2010-2012
NORTH DAKOTA LICENSE APPLICATION FOR BASIC 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 _____

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 basic life support ground ambulance service.

Application is hereby made to operate as a basic 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 of 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 of 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 of 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 of 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 (No PO Boxes):			
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 of manager / squad leader Date

GROUND AMBULANCE OWNERSHIP

Name of exact ownership of service:		
Physical address of service:		
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)					
Does your service staff your substations 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

Make copies if additional pages are needed

Checklist of Required Equipment

North Dakota Licensed Basic Life Support Ground Ambulance

Name of EMS Agency	Date
Name of Person Completing Report	Title
Phone Number	Total # of Ambulances in Service

Item Please place an "X" in boxes if stocked.	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 mmgh/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 9 inches					
Tape - assorted sizes - four rolls minimum					
Blunt shears - two minimum					
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					
Sharps container - one less than half full					
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					
Automatic defibrillator					
Blood pressure manometer with cuff size in large adult, adult child and infant.					
Stethoscope w/adult and pediatric capabilities					
Lower extremity traction splint					
VHF radio with capabilities of meeting EMS standards as determined by the department					
Glutose or glucose - one oral dose minimum					
Disposable gloves - small, medium and large - one box each minimum					
Reflectorized flares for securing scene -3 sets minimum					
Personal protection equipment, such as mask, non-absorbant gown, protective eyewear - four each minimum					
Biological fluid cleanup kit					
Twenty five triage tags					
Pediatric backboard **(required by 7/1/2011)**					
Pediatric traction splint **(required by 7/1/2011)**					
Appropriate pediatric reference material					
Pulse oximeter					
Reflective vests - minimum of two					
Written treatment protocols					
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.

_____ _____

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 blank if your service does not have substations. If the substation ambulance is located within headquartered service area (city limits), substation licensure does not apply. Substations must display headquartered ambulance services name on all units. For each licensure only one roster is permissible. Contact person must be registered under service's personnel roster.

Substation 1

Location of Substation (city)	
Physical Address	Zip Code
Unit Number(s)	Contact person of substation ambulance

Substation 2

Location of Substation (city)	
Physical Address	Zip Code
Unit Number(s)	Contact person of substation ambulance

Substation 3

Location of Substation (city)	
Physical Address	Zip Code
Unit Number(s)	Contact person of substation ambulance

Substation 4

Location of Substation (city)	
Physical Address	Zip Code
Unit Number(s)	Contact person of substation 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