ALABAMA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMS

RSA Tower, 201 Monroe Street, Suite 1100
Mail to: PO Box 303017
Montgomery, AL 36130-3017

EMS Provider Licensure Application

All pages of this form must be typed to be approved

TODAY's DATE:_____ COUNTY of OPERATION:_____ CURRENT SERVICE ID: _____

Application Type

NEW SERVICE: ☐
RENEWAL: ☐

TRANSPORT: ☐
NON-TRANSPORT: ☐
AIR MEDICAL: ☐

BLS: ☐
ALS 1 ESP: ☐
ALS 1: ☐
ALS 2: ☐
ALS 3: ☐

Choose highest level of care to be given by:
BLS: EMT
ALS1 ESP: Paramedic Expanded Scope of Practice
ALS 1: Paramedic
ALS 2: Advanced EMT
ALS 3: Intermediate EMT

Contact & Demographic information MEMBER AARS: ☐

OWNERSHIP TYPE: Corporate, Municipality, or LLC ☐ Sole Proprietorship ☐ (If a Sole Proprietorship, call before app submission.)

OWNER OF SERVICE: _____

NAME OF BUSINESS: _____
(LICENSE SHALL BE ISSUED IN THIS NAME, AND SHALL APPEAR ON BOTH SIDES OF THE VEHICLE)

PHYSICAL ADDRESS: _____ CITY. _____ STATE:____ ZIP:_____
(STREET ADDRESS AND CITY WHERE VEHICLES ARE LOCATED)

MAILING ADDRESS: _____ CITY._____ STATE:____ ZIP:_____

CONTACT PERSON: _____ E-MAIL ADDRESS: _____

BUS. PHONE: (____) _____ EMERGENCY PHONE: (____) _____ FAX :(____) _____

QUALITY ASSURANCE (QA/QI) CONTACT PERSON: _____

PHONE: (____) _____ E-MAIL ADDRESS: _____

TYPES OF COMMUNICATION USED (list minimum of two) Primary: _____ Secondary: _____

Other Communication Methods: _____

Insurance Information

INSURANCE CARRIER: _____ PHONE: ____ _____
(VEHICLE & PERSONNEL) (ATTACH PROOF OF COVERAGE)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE MAKE FILE COPY ---- RETURN THIS ORIGINAL APPLICATION
(FOR OFFICE OF EMS USE ONLY)

CURRENT EXP. DATE: _____ NEW EXP. DATE: _____ CERTIFICATE #- _____

DEPOSIT #: _____ APP.REC'D: _____ FEE REC'D: _____ AMT. REC'D: $ _____ CK/M.O.#: ____

APPROVED BY: _____ DATE: _____

PERMITTED AMBULANCES AND ALS VEHICLES

IF Provider Application is a Relicense: print and include EMS Management Website Vehicle Roster.
Otherwise if application is a New Service: List all active vehicles below.
(Vehicles can not be listed for multiple service numbers, list the primary county of operation only)

Unit Number	Make	Ambulance Type I, II, III or ALS Vehicle Description	Year	Model	Vehicle Identification Number	TAG #	Check if in Service

Provider Personnel Roster

IF Provider Application is a Relicense: print and include EMS Management Website Personnel Roster.
Otherwise if application is a New Service: List all active personnel in alphabetical order below.
*List only Alabama State Licensed EMTs, and all fields on this form must be typed.

	Name (Must Type) Last, First MI Alphabetical order	EMT License Level	EMT License Number	Employment Status Full, P.T, Vol.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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25				
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28				
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30				
31				
32				
33				

	Name (print) Last, First MI Alphabetical order	EMT License Level	EMT License Number	Employment Status Full, P.T, Vol.
34				
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42				
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I certify that the above listed information is true and correct to the best of my knowledge, that this licensed service will provide EMS coverage 24 hours a day, 7 days a week, and that appropriately licensed personnel will be on each run as provided for in the Emergency Medical Services Rules.

