



Nor-Cal EMS Agency Service Provider Application

Service Provider Applicant Information		
Organization Name:		
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Website:
Type of Service Provider Approval Request (check all that apply)		
County:	<input type="checkbox"/> Lassen	<input type="checkbox"/> Modoc
	<input type="checkbox"/> Plumas	<input type="checkbox"/> Sierra
	<input type="checkbox"/> Trinity	
Applicant Type:	<input type="checkbox"/> New/New Level of Service.	<input type="checkbox"/> Annual Renewal
911/Emergency Transport:	<input type="checkbox"/> BLS	<input type="checkbox"/> LALS
	<input type="checkbox"/> ALS	<input type="checkbox"/> CCT
Non-Emergency IFT (or Special Event):	<input type="checkbox"/> BLS	<input type="checkbox"/> ALS
	<input type="checkbox"/> CCT	
EMS Aircraft:	<input type="checkbox"/> Air Ambulance	<input type="checkbox"/> BLS Air Rescue
	<input type="checkbox"/> ALS Air Rescue	
911/Emergency Non-Transport:	<input type="checkbox"/> LALS	<input type="checkbox"/> ALS
Specialty Provider:	<input type="checkbox"/> ALS Fireline	<input type="checkbox"/> Other: _____
Acknowledgements		
<u>Statement of Fact</u>		
<p>_____ I hereby affirm, under penalty of perjury, that all statements and information on this application and any attached (Initial) documents are complete and correct to the best of my knowledge and belief. I understand that any falsification or omission of material fact may cause forfeiture of Nor-Cal EMS provider approval and referral to appropriate entities for criminal investigation if appropriate.</p>		
<u>Statement of Good Faith</u>		
<p>_____ I hereby affirm ownership or control of required vehicles, equipment and supplies to consistently provide quality EMS (Initial) transport and/or non-transport services. I further affirm that I own or have access to suitable maintenance facilities to provide clean, sanitary equipment in good mechanical condition. I agree to participate in a collaborative manner within the Nor-Cal EMS system, which includes referral of certain requests for service to applicable EOA providers as required by Nor-Cal EMS contracts and policies.</p>		
<u>Additional Service Provider Agreement Acknowledgement</u>		
<p>_____ I agree to ensure that my organization and personnel comply with all applicable EMS laws, regulations and Nor-Cal (Initial) EMS medical control policies/protocols.</p>		
<p>_____ I acknowledge that if approved, a separate Nor-Cal EMS service provider agreement may be required. (Initial)</p>		
Signature:		
Signatory Name:	Signatory Title:	
Date Signed:	Signatory E-Mail:	

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Application Requirements Checklist

Application Requirement Description	911 Emergency Transport	IFT &/or Special Event	EMS Aircraft	911 Emergency Non- Transport	ALS Fireline	Tactical EMS
Items required for all applicants (new and renewal)						
Completed application (including checklist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Organizational Chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copies of applicable business licenses/permits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	N/A
List of rates charged for services (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Proof of insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List current EMTs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List of current Paramedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List of current RNs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List of all vehicles/aircraft providing services in the NOR-CAL EMS region (year/make/model, odometer, license #, colors, aircraft description)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Copies of CHP ambulance licenses (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>	N/A
Continuous Quality Improvement Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permit fee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A

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Application Requirement Description	911 Emergency Transport	IFT &/or Special Event	EMS Aircraft	911 Emergency Non- Transport	ALS Fireline	Tactical EMS
Additional Items Required for Renewal Applicants						
List of service complaints received during the past 12 months. Include a summary of the complaint, findings and resolution.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Total number of dispatched calls for the past 12 months broken out by category (911, IFT, special event, fireline, tactical)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copies of all standing order patient care policies and treatment protocols for your RN personnel (air ambulance providers only)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A
Additional items required for new/new level of service applicants, or if there is a substantive change						
Description of services to be provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of service need (including agreement/contract with hospital or facility within the NOR-CAL EMS Region)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Business plan (private providers only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Financial statement for the previous fiscal year (private providers), or agency budget showing budget for EMS services (public providers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Statement or policy regarding accepting or not accepting Medicare assignments and Medicare billing number (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Letter of agreement to provide online medical direction from a Nor-Cal EMS base or alternate base hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of your complaint investigation and resolution process related to billing, personnel and delivery of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of your new employee orientation training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completed/signed 'Alcohol/Drug-Free Workplace Certification Form'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policy related to providing an Alcohol/Drug-Free workplace in accordance with California Government Code § 8355	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A

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Application Requirement Description	911 Emergency Transport	IFT &/or Special Event	EMS Aircraft	911 Emergency Non- Transport	ALS Fireline	Tactical EMS
Description of how supervision of your EMS personnel is provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Items required for new/new level of service applicants, or if there is a substantive change (continued)						
Description of how continuing education (CE) and EMS training of your personnel are provided and monitored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of EMS personnel certification or license verification and monitoring process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Station addresses (EMS aircraft providers, include a latitude and longitude for all aircraft base locations serving the Nor-Cal EMS region)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Description of vehicle/aircraft maintenance program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Description of all communications/dispatch capabilities, or identification of the PSAP that provides dispatch services for your organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of your biomedical equipment maintenance program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of your medical equipment/supplies storage and resupply procedures (including medications and controlled substances)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name, license number and contact information of your medical director (LALS & ALS providers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policies/procedures for handling and disposal of bio-hazardous materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policies/procedures for infection control (including how applicable OSHA requirements are met - fit testing, TB testing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of the NEMSIS/CEMSIS compatible ePCR system used by your organization, and how EMS data will be uploaded to Nor-Cal EMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description of patient care records maintenance process, including retention and storage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Alcohol/Drug-Free Workplace Certification (Required for New Applicants Only)

Organization Name:

Acknowledgements

Applicant hereby certifies compliance with California Government Code § 8355 in matters related to providing an alcohol/drug-free workplace.

Applicant will:

1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession, or use of controlled substances is prohibited and specifying actions to be taken against employees for violations, as required by California Government Code § 8355(a).
2. Establish an alcohol/drug-free awareness program as required by California Government Code § 8355(b), to inform employees about all of the following:
 - a. The dangers of alcohol and drug abuse in the workplace,
 - b. The organization's policy of maintaining an alcohol/drug-free workplace,
 - c. Any available counseling, rehabilitation and employee assistance programs, and
 - d. Penalties that may be imposed upon employees for alcohol/drug abuse violations.
3. Provide that every employee who works for the organization:
 - a. Will receive a copy of the organization's alcohol/drug-free policy statement, and,
 - b. Will agree to abide by the terms of the organization's statement as a condition of employment.

Certification

I, the official named below, hereby swear that I am duly authorized legally to bind the organization to the above described certification. I am fully aware that this certification, executed on the date and in the county below, is made under penalty of perjury under the laws of the State of California.

Signature:

Signatory Name:

Signatory Title:

Date Executed:

Nor-Cal EMS Approval

Approved By:

Approval Date:

Renewal Date: