

AGENCY PROTOCOL APPLICATION

PLEASE TYPE OR PRINT ALL INFORMATION

INTRODUCTORY INFORMATION

This protocol application packet is to be used by the following types of agencies:

- Ground Ambulance Service (310-641 – Subchapter 3)
- Air Ambulance Service (310-641 – Subchapter 13)
- Emergency Medical Response Agency (310-641 – Subchapter 15)

SECTION 1 – TYPE OF APPLICATION

- Initial License Application (An agency not yet licensed)
- Amending or modifying existing protocols (Agency has Department approved protocols on file and is submitting a change or modification.)
- Change in Medical Director (When a new medical director is authorizing care.)

SECTION 2 – BUSINESS INFORMATION

NAME OF AGENCY:

MAILING ADDRESS: (Where the agency receives mail)

PHYSICAL ADDRESS: (The address where the main business office is located)

BUSINESS TELEPHONE:

FAX NUMBER:

NAME OF AGENCY DIRECTOR: (Include cell phone number and email address.)

NAME OF PROTOCOL CONTACT:

(The name of the person who is administratively responsible for all communications regarding protocols. Include cell phone number and email address.)

SECTION 3 – LEVEL OF CARE

Emergency Medical Responder (EMR) (310:641-15-2(k)(2)):
Allows for the use of Emergency Medical Responders as their level of care.

Basic Life Support (BLS) (310:642-3-11(b)(1)):
Means the ambulance service vehicles are equipped with the minimum basic equipment, and staffed with at least one EMT-Basic Attendant on each request for emergency medical service.

Intermediate Life Support (310:641-3-11(b)(2)):
Means the ambulance service vehicles are equipped with the minimum intermediate equipment, and staffed with at least one EMT-Intermediate Attendant on each request for emergency medical service.

Advanced Life Support (310:641-3-11(b)(3)):
Means the ambulance service vehicles are equipped with the minimum advanced EMT equipment and staffed with at least one Advanced EMT Attendant on each request for service, except as permitted in this subchapter.

Paramedic Life Support (310:641-3-11(b)(4)):
Means the ambulance service vehicles are equipped with the minimum paramedic equipment and staffed with at least one EMT-Paramedic Attendant on each request for emergency medical service, or

Air Ambulance Paramedic Life Support (310:641-13-8(a)(1)-(3)):
Paramedic life support means the air ambulance vehicles are equipped with the minimum Paramedic equipment and staffed with at least one Paramedic on each request for service and may respond to both pre-hospital request and interfacility transfers.

SECTION 4 – MEDICAL DIRECTOR

The information regarding the physician licensed in the State of Oklahoma, providing medical direction for the agency. The Department must be notified by the next business day of any change in medical direction has occurred.

SECTION 5 – DESTINATION PROTOCOLS – Complete Enclosed Table (O.A.C.310:641-3-61 or 13-20 Transfer Protocols)

SECTION 6 – QUALITY ASSURANCE PLAN

The **Medical Director shall** be accessible, knowledgeable, and actively involved in quality assurance and the educational activities of the agency's personnel and supervise a quality assurance (QA) program. The appointment of a designee to assist in QA and education activities does not absolve the medical director of their responsibility for providing oversight.

The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceeds the following requirements:

Protect the confidentiality of the information;
Medical Director's Active Involvement in the review of:
Patient refusals;
Air Ambulance utilization;
Airway management;
Cardiac arrest interventions;
Time sensitive medical and trauma cases;
Review other selected patient care reports not specifically included;
Provide internal and external feedback of findings determined through reviews;
Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years.

SECTION 7 – DECLARE PROTOCOL OPTION

Option #1:

The Agency is adopting the state protocol updates as written. Units must carry all equipment listed at the level of care selected when in service.

Option #2:

The Agency is adopting the state protocols with alterations/deletions.
Must supply an electronic copy of the changes made.

Additionally, Option 2 is to be used when an agency has Department approved protocols and is requesting a change to the existing protocols.

Option #3

The Agency is **rejecting** the state protocols and will use their own medical treatment protocols.
The agency must submit an electronic copy of the agency protocols.

