ALABAMA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMS

RSA Tower, 201 Monroe Street, Suite 1100
Mail to: Office of EMS, P.O. Box 303017
Montgomery, AL 36130-3017

EMS Provider License Application

All pages of this form must be typed to be approved
All Plans and Current Insurance Verifications Must Accompany This Application

TODAY's DATE:______________________ CURRENT SERVICE ID:_______

Application Type

NEW SERVICE: ☐ TRANSPORT: $30 ☐ ALS 1 CC: ☐
RENEWAL: ☐ NON-TRANSPORT: $0 ☐ ALS 1: ☐
RECLASSIFICATION: $0 ☐ AIR MEDICAL: $30 ☐ ALS 2: ☐
ALS 3: ☐
BLS: ☐

Choose the highest level of care to be given by:
ALS1 CC: Paramedic Critical Care
ALS 1: Paramedic
ALS 2: Advanced EMT
ALS 3: Intermediate EMT
BLS: EMT

Contact & Demographic information

MEMBER AARS: ☐

OWNERSHIP TYPE: Corporate ☐ Municipality ☐ LLC ☐ Sole Proprietorship ☐ (If Sole Proprietorship, call before submission.)

OWNER OF SERVICE: ______________________________

NAME OF BUSINESS: ______________________________
(LICENSE SHALL BE ISSUED IN THIS NAME, AND SHALL APPEAR ON BOTH SIDES OF THE VEHICLE)

PHYSICAL ADDRESS: ______________________________
(STREET ADDRESS WHERE VEHICLES ARE LOCATED)

CITY: ____________ COUNTY: ____________ STATE: ______ ZIP: ________

MAILING ADDRESS: ______________________________

CITY: ____________ COUNTY: ____________ STATE: ______ ZIP: ________

CONTACT PERSON: ____________________ E-MAIL ADDRESS: ____________________

BUS. PHONE:(____) ____________ EMERGENCY PHONE:(____) ____________ FAX : (_____) ____________

PEDIATRIC EMERGENCY CARE COORDINATOR:______________________________

PHONE: (____) ____________ E-MAIL ADDRESS: ____________________

TYPES OF COMMUNICATION USED (list a minimum of two) PRIMARY:____________________ SECONDARY:____________________

Other Communication Methods:______________________________

Insurance Information

INSURANCE CARRIER: ______________________________ PHONE: (_____) ____________
(VEHICLE & PERSONNEL) (ATTACH PROOF OF COVERAGE)

ADDRESS: ____________________ CITY: ____________ STATE:_____ ZIP:____________

MAKE A COPY FOR YOUR RECORDS --- SUBMIT THE ORIGINAL APPLICATION

(OFFICE OF EMS USE ONLY)

CURRENT EXP. DATE: ____________ NEW EXP. DATE: ____________ CERTIFICATE #: ____________

DEPOSIT #: ______ APP. REC'D: _______ FEE REC'D: _______ AMT. REC'D: $ _______ CK/M.O.#: _____

APPROVED BY: ______________________________ DATE: ____________

Revised 12-05-2019

ALABAMA INCIDENT MANAGEMENT SYSTEM AGREEMENT

AIMS AGREEMENT: The MOUs can be found at: http://www.alabamapublichealth.gov/ems. After accessing the site, go to the AIMS link found on the left-hand column. Please sign and return either one or both of the Memorandums of Understanding (MOUs), signature pages, annually with the renewal application.

Coordinated Deployment of Ambulances: YES ☐ NO ☐

Medical Needs Shelter: YES ☐ NO ☐

Current AIMS E-mail address: ______________________________

If your Service agrees to be available to Standup for the Coordinated Deployment of Ambulances or Medical Needs Shelters during an incident or disaster, please make certain you provide a current E-mail address, which will be monitored at all times by the primary AIMS contact person.

OFF-LINE MEDICAL DIRECTORS SELECTION/MEDICAL DIRECTION FACILITY APPROVAL FORM

This form is to be utilized as both the Off-Line Medical Director's Selection, and Designated Medical Direction Hospital Approval, for all Licensed Transport and Advanced Life Support Services; and it must be completed each time an application is submitted, or when a service selects a new Off-Line Medical Director or Designated Medical Direction Hospital.

