EMS Agency Annual Letter of Compliance

<table>
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<tr>
<th>Agency: ______________________________</th>
<th>Initial____</th>
<th>Renewal____</th>
<th>(check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Licensure:___________________</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
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1. Agency has provided proof of professional liability insurance coverage.  
   ____  ____  ____

2. Agency has provided detailed information outlining geographic location, boundaries, and target population of the proposed emergency response area.  
   ____  ____  ____

3. When providing primary emergency response service, agency assures a response time meeting the following protocol response time criteria:  
   ____  ____  ____
   * Maximum response time of eight (8) minutes for ninety (90%) percent of the runs (when a response time for BLS does not exceed an average of four (4) minutes).
   * Additional consideration will be given to population density and square mile coverage. It is expected that the more sparsely populated areas of the MCA may have response times up to fifteen (15) minutes.

4. Agency is currently a licensed provider by the Department.  
   ____  ____  ____

5. Agency has verified, via the Department license verification website, that assigned medical personnel are currently licensed in accordance to Department regulations and has attached a personnel roster including license #’s and expiration dates.  
   ____  ____  ____

MCA Name:  HEMS, INC. (Wayne County)  
MCA Board Approval Date:  April 11, 2013  
MDCH Approval Date:  August 15, 2013  
MCA Implementation Date:  October 1, 2013
6. Transporting Units - Agency complies with minimum staffing requirements set forth by HEMS.
   BLS Unit - (1) EMT-B & (1) MFR
   LALS Unit - (1) EMT-S & (1) EMT-B
   ALS Unit - (1) Paramedic & (1) EMT-S
   12 Lead Unit - (1) Paramedic and (1) EMT-S
   Critical Care - (1) CCT Paramedic & (1) Paramedic

7. Non Transporting Units - Agency complies with minimum staffing requirements set forth by HEMS.
   MFR - One MFR
   BLS - One EMT-B
   LALS - One EMT-S
   ALS - One Paramedic

8. Agency agrees to provide mutual aid to all agencies in HEMS when available.

9. EMS personnel within the agency are compliant with current NIMS training courses.

10. Agency EMS Communications are in compliance with the MEDCOM plan and HEMS EMS Communications Interoperability protocol.

11. The agency verifies that all EMS personnel meet skill competency with regards to Department, Regional, and HEMS protocol requirements.

12. Assigned medical personnel of agency are current in the following and agency has attached a personnel roster with the expiration dates:
   MFR - BLS card
   EMT-B - BLS card
   EMT-S - BLS card
   Paramedic BLS & ACLS card
   Critical Care - BLS & ACLS card

13. BLS /LALS / ALS agencies have a current CLIA waiver.

14. Agency complies with Department and HEMS equipment requirements.
15. Agency has made provisions for continued maintenance of bio-medical communication/telemetry equipment. __________  __________  __________

16. Agency participates in HEMS integrated Agency/System Quality Improvement an PSRO to perform professional practice review functions including review of prehospital care provided in the MCA and recommendations for improvement of such care, based upon approved protocols. __________  __________  __________

17. Agency has made provisions for continued maintenance of EMS vehicles. __________  __________  __________

18. Number of Vehicles:

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<thead>
<tr>
<th></th>
<th>Non Transporting</th>
<th>Transporting</th>
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<tbody>
<tr>
<td>MFR</td>
<td>__________</td>
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<tr>
<td>BLS</td>
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<td>LALS</td>
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<tr>
<td>Critical Care</td>
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19. Number of Personnel: Please be as accurate as possible. This information will be used by HEMS, Public Health, and others for the continued improvement and care of the personnel within the HEMS MCA.

MFR __________
EMT-B __________
EMT-S __________
Paramedic __________
Critical Care __________
Total # of Agency Employees(include all support) __________
20. Contact Information:

Chief / CEO: _______________________________
Telephone _______________ Fax _____________
Email _________________________________

_______________________________________
(Signature)                        (Date)

CQI
Representative: _______________________________
Telephone _______________ Fax _____________
Email _________________________________

_______________________________________
(Signature)                        (Date)

Physician Director _______________________________

_______________________________________
(Signature)