☐ 1 each size - Nasopharyngeal airways
- ☐ 1 each size - Oropharyngeal airways
- ☐ 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 30 inches
- ☐ 1 - Sterile burn sheet
- ☐ 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:
Mailing Address:			City:
Physical Address of Service:			City:
State:	Zip:	E-mail Address:	
Telephone Number:		Fax Number:	

I, _____ current squad leader/manager for above named ambulance service agree to assume affiliation with _____ Quick Response Unit(s). As a licensed ambulance service 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. 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 2013, or may be terminated by the Quick Response or the ambulance service upon written notice to Division of Emergency Medical Services and Trauma.

Ambulance Squad Leader Signature	**Date**