

**ADIRONDACK-APPALACHIAN REGIONAL  
EMERGENCY MEDICAL SERVICES COUNCIL,  
INC.**

**Regional Medical Advisory Committee**

**APPLICATION FOR APPROVAL OF SERVICE TO PROVIDE ALS  
LEVEL CARE**

**ALS LEVEL APPLYING FOR:**  Intermediate  Critical Care  
 Paramedic

Agency Name \_\_\_\_\_ Agency Code \_\_\_\_\_

Address \_\_\_\_\_

Town/City \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Business Telephone (\_\_\_\_) \_\_\_\_\_

Emergency Telephone (\_\_\_\_) \_\_\_\_\_

Self-Dispatched  Dispatched by \_\_\_\_\_

- Type of Agency:  Ambulance  First Responder  
 All volunteer  Some paid personnel  All paid personnel

CERTIFIED

REGISTERED

*For consideration as a new ALS agency, the regional council requires that the agency either be certified or in the bonafide process of completing application for certification. If the agency is in the process of certification, the application for certification should be attached to this application. This application may be tentatively approved, pending successful certification of the agency by NYS DOH*

- Current Agency Personnel

#CFR \_\_\_\_ #CFR-D \_\_\_\_ #EMT \_\_\_\_ #EMT-D \_\_\_\_

#AEMT-I \_\_\_\_ #AEMT-CC \_\_\_\_ # AEMT-P \_\_\_\_

- Primary Operating Territory (As listed on your certification or registration):

\_\_\_\_\_

- Do any other BLS/ALS agencies serve all or part of your operating territory? Yes No If yes, please list them:
- 

- Do you have a mutual aid agreement/s with any other EMS agency/agencies? Yes No If yes, please list them
- 

- Please describe your response vehicle(s) and the location at which each response vehicle is based:

- What is your primary (nearest) receiving hospital?
- 

- To what other hospitals do you transport patients?
- 

- Do you have a medical control agreement with a medical control facility?  Yes  No

(Please attach a copy of all agreements)

- Does your agency have a physician medical director?  
Yes No If yes, who is your medical director?

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

*(Attach letter of support and agreement for ALS level practice signed by your medical director. This letter should state the ALS level that the medical director is recommending)*

- Does your agency have current malpractice insurance?  
Yes No *(Please provide a certificate of insurance along with this application.)*

- Does your agency have two-way communication capability with the nearest receiving hospital from all areas of your primary operating territory? Yes No  
If no, what method of communication do you use from “dead spots” to contact medical control? \_\_\_\_\_  
\_\_\_\_\_
- Is your agency available 24-hours per day, seven days per week?  
Yes No If no, what arrangements are made to provide coverage to your territory when your agency is not available? \_\_\_\_\_  
\_\_\_\_\_
- Is your agency able to provide at least one EMT on every call?  
Yes No If no, what percentage of your calls last year did not have an EMT on board? \_\_\_\_\_%
- If you are unable to provide an EMT on every call, what percentage of calls last year had a certified first responder on board? \_\_\_\_\_%
- Please estimate the percentage of calls in the next year that will be covered by an AEMT at the level for which you are applying  
\_\_\_\_\_ %
- What was your average call volume for the past three years?  
\_\_\_\_\_ calls per year
- Do you submit PCR's *monthly* to the regional EMS program office?  
Yes No *If no, please explain how PCR's are submitted*\_\_\_\_\_
- Does your agency have its own or participate regularly in a hospital based, county, or regional level QI committee?  
Yes No  
*Briefly describe your QA and evaluation mechanism:*

- Do you have (or plan to have) a defibrillator and other ALS equipment appropriate for the level for which you are applying for each of your emergency response vehicles? Yes No

**PLEASE ATTACH ALL OF THE FOLLOWING TO THIS APPLICATION:**

- Name; address; telephone number; certification level, number, and expiration dates of all of your certified members/employees. Indicate by a \* all members who are currently certified as an AEMT I, CC, P.
- Name and level of training and responsibilities (patient care, motor vehicle operator, dispatcher, etc.) of all other non-certified agency personnel.
- All standard operating procedures and policies of the agency.
- List of agency officers with name, address, telephone (day and evening).
- Contact person for ALS level service (This person must be, at a minimum, certified at the highest ALS level for which you are applying).
- Copy of the ambulance operating certificate. (If certification is pending, attach application for certification)
- Certificate of malpractice/liability insurance.
- Copies of all mutual aid agreements.
- **Letter of support/agreement from your agency medical director**

**FOR FIRST RESPONDER AGENCIES ONLY:**

- List of ambulance agencies that transport patients cared for by your agency, and a copy of your agreement with each of these ambulance agencies. Each mutual aid agreement must address the issue of the AEMT from the first responder agency remaining in charge of patient care throughout transport if no AEMT is on the ambulance.

**We, the \_\_\_\_\_ hereby apply for approval to operate at the \_\_\_\_\_ ALS level. We agree to adhere to all operating standards, protocols, procedures, and standards of emergency medical care defined by the New York State Department of Health and the**

**Adirondack - Appalachian Regional Emergency Medical Services Council and its Medical Advisory Committee (Including automatic ALS dispatch in those circumstances covered by the protocol, if appropriate level ALS is not available from our agency) We further agree to participate as a member of the Regional Quality Improvement Committee, and to submit copies of all PCR's and Continuation forms completed to the appropriate regional office on a monthly basis. We agree that we will attempt to foster mutual aid agreements with surrounding agencies to assure prompt ALS response and to call for ALS intercept in all situations which, according to protocol or EMTs judgment would benefit from ALS care, when an appropriate level of ALS is not available from our agency.**

**We further understand that failure to comply with the above stated terms may result in suspension or revocation of our agency's permission to provide ALS level services.**

**Agency Chief Executive Officer Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Agency ALS Contact Person \_\_\_\_\_ Date \_\_\_\_\_**

**Agency Medical Director Signature \_\_\_\_\_ Date \_\_\_\_\_**