Air Specialty Care Ambulance Service Initial Application
Effective: September 11, 2022

Refer to OSDH EMS Regulation (OAC 310:641-2-3) for complete requirements

(Department use only)

Date Application Received: _____

Date Application Completed: _____

Agency Name: _____

Applicant Checklist

- Specialty care licenses are statutorily limited to patient care and interventions above the Paramedic scope of practice.

- Specialty Care applicants will declare in the application the type or types of specialty care and patients that will be transported by the agency. The types of specialty care and patients may include, but not be limited to:
    - adult, pediatric, infant, neonatal, or a combination of age types,
    - cardiac care, respiratory, neurological, septicemia, or other single or multi-system complications or illnesses requiring specialized treatment during the transport of the patient.

Fee: $600.00 initial fee $600.00

# of aircraft _____ (Add $20.00 for each air ambulance over 2) $_____

# of substations _____ (add $150.00 for each substation $_____

Total enclosed fee: $_____

Completed Application: _____
Separate sections within application –
Protocol application: _____ Personnel roster: _____
Medical director documentation: Substation list: _____
- Consent letter: _____ Equipment list: _____
- Copy of medical license: _____ Curriculum Vitae or Resume: _____
- Copy of OBNDD Registration and DEA Certification: _____

Additional required documentation:
- Business Plan: _____ Communication Policy: _____
- Confidentiality Policy: _____ Contracts (if applicable): _____
- Response Plan: _____ Insurance verification: _____ (aircraft liability, general liability, workers compensation)

All sections complete, signed and notarized: ___

Fees: (OAC 310:2-3 (v) (Non-refundable)

Initial application fee: $600.00
Add $20.00 for each unit over 2 units
Add $150.00 for each substation

Section 1- Business Information

- Enter the name of your agency.
- Enter the mailing address of your agency including city, state, and zip code.
- Enter the physical address of your agency including city, state, and zip code.
- Enter the records retention address (address of where the agency records will be kept) including city, state, and zip code.
- Enter the business telephone number and an emergency telephone number.
- Enter the name of the person who will be a point of contact for the Department.
- Enter an email that the point of contact will be able to access to receive correspondence for the Department.
- Enter the days and times of the agencies operations. Please include the days and times that records will be available for an unannounced inspection review.
- Additional points of contact may be included with the application

Section 2 – Level of Care (310:641-1-7 Air ambulance service) (Staffing requirements are detailed in OAC 310:641-11-8)

- Each licensed specialty care ambulance service shall be staffed in accordance with the agency's policy and standards.
    - The additional training required by the Act for licensed emergency medical personnel to conduct specialty care transports will be beyond the scope of practice of an Oklahoma licensed Paramedic.
    - All Oklahoma licensed Paramedics that have completed training beyond the scope of practice of a Paramedic for the purposes of specialty care transport shall be registered with the Department.

Section 3 – Type of owner (OAC 310:641-2-3 (f) – (g)

Enter the type of ownership for the agency. Essentially, what type of organization will own the license? Examples include:

- Will an ambulance Service District (522 District or a Title 19) District own the license?
- Will a Fire Protection District (Title 18 or Title 19 District) own the license?
- Will a different type of board or trust own the license?

Section 4 - Type of Operation (OAC 310:641-2-3 (f) – (g)

Enter the type of operation for the agency. For Section 4 and 5 - These are examples of type of owner and type of operation combinations:

- A city (or county) owns the license, and the service is based in the city fire department, then governmental city (or county) and fire-based would be marked.
- A city (or county) owns the license, and the service is based in the police department (or county sheriff's office), then governmental city (or county) and law enforcement would be marked.

- A city (or county) owns a hospital, and the service is based in the hospital, then governmental city (or county) and hospital would be marked.
- A city or county owns a hospital, and then appoints a board for the hospital. The city still owns the hospital.
- If a board owns the hospital, then it will be a board or trust that is marked with hospital.
- If the license will be owned by an ambulance Service District (522 District or Title 19) or a Fire District (Title 18 or Title 19), then mark either Fire Based or other type of operation.
- Third service means the agency is not fire or law enforcement based but is governmental owned.

