Department of Health
Office of Emergency Medical & Trauma Prevention

AIR AMBULANCE SERVICE / VEHICLE LICENSURE / TRAUMA VERIFICATION APPLICATION

Service Name: ______________________________ / ______________________________
(Legal Name) *(Also Known As)*

Address: ______________________________ EMS Agency/License #:________ *(If known)*

____

City: ____________________ State: __________ Zip: ______________

Owner/Operator: ______________________________ Phone: ______________

Physician Director:______________________________ Phone:______________

EMS Training Officer: ______________________________ Phone: ______________

E-Mail Address: ______________________________ FAX: ______________

NOTE: If your agency operates as an Air Ambulance AND Ground Ambulance, a separate application is required for each part of the operation.

TRAUMA VERIFICATION REQUESTED? Yes ☐ No ☐

DOES YOUR SERVICE UTILIZE EMS PERSONNEL? Yes ☐ No ☐

IF UTILIZING EMS PERSONNEL, PLEASE CHECK THE LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

REQUESTED RESPONSE AREA (As identified in the regional plan):______________________________

ORGANIZATION TYPE: (check the one that ***best*** applies to your organization)

Private For Profit	☐	Private Non-Profit	☐	Private Volunteer Association	☐
Hospital District	☐	EMS District	☐	Other (specify below)	☐

____

VEHICLES: Please provide the **number** of each type vehicle you are licensing (see page 2):

Air Ambulance (Fixed Wing) ☐ Air Ambulance (Rotary Wing) ☐

RESPONSE INFO: 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	☐	Transports Primary/Secondary	☐
Secondary Responses	☐	Interfacility Transports *Only*	☐

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

DO NOT DUPLICATE

AIR AMBULANCE SERVICE / VEHICLE
LICENSURE / TRAUMA VERIFICATION APPLICATION

EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all air ambulance vehicles to be licensed. Vehicle location is the address in which the vehicle is **physically located.** Check the ***type*** of vehicle(s), fixed or rotary wing. Check to see that each licensed vehicle has a license sticker appropriately displayed. If there is no sticker, request one below.

YOUR SERVICE NAME: ______________________________

YEAR		MAKE AND MODEL	LICENSE PLATE OR FAA NUMBER	ACTUAL ADDRESS OF VEHICLE *(If Different From Page 1)*	AIR AMB FIXED	AIR AMB ROTARY	STICKER NEEDED (Yes or No)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Attach extra sheets as necessary, including all the required information.

NOTE: When *adding, removing*, or *changing* the location of licensed vehicles, contact the licensing office, at the address or telephone number on Page 4.

DO NOT DUPLICATE

 (Revised 8/2007) [SUPERSEDES ALL PREVIOUS FORMS]

AIR AMBULANCE SERVICE / VEHICLE
LICENSURE / TRAUMA VERIFICATION APPLICATION

EMERGENCY MEDICAL *PERSONNEL*

List all medical personnel in your organization who are providing emergency care, aid or transportation, and check the appropriate column(s). Include personnel who are full or part-time, paid or unpaid.

PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.

SERVICE NAME: ____

	NAME (LAST, FIRST, M.I.)	EMT	IV TEC H	AW TECH	IV/AW TECH	ILS TEC H	ILS/AW TECH	PM	OTHER (Specify)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
	PLEASE TOTAL EACH COLUMN:								

Attach additional sheets as necessary, including all the required information.

Legend:
EMT = Emergency Medical Technician
IV TECH = Intravenous Therapy
AW TECH = Airway Technician
IV/AW TECH = IV and Airway
ILS TECH = Intermediate Life Support
ILS/AW TECH = ILS & Airway
PM = Paramedic
OTHER = RN, MD, PA, Flight Nurse

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GENERAL OPERATION

On a separate attachment, please describe in detail, the general operation of your service by answering questions a through i (listed below). Include descriptions of how the service will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. (*complete instructions for completing the Trauma Verification Application and a description of the process can be found on our website at* www.doh.wa.gov/hsqa/emstrauma *click on EMS Agency License Application; Initial Air Ambulance Trauma Verification Process, step 4 "Verification Application and Evaluation Process"). If you require hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).*

a. Dispatch Plan
b. Response Plan (include station locations and system status management if used)
c. Level of Service
d. Type of Transport (if seeking verification as a transport agency)
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

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"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 2 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 3;*
4. *Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
5. *We maintain current liability insurance coverage (copy attached)."*

____ ____________________
Person Completing Application ***(Please Print)*** **Date**

____ ____________________
Owner/Operator ***(Signature & Title)*** **Date**

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AIR AMBULANCE SERVICE / VEHICLE
TRAUMA VERIFICATION APPLICATION

REGIONAL COUNCIL REVIEW AND COMMENT

Service Name: ______________________________ **Phone**: ________________

Address: ____

Contact Person: ______________________________ **Date**: ________________

TYPE OF SERVICE: Ambulance (Transport) ☐ Aid Service (Non Transport) ☐

LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

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

REGIONAL COUNCIL REVIEW AND COMMENT

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 **(Print or Type)**

____
EMS Region

____ ____________________
Signature **Date**

DO NOT DUPLICATE