

# **EMS Service and Vehicle License Application Packet Contents:**

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## In order to process your request:

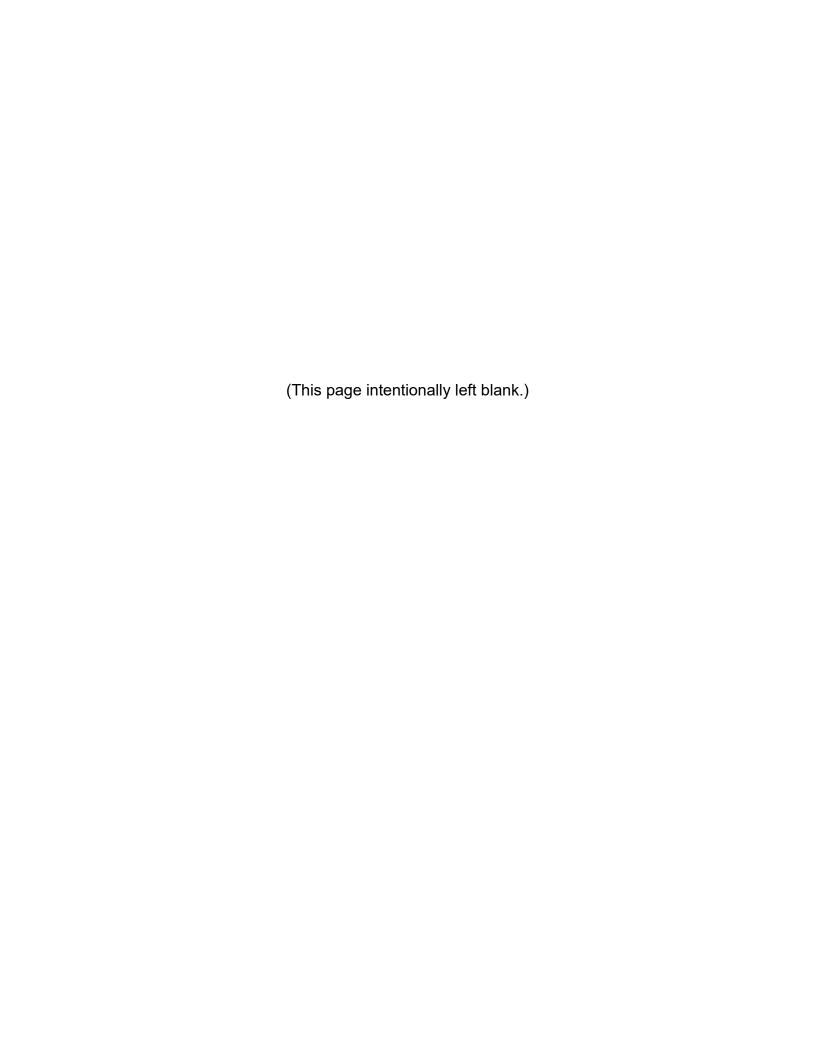
Mail your application and other documents to:

EMS Credentialing P.O. Box 47877 Olympia, WA 98504-7877

#### **Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email <a href="mailto:doh.information@doh.wa.gov">doh.information@doh.wa.gov</a>.





# **Application Instruction Checklist**

When your application for EMS Service and Vehicle License 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 initial EMS Service 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 EMS
   Service and Vehicle License. For example, a 'Change of Response Area' 'Rural
   Services Approval' or 'Level of Care,' etc.
- Renewal—Renew EMS Service and Vehicle License. Enter your current EMS Service license number.

Indicate Service Type: Ambulance (transport) or Aid Service (non-transport).
Check the level of care provided: Check which one applies to you.
<b>Check One:</b> 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.
<b>Federal ID Number (FEIN #):</b> Enter your Federal ID Number, if the business has been issued one.
<b>Legal Owner/EMS Service Name:</b> Enter the owner's name as it appears on the UBI/Master Business License.