Section 5 – Dispatch and communication information (OAC 310:641-2-3 (r)-(s))

(r) Ground Services, Air Ambulances, and prehospital emergency medical response agencies shall submit a communication policy addressing:

(1) receiving and dispatching emergency and non-emergency calls;
(2) ensuring compliance with State and local EMS communication plans.

(s) Specialty Care Services and Stretcher Van services shall submit communication policy addressing the screening process that ensures a request for service will meet the agency's capability, capacity, and licensure requirements. Documentation of the screening will be retained as part of the patient care report or call log."

Section 6 – Aircraft list

- Enter the manufacturer and serial number for each air ambulance you conduct transports with. This can be done on a separate page.

Section 7 – Medical Director OAC 310:641-2-3 (h)

- Enter the name, address, email, and phone number of your Medical Director
- See application checklist and protocol application for required medical director documentation.

Section 8 – Type of Ownership (OAC 310:641-2-3 (f) – (g)

- Enter the name of the agency owner (You must also complete and submit the ownership supplementary form)
- A business plan is also required. The plan must include a financial disclosure statement showing evidence of the ability to sustain the operation for at least one (1) year.

Section 9 – Indirect ownership (OAC 310:641-2-3 (f) – (g)

List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

Section 10 - Mortgage (OAC 310:641-2-3 (f) – (g)

List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

Section 11 - Corporation Officers/ Directors (OAC 310:641-2-3 (f) – (g)
If the disclosing entity is a CORPORATION, list the names, titles, and addresses of the officers and directors.

Section 12 - EMS District Board (OAC 310:641-2-3 (f) – (g)
If the disclosing entity is a '522' District Board, or received money from a '522' District Board, list the names, titles, and addresses of the officers and directors.

Section 13 - Other Ownership or Controlling Interests (OAC 310:641-2-3 (f) – (g)
If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board (“522 or "Title 19"), a city, a county, a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times, and other pertinent information.

Section 14 - Felony Statement (310:641-3-13 (a) (1))
Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

Section 15- Owner Signature (OAC 310:641-2-3 (e)

- Print the license owner's name in the space provided.
- Print the license owner's title in the space provided.
- Enter the date in the space provided.
- The license owner must sign in the space provided.
- The signature must be verified by a notary public.

SEPARATE FORMS - forms included with this application

- Personnel Roster- List all personnel for your agency who provide patient care.
- Substations - Check "yes" if your agency will maintain substations. Complete and submit the ambulance substation form with your application.
- Equipment List - initial or check the box next to each required list item to indicate it is in your agency's possession.
- Protocols Application - work with your Medical Director to complete this application to ensure your agency meets all EMS Protocol requirements.

ADDITIONAL REQUIRED INFORMATION:
1. Communication Policy (OAC 310:641-2-3 (r) -a written policy addressing how you receive and dispatch emergency and non-emergency calls, and stating that you will ensure compliance with State and Local EMS Communication Plans.

2. Response Plan (OAC 310:641- 2-3(t) - must include:
   - How you provide and receive mutual aid with all surrounding, contiguous, or overlapping, licensed service areas,
   - How you provide and receive disaster assistance in accordance with local and regional plans and command structures such as an incident command structure using national incident management support models.

3. Confidentiality Policy (OAC 310:641-2-3 (u)) -A policy ensuring confidentiality of all documents and communications regarding protected patient health information.

4. Business Plan (OAC 310:641-2-3 (x)

5. Insurance Proofs (OAC 310:641 2-3 (g) (2) – (4)
   - General Liability
   - Aircraft Liability
   - Worker's Comp

6. Protocol Application (OAC 310:641-2-3 (j)) - in addition to the included Protocols Application, the following must be provided:

   - Quality Assurance Policy (Section 6 of the Protocols Application) - a written policy that outlines your QA review policy.