SECTION 8 – LIST OF EACH PROTOCOL ALTERATION / DELETION (Use form provided)

SECTION 9 – SIGNATURES:

MEDICAL DIRECTOR AND AGENCY DIRECTOR (Include dates)

SECTION 10 – AUTHORIZED PROCEDURE LIST (APL) (Attached)

Complete and accurate with Medical Director and EMS Director signatures.

Agency authorized procedure list is a summary of all activities, skill, and medications being utilized at the agency. Mark each box with an "X" being authorized and black out any box being denied, deleted, or unauthorized.

A copy of the individual's authorized procedure list, with signatures and dates will need to be filled out for any personnel authorized by the agency medical director operating at the agency and maintained within the individual's credentialing/training/licensure files.

AGENCY PROTOCOL APPLICATION

SECTION 1 – TYPE OF APPLICATION (PRINT OR TYPE)

Date of Application: _____

License No: _____

Purpose:

Initial License Application Amending Existing Protocols Medical Director Change

SECTION 2 – BUSINESS INFORMATION

Agency Name: _____

Mailing Address: _____
CITY ZIP CODE

Physical Address: _____
CITY ZIP CODE

Business Phone: _____ Fax Number: _____

Agency Director: _____ Cell: _____ Email: _____

Protocol Contact: _____ Cell: _____ Email: _____

SECTION 3 – LEVEL OF CARE (Check the certification or licensure of agency or agency application)

Emergency Medical Responder Basic Life Support Intermediate Life Support Advanced Life Support
 Paramedic Life Support Air Ambulance Paramedic Life Support

SECTION 4 – MEDICAL DIRECTOR

Name: _____ MD: DO: Specialty: _____

Address: _____
Mailing Address City State Zip Code

Phone Number: _____ Cell Phone: _____ Email: _____

Oklahoma License Number: _____ OBNDD Number: _____

(If the medical director has changed, submit the documents required on the medical director checklist.)

Each agency or service will have a written plan or policy to address a sudden lapse of medical direction, such as a back-up or reserve medical director. The back-up or reserve medical director will ensure coverage when the agency medical director is unavailable.
Include the agency policy or plan with this application.

SECTION 5 – DESTINATION PROTOCOLS - Complete Enclosed Table (O.A.C.310-641-3-61 OR 13-20 Transfer Protocols)

SECTION 6 – QUALITY ASSURANCE PLAN – Attach a copy of the Quality Assurance Plan with this application

The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceed the following requirements:

- Protect the confidentiality of the information;
- Review patient refusals;
- Review air ambulance utilization;
- Review airway management;
- Review cardiac arrest;
- Review time sensitive medical and trauma cases;
- Review other selected patient care reports not specifically included;
- Provide internal and external feedback of findings determined through reviews;
- Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years

SECTION 7 – DECLARE PROTOCOL OPTION (The Agency must mark one of the below)

- OPTION #1 - The Agency is adopting the 2018 Oklahoma State Protocols as written.
- OPTION #2 - The Agency is adopting the 2018 Oklahoma State Protocols with additions, deletions, or alterations.
- OPTION #3 - The Agency is rejecting the 2018 Oklahoma State Protocols and will use Agency independent protocols.

SECTION 8 – DEFINE EACH PROTOCOL ALTERATION / DELETION (Use Section 8 form attached)

(Agency must attach scientific data or evidence for protocol requests not within the Oklahoma State Protocols or existing scope of practice.)

