Susquehanna Regional EMS Council, Inc.
62 Lusk Street ▪ Johnson City, NY 13790
Ph 607.699.1367 ▪ Fax 607.397.2728

SUSQUEHANNA REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE

Application for EMS Agency Level of Care Upgrade
(Pursuant to NYS EMS Policy Statement 11-05)
Please Type or Print All Information

GENERAL INFORMATION NYS EMS Agency Code:______________________

Name of EMS Organization: ____

Mailing Address of Organization: ______________________________________
(Street and Number)

____
(City/Village/Town) (State and Zip Code)

PROPOSED LEVEL OF CARE (Check all that apply)

- ❑ Automated External Defibrillation (AED)
- ❑ Nebulized Albuterol by EMT-Basics
- ❑ Glucometry by EMT-Basics
- ❑ Advanced Life Support - Intermediate
- ❑ Advanced Life Support - Critical Care
- ❑ Advanced Life Support - Paramedic

AGENCY ORGANIZATIONAL TYPE (Please Check All Categories That Apply):

- ❑ Ambulance Service
- ❑ First Response Team*
- ❑ Not-For-Profit
- ❑ Commercial/Proprietary
- ❑ Municipal
- ❑ Hospital-Based
- ❑ Fire Department
- ❑ Independent
- ❑ Other__________________________

*Per § 3005 (6), NYS Public Health Law, first response teams seeking to begin Advanced Life Support service must successfully complete the Certificate of Need process through the Regional EMS Council, and obtain an ALFR operating certificate from the NYS Department of Health.

AGENCY LEADERSHIP PROFILE

Chief Executive Officer:___________________________________ Title:__________________

Mailing Address:____
(Street and #) (City/Town/Village) (State/Zip)

Home Telephone:______________________ Business Telephone:_________________________

Chief Operational Officer:___________________________________ Title:___________________

Mailing Address:____
(Street and #) (City/Town/Village) (State/Zip)

Home Telephone:______________________ Business Telephone:_________________________

Agency Medical Director:___________________________________ Title:___________________

Mailing Address:____
(Street and #) (City/Town/Village) (State/Zip)

NYS License Number:__________________ Business Telephone:_________________________

ALS/ILS Supervisor:_______________________________________ Title:___________________

Mailing Address:____
(Street and #) (City/Town/Village) (State/Zip)

Home Telephone:______________________ Business Telephone:_________________________

AGENCY STAFFING PROFILE - All Information Requested is as of Date of Application

1. Total Number of Active EMS Members in Organization (These are members who participate in any capacity in EMS operations, including those who only drive vehicles. Please do not include members who do not participate in EMS calls at all.)	
2. Total Number of Active EMS Members in Organization who Perform any Patient Care	
3. Total Number of Active EMS Members in Organization who act as Crew Chiefs or Patient Care Team Leaders	
4. Total Number of Active EMS Members in Organization who are currently NYS Certified as Certified First Responders without AED training.	
5. Total Number of Active EMS Members in Organization who are currently NYS Certified as Certified First Responders with AED training	
6. Total Number of Active EMS Members in Organization who are currently NYS Certified as EMT-Basics.	
7. Total Number of Active EMS Members in Organization who are currently NYS Certified as AEMT-Intermediates	
8. Number of current NYS AEMT-Is Trained/Authorized in Manual Defibrillation	
9. Total Number of Active EMS Members in Organization who are currently NYS Certified as AEMT-Critical Care Technicians	
10. Total Number of Active EMS Members in Organization who are currently NYS Certified as AEMT-Paramedics	
11. Total Number of Active EMS Members in Organization who are Certified Public Access Defibrillation (PAD) Providers (AHA, ARC, NSC, ASHI, etc.)	
12. Total Number of Active EMS Members in Organization who are Certified only in CPR and/or Basic First Aid	

AGENCY VEHICLE PROFILE

Please provide a list of all agency-owned/operated vehicles, which are routinely used to respond to EMS calls. For each, please check the box indicating the type of vehicle, and those indicating the treatment modalities with which it is proposed that each vehicle be equipped:

Definitions:

Ambulance - Any authorized emergency vehicle equipped for, and normally used for the purpose of caring for and transporting patients from the scene of a call to the hospital.

