**EMS Agency Participation Agreement**

This document or an equivalent is required for all participating BLSFR agencies with DOH issued ID number.

**Purpose:**

It being recognized that {Ambulance Service Name} (herein after referred to as XXX) is a duly authorized Ambulance Service, Certified by the New York State Department of Health (NYSDOH), and providing ambulance service to territory established under Article 30/30A of Public Health Law (A30 PHL), which includes in whole or in part the response area of {Non-transport BLSFR Service Name} (herein after referred to as ZZZ) in the {City, Town, Hamlet or District} of, {Name of County} County.

And also in recognition that {ZZZ} is a Basic Life Support First Response (BLSFR) EMS agency also recognized within its municipality and by the NYSDOH to provide non-transporting BLS Emergency Medical Services.

The following agreement is hereby entered into for the purpose of ensuring rapid effective response, appropriate patient care and the delivery of persons in need of medical care to appropriate medical facilities, through the cooperative efforts of the organizations consenting to this agreement.

This agreement shall take effect upon the date of endorsement indicated below and shall be renewed annually by the Chief Operating Officers (COOs) of each organizational. Alterations or amendments to this agreement may be made at any time by written consensus and re-execution of this agreement.

**Terms of Agreement**

**{XXX} and {ZZZ} shall:**

* Provide for the identification of its prehospital certified members by badge, ID card, uniform or other visible identification to insure rapid recognition of certified responders and their authorized level of provider care and authorizing agency.
* Participate in QA/QI review of all responses for which a patient contact occurred. And further to resolve any identified patient care issues through training, remediation, discipline or protocol review as appropriate to insure continued effective patient care and compliance with state and regional patient care protocols.
* Participate with any Mutual Aid Response agency, dispatched or responding in place of either {XXX} or {ZZZ} due to the unavailability of either service, holding to the same participation standard and expectations stated in this agreement.
* Adhere to applicable state and regional policies, procedures and patient care protocols.
* Resolve member participation issues through cooperative discussion between the COOs of each organization promptly upon notice of any instance or circumstance which impairs the cooperative intent of this agreement or which compromises in any way the delivery of appropriate patient care.
* Provide notification in advance of training, drills and educational opportunities sponsored by either agency, at which members may obtain, renew or refresh EMS certification or rescue/responder skills.

**{XXX} shall:**

* Respond whenever possible to any medical emergency, standby or other public need as determined by county 911 dispatch, and provide prehospital medical care and patient transport in fulfillment of its operating authority under Article 30/30A of Public Health Law (A30 PHL).
* Remain an active participant in the {Name of County} County Mutual Aid and MCI/Disaster Plan such that all Medical Emergencies shall be responded to either by {XXX} or another ambulance service providing Mutual Aid Response.
* Accept any patient presented for transport, to which {ZZZ} provides initial BLS care, to insure timely transport of such patient(s) to an appropriate Article 30 designated facility or hospital.
* Accept Prehospital Care Reports (PCRs) turned over to {XXX} by {ZZZ} that document the findings and care provided to patients(s) treated by {ZZZ}.
* Replenish such disposable medical items or supplies used by {ZZZ} on calls for which {XXX} was the transporting agency, the list of such replenishable items to be agreed upon in writing by the COOs of each organization.

**{ZZZ} shall:**

* Respond whenever possible to any medical emergency, standby or other public need as determined by county 911 dispatch, and provide prehospital medical care at the Basic Life Support (with Defibrillation or PAD) Level of care, within the {ZZZ} response area.
* Report to 911 dispatch the condition and number of patients found at any incident to facilitate the preparedness and appropriate response by {XXX} crews and responding vehicles.
* Not cease the provision of patient care and/or monitoring until such care is turned over to another qualified/certified care provider, once patient care has been initiated.
* Turn over for treatment and transport to {XXX} any patient to which {ZZZ} provides initial BLS (and/or Defib/PAD) prehospital care.
* Insure that the prehospital care provider in charge of patient care will at all times be the {ZZZ} responder with the highest level of certification on scene, until such time as {XXX} arrives at the incident and patient care is turned over to the {XXX} member responsible for the call.
* Participate in ICS / Unified Command for incidents requiring ongoing incident management.
* Adhere to NYS DOH Policies regarding BLSFR Agencies, [06-04 BLS-FR Services Information](http://www.health.ny.gov/professionals/ems/policy/06-04.htm) and [DOH Policy 98-05 Responsibilities of EMS Providers to coordinate EMS Resources](http://www.health.ny.gov/professionals/ems/policy/98-05.htm).
* Maintain a list of supplies, equipment and authorized response vehicles as identified in DOH Policy [06-04 BLS-FR Services Information](http://www.health.ny.gov/professionals/ems/policy/06-04.htm).

This Agreement is entered into this \_\_\_\_\_\_\_\_ Day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 200\_\_.

Signed,

For {XXX}:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chief Operating Officer

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For {ZZZ}:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chief Operating Officer

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name and Affiliation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy Distribution shall be:

* 1 copy to each organization's records officer or COO
* 1 copy to {Name of County} County 911 Dispatch Center
* 1 copy to {Name of County} County EMS Coordinator
* 1 copy to New York State Dept of Health

Attn: {ZZZ} BLSFR Service File

Note: A computer file version of this document, easily edited for your use, is available in Microsoft WORD.

To request the "electronic version" of this document, please contact DOH BEMS at (518) 402-0996x2 with a valid email address to which the file may be sent.