Signature of Applicant: _____ Date: _____

ALABAMA INCIDENT MANAGEMENT SYSTEM AGREEMENT

AIMS AGREEMENT: The MOUs can be found at the OEMST Web site: www.adph.org/ems. After accessing the site, go to the AIMS link found on the left-hand column. Please sign and return either one or both of the Memorandums of Understanding (MOUs), signature pages, annually with the renewal application.

Coordinated Deployment of Ambulances: YES ☐ NO ☐

Medical Needs Shelter: YES ☐ NO ☐

Current AIMS E-mail address: _____

If your Service agrees to be available to Standup for the Coordinated Deployment of Ambulances or Medical Needs Shelters during an incident or disaster, please make certain you provide a current E-mail address, which will be monitored at all times by the primary AIMS contact person.

OFF-LINE MEDICAL DIRECTORS SELECTION/MEDICAL DIRECTION FACILITY APPROVAL FORM

This form is to be utilized as both the Off-Line Medical Director's Selection, and Designated Medical Direction Hospital Approval, for all Licensed Transport and Advanced Life Support Services; and it must be completed each time an application is submitted, or when a service selects a new Off-Line Medical Director or Designated Medical Direction Hospital.

Physician's Name: _____, **Affiliated with:** _____Hospital

Hospital Phone: (____) _____ **Alabama License** #: _____ **Physician's MCID** #: _____

By signing this application, I understand that I am committing myself to serve as the Off-Line Medical Director for:

_____ **Ambulance/Emergency Service of** _____ **County**

I will be expected to perform the duties thereof, as outlined in **Section 420-2-1-.06, et.** al, of the State Emergency Medical Services Rules.

_____ _____

PHYSICIAN'S SIGNATURE (original) **DATE**

MEDICAL DIRECTION HOSPITAL INFORMATION

Designated Med Direction Hosp: _____ **City:** _____ **State:** _____ Zip: _____

Contact Person: _____ **Phone:** (____) _____ **Fax** #- (____) _____

E-mail Address: _____

(FOR ALABAMA DEPARTMENT of PUBLIC HEALTH USE ONLY)

The above listed Off-Line Medical Director and the Designated Medical Direction Hospital have been reviewed and are recommended for approval.

ADPH OFFICE OF EMS: _____ **Date:** _____

ADVANCED LIFE SUPPORT AGREEMENT

NAME OF SERVICE: _____

TYPE OF APPLICATION: ALS 1: ☐ Nitrous Oxide: ☐
ALS 2: ☐ Morphine Sulfate: ☐
ALS 3: ☐ Fentanyl: ☐

NUMBER AND TYPE OF ADVANCED LIFE SUPPORT BOXES USED:

MEDICATION BOXES ____

TOTAL NUMBER of MORPHINE SULFATE SYRINGES ____

TOTAL NUMBER of FENTANYL VIALS ____

RESPONSIBLE PARTY

I understand it is my responsibility to insure proper program administration. I also agree to notify the Alabama Department of Public Health, Office of EMS, and the participating hospital pharmacy, if applicable, of any changes in operating procedures or personnel which would alter the content of the current authorization. This agreement will become effective upon approval by the Alabama State Board of Health.

The "responsible party" listed should be someone in authority such as mayor, public safety director, fire chief, police chief, ambulance service owner, etc.

NAME: _____ TITLE: _____

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: ___ ZIP: _____ PHONE: (___) _____

FAX PHONE: (___) _____ E-MAIL ADDRESS: _____

SIGNATURE: _____ DATE: _____

DELEGATED RESPONSIBLE PARTY

The "Delegated Responsible Party" should be someone appropriately licensed to handle substances contained in the prehospital kit(s), including Nitrous Oxide, Morphine Sulfate, and/or Fentanyl.

