AGENCY: _____ Initial____ Renewal____ (check one)

LEVEL OF LICENSURE: _____

Section 1: Must meet requirements in Step 1 before proceeding to Step 2.
Please answer the following question to determine your agency's compliance with the EMS Act. (P.A. 368 of 1978 as amended) to be licensed by MDCH to operate in the HEMS MCA:

1. Detail in the space below the agency's service area meeting the HEMS protocol response time criteria and the jurisdiction the service area is located:

2. Does your agency have at a minimum 1 (one) ambulance available 24-hours a day, 7days a week to respond only to emergencies within the service area identified above, meeting HEMS MCA response time criteria? Yes:____ No:____

    a. If yes, provide the address/location of the ambulance dedicated to respond only to requests for emergency response within the service area.

    b. If yes please attach a three month 24-7 staffing schedule for the ambulance dedicated to respond only for emergency request.

3. What documentation can be provided to support that a minimum of 1 (one) ambulance is available 24 hours a day, 7 days a week to respond only to requests for emergency response within the service area described in question 1, above. (check all that are applicable, but at least one and attach documentation):

____ Jurisdiction municipal 9-1-1 provider *(no documentation needed)*
____ Contract with jurisdiction to provide 9-1-1 response/transportation
____ Letter (or contract) from authorized jurisdictional representative recognized the presence of and availability of 1(one) ambulance to respond to request for emergency response within the service area described in question 1.
____ Other documentation of the presence of and availability of 1 (one) ambulance to respond to requests for emergency response within the service area described in question 1. Meeting HEMS MCA protocol response time requirements, such as run reports of actual emergency responses from the current 12 month license period etc.

4. Agency PCR data is submitted to MI-EMSIS: YES____ NO____ Program used:_____

5. EMS personnel submit PCR or Field note (protocols 5-22, 6-35) to ED Staff before leaving the ED to facilitate the transfer of patient care: YES____ NO____

6. EMS Agency & Personnel complete annual protocol updates & training: Yes___ No___

7. EMS Agency utilizes Alternate Staffing Protocol: YES____ NO____. (If No skip rest of questions)
   a. Agency complies with required Alternate Staffing reporting requirements as outlined in protocol 9-17. Yes____ No____

Section 2: Facility and Service Participation

	YES	NO	N/A
1. 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 and 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.	___	___	___
2. 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.	___	___	___
3. 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 or 12 Lead Unit – (1) Paramedic & (1) EMT-S	___	___	___
Critical Care – (1) CCT Paramedic & (1) Paramedic	___	___	___
4. 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	___	___	___
5. Agency agrees to provide mutual aid to all agencies in HEMS when available.	___	___	___

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

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

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

9. Assigned medical personnel of agency are current in the following: **MFR- BLS Card, EMT-B/ BLS Card, EMT-S/ BLS Card, Paramedic & CCT Paramedic – BLS & ACLS Card**, and the agency has attached a personnel roster with the expiration dates. ___ ___ ___

10. Agency complies with the Department and HEMS equipment requirements. ___ ___ ___

11. Agency has made provisions for continued maintenance of bio-medical communication-telemetry equipment. ___ ___ ___

12. Agency participates in HEMS integrated Agency-System Quality Improvement and PRSRO to preform professional practice review functions including review of prehospital care provided in the MCA & recommendations for improvements of such care, based upon approved protocols. ___ ___ ___

13. Agency has made provisions for continued maintenance of EMS Vehicle. ___ ___ ___

14. Number of Vehicles:

	Non - Transporting	**Transporting**
MFR	_____	_____
BLS	_____	_____
LALS	_____	_____
ALS	_____	_____
Critical Care	_____	_____

15. 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)	_____

I ATTEST THAT THE INFORMATION PROVIDED IS ACCURATE AND TRUE. AUTHORIZED SIGNATURE FOR THE EMS AGENCY:

_____

Contact Information/Agency:

