Oklahoma State Department of Health
Protective Health Services
Financial Management
Emergency Systems/EMS Division
PO Box 268823 Oklahoma City, OK 73126-8823
123 Robert S. Kerr Ave, suite 1702
Oklahoma City, OK 73102-6406

INSTRUCTIONS FOR THE COMPLETION OF OKLAHOMA'S SPECIALTY CARE AMBULANCE SERVICE INITIAL APPLICATION FORMS

Oklahoma State Department of Health
Protective Health Services
Financial Management
Emergency Systems/EMS Division
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APPLICATION: Please type or print all information, except where a signature is required.

License Fees

Type of Fee	Reg	Fee for Initial License	Initial Vehicles	Substation
Fee for license	**O.A.C. 310:641-11-2 (g) (11)**	**$600.00 (non-refundable)**	**$20.00 for each unit after two units for transport (non-refundable)**	**$150.00 each (Non-refundable)**
Renewal of license	**310:641-11-4 (a) (2)**	**$100.00 (non-refundable)**	**$20.00 for each after two units(non-refundable)**	**$50.00 (non-refundable)**
Amendment	**310:641-11-7 (b)**	**$100.00**		**$100.00**

Section 1 – Type of Application

- Enter the date of the application.
- Enter the application purpose.
- Enter the agency license number if submitting an application amendment.

Section 2 – 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.

Section 3 – Type of Service (Ground or Air)

- Ground vehicle
- Air ambulances (Fixed-wing or Rotor-wing)

**Specialty Care shall be used solely for interhospital transport of patients requiring specialized en route medical Monitoring and advanced life support which exceed the capabilities of the equipment and personnel provided by paramedic life support.*

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Section 4 – Type of Owner *(O.A.C. 310:641-11-2 (g) (1) (A) – (B))*
Enter the type of ownership for the agency. Essentially, what type of organization will own the license?

- 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 5 – Type of Operation *(O.A.C. 310:641-11-2 (g) (1) (A) – (B))*
Enter the type of operation for the agency. For Section 5 and 6 – 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 Government owned, but not operated as part of the fire or law enforcement departments.

Section 6 –Communication policy (310:641-11-2 (g) (8))
Agency Dispatch

- Enter the agency phone number to be used by dispatch to contact by phone.
- Enter who will receive the call (i.e. crew members, agency dispatcher).

Other Dispatch

- Enter the agency that is providing dispatch to the agency.
- Enter the phone number of the agency providing dispatch for the agency.

Radio System

- Enter the type of two-way radio communication maintained by the agency (UHF/VHF/800 MHz
- Enter the frequency being used for dispatch if applicable.

The regulation states:

A written communication policy addressing:
(A) the receiving and dispatching of emergency and non-emergency calls;
(B) ensuring compliance with State and local EMS Communication Plans; and

(C) applicants for this license will provide documentation that a screening process is in place to ensure a request for transport of a specialty care patient 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 7– Quality Assurance Plan (310:641-11-2 (g) (5))
The agency must develop and submit a quality assurance plan. The plan must show how the medical director will be involved with the review of patient care as outlined in the plan. The plan must include: 1) patient care refusals, 2) airway management interventions, (3) time sensitive medical, (4) time sensitive trauma, (5) cardiac arrests, and (6) a random review of a portion of all remaining patient care reports.

Section 8 – Protocols (310:641 11-2 (g) (7))
a copy of patient care protocols and quality assurance plan detailing the care, interventions, and scope of practice beyond the Paramedic, as required by medical control physician and as prescribed by the Act and this Chapter.

Section 9 – Additional Documentation
- These additional documents that are to be submitted with the application.
- Applications without these documents are incomplete.
- If the agency is contracting for equipment or personnel, submit copies of the contracts.

Section 10 - Type of Owner (310:641-11-2 (g) (1) (A) - (B))
- 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 11 – Indirect Ownership (310:641-11-2 (g) (1) (A) - (B))
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 12 – Mortgage (310:641-11-2 (g) (1) (A) - (B))
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 13 – Corporation Officers / Directors (310:641-11-2 (g) (1) (A) - (B))
If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

Section 14 – Felony Statement (310:641-11-2 (g) (1) (A) - (B))
Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the felony conviction.

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Section 15 - EMS District Board (310:641-11-2 (g) (1) (A) - (B))
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 16 – Other Ownership or Controlling Interests (310:641-11-2 (g) (1) (A) - (B))
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 17 – Owner Signature (310:641-11-2 (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.

Additional Forms

- **Personnel Roster** – List all personnel for your agency who provide patient care.

- **Inspection Forms** – This form is used by the Department for inspections. Complete the form to provide us with your ambulance's information as well as an equipment checklist. Complete this form for each of your agency's ambulances. The Record Review checklist detail records to be maintained at the agency.

- **Medical Director** – See the attached Medical Director Checklist to ensure you are sending all of the required information.

- **Substations** – Check "yes" if your agency will maintain substations. Complete and submit the Air Ambulance Substation form with your application.

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) 271-4027.