**Legal Owner/EMS Service 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.

**EMS Service Name:** Enter the name as advertised on signs or Web site. For example, 'Fire District #99,' 'Woodbridge Fire and Rescue,' etc.

**EMS Service Physical Address:** Enter the physical street location including city, state, zip and county.

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

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

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<ol> <li>Specific Information:</li> <li>Organization Type: Please check the one organization that best applies to your service.</li> </ol>
3. Personnel Status: Indicate your EMS Service staffing model, see definitions below.
Paid: All staff are compensated
Volunteer: All staff are volunteer
Combination: A combination of any of the following:
Some staff are paid
<ul> <li>Some staff are volunteer and receive some form of nominal compensation</li> </ul>
Some staff are volunteer and receive no compensation
List the total number of Paid, Volunteer, Advanced First Aid (AFA) personnel, and the total number of Non-Medically Trained Driver (NMTD). NMTD are persons who do not hold a EMS certification issued by the Department of Health.
You must provide a copy of your current roster from EMS Certification online. If you need assistance please contact EMS credentialing 360-236-4859.
<b>4. Level of Service and Hours of Operation:</b> Enter the level(s) of service provided, if using SCT providers identify staffing model.
<b>5. EMS Supervisor Information:</b> Enter the name, phone number, and email address of the EMS Supervisor who is able to answer questions about licensing, vehicle licensing, and personnel association issues. Include a Department of Health credential number, if applicable.
<b>6. Supervision:</b> Enter name of the County Medical Program Director and their Department of Health credential number.
7. 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.
<b>Change of Ownership Information:</b> If applicable, list the previous legal owner name, previous name, previous service credential number, effective date of ownership change and physical address.
<b>8. Emergency Medical Vehicles:</b> Provide year, make and model, license plate number, actual address of vehicle, AMB or AID, and VIN. Attach additional completed pages if you need more space.
<b>9. General Operation:</b> Provide information regarding the organization's general operation. Attach additional completed pages if you need more space.
<b>10. Rural Attestation:</b> Complete this section if you are operating with approval, or requesting approval as a rural service with non-medically trained drivers as shown in RCW 18.73.150. The representative must read the affirmation statement thoroughly to ensure the provision of this section are understood. Then, print and sign name and enter the date.
<b>11. Signatures:</b> The representative must read the affirmation statement thoroughly to ensure the provisions of this section are understood. Then, print and sign name

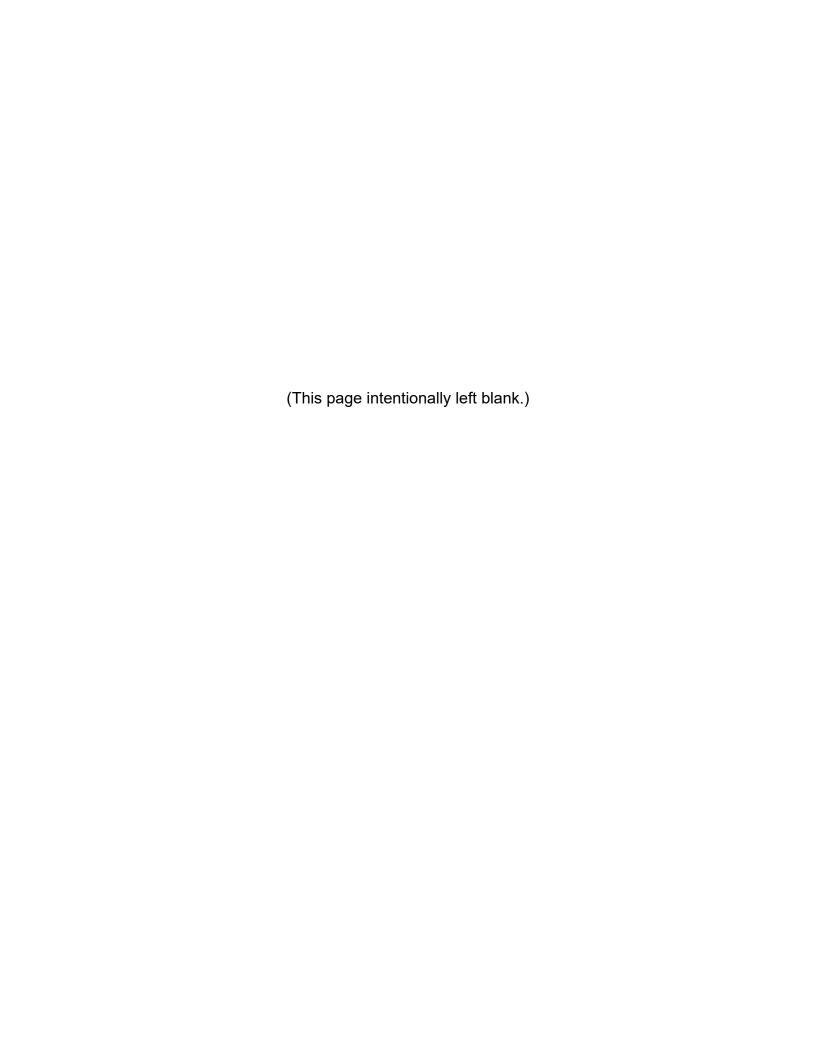
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and enter the date.