Physician's Name: ____________________, **Affiliated with:** ____________________________ Hospital

Hospital Phone: (____) ____________ **Alabama License** #: __________ **Physician's MCID** #: __________

By signing this application, I understand that I am committing myself to serve as the Off-Line Medical Director for:

____________________________ **Ambulance/Emergency Service of** ________________ **County**

I will be expected to perform the duties thereof, as outlined in **Section 420-2-1-.06, et.** al, of the State Emergency Medical Services Rules.

____ ____________________

PHYSICIAN'S SIGNATURE (original) **DATE**

MEDICAL DIRECTION HOSPITAL INFORMATION

Designated Med Direction Hosp: ________________ **City:** ____________ **State:** _____ Zip: ______

Contact Person: ____________________ **Phone:** (____) ____________ **Fax** #: (____) __________

E-mail Address: ____

(OFFICE OF EMS USE ONLY)

The above listed Off-Line Medical Director and the Designated Medical Direction Hospital have been reviewed and are recommended for approval.

ADPH OFFICE OF EMS: ________________________________ **Date:** ____________

ADVANCED LIFE SUPPORT AGREEMENT

NAME OF SERVICE: ______________________________

TYPE OF APPLICATION:
- ALS 1 CC: ☐
- ALS 1: ☐
- ALS 2: ☐
- ALS 3: ☐
- BLS: ☐
- Nitrous Oxide: ☐
- Morphine Sulfate: ☐
- Fentanyl: ☐

NUMBER AND TYPE OF ADVANCED LIFE SUPPORT BOXES USED:

MEDICATION BOXES: ____

TOTAL NUMBER of MORPHINE SULFATE SYRINGES: ____

TOTAL NUMBER of FENTANYL VIALS: ____

RESPONSIBLE PARTY

I understand it is my responsibility to insure proper program administration. I also agree to notify the Alabama Department of Public Health, Office of EMS, and the participating hospital pharmacy, if applicable, of any changes in operating procedures or personnel which would alter the content of the current authorization. This agreement will become effective upon approval by the Alabama State Board of Health.

The "responsible party" listed should be someone in authority such as mayor, public safety director, fire chief, police chief, ambulance service owner, etc.

NAME: ______________________________ TITLE: ______________________________

ADDRESS: ______________________________ COUNTY: ______________

CITY: ______________ STATE: ___ ZIP: ________ PHONE: (____) ______________

FAX PHONE: (____) ____________ E-MAIL ADDRESS: ______________________________

SIGNATURE: ______________________________ DATE: ______________

DELEGATED RESPONSIBLE PARTY

MUST BE AN APPROPRIATELY LICENSED EMSP IN THE STATE OF ALABAMA

The "Delegated Responsible Party" should be someone appropriately licensed to handle all substances contained in the prehospital kit(s), including Nitrous Oxide, Morphine Sulfate, and/or Fentanyl if applicable.

NAME: ______________________________ LICENSE #: ________ TITLE: ______________________

PHONE: (____) ____________ E-MAIL ADDRESS: ______________________________

SIGNATURE: ______________________________ DATE: ______________

Revised 12-05-2019

PHARMACY or PHARMACEUTICAL SUPPLY AGREEMENT

NAME OF SERVICE: ____

I agree to notify, in writing, the authorized pharmacy and the Alabama Department of Public Health, Office of EMS, of any changes or operational procedures, which would alter the content of the current authorization. Some services may change their Fluid/Medication Plans and purchase through the use of a DEA-222 Official Order Form, including Nitrous Oxide/Oxygen mixture, and/or Morphine Sulfate/Fentanyl from an outside vendor. If your service continues to operate its ALS authorization through the hospital pharmacy, then you must understand that the Nitrous Oxide/Oxygen mixture and the Morphine Sulfate/Fentanyl (if either is applicable to this authorization) must be dispensed under the authorization of the hospital pharmacy currently supplying and re-supplying I.V. Fluids and Medications to this service. This agreement will become effective upon its approval by the Alabama State Board of Health.