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OKLAHOMA State Department of Health

Specialty Care Ambulance Agency Application Checklist

Date application received: _____ Date complete application received: _____

Reason for package: Initial ____ Amended ____ Update ____ Other: _____

Agency Name: _____

Type of Service: Ground: _____ Air: _____

Please check each item:

1. Amount $ _____ _____ Fee Paid (310:641-13-2 (b)

Section	Content	Regulation (O.A.C)	Complete (Yes/No)
1	Type of Application		
2	Business Information		
4	Type of Owner		
5	Type of Operation		
6	Communication Plan	310:641-11-2 (g) (8)	
7	Medical Director	310:641-11-2 (g) (5)	
8	Quality Assurance Plan	310:641-11-2 (g) (7)	
9	Protocols	310:641-11-2 (g) (7)	
10	Insurances:	310:641-11-2 (g) (2)-(4)	
	Contracts	310:641-11-2 (g) (6)	
	Confidentiality Policy	310:641-11-2 (g) (10)	
	Business Plan	310:641-11-2 (k)	
	Personnel roster	310:641-11-8	
	Vehicle Checklists	310:641-11-17	
	Response Plan	310:641-11-2 (g) (9)	
	Type of Ownership	310:641-11-2 (g) (1) (A) – (B)	
11	Indirect ownership	310:641-11-2 (g) (1) (A) – (B)	
12	Mortgage	310:641-11-2 (g) (1) (A) – (B)	
13	Corp. officers/directors	310:641-11-2 (g) (1) (A) – (B)	
14	Felony Statement	310:641-11-2 (g) (1) (A) – (B)	
15	EMS District Board	310:641-11-2 (g) (1) (A) – (B)	
16	Other Ownership	310:641-11-2 (g) (1) (A) – (B)	
17	Owner signature	310:641-11-2 (e)	
18	Personnel Roster	310:641-11-8	
Separate form	Inspection Forms		
Separate form	Substation list		
Separate form	Medical Director Checklist		

Medical Director Checklist (Specialty Care)

Agency Name: _____

Medical Director _____

Please provide these items or copies of these items:
If you change your Medical Director, a new Medical Director Checklist will be needed.

- Letter from the physician agreeing to be your Medical Director
- Copy of Medical Director's State Medical License
- Copy of Medical Director's OBNDD or DEA certificate
- Medical Director's Curriculum Vitae
- Medical Director's Primary Practice Address
- Medical Director's Email Address
- Name of Hospital where Medical Director is On Staff
- Medical Director's Specialty
- Medical Director's Approval of Protocols
- Copy of Specialty Care protocols for agency

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Specialty Care Ambulance Service Application

License Fees

Type of Fee	Reg	Fee for Initial License	Initial Vehicles	Substation
Fee for license	O.A.C. 310:641-11-2 (g) (11)	$600.00 (non-refundable)	$20.00 for each unit after two units for transport (non- refundable)	$150.00 each (Non-refundable)
Renewal of license	310:641-11-4 (a) (2)	$100.00 (non-refundable)	$20.00 for each after two units(non- refundable)	$50.00 (non-refundable)
Amendment	310:641-11-7 (b)	$100.00		$100.00

SECTION 1 – TYPE OF APPLICATION (Print or Type) To renew, use the Agency Renewal form on our website.

Date of Application _____ Purpose: Initial ____ Amended ____ Update____ License No: _____

SECTION 2 – BUSINESS INFORMATION

Service Name: _____

Mailing Address: _____
City State Zip Code

Physical Address: _____
City State Zip Code

Record Retention Address: _____
City State Zip Code

Business Telephone: _____ Emergency Telephone: _____

Director / Administrator / Coordinator / CEO Name: _____
(Additional contact information can be provided by the applicant)

Email Address: _____

Hours of Business Operation (Include days and times): _____

SECTION 3 – Type of Service

Ground ____
Air (FW or RW) ____

Specialty Care shall be used solely for interhospital transport of patients requiring specialized en route medical monitoring and advanced life support which exceed the capabilities of the equipment and personnel provided by paramedic life support.

SECTION 4 – TYPE OF OWNER

Governmental City ____
Governmental County ____
Governmental Federal ____
Governmental Tribal ____
Private (Not For Profit) ____
Private (For Profit) ____
Board or Trust (Other) ____
522, Title 18 or 19 Board ____

SECTION 5 – TYPE OF OPERATION

Fire Based ____
Law Enforcement ____
Hospital ____
3rd Service (government owned) ____
Private ____
Other:_____

SECTION 6 – PUBLIC ACCESS AND DISPATCH (Communication Plan) *(O.A.C. 310:641-11-2 (g) (8) (A) – (C)*

Agency Dispatch

Agency phone number where calls are received: (___) ___-_____The call is received by: _____

Other Dispatch

Agency providing dispatch: _____ Phone number for agency providing dispatch: (___) ___-_____.

Radio System (How are you dispatched?)