First Response Vehicle - Any agency-owned and/or operated authorized emergency vehicle which is normally used by the agency for the purpose of responding to the scene of an EMS call with personnel and patient care equipment, but which is not used for patient transport from the scene of the call to the hospital. This can include fire apparatus that is also routinely used for EMS response, as well as cars and four-wheel-drive vehicles dedicated solely to EMS response, **including** personally owned vehicles equipped as authorized emergency vehicles, and having County-issued radio identification numbers.

Vehicle ID#	Vehicle Type	Care Modalities to be Carried		
	❑ Ambulance ❑ First Response Vehicle	❑ AED ❑ BLS Epi-Pens ❑ BLS Albuterol ❑ BLS Glucometry	❑ Adv. Airway Mgt ❑ TT Jet Ventilation ❑ IV Therapy ❑ Intraosseous Inf.	❑ ALS Medications ❑ Manual Defibrillator ❑ External Pacing ❑ 12-Lead ECG
	❑ Ambulance ❑ First Response Vehicle	❑ AED ❑ BLS Epi-Pens ❑ BLS Albuterol ❑ BLS Glucometry	❑ Adv. Airway Mgt ❑ TT Jet Ventilation ❑ IV Therapy ❑ Intraosseous Inf.	❑ ALS Medications ❑ Manual Defibrillator ❑ External Pacing ❑ 12-Lead ECG
	❑ Ambulance ❑ First Response Vehicle	❑ AED ❑ BLS Epi-Pens ❑ BLS Albuterol ❑ BLS Glucometry	❑ Adv. Airway Mgt ❑ TT Jet Ventilation ❑ IV Therapy ❑ Intraosseous Inf.	❑ ALS Medications ❑ Manual Defibrillator ❑ External Pacing ❑ 12-Lead ECG
	❑ Ambulance ❑ First Response Vehicle	❑ AED ❑ BLS Epi-Pens ❑ BLS Albuterol ❑ BLS Glucometry	❑ Adv. Airway Mgt ❑ TT Jet Ventilation ❑ IV Therapy ❑ Intraosseous Inf.	❑ ALS Medications ❑ Manual Defibrillator ❑ External Pacing ❑ 12-Lead ECG
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Certification: I hereby certify that, to the best of my knowledge and belief as of this date, all information given in the foregoing application and its attachments is true and complete. I understand that any false or misleading statements given on or in support of this application may be deemed grounds for its denial, or for revocation of any authorization based upon it.

By____ ______________________

(Chief Executive Officer of Applicant Agency) Date of Signature

SREMS COUNCIL | Susquehanna Regional EMS Council, Inc.
62 Lusk Street ▪ Johnson City, NY 13790
Ph 607.699.1367 ▪ Fax 607.397.2728

Please Read the Following Agreement, and Sign as Indicated

AGREEMENT made as of the _________ day of ____________, _______ by and between

____, (Hereinafter referred to as the "AGENCY"), and the Susquehanna Regional Emergency Medical Advisory Committee, (hereinafter referred to as the REMAC):

WITNESSESTH:

WHEREAS, THE REMAC, through its duly-licensed and appropriately-experienced physician members, oversees a prehospital Emergency Medical Services Advanced Life Support System, as defined in Section 3001 of the NYS Public Health Law, and

WHEREAS, each EMS agency participating in this System must have a qualified physician Medical Director who extends his or her medical license, to a limited degree, for the practice of approved Advanced Emergency Medical Technicians operating within the System; and

WHEREAS, the AGENCY is desirous of participating in said Advanced Life Support System, thereby permitting its approved Advanced Emergency Medical Technician to function under the license of this Medical Director, and to receive on-line medical control from the Medical Control Facilities participating in the Susquehanna Regional EMS Medical Control Plan; and

WHEREAS, THE REMAC is desirous to extend the benefits of prehospital Advanced Life Support to all of the people of the Region through the participation in its Advanced Life Support System of qualified Prehospital Emergency Medical Services agencies;

NOW, THEREFORE, IT IS AGREED AS FOLLOWS:

1. The physician Medical Director of the Agency will extend, to a limited degree, his/her license to practice medicine in the State of New York, to those Advanced Emergency Medical Technicians who are members or agents of the AGENCY, and whom the Medical Director has individually approved and authorized, and who meet the current requirements for practice within the System, for their practice, to the level of their certification, within the System.
2. The Medical Control Facilities will, to the extent of their agreements with the REMAC, provide twenty-four hour per day on-line physician medical control to those Advanced Emergency Medical Technicians who possess and identify themselves with a valid ALS TEK Number issued by the System, and who are practicing as members or agents of the AGENCY.