SECTION 9 – SIGNATURES

MEDICAL DIRECTOR SIGNATURE: _____ DATE: _____

AGENCY DIRECTOR SIGNATURE: _____ DATE: _____

SECTION 10 – AUTHORIZED PROCEDURE LIST (Attached)

SECTION 5 – DESTINATION PROTOCOLS (See O.A.C. 310:641-3-61)

AGENCY PROTOCOL CONTACT (Required):

NAME: _____

CELL PHONE NUMBER: _____

EMAIL ADDRESS: _____

Regulation	Facilities within a reasonable range (Please list)
3-61 (c) or 13-20 (f)	

3-61 (d) or 13-20 (g)	(1) medical and trauma non-emergency transports shall be transported to facility of patient's choice, if within reasonable service range (see list above)
3-61 (d) or 13-20 (g)	(2) emergency, non-injury related, non-life threatening transports shall be transported to the facility of the patient's choice if within reasonable service range (see list above)
3-61 (d) or 13-20 (g)	(3) emergency, injury related transports shall adhere to the OK Triage, Transport, and Transfer Guidelines... and ensure that patients are delivered to the most appropriate hospital, either within their region or contiguous regions.
List facilities that your agency would transport to:	A. _____ B. _____ C. _____ D. _____
3-61 (d) or 13-20 (g)	(4) severely injured patients as described in the OK Triage, Transport and Transfer Guidelines...shall be transported to a hospital classified at Level I or II...unless a Level III facility identified in a regional plan is capable of providing definitive care. If time and distance are detrimental to the patient, then transport to the closest appropriate hospital identified in the regional plan.
List facilities that your agency would transport to:	A. _____ B. _____ C. _____ D. _____
3-61 (d) or 13-20 (g)	(5) Stable patients at risk for severe injury or with minor to moderate injury as described in the OK Triage, Transport, and Transfer Guidelines shall be transported to the closest appropriate facility, or by patient choice consistent with regional guidelines
List facilities that your agency would transport to:	A. _____ B. _____ C. _____ D. _____

Section 8 – Protocol addition, deletion, or alteration

Protocol Name	Protocol page #	Item being added, deleted, or altered	Evidence or explanation provided

Authorized Procedure List

AGENCY

INDIVIDUAL

Agency Name:											
Agency Director Signature:						DATE:					
Medical Director Signature:						DATE:					
Employee Name:		Level:		Signature:		DATE:					
APL MUST MATCH PROTOCOLS						***APL MUST MATCH PROTOCOLS***					
SCOPE OF PRACTICE						SCOPE OF PRACTICE					
AIRWAY	EMR	EMT	I/85	AEMT	NRP	CARDIAC - CIRCULATION	EMR	EMT	I/85	AEMT	NRP
Airway Assessment						CPR					
Oxygen Therapy--Nasal Cannula						AED					
Oxygen Therapy--Non Rebreather Mask						Mechanical CPR Device					
Oxygen Therapy-Partial Rebreather Mask						12-Lead Cardiac Monitor Application					
Oxygen Therapy-Simple Face Mask						12-Lead Cardiac Monitor Transmission					
Oxygen Therapy-Venturi Mask						12-Lead Cardiac Monitor Interpretive					
Oxygen therapy-Humidifiers						Single Lead Cardiac Monitor Interpretive					
Airway Obstruction Management						Manual Defibrillation					
Head Tilt-Chin lift						Cardioversion-Electrical					
Jaw Thrust						Carotid Massage					
Modified Jaw Thrust						Transcutaneous Pacing-Manual					
BLS Artificial Ventilation						Internal pacing-monitor ONLY					
Pulse Oximetry						Ventricular assist device					
BVM						Induced Hypothermia Therapy					
Airway-Nasal						IMMOBILIZATION / LIFTING	EMR	EMT	I/85	AEMT	NRP
Airway-Oral						C-Collar					
Airway-Laryngeal Mask						CID (Cervical Immobilization)					
Intubation-Orotrachael						Pedi Board					
Intubation-Nasal Trachael						Long Spine Board					
Airway Dual Lumen						Scoop					
Airway Supraglottic						Rapid Manual Extrication					
Suctioning-Upper Airway						Extremity Stabilization					
Suctioning-Tracheobronchial						Vest Type Extrication Device					
Obstruction-Direct laryngoscopy						Traction Splint					
Non-Invasive Positive Pressure Ventilation						Mechanical Patient Restraint					
End Tidal-Co2 Monitoring						Urgent Maneuvers Endangered Patient					
Wave-Form Capnography						Pelvic Splint					
Impedance Threshold Device						Portable Pt. Transport Device (Megamover)					
Automated Transport Ventilator (ATV)						MEDICATION ADMINISTRATION ROUTES	EMR	EMT	I/85	AEMT	NRP
Chest decompression--Needle						Intraosseous					
Cricothyrotomy--Percutaneous						Auto-injector					
Cricothyrotomy--Surgical						IV Push					
Gastric Decompression--NG Tube						IV Bolus					
Gastric Decompression--OG Tube						IV Piggyback					
Stoma/Tracheostomy Management						Indwelling Catheters					
MEDICATION ADMINISTRATION ROUTES	EMR	EMT	I/85	AEMT	NRP	Implanted Central IV Ports					
Inhalation						Rectal					
Oral						Ophthalmic					
Sublingual						Topical					
Nasogastric						Transdermal					
Intranasal						Buccal					
Intramuscular						Subcutaneous					