# **License Requirements**

Complete the application including the following:
1. Dispatch Plan
2. Deployment Plan
3. Response Plan (include station locations and system status management)
4. Response Area
5. Tiered Response and Rendezvous Plan
6. Back-up Plan to Respond
7. Identify how certified EMS providers receive continuing medical education in $\dots$ accordance with $$ WAC 246-976-161 $$
Include evidence of current liability insurance coverage to include professional, general and motor vehicle.
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 service at the time verification goes into effect
Provide a map of Response Area
<b>Note</b> : Maps of Response Areas are available in the respective Regional EMS and Trauma Care Office and plans are posted on the <u>website</u> . The minimum and maximum number of verified services by type and the distribution by response areas are specified in the approved regional EMS plans.





Date Stamp Here

EMS Service	e and Vehic	le License	Application
This is for:	☐ Change of Own	ership	Amendment
☐ Renewal Licer	nse #	<del> </del>	
Service Type:   Ambulance (tra	nsport)	☐ Aid Service	(non transport)
Level of care provided - Check of	only one:   BLS	□ ILS □ A	ALS
Check One			
☐ Association	☐ Limited Part	nership	Sole Proprietor
☐ Corporation	☐ Municipality	(City)	☐ State Government Agency
☐ Federal Government Agency	☐ Municipality	(County)	☐ Tribal Government Agency
☐ Limited Liability Company	□ Non-Profit C             □	orporation	☐ Trust
Limited Liability Partnership	☐ Partnership		
1. Demographic Informa	ation		
UBI#		Federal Tax ID (F	EIN) #
Legal Owner/EMS Service Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)	1	Fax (enter 10 o	digit #)
Email Address		Web Address:	
Name (Business name as advertised	on signs or Web site	)	
Physical Address			
City	State	Zip Code	County
Phone (enter 10 digit #)	I	Fax (enter 10 o	digit #)
Mailing Address (If different than phys	sical address)		
City	State	Zip Code	County