7. Contracts for equipment and services are to be submitted, if applicable.

Department Application Procedures:

After submitting your application, it will be reviewed by Department staff for completeness, accuracy, and legibility. You will be contacted if the package is incomplete or additional information is required. Once the application is complete, an EMS Administrator will be assigned to conduct an initial inspection of your files, equipment, and facility. Upon receipt of the EMS Administrator's inspection report, your EMS Agency Certificate will be mailed to the address on record. Information regarding your Air ambulance application package may be obtained by calling (405) 426-8480.

Section 1 – Business Information

Service Name: _____

Mailing Address: _____
Street City State Zip code

Physical Address: _____
Street City State Zip code

Record Retention Address: _____
Street City State Zip code

*if record retention location is out of state, describe how will the records be available at the physical address:

_____

_____

Business Telephone: _____ Emergency Telephone: _____

Agency Director: _____ Telephone: _____

Director email: _____

Additional point of contact _____Telephone: _____

PoC email: _____

Business hours (Days and times your office accepts business calls: _____

Section 2 - Level of Care

Paramedic life support: ☐

Section 3 – Type of Owner

Governmental: City ◯

Governmental: County ◯

Governmental: Federal ◯

Governmental: Tribal ◯

Private (For Profit) ◯

Private (Not for Profit) ◯

522, Title 18 or Title 19 Board ◯

Other ◯

Section 4 – Type of Operation

Fire-Based ◯

Law Enforcement ◯

Hospital ◯

3rd Service ◯
(Government Owned)

Private ◯

Other ◯

Section 5 – Dispatch and communication information

Dispatch phone number where calls are received: _____

Calls are received by: _____

SECTION 6 –Air Ambulances List all vehicles that will be used for patient transport. Use a separate sheet if necessary.

Manufacturer: _____Serial No. _____

Manufacturer: _____Serial No. _____

Manufacturer: _____Serial No. _____

SECTION 7 – Medical Director - See "Additional Required Documentation"

Medical Director Name _____Telephone _____

Address _____

Email address: _____

SECTION 8 – Type of ownership

○ **Government Ownership (City, County, State or Federal) Describe: _____**
○ **Sole Proprietorship. List name of owner: _____**
○ **Partnership. List partners on a separate sheet if necessary: _____**
○ **Corporation. List name of Corporation: _____**
○ **Disclosing entity that receives money from or contracts with a 522 District.**
Give 522 District name: _____
○ **Disclosing entity that receives money from or contracts with an Ambulance service District (Title 19)**
Give Ambulance Service District name: _____
○ **Other (Specify):**

SECTION 9 -Indirect Ownership (If Applicable)

If disclosing entity is indirectly owned by another individual, agency or other entity with a controlling interest, separately, or in combination amounting to an ownership interest of 5% or more, provide a list of names and addresses of each individual or entity:

If disclosing entity has no indirect ownership, check here: ☐

SECTION 10 -Mortgage (If Applicable)

If disclosing entity has individuals, organizations, or other entities with an interest in the form of the mortgage or other obligation, provide a list of names and addresses of each individual or entity:

If disclosing entity has no such other entities, check here: ☐

SECTION 11 -Corporation Officers/Directors (If Applicable)

If the disclosing entity is a CORPORATION, list the names, addresses and titles of the corporation's officers and directors:

If disclosing entity is not a corporation, check here: ☐

SECTION 12 -EMS District Board (If Applicable)

If disclosing entity is a 522 District Board, or receives money from a 522 District Board, list the names, addresses and titles of the board's officers and directors:

If disclosing entity is not a 522 District Board, check here: ☐

SECTION 13 - Other Ownership or Controlling Interests (If Applicable)

If disclosing entity is an established Ambulance District Board established by Title 19 District Board, or receives money from an established Ambulance District Board established by Title 19 District Board, a city, county, council, or other entity, provide a list the names, addresses and titles of the officers, directors, commissioners, council members, etc. Provide meeting times, dates, and other pertinent information:

If disclosing entity is not an established Ambulance District Board established by Title 19 District Board, a city, county, council or other entity, check here: ☐

SECTION 14 - Felony Statement

Have any of the owners, principals, officers, or directors of the disclosing entity ever been convicted of a felony?

