Application for Agency License Renewal Bureau of EMS & Trauma

SECTION I — SERVICE INFORMATION

License No: _____

Name of Service: _____

Physical Address: _____

City: _____ County: _____ State: _____ Zip: _____

Mailing Address:

City: _____ County: _____ State: _____ Zip: _____

Business Phone: (____) _____ Fax: (____) _____ Emergency Phone: (____) _____

Owner of Service: _____

☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital
☐ Government ☐ Fire Dept ☐ Rescue Squad

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

EMS Director: _____ EMS Assistant: _____ o n/a

Work Phone: (____) _____ Work Phone: (____) _____

Mobile Phone: (____) _____ Mobile Phone: (____) _____

Email Address: _____ Email Address: _____

License Category Applied For: Ground Ambulance ☐ EMT First Responder ☐

Type of Organization: ☐ Hospital Based ☐ Industry ☐ Fire Dept.
☐ Rescue Squad ☐ County Government
☐ Private Provider ☐ City Government

Level of Service: ☐ EMT-Basic ☐ Advanced EMT ☐ EMT-Paramedic ☐ Nurse

Services Offered: ☐ Non-Emergent Transport ☐ 911 Response with Transport ☐ Rescue
☐ 911 Response without Transport ☐ Hazmat ☐ Paramedic Intercept

This is to certify that all information in this application is accurate and complete.

_____
Signature of Person in Charge

Section II: Employee & Member Contact Information

This section must include all personnel associated with ambulance duties, patient care, and/or documentation; including EMT's, Drivers, RN's, Pilots, Fleet Mechanics, etc. This section may not be by providing a copy of the agency's Continuum Roster.

Last Name	First Name	Address	Phone Number	SC Cert #	Expiration MM/YY

Last Name	First Name	Address	Phone Number	SC Cert #	Expiration MM/YY

Last Name	First Name	Address	Phone Number	SC Cert #	Expiration MM/YY

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Healthy People. Healthy Communities.

Last Name	First Name	Address	Phone Number	SC Cert #	Expiration MM/YY

Section III. Vehicle Information

Official Use Only

VIN	Year	Permit	Tag	Make	Model	Unit Type

Official Use Only

VIN	Year	Permit	Tag	Make	Model	Unit Type

Official Use Only

VIN	Year	Permit	Tag	Make	Model	Unit Type

Section IV: Vehicle Locations & Type

	Number of Primary Units			Number of Backup Units		
Must include Station Name, Street Location, and Phone # for each Station	Basic Units	AEMT Units	Paramedic Units	Basic Units	AEMT Units	Paramedic Units
0 Headquarters						
0 Substations						

Section V: Additional Operational Information

Insurance Information-

Attach a copy of Certificate of Insurance from Vendor

Name of Insurance Company: _____

Name of Agent: _____

Phone Number: _____

Mailing Address of Agent: _____

City/State/Zip Code: _____

Types of Coverage: ☐ Liability ☐ Medical Malpractice ☐ Property Damage

Limits of Coverage: Medical Malpractice $_____ Liability $_____

**If your agency or municipality is self-insured, please provide documentation of the types & limits of coverage.*

Radio Information:

Radio Frequencies ☐ UHF Tx: _____ _____ _____ _____

☐ VHF Rx: _____ _____ _____ _____

Dispatch Hospital Other Other

If using Frequencies other than those listed attach a list of each individual frequency.

Each unit can communicate with:

☐ Company Base ☐ Fire Dept ☐ Law Emforcement ☐ Hospital

☐ EMS ☐ Emergency Operations ☐ Other_____

Does each unit have a cell phone? ☐ Yes ☐ No

Is a Dispatch log maintained and available for audit; including date & time of call received, type of call, and time unit was enroute? ☐ Yes ☐ No

How will your units be dispatched?

