

Section 5 – Type of Operation

Enter the type of operation for the agency. For Section 5 and 6 – These are examples of type of owner and type of operation combinations:

- A city (or county) owns the license, and the service is based in the city fire department, then governmental city (or county) and fire-based would be marked.
- A city (or county) owns the license, and the service is based in the police department (or county sheriff's office), then governmental city (or county) and law enforcement would be marked.
- A city (or county) owns a hospital, and the service is based in the hospital, then governmental city (or county) and hospital would be marked.
- A city or county owns a hospital, and then appoints a board for the hospital. The city still owns the hospital.
- If a board owns the hospital, then it will be a board or trust that is marked with hospital.
- If the license will be owned by an Ambulance Service District (522 District or Title 19) or a Fire District (Title 18 or Title 19), then mark either Fire Based or other type of operation.
- Third service means the agency is not fire or law enforcement based but is governmental owned.

Section 6 –Communication Policy (O.A.C. 310:641-15-2 (h) (8) (A and B))

Agency Dispatch

- Enter the agency phone number to be used by dispatch to contact by phone.
- Enter who will receive the call (i.e. crew members, agency dispatcher).

Other Dispatch

- Enter the agency that is providing dispatch to the agency.
- Enter the phone number of the agency providing dispatch for the agency.

Radio System

- Enter the type of two-way radio communication maintained by the agency (UHF/VHF/800 MHz)
- Enter the frequency being used for dispatch if applicable.

(NOTE: The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. The communication plan must be compliant with Local, State and Federal communication plans. The agency must complete and submit a statement stating the agency has a communication policy as part of this application.)

Section 7 – Quality Assurance Plan and Protocols (310:641-15-2 (H) (7) (A) – (C))

See Protocol Application Forms

Section 8 – Additional Documentation

- These additional documents that are to be submitted with the application.
- Applications without these documents are incomplete.
- Contracts for equipment and services are to be submitted, if applicable.

- For each unit the applicant owns, complete a vehicle checklist and submit with the application

Section 9 – Proposed Level of Service in Proposed Response Area

(O.A.C. 310:641-15-2 (k) (1) – (3))

Enclose a description of the proposed level of service in the response area and include:

- 1) a map defining the primary emergency response area including base station, substations, posts, and consistent with local or regional emergency communication plans (e.g. 911 center);*
- 2) a description of the level of care to be provided and describing any variations in care within the area; and*
- 3) Emergency Medical Response Agency applicants will provide documentation that reflects compliance with existing sole-source ordinances.*

Section 10 – Type of Owner (O.A.C. 310:641-15-2 (h) (1) (A)- (B))

- Enter the name of the agency owner (You must also complete and submit the ownership supplementary form)
- A business plan is also required. The plan must include a financial disclosure statement showing evidence of the ability to sustain the operation for at least one (1) year.

Section 11 – Indirect Ownership (O.A.C. 310:641-15-2 (h) (1) (A)- (B))

List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

Section 12 – Mortgage (O.A.C. 310:641-15-2 (h) (1) (A) - (B))

List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

Section 13 – Corporation Officers / Directors (O.A.C. 310:641-15-2 (h) (1) (A) - (B))

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

Section 14 – Felony Statement (O.A.C. 310:641-15-7 (a) (1))

Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

Section 15 - EMS District Board (O.A.C. 310:641-15-2 (h) (1) (A) - (B))

If the disclosing entity is a '522' District Board, or received money from a '522' District Board, list the names, titles and addresses of the officers and directors.

Section 16 – Other Ownership or Controlling Interests

(O.A.C. 310:641-15-2 (h) (1) (A) - (B))

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board ("522 or "Title 19"), a city, a county , a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Section 17– Owner Signature (O.A.C. 310:641-15-2 (f))

- Print the license owner’s name in the space provided.
- Print the license owner’s title in the space provided.
- Enter the date in the space provided.
- The license owner must sign in the space provided.
- The signature must be verified by a notary public.

Additional Forms

- **Personnel Roster** – List all personnel for your agency who provide patient care.
- **Inspection Forms** – This form is used by the Department for inspections. Complete the form to provide us with your ambulance’s information as well as an equipment checklist. Complete this form for each of your agency’s ambulances. The Record Review checklist detail records to be maintained at the agency.
- **Medical Director** – See the attached Medical Director Checklist to ensure you are sending all of the required information.
- **Approved Procedures List** – Part of Protocol Application forms
- **Substations** – Check “yes” if your agency will maintain substations. Complete and submit the Ambulance Substation form with your application.