YES_____ NO_____

If yes, please indicate details on a separate piece of paper. The applicant may also submit court documents detailing the felony conviction.

SECTION 15- Owner Signature

This application form must be signed by the party or parties who shall be considered the owner agency (certificate holder) and who are responsible for compliance of the act and rules. The signature must be witnessed by a commissioned Notary Public.

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge.

Print name _____ Title _____

Signature _____ Title _____

Signed before this _____day of _____, _____.
Day Month Year

Notary Signature _____

My commission expires _____

310:641-11-12. Air ambulance equipment

The following medical equipment shall be required to be on board every aircraft certified by the Department for air medical services:

- The medical control physician will authorize all equipment and medications placed on the units for patient care.
- The authorized equipment and medications will be detailed on a unit checklist and will match the equipment and supplies with detailed defined minimums needed to treat patients in the manner in the agency approved protocols. The checklist will also meet the requirements described in the ambulance file section of this subchapter.
- The medications authorized by the medical director will be detailed on the unit checklist to include the number, weight, and volume of the medication containers.
- At a minimum, the following equipment and supplies will be present on each specialty care unit when transported specialty care patients:
    - age and size appropriate oropharyngeal and nasopharyngeal airways, single wrapped for sanitation purposes;
    - functioning portable suction device with age and size appropriate tubing and tips;
    - age and size appropriate bag-valve-mask resuscitators;
    - portable (secured in each vehicle) and wall mounted oxygen sets, with age and size appropriate tubing cannulas and masks;
    - spare portable oxygen cylinder, secured to manufacturing specifications;
- Bandaging materials to include:
    - two (2) burn sheets clean wrapped and marked in plastic bag that need not be sterile.
    - fifty (50) sterile 4"x4" dressings.
    - six (6) sterile 6"x8" or 8"x10" dressings.
    - ten (10) roller bandages, 2" or larger.
    - Four (4) rolls of tape (minimum of one (1") inch width).
    - four (4) sterile occlusive dressings, 3" x 8" or larger.
    - four (4) triangular bandages.
    - one (1) pair of bandage scissors.
- Fracture immobilization devices to include:
    - one (1) adult and one (1) pediatric traction splint or equivalent device capable of adult and pediatric application.
    - two (2) upper and two (2) lower extremity splints in adult and pediatric sizes.
    - short spine board or vest type immobilizer, including straps and accessories as described within the agency protocols.
    - two (2) adult and one (1) pediatric size long spine board including straps and head immobilization devices.
    - two (2) rigid or adjustable extrication collars in large, medium, small adult sizes, and pediatric sizes for children ages 2 years or older and one (1) infant collar. Collars shall not be foam or fiber filled.
- Miscellaneous medical equipment to include:
    - one (1) infant, one (1) child, two (2) adult, and one (1) extra-large blood pressure cuffs;
    - stethoscope, one (1) adult and one (1) pediatric sizes.
    - obstetrical kit with towels, 4"x4" dressing, umbilical tape, bulb syringe, cord cutting device, clamps, sterile gloves, aluminum foil, and blanket.
    - universal communicable disease precaution equipment including gloves, mask, goggles, gown, and other universal precautions.
    - blood-glucose measurement equipment per medical direction and Department approval.