☐ 911

☐ Self Dispatched

☐ Third Party Vendor (Specify) _____

Non-emergency Phone Number: _____

Section VI: Contact Information

Training Officer

Name: _____ Office Phone #:_____

Mobile Phone #: _____ Email: _____

Data Manager

Name: _____ Office Phone #: _____

Mobile Phone #: _____ Email: _____

Fleet Manager (personnel responsible for preparing units for permitting inspection)

Name: _____ Office Phone #: _____

Mobile Phone #: _____ Email: _____

Mutual Aid Agreements: Please check if applicable ☐ Yes ☐ No

Please include a copy of any mutual aid agreements that your service may have concerning non-disaster related agreements. Example: A non-emergent transport service has a mutual aid agreement with the local 911 service to provide emergency response within a given area or nursing home/residential care facility.

Controlled Substances: Please check if applicable ☐ Yes ☐ No

If your service carries any controlled substances or have them listed in your protocols, please provide a copy of your South Carolina State Controlled Substance Registration. (This is the South Carolina equivalent to the DEA License)

Section VII: Infection Control

Please review The Ryan White Comprehensive Aids Resources Emergency Act of 1990.

Indicate below the name of the person who will serve as your designated officer. If your designated officer changes, you must notify the department, in writing, with the name of the new designated officer within five (5) days of the change.

Infection Control Officer

Name: _____

Phone #: _____ Email: _____

O Please include a copy of the company's exposure control plan in accordance with current OSHA Regulations.

Section VIII- Call Information

1. How many vehicle(s) are fully equipped to the:
    a. EMT -Basic level? _____
    b. Advanced EMT level? _____
    c. Paramedic level? _____

2. What is the number of permitted vehicle(s) in your fleet? _____

3. What is the total number of calls that your service was dispatched to during the last six (6) months? _____

4. What is the total number of call that your service responded to during the last six (6) months? _____

5. What is the average number of calls your service runs per DAY?
    Answer from number 4: _____ ÷ 6 months = _____ ÷ 30 days
    Emergent or Non-Scheduled _____ + Non-Emergent or Scheduled _____ =_____

Ambulance Services:

6. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the Paramedic level and staffed with at least one (1) Paramedic and one (1) EMT-Basic?
_____

7. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the AEMT level and staffed with at least one (1) AEMT and one (1) EMT-Basic? _____

8. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the EMT-Basic level and staffed with at least one (1) EMT-Basic and one (1) non-certified driver? _____

EMT First Responder Services:

9. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the Paramedic level and staffed with at least one (1) Paramedic? _____

10. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the AEMT level and staffed with at least one (1) AEMT? _____

11. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the EMT-Basic level and staffed with at least one (1) EMT-Basic? _____

I hereby certify that the above statements are true and correct to the best of my knowledge.

EMS Director Signature: _____ Date: _____/ _____/ _____

Medical Control Physician

South Carolina Department of Health and Environmental Control
Bureau of EMS & Trauma
Medical Control Physician Update Form

1. Service Information

Service Name_____ SC DHEC License #_____

Service Mailing Address_____

City/State/Zip code_____

Telephone Number_____ Emergency Number_____

2. Medical Control Physician (MCP) Information

☐ Primary ☐ Assistant

Name of MCP _____

SC BOME #_____ SC DHEC BEMS# SC_____

Email Address_____ Gender: ☐ Male ☐ Female

Mailing Address_____

City/State/Zip_____

Phone #_____

Emergency # _____

Race: (Select)
☐ American Indian or Alaskan Native
☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White ☐ Other

Ethnicity: (Select)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Statement of Understanding & Authorized Signatures:
I have read and understood the duties & responsibilities of the Medical Control Physician as outlined in Regulation 61-7§ 402 (A through G) and § 44-61-130. Of the EMS law also included on this form. Further, if my EMS service has a State- Approved In-Service Training program, I accept full responsibility for the program and understand that I may not waive anyone from the State recertification examination until I have attended a State-Approved EMS Medical Control Workshop. If I have not already attended a Medical Control Physician Workshop, I understand that I must attend the next available workshop within the next twelve (12) months to remain as Medical Control Physician for the above EMS service.

☐ I have attended a Medical Control Workshop ☐ I have not attended a Medical Control Workshop

Signature of Primary MCP & Date **Signature of Assistant MCP & Date**

_____ _____

I understand that I must Notify the SCDHEC Bureau of EMS & Trauma of any change in Medical Control, Drug List, and/ or Standing Orders/Protocols within ten (10) days (Regulation 61-7 ,§ 402 E)

Signature of EMS Director & Date _____