*****BLACK OUT BOX COMPLETELY FOR ITEMS NOT IN THE PROTOCOL*****

Authorized Procedure List

 AGENCY

 INDIVIDUAL

APL MUST MATCH PROTOCOLS						***APL MUST MATCH PROTOCOLS***					
SCOPE OF PRACTICE						SCOPE OF PRACTICE					
	EMR	EMT	I/85	AEMT	NRP	FORMULARY	EMR	EMT	I/85	AEMT	NRP
Hemorrhage control-direct pressure						Etomidate					
Hemorrhage control-tourniquet						Fentanyl					
Shock Treatment						Glucagon					
Lifting and Moving Patients						Glucose					
Helmet Removal (Sports)						Haloperidol					
Helmet Removal (Motorcycle)						Hydralazine					
Child-Birth / Complication						Hydroxocobalamin					
Blood-glucose monitoring						Ipratropium Bromide					
Automated BP						Lactated Ringers					
Manual BP						Labetalol					
Respiratory Rate						Lidocaine			IO	IO	
Manual Pulse						Lidocaine 2% Intravascular			IO	IO	
Eye irrigation						Lidocaine Viscous Gel					
Urinary catheterization						Lorazepam					
Venous Blood Sampling						Magnesium Sulfate					
Central line-monitoring						Methylprednisolone					
Intraosseous Initiation						Midazolam					
IV-maintain of non-medicated fluids						Morphine Sulphate					
IV-maintain of medicated fluids						Hydromorphone					
IV Initiation-Peripheral						Narcan (Naloxone)	Nasal	Nasal			
Thrombolytic therapy-monitoring						Nitroglycerin Metered Dose/Tablet-Patient's					
Medication Assisted Intubation						Nitroglycerin Metered Dose/Tablet agency supplied					
SCOPE OF PRACTICE						SCOPE OF PRACTICE					
FORMULARY	EMR	EMT	I/85	AEMT	NRP	FORMULARY	EMR	EMT	I/85	AEMT	NRP
Albuterol-Proventil-Ventolin (pt. prescribed)						Nitroglycerin-IV Infusion					
Albuterol-Proventil-Ventolin (agency)						Nitroglycerin-Ointment					
Assist with Pt. Prescription Beta Agent						Norepinephrine					
Aspirin						Normal Saline - IV Infusion					
Activated Charcoal						Ondansetron					
Adenosine						Oxygen					
Amiodarone						Phenylephrine 2%					
Atropine Sulfate						Pralidoxime Chloride					
Calcium Chloride						Sodium Bicarbonate					
Dextrose 5%Water						Topical Hemostatic Agent					
Dextrose (D50)						FORMULARY MISCELLANEOUS SKILLS	EMR	EMT	I/85	AEMT	NRP
Dextrose (D25)											
Diazepam											
Diltiazem											
Diphenhydramine											
Dopamine											
Duodote Auto Injector						MISCELLANEOUS SKILLS ADDITIONS	EMR	EMT	I/85	AEMT	NRP
Epinephrine 1:1000											
Epinephrine 1:10,000											
Epinephrine Auto injector											

*****BLACK OUT BOX COMPLETELY FOR ITEMS NOT IN PROTOCOL*****