  - CPAP per medical direction and Department approval.
- Other mandatory equipment to include:
  - Two (2) appropriately labeled or designated waste receptacles for:
  - waste that is contaminated by bodily fluids or potentially hazardous infectious waste, and
  - waste that does not present a biological hazard, such as plastic or paper products that are not contaminated.
  - two-way radio communication equipment utilizing VHF frequency 155.3400 as detailed in this Chapter and through the Statewide Interoperability Governing Body.
  - one (1) sturdy, lightweight, all-level cot for the primary patient that is compliant with the vehicle manufacturing standards in place at the time of purchase.
  - at least three (3) strap type restraining devices (chest, hip, and knee), and compliant shoulder harness shall be provided per stretcher, cot, and litter (not less than two (2") inches wide, nylon, easily removable for cleaning, two (2) piece assembly with quick release buckles).
  - electronic or paper patient care run reports.
  - two (2) fire extinguishers; one (1) in the cab of the unit, and one in the patient compartment of the vehicle each mounted in a manner that allows for quick release and is compliant with the ambulance manufactures building standards. Each extinguisher is to be dry powder, ABC, and a minimum of five (5) pounds.
  - two (2) operable flashlights;
  - all ambulance equipment and supplies shall be maintained in accordance with sanitation requirements in this Chapter. Additionally, sterility shall be maintained on all sterile packaged items.
  - digital or strip type thermometer and single use probes.
  - six (6) instant cold packs.
  - one (1) length/weight-based drug dose chart or tape.
  - a minimum of two (2) DOT approved reflective vests.
  - As approved by local medical direction, a child restraint system or equipment for pediatric patients, as provided under the limits of the agency license.

Agency personnel roster

Instructions: List all certified and licensed personnel associated with the application/agency. Please list the names in alphabetical order. Please type or print only.

Volunteer means a person that does not receive compensation or is compensated at less than minimum wage.

Agency Name _____ Date _____

Name (last, first, and MI)	Certification/License level	SSN
Address	Certification/license number	Full/Part time/volunteer
1.		
		Full Time
2.		
		Full Time
3.		
		Full Time
4.		
		Full Time
5.		
		Full Time
6.		
		Full Time
7.		
		Full Time
8.		
		Full Time
9.		
		Full Time
10.		
		Full Time
11.		
		Full Time
12.		
		Full Time
13.		
		Full Time
14.		
		Full Time
15.		
		Full Time
16		
		Full Time

Air Specialty Care Ambulance Service List of Substations

Do you have units positioned at locations other than the business office or main station? **Yes** ☐ **No** ☐

If yes, list the address and physical location, if different from the address of the units.

Make additional copies of this page if necessary.

Substation Name or Number	Address	City, Zip	Phone number at Substation

OKLAHOMA STATE DEPARTMENT OF HEALTH
Oklahoma.gov/Health | 405-426-8000

February 7, 2022

To: All Licensed Ambulance Services
All Certified Emergency Medical Response Agencies

Re: Changes to the Protocol Approval Process

Dear Agency Directors and Medical Directors:

Over the last few months, the Department has been working to streamline the protocol approval process.

The protocol submission process has been modified in order empower your agency and medical director in the protocol approval process. The Department will be approving your protocol submissions based on the agencies submitted attestation. Agency protocols will be reviewed and verified during inspections and investigations.

If your protocol is pending approval, the attestation is required. No other documentation is required with the updated application. We will join the submitted protocol(s) with the attestation.

Protocols will be reviewed for six specific items detailed on the application. When the application and protocol are approved, you will receive an approval letter allowing for implementation.

Submit all protocol changes to the Department, including the protocol application and attestation. Please note, the last protocol the Department has on file will be the protocol used during inspections and investigations.

If your agency has an approved protocol in place and you are not requesting a change, no action is needed.

Forms for submittal will be available on the Oklahoma State Department of Health web page for your convenience. Please contact Dale Adkerson if you have any questions. You may contact me at 405.426.8480 or by email at dalea@health.ok.gov or esystems@health.ok.gov.

Professionally,

Dale Adkerson
Administrative Program Manager – EMS Division
OSDH – Emergency Systems

Enclosed:

- Specific statutory and regulatory references
- Updated Protocol Application

AGENCY PROTOCOL APPLICATION

INTRODUCTORY INFORMATION

This protocol application packet applies to the following types of agencies:

- Ground Ambulance Service (310:641 - Subchapter 3)
- Air Ambulance Service (310:641 - Subchapter 13)
- Emergency Medical Response Agency (310:641 - Subchapter 15)

SECTION 1 - TYPE OF APPLICATION

- Initial License Application (An agency not yet licensed)
- Amending or modifying existing protocols (OSDH Certified or Licensed Agency with Department approved protocols.)
- Change in Medical Director (When a new medical director is authorizing care.)