TYPE OF APPLICATION:
- ALS 1 CC: ☐
- ALS 1: ☐
- ALS 2: ☐
- ALS 3: ☐
- BLS: ☐

- Nitrous Oxide: ☐
- Morphine Sulfate: ☐
- Fentanyl: ☐

NUMBER AND TYPE OF ADVANCED LIFE SUPPORT BOXES USED:

MEDICATION BOXES: ____

TOTAL NUMBER of MORPHINE SULFATE SYRINGES: ____

TOTAL NUMBER of FENTANYL VIALS: ____

NAME OF PHARMACY or PHARMACEUTICAL SUPPLY CO.: ______________________

ADDRESS: ______________________ COUNTY: __________

CITY: ______________ STATE: ____ ZIP: _______ PHONE: (____) __________

*PHARMACY DIRECTOR/CHIEF PHARMACIST: ______________________
(Print)

*List name of contact person or customer service for services purchasing fluids/drugs through a vendor. See the Fluid/Drug Plan.

E-MAIL ADDRESS: ______________________

**SIGNATURE: ______________________ DATE: __________

**No signature required for services that purchase fluids and drugs through a vendor. See the Fluid/Drug Plan.

DELEGATED RESPONSIBLE PHARMACIST

IF SAME PERSON AS ABOVE PLEASE LEAVE THIS AREA BLANK

Listed below are the name, title, and signature of the pharmacist to whom responsibility for the above program will be delegated to. Information on services that purchase fluids and medications through a vendor can be found in the Fluid/Drug Plan guidelines.

NAME: ______________________ TITLE: __________

E-MAIL ADDRESS: ______________________

SIGNATURE: ______________________ DATE: __________

NOTE: After completing your portion of the application, please make one photocopy for your records and submit the entire original application to the Alabama Department of Public Health, Office of EMS.

Provider Electronic Patient Care Report Agreement

Service Name: ____

Today's Date: ______________

I understand that as part of being a licensed EMS service by the Alabama Department of Public Health's Office of EMS (OEMS), I agree to the following:

- All Electronic Patient Care Reports (ePCRs) will be submitted to the OEMS within the timeframe alloted by the state EMS Director, with potential licensure action being the consequence of un-timely submission.
- Policies will be implemented within my service to ensure the highest accuracy of data possible.
- Upon receipt of my service license, OEMS approved software will be used to submit ePCRs. Every service's third-party software must go through a testing procedure to ensure compatibility, before approval will be granted.
- I will ensure availability of computer(s) and internet to the necessary employees, for the completion and submission of ePCRs, even if computer(s) are at another location.

Owner/Chief Operating Officer Name Printed: ______________________________

Today's Date: ______________ Owner/COO Signature: ______________________________

EMS Chief/Officer Name Printed: ______________________________

Today's Date: ______________ EMS Chief/Officer Signature: ______________________________

I plan to use the following software to submit ePCRs to the OEMS.

State Software: Long Term ☐ Until Third-Party Software Approval ☐

Other approved software that has been tested: ______________________________

(OFFICE OF EMS USE ONLY)

Approved ePCR Number: ______________

Approved By: ______________________________

ALABAMA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMS

RSA Tower, 201 Monroe Street, Suite 1100
Mail to: Office of EMS, P.O. Box 303017, Montgomery, AL 36130-3017, Fax: 334-206-0364

EMS Web Management Form

All pages of this form must be typed to be approved

Service Name: ______________________ License Number: ________ Date: __________

* A licensed service must assign at least a Primary and a Backup Administrator who will be responsible for maintaining the vehicle and personnel rosters.
* If an Administrator needs to administer more than one service, each service needs to submit a form.
* The E-mail address provided on this form will be the username for that person.
* The password for each person will be sent directly to that person's email address.

Primary Administrator

Last Name ______ First Name ______ Middle Name ______

SSN ______ Phone Number ______ Cell Phone Number ______ Email Address (must be unique and will be your username) ______

I will not share access to this site with any other individual.