NAME: _____ TITLE: _____

PHONE: (___) _____ E-MAIL ADDRESS: _____

SIGNATURE: _____ DATE: _____

PHARMACY or PHARMACEUTICAL SUPPLY AGREEMENT

NAME OF SERVICE: _____

I agree to notify, in writing, the authorized pharmacy, and the Alabama Department of Public Health, Office of EMS, of any changes or operational procedures which would alter the content of the current authorization. Some services may change their Fluid/Medication Plans and purchase through the use of a DEA-222 Official Order Form, including Nitrous Oxide/Oxygen mixture, and/or Morphine Sulfate/Fentanyl from an outside vendor. However, it your service continues to operate its ALS authorization through the hospital pharmacy, then you must understand that the Nitrous Oxide/Oxygen mixture and the Morphine Sulfate/Fentanyl (if either is applicable to this authorization) must be dispensed under the authorization of the hospital pharmacy currently supplying and re-supplying I.V. Fluids and Medications to this service. This agreement will become effective upon its approval by the Alabama State Board of Health.

TYPE OF APPLICATION:
ALS 1: ☐ Nitrous Oxide: ☐
ALS 2: ☐ Morphine Sulfate: ☐
ALS 3: ☐ Fentanyl: ☐

NUMBER AND TYPE OF ADVANCED LIFE SUPPORT BOXES USED:

MEDICATION BOXES ____

TOTAL NUMBER of MORPHINE SULFATE SYRINGES ____

TOTAL NUMBER of FENTANYL VIALS ____

NAME OF PHARMACY or PHARMACEUTICAL SUPPLY CO.: _____

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: ____ ZIP: _____ PHONE: (____) _____

*PHARMACY DIRECTOR/CHIEF PHARMACIST: _____
(Print)

*List name of contact person or customer service for services purchasing fluids/drugs through a vendor. See the Fluid/Drug Plan.

E-MAIL ADDRESS: _____

**SIGNATURE: _____ DATE: _____

**No signature required for services that purchase fluids and drugs through a vendor. See the Fluid/Drug Plan.

DELEGATED RESPONSIBLE PHARMACIST

Listed below are the name, title, and signature of the pharmacist to whom responsibility for the above program will be delegated to. Information on services that purchase fluids and medications through a vendor can be found in the Fluid/Drug Plan guidelines.

NAME: _____ TITLE: _____

E-MAIL ADDRESS: _____

SIGNATURE: _____ DATE: _____

NOTE: After completing your portion of the application, please make one photocopy for your records and submit the entire original application to the Alabama Department of Public Health, Office of EMS.

Provider Electronic Patient Care Report Agreement

Service Name: _____

Today's Date: _____

I understand that as part of being a licensed EMS service by the Alabama Department of Public Health's Office of EMS (OEMS), I agree to the following:

- All Electronic Patient Care Reports (ePCRs) will be submitted to the OEMS within the timeframe alloted by the state EMS Director, with potential licensure action being the consequence of un-timely submission.
- Policies will be implemented within my service to ensure the highest accuracy of data possible.
- Upon receipt of my service license, OEMS approved software will be used to submit ePCRs. Every service's third-party software must go through a testing procedure to ensure compatibility, before approval will be granted.
- If approved third-party software is not available at my service, an individual will attend a class in the OEMS office and receive the software at no cost to the service or individual. This person(s) will be instructed in administration of this free software.
- I will ensure availability of computer(s) and internet to the necessary employees, for the completion and submission of ePCRs, even if computer(s) are at another location.

Owner/Chief Operating Officer Name Printed: _____

Today's Date: _____ Owner/COO Signature: _____

EMS Chief/Officer Name Printed: _____

Today's Date: _____ EMS Chief/Officer Signature: _____

I plan to use the following software to submit ePCRs to the OEMS.

State Software: Long Term ☐ Until Third-Party Software Approval ☐

Other approved software that has been tested: _____

Testing requirements are available at http://emsis.net/Alabama

Below is only for agencies that have not received training and must use state software.