SECTION 2- BUSINESS INFORMATION

- Name of Agency:
- Mailing Address: (Where the agency receives mail)
- Physical Address: (The address of the business office)
- Business Telephone:
- Fax Number:
- Name of Agency Director: (Include phone number and email address.)
- Name of Protocol Contact or Secondary Contact: (The name of the person who is administratively responsible for all communications regarding protocols. Include cell phone number and email address.)

SECTION 3- TYPE OF AGENCY AND LEVEL OF CARE

- Emergency Medical Responder (EMR) (310:641-15-2(k)(2)): Allows for the use of Emergency Medical Responders as their level of care.
- Basic Life Support (BLS) (310:642-3-11(b)(1)): Means the ambulance service vehicles are equipped with the minimum basic equipment, and staffed with at least one EMT-Basic Attendant on each request for emergency medical service
- Intermediate Life Support (310:641-3-11(b)(2)): Means the ambulance service vehicles are equipped with the minimum intermediate equipment, and staffed with at least one EMT-Intermediate Attendant on each request for emergency medical service.
- Advanced Life Support (310:641-3-11(b)(3)): Means the ambulance service vehicles are equipped with the minimum advanced EMT equipment and staffed with at least one Advanced EMT Attendant on each request for service, except as permitted in this subchapter.

- Paramedic Life Support (310:641-3-11(b)(4)): Means the ambulance service vehicles are equipped with the minimum paramedic equipment and staffed with at least one EMT-Paramedic Attendant on each request for emergency medical service, or
- Air Ambulance Paramedic Life Support (310:641-13-8(a)(1)-(3)): Paramedic life support means the air ambulance vehicles are equipped with the minimum Paramedic equipment and staffed with at least one Paramedic on each request for service and may respond to both pre-hospital request and interfacility transfers.

SECTION 4 - MEDICAL DIRECTOR

The information regarding the physician licensed in the State of Oklahoma, providing medical direction for the agency. The Department must be notified by the next business day of any change in medical direction has occurred.

SECTION 5 - DESTINATION PROTOCOLS - Complete Enclosed Table (O.A.C.310:641-3-61 or 13-20 Transfer Protocols)

SECTION 6 - QUALITY ASSURANCE PLAN

The **Medical Director shall** be accessible, knowledgeable, and actively involved in quality assurance and the educational activities of the agency's personnel and supervise a quality assurance (QA) program. The appointment of a designee to assist in QA and education activities does not absolve the medical director of their responsibility for providing oversight.

The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceeds the following requirements:

Medical Director's Active Involvement in the review of:

- Patient refusals;
- Air Ambulance Utilization;
- Airway Management;
- Cardiac Arrest interventions;
- Time sensitive medical and trauma cases;
- Review other selected patient care reports not specifically included;
- Provide internal and external feedback of findings determined through reviews;
- Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years.

SECTION 7 - DECLARE PROTOCOL OPTION

- **Option #1:** The Agency is adopting the state protocol updates as written. Units must carry all equipment listed at the level of care selected when in service.

- **Option #2:** The agency is adopting state protocols with modifications. The agency must supply the an electronic copy of the modifications. Additionally, Option 2 is to be used when an agency has Department approved protocols and is requesting a change to the existing protocols.
- **Option #3:** The Agency is **rejecting** the state protocols and will use their own medical treatment protocols. The agency must submit an electronic copy of the agency protocols.

SECTION 8 - LIST OF EACH PROTOCOL ALTERATION/ DELETION (Use form provided)

SECTION 9 - AUTHORIZED PROCEDURE LIST (APL) (Attached)
Complete and accurate with Medical Director and EMS Director signatures.