Department Application Procedures

After submitting your application, it will be reviewed by Department staff for completeness, accuracy and legibility. You will be contacted if the package is incomplete or additional information is required. Once the application is complete, an EMS Administrator will be assigned to conduct an initial inspection of your files, equipment and facility. Upon receipt of the EMS Administrator’s inspection report, your EMS Agency Certificate will be mailed to the address on record. Information regarding your Ground Ambulance application package may be obtained by calling (405) 426-8480

Oklahoma State Department of Health
 Protective Health Services
 Financial Management
 Emergency Systems/EMS Division
 Oklahoma State Health Department
 PO Box 268823
 Oklahoma City, OK 73126-8823



OKLAHOMA
 State Department
 of Health

Pre Hospital Emergency Medical Response Agency Application Checklist

Date application received: _____ Date complete application received: _____

Reason for package: Initial ____ Amended ____ Update ____ Other _____

Agency Name: _____

Level of Care: EMR ____ EMT ____ Intermediate ____ AEMT ____ Paramedic ____

Please check each item:

1. Amount \$ _____ Fee Paid (O.A.C. 310:641-15-2 (h) (11) and 15-6 (a) (2))

Section	Content	Regulation (O.A.C)	Complete (Yes/No)
1	Type of Application		
2	Business Information		
3	Level of Care	310:641-15-2 (k) (2)	
4	Type of Owner		
5	Type of Operation		
6	Communication Policy	310:641-15-2 (h) (8) (A and B)	
7	Quality Assurance Plan and Protocols	310:641-15-2 (h) (7) (A) – (C)	
8	Proposed Level of Service in proposed Area	(O.A.C. 310:641-15-2 (k) (1) – (3))	
9	Additional Documents		
	Insurances:	310:641-15-2 (h) (2) - (4)	
	Contracts:	310:641-15-2 (h) (7)	
	Medical Director:	310:641-15-2 (h) (5) and 15-13	
	Confidentiality Policy:	310:641-15-2 (h) (10)	
	Personnel roster:	310:641-15-10	
	Response Plan:	310:641-15-2 (h) (9) (A) – (B)	
	Type of Ownership	310:641-15-2 (H) (1) (A) – (B)	
Indirect ownership	310:641-15-2 (H) (1) (A) – (B)		
11	Mortgage	310:641-15-2 (H) (1) (A) – (B)	
12	Corp. officers/directors	310:641-15-2 (H) (1) (A) – (B)	
13	Felony Statement	310:641-15-8 (a) (2)	
14	EMS District Board	310:641-15-2 (H) (1) (A) – (B)	
15	Other Ownership	310:641-15-2 (H) (1) (A) – (B)	
16	Owner signature	310:641-15-2 (f)	
Separate form	Substation list		
Separate form	Medical Director Checklist		
Separate form	Protocols Application Packet		
Separate form	Equipment Checklists		

Medical Director Checklist

Agency Name: _____

Medical Director _____

Please provide these items or copies of these items:

If you change your Medical Director, a new Medical Director Checklist will be needed.

- Letter from the physician agreeing to be your Medical Director
- Copy of Medical Director's State Medical License
- Copy of Medical Director's OBND or DEA certificate
- Medical Director's Curriculum Vitae
- Medical Director's Primary Practice Address
- Medical Director's Email Address
- Name of Hospital where Medical Director is On Staff
- Medical Director's Specialty
- Provide documentation showing what steps will be taken in the event of a Lapse in Medical Direction – such as a back-up or reserve Medical Director.
- Completed EMS Protocols Application. This can be found on our website.



Pre-Hospital EMRA Application

Certification fees

Type of Fee	Regulation	Fee for Initial Certification
Fee for certification	O.A.C. 310:641-15-2 (h) (11)	\$50.00 (non- refundable)
Renewal of certification	310:641-15-6 (a) (2)	\$20.00 (non-refundable)