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2. Specific Inform	nation						
Organization Type: (che	ck one on	ly)					
☐ City Fire Department		Fire District			Municipal (	(city/county)	
☐ City/Fire District Comb	oined 🗌	Hospital District			Private Vol	lunteer Association	
☐ EMS District		Industrial Fire Departr	nent		Search & F	Rescue	
☐ Federal Fire Departme	ent 🗌	Law Enforcement			Other		
3. Personnel State	us						
Please submit your curren		m the Department of	Health	EMS C	ertification	Online.	
Staffing Model: Paid	Volunteer	☐ Combination					
Number of EMS personnel	that are:	Paid	\	/oluntee	er	_Combination	
Number of personnel non-c			anced F	irst Aid)		– Ion-Medically Trained Drive	rs
4. Levels of Serv						•	
Identify all levels of servic		-		LS	☐ ILS	☐ ALS	
•	•	_					
Do you provide Special C	•	· / <u>—</u>	_ N				
On a separate sheet prov		•				provided by the	
organization. If providing			Lanning	modei.			
5. EMS Superviso	or Inforn	nation		14/4 04	-4- DOLLO		
EMS Supervisor				WA St	ate DOH C	redential # (if applicable)	
Email Address				Phone	e (enter 10 d	digit #)	_
6. Supervision				ı			
Name of County Medical Program Director  WA State DOH Credential #							
Name of MDDD/EMO Occur				WA Chata DOLL One dential #			
Name of MPDD/EMS Service Physician				WA State DOH Credential #			
7. Additional Info	rmatior	1					
Legal Owner Information							
List names, addresses, pho		s, and titles of corporate		<u> </u>			_
Name	Address		Phone	e (enter	10 digit #)	Title	_
							_
							_
							_
Change of Ownership In							
Previous Name of Legal Owner					Previous	Service Credential #	
Previous Name of Service					Effective	Date of Change	
TIEVIOUS INAITIE OF SELVICE					LIIECUVE	Date of Griange	

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## 8. 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 RCW 70.168).

See our website for the complete EMS and Trauma Care System Statutes.

Station Na	me and Physical add	lress of veh	icle			
City			State	Zip Code	County	
Vehicle Inf	ormation					
Year	Make and Model					AMB AID
License Pla	ate Number	VIN				
Year	Make and Model					☐ AMB ☐ AID
License Pla	ate Number	VIN				
Year	Make and Model	1				☐ AMB ☐ AID
License Pla	ate Number	VIN				
Year	Make and Model					☐ AMB ☐ AID
License Pla	ate Number	VIN				
Station Na	me and Physical add	lress of veh	icle			
City			State	Zip Code	County	
Vehicle Inf						
Year	Make and Model					☐ AMB ☐ AID
License Pla		VIN				
Year	Make and Model					☐ AMB ☐ AID
License Pla		VIN				
Year	Make and Model					☐ AMB ☐ AID
License Pla		VIN				
Year	Make and Model					☐ AMB ☐ AID
License Pla	ate Number	VIN				

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	of your service; including how it will operate in a manner consistent with approved Regional Patient Care Procedures. For more information on te.
Provide an explanation of your:	
4. Response area	
6. Back-up plan to respond (may not a	pply to agencies doing interfacility transports only)
7. Identify how certified EMS providers  161	receive continuing medical education in accordance with WAC 246-979-
	response plan must be informed by you that they are participants and must h additional completed pages if you need more space.
10. Rural Attestation: To be	e completed by agencies with non-medically trained ambulance drivers
•	formation provided on this application is true and correct, and that:
	dically trained driver is at least 18 years of age.
<ol><li>We have performed a Washington trained driver has no reported offen</li></ol>	State Patrol background check and have verified that each non-medically uses.
3. We have verified that each non-me	dically trained driver holds a valid driver's license with no restrictions.
Signature of Owner/Operator	Date
Print Name	Print Title