- Agency authorized procedure list is a summary of all activities, skill, and medications being utilized at the agency. Mark each box with an "X" being authorized and black out any box being denied, deleted, or **unauthorized**.
- A copy of the individual's authorized procedure list, with signatures and dates will need to be filled out for any personnel authorized by the agency medical director operating at the agency and maintained within the individual's credentialing/training/licensure files.

Section 10 – AGENCY DIRECTOR AND MEDICAL DIRECTOR SIGNATURES.

SECTION 11 – ATTESTATION
Medical Director and Agency Director (Include dates)
The Signature also includes an attestation that the protocol that is submitted meets one or more the following Criteria:

- 310:641-5-20 Scope of Practice authorized by certification or licensure;
- 310:641 Scope of License for the Agency Certification or Licensure (See Subchapters 3, 9, 13, and 15)
- The 2011 EMR Oklahoma Instructor Guidelines;
- The 2011 EMT Oklahoma Instructor Guidelines;
- The Intermediate (I-85) Transitions Syllabus;
- The 2011 AEMT Oklahoma Instructor Guidelines; and/or
- The 2011 Paramedic Oklahoma Instructor Guidelines.

Return the application and any supporting documentation to:

OSDH – EMS Division
123 Robert S. Kerr – Suite 1702
Oklahoma City, OK 73102-6460

Fax: 405-900-7560
Email: esystems@health.ok.gov

AGENCY PROTOCOL APPLICATION

SECTION 1 – TYPE OF APPLICATION (Print or Type)

Date of Application: _____ **Agency Number:** _____

Purpose:

Initial Application ☐ **Protocol Amendment** ☐ **Change in Medical Director** ☐

SECTION 2 – BUSINESS INFORMATION

Agency Name: _____

Mailing Address: _____

Physical Address: _____

Business Telephone: _____ **Email:** _____

Agency Director / Administrator Name: _____

Secondary Contact: _____ **Email:** _____

SECTION 3: TYPE OF AGENCY

EMRA ☐

Ground Ambulance ☐

Air Ambulance ☐

LEVEL OF CARE (CHECK HIGHEST LEVEL PROVIDED)

EMR ☐

EMT ☐

Intermediate ☐

AEMT ☐

PARAMEDIC ☐

SECTION 4: MEDICAL DIRECTOR

Name: _____ **MD DO** **SPECIALTY:** _____

Address: _____

Phone Number: _____ **Email:** _____

State License No.: _____ **OBNDD No.:** _____

If your medical director has changed, please submit the required documents from the checklist.

Each agency or service will have a plan or policy that will address a sudden lapse of medical direction, such as a back-up or reserve medical director, which is used to ensure coverage when a medical director is not available. Include your policy or plan with this application.

Oklahoma State Department of Health – EMS Division
123 Robert S. Kerr – Suite 1702 - OKLAHOMA CITY, OK 73102-6460
OFFICE: 405-426-8480
FAX: 405-900-7560
EMS Division (oklahoma.gov)

SECTION 5 – DESTINATION PROTOCOLS (See Page 3)

SECTION 6 – QUALITY ASSURANCE PLAN

(If this is an initial application or if your plan has changed, please Attach a copy of the Quality Assurance Plan)

The Agency must submit a clearly defined Quality Assurance Plan/Policy that meets or exceeds the following requirements:

- **o Review patient refusals;**
- **o Review air ambulance utilization;**
- **o Review airway management;**
- **o Review cardiac arrest interventions;**
- **o Review time sensitive medical and trauma cases;**
- **o Review other selected patient care reports not specifically included; and**
- **o Provide internal and external feedback of findings determined through reviews;**

Documentation of the feedback will be maintained as part of the quality assurance documentation by the agency for three (3) years.