SECTION 1 – TYPE OF APPLICATION (Print or Type) Date of Application _____ Purpose: Initial _____ Update _____ Certification No: _____		
SECTION 2 – BUSINESS INFORMATION Agency Name: _____ Mailing Address: _____ <div style="text-align: right; font-size: small; margin-right: 50px;">City State Zip Code</div> Physical Address: _____ <div style="text-align: right; font-size: small; margin-right: 50px;">City State Zip Code</div> Record Retention Address: _____ <div style="text-align: right; font-size: small; margin-right: 50px;">City State Zip Code</div> Business Telephone: _____ Emergency Telephone: _____ Director / Administrator / Coordinator / Chief Name: _____ <small>(Additional points of contact may be included with the application)</small> Email Address: _____ Hours of Business Operation (Include days and times): _____		
SECTION 3 – LEVEL OF CARE Emergency Medical Responder _____ Basic Life Support _____ Intermediate Life Support _____ Advanced (EMT) Life Support _____ Paramedic Life Support _____	SECTION 4 – TYPE OF OWNER Governmental City _____ Governmental County _____ Governmental Federal _____ Governmental Tribal _____ Private (Not For Profit) _____ Private (For Profit) _____ Board or Trust (Other) _____ 522, Title 18 or 19 Board _____	SECTION 5 – TYPE OF OPERATION Fire Based _____ Law Enforcement _____ Hospital _____ 3 rd Service (government owned) _____ Private _____ Other: _____
SECTION 6 – Communication Policy (O.A.C. 310:641-15-2 (h) (8) (A and B)) Agency Dispatch Agency phone number where calls are received: () - The call is received by: _____ Other Dispatch Agency providing dispatch: _____ Phone number for agency providing dispatch: () - _____ Radio System (How are you dispatched?) Cell Phone _____ VHF _____ UHF _____ 700Mhz _____ 800Mhz _____ Frequency _____ Does the agency applicant have a communication policy that addresses receiving and dispatching emergency and non-emergency calls that is State and Federal compliant? Yes ___ No ___ <i>(You must include a policy statement)</i>		
SECTION 7 – QUALITY ASSURANCE PLAN and Protocols (O.A.C. 310:641-15-2 (h) (7) (A) – (C)) See enclosed Protocol Application		

SECTION 8 – Proposed Level of Service in Proposed Response Area (O.A.C. 310:641-15-2 (k) (1) – (3))

Enclose a description of the proposed level of service in the response area and include: 1) a map defining the primary emergency response area including base station, substations, posts, and consistent with local or regional emergency communication plans (e.g. 911 center); 2) a description of the level of care to be provided and describing any variations in care within the area; and 3) Emergency Medical Response Agency applicants will provide documentation that reflects compliance with existing sole-source ordinances.

SECTION 9 – Additional documentation (Return with Application)

Certificate of Vehicle Insurance (\$1,000,000.00) (O.A.C. 310:641- 15-2 (h) (2))
Professional Liability Insurance (\$1,000,000.00) (O.A.C. 310:641- 15-2 (h) (3))
Workers' Compensation Program Verification (O.A.C. 310:641- 15-2 (h) (4))
Copies of Contacts for Equipment & Services (O.A.C. 310:641- 15-2 (h) (6)) (if applicable)
Confidentiality Policy (O.A.C. 310:641-15-2 (h) (10))
Personnel Roster (form enclosed) (O.A.C. 310:641- 15-10))
Response plan (O.A.C. 310:641-15-2 (h) (9))
Medical Director (O.A.C. 310:641-15-2 (h) (5) and 15-13)
Letters of support (EMS and Governmental) (O.A.C. 310:641-15-2 (i) - (j))

SECTION 10 – TYPE OF OWNERSHIP (O.A.C. 310:641-15-2 (h) (1) (A)- (B))

___ Government Ownership (City, State or Federal) – Give Description: _____
___ Sole Proprietorship. List name of owner: _____
___ Partnership. List partners: _____
___ Corporation. Name of corporation: _____
___ Disclosing entity received money from, or contracts with , a '522' District (Article X);
Give '522' district name: _____
___ Disclosing entity received money from or contracts with, an 'Ambulance Service' District (Title 19);
Give 'Ambulance Service' district name: _____
___ Other (Specify): _____

SECTION 11 – INDIRECT OWNERSHIP (O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (if applicable)

List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

NAME	ADDRESS
_____	_____
_____	_____

SECTION 12 – MORTGAGE (O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (if applicable)

List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

NAME	ADDRESS
_____	_____
_____	_____

SECTION 13 – CORPORATION OFFICERS / DIRECTORS (O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (if applicable)

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

OFFICERS NAME	TITLE	ADDRESS
_____	_____	_____
_____	_____	_____

CORPORATION DIRECTORS

DIRECTORS NAME	TITLE	ADDRESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 14 – FELONY STATEMENT (O.A.C. 310:641-15-7 (a) (1))

Has any owner, principal, officer, or director been convicted of a felony? Yes _____ No _____.
If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

SECTION 15 – EMS DISTRICT BOARD (“522” or “Title 19” District) (O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (if applicable)

If the disclosing entity is a ‘522’ District Board, or received money from a ‘522’ District Board, list the names, titles and addresses of the officers and directors.