3. The AGENCY will abide by the rules, regulations, and protocols of THE REMAC, as they exist at the time of the acceptance of this agreement, and as they may be amended and promulgated from time-to-time in the future.
4. The AGENCY will abide by any standards of training and in-service education and practice required by THE REMAC, and will require its members and agents to attend any and all classes or training sessions which may be required by THE REMAC.
5. The AGENCY will assure that only those Advanced Emergency Medical Technicians who have current authorization from THE REMAC will function as Advanced Emergency Medical Technicians within, or on behalf of the AGENCY.
6. The AGENCY will adhere to, and assure that its members and agents adhere to, the current Regional EMS protocols, or such other prehospital EMS treatment protocols as shall be adopted by the REMAC.
7. The AGENCY, and all those members and agents acting on its behalf, will contact a Medical Control Facility, and obtain on-line physician medical control direction, before performing any type of treatment not specified as "standing orders" in the applicable treatment protocols for the level of AEMT performing care, or in any case when the course of treatment for the patient is unclear to the attending AEMT. In all such cases, the AGENCY and its members and agents shall abide by the orders of the on-line medical control physician, unless doing so would result in the AGENCY or its members or agents exceeding the level and scope of their training, certification, and authorized level of care.
8. The AGENCY will purchase, stock, and maintain on all of its Advanced Life Support vehicles all such equipment and supplies as may be specified and required by THE REMAC for the level of care it authorizes the AGENCY to provide.
9. The AGENCY will complete a standard New York State Prehospital Care Report and ALS Continuation Form thereof, or State-Approved electronically generated equivalent, for each patient or call to which it is dispatched to respond. A copy of the completed Report shall be furnished in a timely manner, as defined by the REMAC, to any receiving hospital to which the AGENCY has transported any patient who is the subject of such a Report.
10. The AGENCY will submit to the Susquehanna Regional EMS Program Agency the research copy of the Prehospital Care Report, and any attached ALS Continuation Form thereof, for each call or patient to which it is dispatched to respond. The use of a State-approved electronic reporting system, which automatically transmits the information contained in these reports, shall be deemed an acceptable substitute for this requirement.
11. The AGENCY will participate, as directed by THE REMAC, in any and all Quality Improvement or other audit activities of the AGENCY'S prehospital care activities, and will promptly make available to the REMAC any records and/or personnel necessary to do so.
12. 12. The AGENCY will strive to provide, as a priority goal, its approved level of Advanced Life Support care to all of its patients requiring it, on a twenty-four-hour-per-day basis.
13. The AGENCY will recognize, respect, and abide by the medical control facility's authority to withhold medical control orders to the AGENCY, if the facility's physician deems the AGENCY to be out of compliance with any of the provisions of the this agreement.
14. The AGENCY will recognize, respect, and abide by its Medical Director's and/or the REMAC’s authority to withdraw authorization of the AGENCY to operate at the Advanced Life Support level for any cause that the Medical Director or REMAC deems appropriate.

15. The AGENCY will, when indicated by the applicable protocols or procedures adopted by THE REMAC and by the actual or suspected condition of a patient, seek assistance from or rendezvous with an advanced life support unit capable of a providing care not available at that time from the AGENCY. In no case shall seeking such assistance or rendezvous result in a substantial delay in the transportation to definitive care (hospital) of a patient with an actual or suspected serious or critical illness or injury.

IN WITNESS HEREOF, the parties hereto have duly executed this AGREEMENT as of the day and year first written above.

By____ ______________________
(Chief Executive Officer of Applicant Agency) Date of Signature

By____ ______________________
(Medical Director of Applicant Agency) Date of Signature

By____ ______________________
(Chairman, Susquehanna REMAC) Date of Signature