ADMINISTRATOR HAS ALL RIGHTS

Signature ______ Date ______

Backup Administrator

Last Name ______ First Name ______ Middle Name ______

SSN ______ Phone Number ______ Cell Phone Number ______ Email Address (must be unique and will be your username) ______

I will not share access to this site with any other individual.

ADMINISTRATOR HAS ALL RIGHTS

Signature ______ Date ______

Primary View Only User

Last Name ______ First Name ______ Middle Name ______

SSN ______ Phone Number ______ Cell Phone Number ______ Email Address (must be unique and will be your username) ______

I will not share access to this site with any other individual.

Signature ______ Date ______

View Only Rights

- Personnel ☐
- Vehicles ☐
- Reports ☐

Backup View Only User

Last Name ______ First Name ______ Middle Name ______

SSN ______ Phone Number ______ Cell Phone Number ______ Email Address (must be unique and will be your username) ______

I will not share access to this site with any other individual.

Signature ______ Date ______

View Only Rights

- Personnel ☐
- Vehicles ☐
- Reports ☐

(OFFICE OF EMS USE ONLY)

Received date: ______ Processed date: ______

DISPATCH CENTER INFORMATION

Service Name ____

Dispatching Agency Name ____

Dispatching Agency Director ____

Dispatching Agency Contact ____

Please provide two (2) phone numbers for your agencies dispatch center.

Dispatch phone (1) ______________________________

Dispatch phone (2) ______________________________

Please provide the mailing address of your agencies dispatch center.

Dispatch Agency Mailing Address

PHYSICAL ADDRESS: ______________________________ CITY. ____________ STATE:____ ZIP:________

MAILING ADDRESS: ______________________________ CITY.____________ STATE:____ ZIP:________

Director's email address ____

Monitored Dispatch email address ____
(preferred 24/7)

Dispatch Agency Fax ____

ADVANCED LIFE SUPPORT AUTHORIZATION AND/OR LICENSURE APPROVAL/DISAPPROVAL

The following signature is required by the Office of EMS for an EMS Provider's entry and/or renewal into the I.V. Fluid/Medication/Nitrous Oxide/Morphine Sulfate Supply/ReSupply Program, for Ambulance Transport Licensure, and for letters of ALS Authorization to be issued.

NAME OF SERVICE: ______________________________

RESPONSIBLE PARTY SIGNATURE: ______________________________
Must Be Signed in Order to Process

NOTE: After completing your portion of the application, please make one photocopy for your records and submit the entire original application to Alabama Department of Public Health, Office of EMS. However, you need not return any of the check-lists, the Controlled Substances Guidelines for ALS Services, the PMO example, nor the Drug Box Inspection Report. These all serve as guidelines or for informational purposes only.

(OFFICE OF EMS USE ONLY)

STATE BOARD OF HEALTH/DESIGNEE ACTION

REVIEW DATE: ______________________________

NON-TRANSPORT:	**APPROVED** ☐	**DISAPPROVED** ☐
TRANSPORT:	**APPROVED** ☐	**DISAPPROVED** ☐
BLS:	**APPROVED** ☐	**DISAPPROVED** ☐
ALS:	**APPROVED** ☐	**DISAPPROVED** ☐

REASON:

____

STATE BOARD OF HEALTH SIGNATURE: ______________________________

Alabama EMS Agency/Provider Topography

Organizational Mission

Business Structure

	Fire	Law Enforcement	EMS	Hospital	Air Medical	Other
County	☐	☐	☐	☐	☐	☐
City (includes towns)	☐	☐	☐	☐	☐	☐
For Profit Corporation (includes partnerships, LLCs, and sole proprietorships)	☐	☐	☐	☐	☐	☐
Non-Profit Organization (includes non-profit associations and non-profit corporations)	☐	☐	☐	☐	☐	☐
State	☐	☐	☐	☐	☐	☐
Federal	☐	☐	☐	☐	☐	☐
Military	☐	☐	☐	☐	☐	☐
Tribal	☐	☐	☐	☐	☐	☐

****Place an (X) in the appropriate box. *NOTE: You should only mark one (1) box.*