

EMS Agency Verification and Vehicle License Application Packet

Contents:

1. 530-071Contents List and Mailing Information 1 Page
2. 530-072Application Instructions Checklist.....2 Pages
3. 530-146Verification Requirements..... 1 Page
4. 530-059EMS Agency Verification and Vehicle License Application 5 Pages
5. 530-069Regional Council Review and Comment 1 Page
6. RCW/WAC and Online Web Site Links 1 Page

In order to process your request:

Return Completed Applications to:

EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

When your application for EMS Agency Verification and Vehicle License Application is received by the Department of Health (DOH), it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

Indicate type of application—new, change of ownership, amended or renewal.

- **New**—First time requesting an Agency Verification and Vehicle License.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed service.
- **Amended**—Request the addition or elimination of information on the Agency Verification and Vehicle License.
- **Renewal**—Renew Agency Verification and Vehicle License. Enter your current agency license number.

Indicate service type: Ambulance (transport), or Aid Service (non-transport).

Check One:

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

1: Demographic Information:

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Legal Owner/Operator Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax number.

Email and Web Address: Enter the owner's email and Web addresses, if applicable.

Agency Name: Enter the agency name as advertised on signs or Web site.

Agency Physical Address: Enter the agency physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the agency phone and fax number.

Mailing Address: Enter the agency mailing address, if different than physical address.

- 2: Agency Specific Information:**
Level of care provided on a 24-hour basis: Check which one applies to you.
Requested response area: Identified in the regional plan.
Organization Type: Please check the one organization that best applies to your organization.
Response Information: Provide a number for each EMS activity. **Primary response**, first out/first alarm. **Secondary response**, responding at primary agency request, 2nd out alarm. First time applicants need not provide this information
Personnel Status: Check whether paid or volunteer and number of EMS personnel that are paid or volunteer.
- 3: Contact Information:**
Contact person:
Enter the name, phone number, and email address of the person who is able to answer questions about agency licensing, vehicle licensing, and agency personnel association issues. Include a Washington State DOH credential number, if applicable.
- 4: Supervision:**
Enter the name of the County Medical Program Director.
- 5: Additional Information:**
Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, LLC members or manager, partners, etc. Attach additional completed pages if you need more space.
Change of Ownership Information: If applicable, list the previous legal owner name, previous name of agency, previous service credential number, effective date of ownership change and physical address.
- Emergency Medical Vehicles:**
Document how extrication will be provided when needed. Provide year, make and model, license plate number, actual address of vehicle, AMB or AID, and VIN number.
Emergency Medical Services Personnel:
Indicate personnel in your organization who will be providing emergency care, aid or transportation, showing their highest EMS qualification (EMT, paramedic, etc.). Identify if any EMT personnel have IV or Supraglottic airway special skills endorsements. Include all EMS personnel who are full or part-time. Attach additional completed pages if you need more space.
- Signature:**
Signature of legal owner or authorized representative.
Date signed.
Print name of legal owner or authorized representative.
Print title of legal owner or authorized representative.
- Regional Council Review and Comment:**
Send this form along with a copy of your completed application to the Regional EMS Council in whose area the service is applying for response area assignment.

Verification Requirements

- Check with the Regional EMS Council to assure that the need for an additional service exists. If the response area is saturated with the maximum services, the application will not be consistent with the Regional EMS Plan.

Note: Maps of Response Areas are available in the respective Regional EMS and Trauma Care Office and plans are posted on the [website](#). The minimum and maximum number of verified services by type and the distribution by response areas are specified in the approved regional EMS plans.

- Complete the application including the following:
 - a. Dispatch Plan
 - b. Response Plan (include station locations and system status management)
 - c. Level of Service
 - d. Type of Transport (emergency or inter-facility)
 - e. Tiered Response and Rendezvous Plan
 - f. Back-up Plan to Respond
 - g. Interagency Relations
 - h. A detailed explanation of how the applicant's proposal avoids unnecessary duplication of resources/services as outlined in the Approved Regional Plan "Needs and Distribution of Services" provisions
 - i. A detailed explanation of how the applicant agency will meet the specific needs as outlined in the Approved Regional Plan
- Include evidence of current liability insurance coverage: Provide a copy of the liability insurance coverage policy, an ACCORD certificate of insurance, or a letter from a licensed insurer verifying the required insurance will be in place for the applicant agency at the time verification goes into effect.
- Provide a detailed narrative on each of the following:
 - a. Consistency with the Approved Regional Plan and Patient Care Procedure
 - b. Vehicles and Equipment
 - c. Sufficient Staffing Levels
 - d. Trauma Training Program
 - 1. How the service's present Certified EMS Personnel have been, or will be, trained so they have the necessary understanding of Department-approved Medical Program Director (MPD) protocols.
 - 2. How the service will assure that its personnel understand their obligation to comply with the MPD protocols.
 - 3. How the service will assure that its personnel will maintain currency with the protocols whenever they are revised.
 - 4. How the service will address numbers 1-3 for new personnel as they join the organization.
 - e. Participation and compliance with Regional Quality Improvement.