List people who will attend, state software training:
(Reservation and attendance of training must be made in advance of service license issuance)

Name: _____ Training Date: _____

Name: _____ Training Date: _____

Name: _____ Training Date: _____

ADPH Office of EMS

EMS Web Management Form

Service Name: _____ License Number: _____ Date: _____

* All Licensed services must assign an Training Officer and backup that will maintain a roster of vehicles, and personnel. (Must have access to personnel records)
* Training Officer/backup must keep Vehicle Lists, Personnel Roster, Education Dates, and Photographs up to date.
* A Single Training Officer can manage multiple Licensed Providers with a single Username (Email address). (Each service must fill out EMS Web Management Form)
* No individual with access to this system shall share access with any other person.
* An users access expires with the expiration of the Licensed Service's license, unless that service reenters this form, at next license.
* Information entered on the EMS Management site will directly effect individual licenses, therefore should be handled timely and accurately.
* Information gathered from this system is the intellectual property of Alabama Department of Public Health and should be handled appropriately
* Password will be sent directly to your email address, you should unblock the addresses that end with "adph.state.al.us"

Primary Training Officer

Last Name _____ First Name _____ Middle Name _____

SSN _____ Direct Contact Number _____ Cell Phone Number _____ Email Address not shared with any other person will also be your username _____

I understand my duties are to update Rosters, Education information, and pictures, accurately and timely. I will also not share access to this site with any other individual.

Signature _____ Date _____

Site Access Rights

Training Officer has all rights

Other Licensed Services-Counties you work for

Backup Training Officer

Last Name _____ First Name _____ Middle Name _____

SSN _____ Direct Contact Number _____ Cell Phone Number _____ Email Address not shared with any other person will also be your username _____

I understand my duties are to update Rosters, Education information, and pictures, accurately and timely. I will also not share access to this site with any other individual.

Signature _____ Date _____

Site Access Rights

Training Officer has all rights

Other Licensed Services-Counties you work for

Owner / Chief of Service

Last Name _____ First Name _____ Middle Name _____

SSN _____ Direct Contact Number _____ Cell Phone Number _____ Email Address not shared with any other person: will also be your username _____

I will not share access to this site with any other individual.

Signature _____ Date _____

View Only Rights

Personnel ☐

Vehicles ☐

Reports ☐

Other Licensed Services-Counties you work for

Supervisor or Other

First Name _____ Middle Name _____

SSN _____ Direct Contact Number _____ Cell Phone Number _____ Email Address not shared with any other person: will also be your username _____

I will not share access to this site with any other individual.

Signature _____ Date _____

View Only Rights

Personnel ☐

Vehicles ☐

Reports ☐

Other Licensed Services-Counties you work for

Revised Apr 17, 2014

DISPATCH CENTER INFORMATION

Service Name _____

Dispatching Agency Name _____

Dispatching Agency Director _____

Dispatching Agency Contact _____

Please provide two (2) phone numbers for your agencies dispatch center.

Dispatch phone (1) _____

Dispatch phone (2) _____

Please provide the mailing address of your agencies dispatch center.

Dispatch Agency Mailing Address

PHYSICAL ADDRESS: _____ CITY. _____ STATE:____ ZIP:_____

MAILING ADDRESS: _____ CITY._____ STATE:____ ZIP:_____

Director's email address _____

Monitored Dispatch email address _____
(preferred 24/7)

Dispatch Agency Fax _____

ADVANCED LIFE SUPPORT AUTHORIZATION AND/OR LICENSURE APPROVAL/DISAPPROVAL

The following signature is required by the Office of EMS for an EMS Provider's entry and/or renewal into the I.V. Fluid/Medication/Nitrous Oxide/Morphine Sulfate Supply/ReSupply Program, for Ambulance Transport Licensure, and for letters of ALS Authorization to be issued.