Cell Phone ____ VHF ____ UHF ____ 700Mhz ____ 800Mhz ____ Other Frequency _____

Have a communication policy that addresses receiving and dispatching emergency and non-emergency calls that is State and Federal compliant? (You must include a policy statement) A screening process is also required to ensure a request for service meets the agency's capability, capacity, and licensure requirements. Screening documentation will be retained with patient records or call log.

SECTION 7 – QUALITY ASSURANCE PLAN *(O.A.C. 310:641-11-2 (g) (7)*

The agency must develop and submit a quality assurance plan. The plan must include the review of the following:

Patient Care Refusals ___	Air Ambulance Utilization ___	Airway Management Interventions ___
Time Sensitive Medical ___	Time Sensitive Trauma ___	Cardiac Arrests Interventions ___
Random Patient Care Report Review ___		

SECTION 8 – PROTOCOLS *(O.A.C. 310:641-11-2 (g) (5))*

A copy of patient care protocols and quality assurance plan detailing the care, interventions, and scope of practice beyond the Paramedic, as required by medical control physician and as prescribed by the Act and this Chapter.

SECTION 9 – Additional documentation (Return with Application)

Certificate of vehicle (air or ground) Insurance ($1,000,000.00)	(O.A.C. 310:641- 11-2 (g) (2)
Professional Liability Insurance ($1,000,000.00)	(O.A.C. 310:641- 11-2 (a) (3)
Workers' Compensation Program Verification	(O.A.C. 310:641- 11-2 (a) (4)
Copies of Contacts for Equipment & Services	(O.A.C. 310:641- 11-2 (a) (6) (if applicable)
Confidentiality Policy	(O.A.C. 310:641-11-2 (g) (10))
Business plan and financial disclosure	(O.A.C. 310:641- 11-2 (k))
Personnel Roster (form enclosed)	(O.A.C. 310:641-11-8))
Vehicle checklist for equipment	(O.A.C. 310:641-11-10))
Medical Director information	*(O.A.C. 310:641-11-2 (g) (7) and 11-13)*
Response plan	*(O.A.C. 310:641-11-2 (g) (9))*

SECTION 10 – TYPE OF OWNERSHIP *(310:641-11-2 (g) (1) (A)- (B)) (if applicable)*

____ Government Ownership (City, State or Federal) – Give Description: _____

____ Sole Proprietorship. List name of owner: _____

____ Partnership. List partners: _____

____ Corporation. Name of corporation: _____

____ Disclosing entity received money from, or contracts with , a '522' District (Article X);
Give '522' district name: _____

____ Disclosing entity received money from or contracts with, an 'Ambulance Service' District (Title 19);
Give 'Ambulance Service' district name: _____

____ Other (Specify): _____

SECTION 11 – INDIRECT OWNERSHIP *(310:641-11-2 (g) (1) (A)- (B)) (if applicable)*

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.

NAME	ADDRESS
_____	_____
_____	_____

SECTION 12 – MORTGAGE *(310:641-11-2 (g) (1) (A)- (B)) (if applicable)*

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).

NAME	ADDRESS
_____	_____
_____	_____

SECTION 13 – CORPORATION OFFICERS / DIRECTORS *(310:641-11-2 (g) (1) (A)- (B))* *(if applicable)*

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

OFFICERS NAME	TITLE	ADDRESS

CORPORATION DIRECTORS

DIRECTORS NAME	TITLE	ADDRESS

SECTION 14 – FELONY STATEMENT *(O.A.C. 310:641-11-5 (a) (2))*

Has any owner, principal, officer, or director been convicted of a felony? Yes ____ No ____.
If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the the felony conviction.

SECTION 15 – EMS DISTRICT BOARD ("522" or "Title 19" District) *(310:641-11-2 (g) (1) (A)- (B))* (if applicable)

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.

Name: _____ Position: _____
Address: _____ Contact Number: _____
Name: _____ Position: _____
Address: _____ Contact Number: _____

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contact or contracts to provide ambulance services with this form.

SECTION 16 – OTHER OWNERSHIP OR CONTROLLING INTERESTS *(310:641-11-2 (g) (1) (A)- (B))* (if applicable)

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.

Name: _____ Position: _____ Ownership %: _____
Address: _____ Contact Number: _____

Name: _____ Position: _____ Ownership %: _____
Address: _____ Contact Number: _____

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contract(s) to provide ambulance service to this form.

SECTION 17 - OWNER SIGNATURE *310:641-11-2 (e)*

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. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name	Title	Date	Signature

Signed before this _____ day of _____. My Commission Expires: _____/_____/_____ _____

OKLAHOMA
State Department
of Health

SPECIALTY CARE AMBULANCE AGENCY PERSONNEL ROSTER *(O.A.C. 310:641-11-8)*

Instructions: List all personnel associated with the agency that provizdes patient care. 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: _____/_____/_____

Person Providing the Information: _____ Title: _____

Name (Last, First and Middle Initial) Address	Level of License OK License Number and expiration date	SSN Full/Part Time or Volunteer
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

OKLAHOMA State Department of Health

Name (Last, First and Middle Initial)	Level of License	SSN
Address	OK License Number and expiration date	Full/Part Time or Volunteer
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

_____

Signature

_____/_____/_____

Date