SECTION 7 – PROTOCOL OPTIONS (Select one of the three options)

☐ **Option 1: Agency is adopting the 2018 state protocol as written.**

☐ **Option 2: Agency is modifying the 2018 state protocol (Detail modification or amendments on page 4)**

☐ **Option 3: Agency is not adopting the 2018 state protocols and will submit their own agency specific protocols.**

SECTION 8 – DEFINE EACH PROTOCOL MODIFICATION (Use additional pages if needed)

Agency must attach scientific data or evidence for protocol requests that are not within the state protocols or existing scope of practice. (See Page 4)

SECTION 9 – SUMMARY OF AGENCY PROTOCOLS or LIST OF AUTHORIZED PROCEDURES (SEE PROTOCOL APPLICATION INSTRUCTIONS)

SECTTION 10 – AGENCY AND MEDICAL DIRECTOR SIGNATURES

By signing the application, the agency director and the medical director approve the protocols submitted to the Department for review and approval.

Agency Director Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

SECTION 4 – CHANGE OF MEDICAL DIRECTOR CHECKLIST

Medical Director's Consent Letter	
Medical Director's State Medical License	
Medical Director's OBNDD or DEA Certificate	
Curriculum Vitae	
Completed Protocols Application with new medical director information, signature and attestation.	

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SECTION 5 – DESTINATION PROTOCOLS
(See OAC 310:641-3-61 (ground agencies) or 13-20 (air agencies)

Regulations	List facilities within a reasonable range
3-61 (c) or 13-20 (f)	

3-61 (d) or 13-20 (g)	(1) medical and trauma non-emergency transports shall be transported to facility of patient's choice, if within reasonable service range (see list above)
3-61 (d) or 13-20 (g) (2)	(2) emergency, non-injury related, non-life threating transports shall be transported to the facility of the patient's choice if within reasonable service range (see list above)
3-61 (d) or 13-20 (g)	(3) emergency, injury related transports shall adhere to the OK Triage, Transport, and Transfer Guidelines… and ensure that patients are delivered to the most appropriate hospital, either within their region or contiguous regions.
List facilities that your agency would transport to:	A.
	B.
	C.
3-61 (d) or 13-20 (g)	(4) severely injured patients as described in the OK Triage, Transport and Transfer Guidelines…shall be transported to a hospital classified at Level I or II…unless a Level III facility identified in a regional plan is capable of providing definitive care. If time and distance are detrimental to the patient, then transport to the closest appropriate hospital identified in the regional plan
List facilities that your agency would transport to:	A.
	B.
	C.
3-61 (d) or 13-20 (g)	(5) Stable patients at risk for severe injury or with minor to moderate injury as described in the OK Triage, Transport, and Transfer Guidelines shall be transported to the closest appropriate facility, or by patient choice consistent with regional guidelines.
List facilities that your agency would transport to:	A.
	B.
	C.

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SECTION 8 – PROTOCOL MODIFICATIONS
(e.g., additions, deletions, or alterations)

Protocol Name	Protocol page #	Modified item	Supporting evidence provided

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Section 11: Attestation

Agency Name: _____ **Agency No.:**_____
Agency Director: _____
Medical Director: _____

By completing and signing this attestation, the agency director and the medical director attests the contents of this application are in compliance with the following requirements:

Requirement	Agency Director Initials	Date	Medical Director Initials	Date
Certified and Licensed Emergency Medical Personnel Scope of Practice (OAC 310:641-5-20)				
Certified and Licensed Emergency Medical Personnel Educational Guidelines (EMR, EMT, Intermediate, AEMT, and Paramedic)				
Certified and Licensed Agency Scope of Licensure (OAC 310:641 Subchapters 3, 11, 13, and 15)				
Patient Safety (OAC 310:641 Subchapters 3, 11, 13, and 15)				
Destination Protocols (OAC 310:641 – 3 – 61 and 13-20)				
Quality Assurance (OAC 310:641-3-10, 11-2, 13-2, 15-2, and 15-3)				
Medical Director Approval (63 O.S. 1-2506)				

Agency Director Signature: _____ **Date:** _____

Medical Director Signature: _____ **Date:** _____

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