9. General Operation

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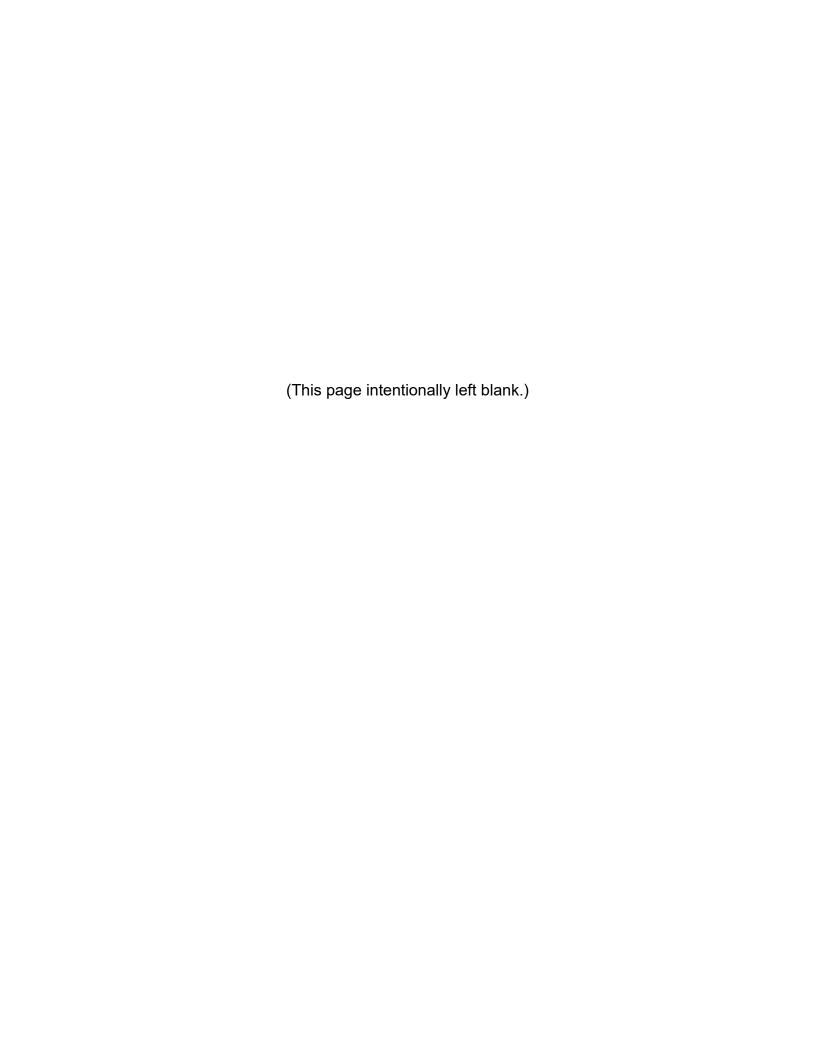
#### 11. Signatures

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

- We operate in a manner that is consistent with the Washington State Triage tools; EMS and Trauma Care Council Regional Plan, pre-hospital Patient Care Procedures, and department approved County Operating Procedures.
- 2. Our current certified EMS personnel are familiar with and utilize a Department of Health approved Medical Program Director (MPD) patient care protocols.
- 3. Provide initial training and updates to certified EMS personnel on department-approved prehospital triage procedures, regional patient care procedures, county operating procedures, county medical program director policies, and patient care protocols.
- 4. If using providers with provisional certifications our EMS service is following requirements listed in provisional emergency services provider certification eligibility <u>RCW 18.71.097</u>.
- 5. In accordance with <u>RCW 43.70.490</u>, our certified EMS personnel are adequately trained in and familiarized with techniques, procedures, and protocols for best handling situations in which persons with particular disabilities are present at the scene of an emergency.
- 6. The vehicles identified in emergency medical vehicle part of the application meet the minimum equipment requirements for the level and type of trauma verification requested by our service for the level(s) of service provided in <u>WAC 246-976-300</u>.
- 7. We maintain current liability insurance coverage as identified in <u>WAC 246-976</u>. To include the motor vehicle liability coverage required in <u>RCW 46.30.020</u> (ambulance and aid services only) and professional and general liability coverage.
- 8. We meet the minimum staffing requirements as identified in <u>WAC 246-976</u>.
- 9. Participate in the Washington state EMS electronic data system in accordance with RCW 70.168.090(2) and WAC 246-976.

Signature of Owner/Operator	Date	
Print Name	Print Title	

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### **RCW/WAC and Online Website Links**

#### **RCW/WAC Links**

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Emergency Medical Services and Trauma System, RCW 18.71

Emergency Medical Services and Trauma System, RCW 18.73

Emergency Medical Services and Trauma System, WAC 246-976

#### **Online**

Emergency Medical Services and Trauma System web page