

## **EMS Provider Supervisory Organization Application Packet**

### **Contents:**

1. 530-130 ..... Contents List and Mailing Information..... 1 page
2. 530-131 ..... Application Instruction Checklist ..... 2 pages
3. 530-123 ..... EMS Provider Supervisory Organization Application ..... 3 pages
4. RCW/WAC and Online Web Site Links ..... 1 page

### **In order to process your request:**

**Mail your application and  
other documents to:**

EMS Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

(This page intentionally left blank.)

## **EMS Provider Supervisory Organization Application Instructions Checklist**

When your application for EMS Provider Supervisory Organization is received by the Department of Health, it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

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

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

- **New**—First time requesting approval as an EMS provider supervisory organization.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of the EMS provider supervisory organization.
- **Amended**—Request the addition or elimination of information about the EMS provider supervisory organization.
- **Renewal**—Renew approval as an EMS provider supervisory organization.

**Organization Type:** Please check the one organization that best applies to your organization.

**Applicant Organization's Operation:** On a separate attachment, please provide the requested information.

**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.

**Applicant Organization Name:** Enter the organization's name as advertised on signs or web site.

**Mailing Address:** Enter the organization's complete mailing address including city, state, zip code and county.

**Physical Address:** Enter the organization's physical street location including city, state, zip code and county.

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

**Email and Web Address:** Enter the organization's email and agency web addresses, if applicable.

**2. Contact Information:**

Enter the name, phone number, and e-mail address of the EMS contact person. Include a Washington State credential number, if applicable.

- 3. Supervision:**  
Enter name of the County Medical Program Director.
- 4. Additional Information:**
- **Applicants Organization's Operations:** On a separate attachment provide the information requested regarding the organization's operations.
  - **EMS Personnel Information:** Indicate the status and number of your paid and volunteer EMS personnel.
  - **Applicants Organization's Personnel Credential Information:** On a separate attachment provide the information requested regarding the organization's EMS personnel. Include full or part-time personnel.
- 5. Statements and Signatures:**  
The organization's representative must read the affirmation statement thoroughly to ensure the provisions of this section are understood. Then, print and sign name and enter the date.

You may obtain information for your local council by contacting your local EMS system or the Regional EMS and Trauma Care Council administrator. A link is provided below which will allow you to determine which region your county is in and the other to provide you with regional council contact information.

Regional Map: <http://www.doh.wa.gov/hsqa/emstrauma/download/desigmap.pdf>

Regional Administrator: <http://www.doh.wa.gov/hsqa/emstrauma/regional.htm>



## 2. Contact Information

Contact Person Name:

Business Phone (enter 10 digit #):

WA State Credential number: (if applicable)

Alternate Phone (enter 10 digit #):

Email Address:

## 3. Supervision

Name of EMS County Medical Program Director:

## 4. Additional Information

**Applicant Organization's Operation:** On a separate attachment, provide the following:

**Law Enforcement, Search & Rescue and Disaster related resources:** Describe, in detail, how your agency will work together with the local EMS and Trauma System.

### Businesses:

- Describe your general operation and explain how your organization will augment the local EMS and trauma system. Include distance and time from the nearest licensed EMS provider to your location and list any barriers or restrictions EMS provider's may encounter, while responding, that could delay patient care.
- Provide your rationale for an increased level of patient care for injured employees, above the level of Labor and Industry requirement's defined in [WAC 296-307-03905](#). Be specific and attach supporting documentation.
- Describe, in detail, how your agency will work together with the local EMS and trauma system.

### Application Organization's Paid and Volunteer Status:

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

Number of EMS personnel that are: \_\_\_\_\_Paid \_\_\_\_\_Volunteer

**Applicant Organization's Personnel Credential Information:** On a separate attachment, provide the following:

The name, credential number, and level of certification (EMR, EMT, AEMT or Paramedic) for all Washington State Department of Health certified EMS personnel in your organization who will be engaged in providing emergency care, include full or part-time personnel. For EMTs with IV or supraglottic airway endorsements, identify as EMT-IV or EMT-SGA. This endorsement is on their certification card.

## 5. Statements and Signatures

### Applying Organization Statement and Signature

I/We hereby affirm and declare the information provided is true and correct, and agree this organization:

1. Will not operate an Aid or Ambulance service and understands to do so would require state licensure; and
2. Will operate in a manner that is consistent with the regional prehospital patient care procedures and the county operating procedures. This organization will integrate into the EMS and Trauma Care System in our community; and
3. Will follow DOH approved County Medical Program Director (MPD) protocols and MPD medical direction when our certified EMS personnel provides patient care; and
4. Will require EMS personnel to participate in educational programs to meet required state education necessary for recertification; and
5. Ensure that the certified EMS personnel will comply with all statutes and rules regarding prehospital EMS while performing their assigned duties with our organization.

Organization Representative Name (Print):

Signature:

Organization Representative Title (Print):

Date:

### Local EMS Council Chair Statement and Signature (Regional EMS/TC Council's signature when local councils do not exist)

Although these signatures are required, only the Department of Health may approve an EMS Provider Supervisory Organization:

\_\_\_\_\_ We recommend approval.

\_\_\_\_\_ We **do not** recommend approval (attach memo for details) of this applicant based on the operation/mission identified and the statements provided above. If recommended for approval, this applicant is an essential component to the local EMS and Trauma Care system and will integrate into the system following county MPD protocols, regional patient care procedures, and county operating procedures.

Organization Representative Name (Print):

Signature:

Date:

### Medical Program Director Statement and Signature

\_\_\_\_\_ I recommend approval.

\_\_\_\_\_ I **do not** recommend approval (attach memo for details) of this applicant based on the operation/mission identified and the statements provided above. If recommended for approval, this applicant is an essential component to the local EMS and Trauma Care system and will integrate into the system following county MPD protocols, regional patient care procedures, and county operating procedures.

County MPD Name (Print):

Signature:

Date:

(This page intentionally left blank.)

## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Emergency Medical Services and Trauma System Laws, RCW 18.71](#)

[Emergency Medical Services and Trauma System Laws, RCW 18.73](#)

[Emergency Medical Services and Trauma System Rules, WAC 246-976](#)

### **On-line**

[Emergency Medical Services and Trauma System , Web Page](#)