2010-2012
NORTH DAKOTA LICENSE APPLICATION FOR CRITICAL CARE AIR 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 Air Ambulance Service)

in the City of _____, County of _____

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.

Whereas, the _____ ,
(Name of Air 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 air 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 a fee of fifty dollars is required at time of submission and made payable to:

North Dakota Department of Health.

_____ _____
Signature **Date**

DEMS OFFICE USE ONLY
License Number
Date Issued
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#_____

AIR AMBULANCE AIRCRAFT INFORMATION

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

PLEASE COMPLETE FOR ALL AIRCRAFT(S) USED AS AN CRITICAL CARE AIR AMBULANCE

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

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

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

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

LIST OFFICERS FOR

_____
(Name of Critical Care Air 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 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 EMERGENCY MEDICAL SERVICES WITHIN 30 DAYS OF THE CALL.

_____ Signature

_____ Date

AIR 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 **Aircraft** 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

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. 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 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.

_____ _____

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)

CHECKLIST OF REQUIRED EQUIPMENT

All aircraft used for patient care and transport must contain the following

Place an "X" by each item if stocked. All aircraft used are subject to inspection

	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 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 fifteen liters per minute for one hour.
	Mouth-to-mask artificial ventilation device with a supplemental oxygen inlet port such as a pocket mask, 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 twenty liters per minute and achieving a minimum of three hundred 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
	Any specialized equipment as ordered by physician or medical director