Chief/CEO: _____
Telephone: _____ **Fax:** _____
Email: _____

_____ _____
(Signature) **(Date)**

ALS/Coordinator: _____
Telephone: _____ **Fax:** _____
Email: _____

Training Coordinator: _____
Telephone: _____ **Fax:** _____
Email: _____

CQI/PSRO Liaison: _____
Telephone: _____ **Fax:** _____
Email: _____

Agency Physician Director: _____
Telephone: _____ **Fax:** _____
Email: _____

_____ _____
(Signature) **(Date)**

Check List:
(Attachments)

THE FOLLOWING ARE REQUIRED DOCUMENTS FOR LSA RENEWALS

____ MDCH Part 1 – Requiring Medical Director Signature (BLS-LALS & ALS)

____ MDCH Part 2 for each vehicle, a comprehensive list of vehicle information or a Copy of State EMS Agency License (BLS-LALS & ALS)

____ Included EMS Agency Annual Letter of Compliance (BLS-LALS & ALS)

____ Include a list of Licensed EMS Personnel in HEMS (list must have license number & expiration date) (BLS-LALS & ALS)

____ List showing current certification in BLS for all EMS personnel and ACLS for Paramedic with expiration date (BLS-LALS & ALS)

____ Copy of CLIA Waiver (BLS-LALS & ALS)

____ Copy of Insurance Certificate (BLS-LALS & ALS)

____ Attach a 3 month Schedule 24-7 staffing outlined in Section 1, 2B. (BLS-LALS & ALS)

____ LALS and ALS services must include the Annual Pharmacy System "Memorandum of Understanding"

OPTIONAL FORMS ARE REQUIRED IF YOUR LSA OFFERS THESE SERVICES

____ Included Additional Service Letter of Compliance (optional ALS)

____ included & required for Helicopter Services is the Helicopter Letter of Compliance

____ Includes ALT Staffing (ALS) request and documentation for annual license period

Date: _____

Agency: _____ Initial _____ Renewal _____ (check one)

As of the date indicated above, I hereby certify that the above indicted agency complies with the requirements of the Wayne County Medical Control Board (HEMS) for the continued participation in the following supplemental services: (Check all that apply/approved)

_____ **12 Lead Program** – Agency operates the 12 lead program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum.

_____ **Critical Care Program** – Agency operates the Critical Care program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum. The agency complies with all requirements as set forth by the HEMS Inter-Facility Protocol.

Please provide CCT Unit Numbers: _____ _____ _____ _____ _____ _____

_____ **EMD Program** - Agency operates the Emergency Medical Dispatch program under the supervision of a physician who is responsible for the oversight of the Quality Improvement program and training curriculum. Provide name of Program: _____

EMD Training Coordinator: _____ Physician: _____

_____ **Helicopter Agency Annual Letter of Compliance** – **Agency** will submit annual Department license renewal application along with letter of compliance at least 60 days prior to renewal date. **Agency** meets all state and federal aircraft equipment and safety standards and agrees to submit proof upon request of HEMS. **Agency** agrees to provide referring agencies within HEMS with training in appropriate procedures to be used when operating with helicopter EMS services. **Agency** will submit copies of patient care reports for transports within HEMS to HEMS PSRO within 72 hours of transport.

_____**Quality Improvement -** Agency has in place an internal Quality Improvement program which includes a formal peer review process which interacts actively with the professional review/QI program conducted by HEMS through the Wayne County Medical Control Advisory Board under MDPH approved protocols. All QA materials including correspondence between Agencies QI program and Wayne County EMS system's QI program are handled as confidential in accordance with applicable section of State Law.

I certify that the agency complies with all training requirement and maintains records of all required training for personnel trained under the protocols set forth by HEMS (Wayne County Medical Control Board) and the records are available for inspection by the Department and HEMS. The agency assures that additional equipment requirements as defined in the protocols are met.

Chief/CEO Signature: _____

Chief/CEO – Printed: _____
Telephone: _____ Fax: _____
Email: _____