Name: _____	Position: _____
Address: _____	Contact Number: _____
Name: _____	Position: _____
Address: _____	Contact Number: _____

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contact or contracts to provide ambulance services with this form.

SECTION 16 – OTHER OWNERSHIP OR CONTROLLING INTERESTS (O.A.C. 310:641-15-2 (h) (1) (A)- (B)) (if applicable)

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board (“522 or “Title 19”), a city, a county , a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Name: _____	Position: _____	Ownership %: _____
Address: _____	Contact Number: _____	
Name: _____	Position: _____	Ownership %: _____
Address: _____	Contact Number: _____	

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contract(s) to provide ambulance service to this form.

SECTION 17 - OWNER SIGNATURE (O.A.C. 310:641-15-2 (f))

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name _____ Title _____ Date _____ Signature _____
Signed before this _____ day of _____. My Commission Expires: ____ / ____ / _____

Oklahoma State Department of Health
 Protective Health Services
 Financial Management
 Emergency Systems/EMS Division
 Oklahoma State Health Department
 PO Box 268823
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OKLAHOMA
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PRE-HOSPITAL EMERGENCY MEDICAL RESPONSE AGENCY PERSONNEL ROSTER (O.A.C. 310:641-15-10)

Instructions: List all certified and licensed personnel associated with the application/agency. Please list the names in alphabetical order. Please type or print only.

Volunteer means a person that does not receive compensation or is compensated at less than minimum wage.

Agency Name: _____ Date: ____/____/____

Person Providing the Information: _____ Title: _____

Name (Last, First and Middle Initial)	Level of License	SSN
Address	OK License Number and expiration date	Full/Part Time or Volunteer
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name (Last, First and Middle Initial)

Level of License

SSN

Address

OK License Number
and expiration date

Full/Part Time
or Volunteer

11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Signature _____

_____/_____/_____
Date

Oklahoma State Department of Health
Protective Health Services
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Minimum Required Prehospital EMRA Equipment List (OAC 310:641-15-11(d))

Check or initial below to indicate that these minimum required supplies and equipment are available to be present during each emergency medical response provided by your agency .

- one (1) each adult, pediatric, and infant size bag-valve-mask resuscitators,
- one (1) complete set of oropharyngeal airways, single wrapped for sanitation purposes,
- (3) portable oxygen system with two (2) each oxygen masks in adult, pediatric, and infant sizes,
- two (2) adult nasal cannulas,
- portable suction device with age and size appropriate tubing and tips,
- one (1) bulb syringe with saline drops, sterile, in addition to any bulb syringes in an obstetric kit,
- instant cold packs,

Sterile dressing and bandages, to include:

- sterile burn sheets,
- sterile 4"x4" dressings,
- sterile 6"x8" or 8"x10" dressings,
- roller bandages, 2" or larger,
- rolls of tape (minimum of one (1) inch width),
- sterile occlusive dressings, 3" x 8" or larger,
- triangular bandages, and
- scissors.
- blood pressure cuff kit in adult, pediatric, and infant sizes.
- obstetrics kit,
- blankets,
- universal precaution kit for each person attending a patient,
- blood-glucose measurement equipment per medical direction and Department approval,
- AED with adult and pediatric capability,
- adult and pediatric upper and lower extremity splints,
- spinal immobilization equipment per medical control authorization,
- adult traction splint,
- patient care reports,
- digital thermometer.

Include a list of any additional equipment that will be available during each emergency medical response provided by your agency .

Person Providing information: _____

Signature: _____ Date: _____

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Pre-Hospital Emergency Medical Response Agency List of Substations

Do you have units positioned at locations other than the business office or main station? YES ___ NO ___

If yes, list the address and physical location, if different from the address of the units. Make additional copies of this page if necessary.

Substation Name or Number	Address	City, Zip	Phone Number at Sub-station