NAME OF SERVICE: _____

RESPONSIBLE PARTY SIGNATURE: _____

STATE BOARD OF HEALTH/DESIGNEE ACTION

REVIEW DATE: _____

TRANSPORT: **RECOMMEND APPROVAL** ☐ **DISAPPROVAL** ☐

ALS: **RECOMMEND APPROVAL** ☐ **DISAPPROVAL** ☐

REASON: _____

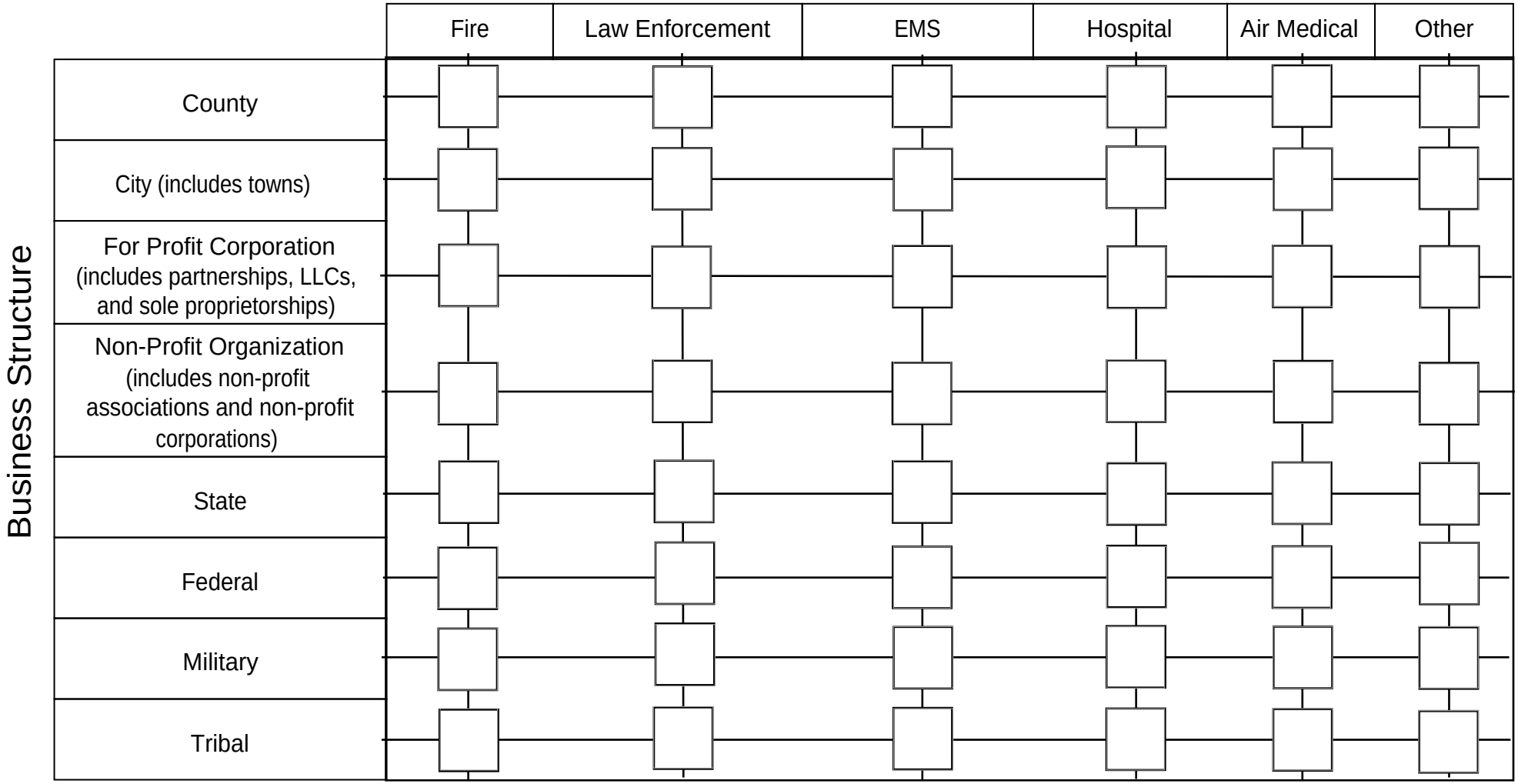
_____

STATE BOARD OF HEALTH SIGNATURE: _____

NOTE: After completing your portion of the application, please make one photocopy for your records and submit the entire original application to Alabama Department of Public Health, Office of EMS. However, you need not return any of the check-lists, the Controlled Substances Guidelines for ALS Services, the PMO example, nor the Drug Box Inspection Report. These all serve as guidelines or for informational purposes only.

Alabama EMS Agency/Provider Topography

Organizational Mission



****Place an (X) in the appropriate *box. You should only* mark one (1) *box.*