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Date
Stamp
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EMS Agency Verification and Vehicle License Application

This is for: New Change of Ownership Amendment
 Renewal License # _____

Service Type: Ambulance (transport) Aid Service (non transport)

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | |

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
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Legal Owner/Operator Name

Mailing Address

City	State	Zip Code	County
------	-------	----------	--------

Phone (enter 10 digit #)	Fax (enter 10 digit #)
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Email Address	Web Address:
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Agency Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip Code	County
------	-------	----------	--------

Agency Phone (enter 10 digit #)	Fax (enter 10 digit #)
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Mailing Address (If different than physical address)

City	State	Zip Code	County
------	-------	----------	--------

For Office Use Only

Credential # _____ Date Issued _____

2. Agency Specific Information

Level of care provided on a 24-hour basis: BLS ILS ALS

Requested response area (as identified in the regional plan): _____

Organization Type (check one only)

- | | | |
|--|---|--|
| <input type="checkbox"/> City Fire Department | <input type="checkbox"/> Fire District | <input type="checkbox"/> Municipal (city/county) |
| <input type="checkbox"/> City/Fire District Combined | <input type="checkbox"/> Hospital District | <input type="checkbox"/> Private Volunteer Association |
| <input type="checkbox"/> EMS District | <input type="checkbox"/> Industrial Fire Department | <input type="checkbox"/> Search & Rescue |
| <input type="checkbox"/> Federal Fire Department | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Other |

Response Information

Please provide the number for each EMS activity listed below, for your last full calendar year (if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information):

Primary Responses	<input type="text"/>	Transports Primary/Secondary	<input type="text"/>
Secondary Responses	<input type="text"/>	Inter-facility Transports Only	<input type="text"/>

Personnel Status

Are your EMS personnel primarily: (check one) Paid Volunteer

Number of EMS personnel that are: Paid _____ Volunteer _____

3. Contact Information

Contact Person Name

WA State DOH Credential # (if applicable)

Email Address

Phone (enter 10 digit #)

4. Supervision

Name of County Medical Program Director

5. Additional Information

Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone #	Title

Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Service

Previous Service Credential #

Effective Date of Ownership Change

Emergency Medical Vehicles

Please provide the following information for all vehicles to be licensed. Vehicle location is the address in which the vehicle is physically located. Indicate the type of vehicle(s):
 AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030 and consistent with 70.168). See our website for the complete [EMS and Trauma Care System Statutes](#).

Please review WAC 246-976-260 through 390 to ensure your vehicles meet all requirements.
 WAC 246-976-300 requires all licensed EMS agencies to document how extrication will be provided when needed. See our website for the complete [EMS and Trauma Care System Rules](#).

Document how extrication will be provided when needed. _____

	Year	Make and Model	License Plate Number	Actual Address of Vehicle (if different from page 1)	Choose One (✓)		Vehicle Identification Number (VIN)
					AMB	AID	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Note: When adding, removing, or changing the location of licensed vehicles, it is always necessary to notify the Department of the change(s). The Vehicle Changes Application is available on our [website](#).

Emergency Medical Services Personnel

List all personnel in your organization who will be engaged in providing emergency care, aid or transportation, showing their highest EMS qualification (EMT, Paramedic, etc.). Also mark the box(s) if any EMT has an IV or SGA endorsement on their certification card. Include all EMS personnel who are full or part-time. Attach additional completed pages if you need more space.

Keep a copy of this document on file for inspection by the Department of Health.

	Name/Credential #	*AFA	EMR	EMT	Endorsements		AEMT	PM
					IV	SGA		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								

Legend:

***AFA** = the Department of Health does not regulate Advanced First Aid personnel.

EMR= Emergency Medical Responder

SGA = Supraglottic Airway Endorsement

EMT = Emergency Medical Technician

AEMT = Advanced Emergency Medical Technician

IV = Intravenous Therapy Endorsement

PM = Paramedic

Signature

I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures.
2. The vehicles identified on Page 3 meet the minimum equipment requirements for the level and type of trauma verification requested by our service.
3. We meet the minimum staffing requirements for verification as identified on Page 4.
4. Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols.
5. We maintain current liability insurance coverage (**copy attached**).

Signature of Owner/Operator

Date

Print Name

Print Title

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Regional Council Review and Comment

This portion to be completed by the agency applying for licensure and mailed to the department with your completed application packet.

EMS Agency Name _____

Address: _____

Contact Person _____

Phone (enter 10 digit #): _____ Date: _____

Level of care provided on a 24-hour basis: BLS ILS ALS

Ambulance (transport) Aid Service (non-transport) Air Ambulance

The signature below is required in accordance with [WAC 246-976-390](#). Please note that only DOH may approve licensure and verification of services.

This portion to be completed by the Regional Council Representative and returned to the department.

Does this application for verification appear to be consistent with the Regional Plan?

Yes

No Attach documentation to explain a "No" answer.

Regional EMS Council Representative

EMS Region

Signature

Date

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Emergency Medical Services and Trauma System RCW	<u>RCW 18.71</u>
Emergency Medical Services and Trauma System RCW	<u>RCW 18.73</u>
Emergency Medical Services and Trauma System WAC	<u>WAC 246-976</u>

On-line

Emergency Medical Services and Trauma System	<u>Web Page</u>
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