

ALABAMA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMS

208 Legends Court Prattville, AL 36066
Mail to: Office of EMS, P.O. Box 303017
Montgomery, AL 36130-3017



EMS Provider Service 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
RENEWAL: NON-TRANSPORT: \$0
RECLASSIFICATION: \$0 AIR MEDICAL: \$30

ALS 1 CC:
ALS 1:
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

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: _____

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: _____

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 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

(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: _____

PHARMACY or PHARMACEUTICAL SUPPLIER 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:

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 allotted by the state EMS Director.
- 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.

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



208 Legends Court Prattville, AL 36066
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 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	

Rights

Edit Rights

View Only

Backup User 1

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	

Rights

Edit Rights

View Only

Backup User 2

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	

Rights

Edit Rights

View Only

Backup User 3

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	

Rights

Edit Rights

View Only

(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: _____

Dispatch Supervisor email address _____

Monitored Dispatch email address _____
(preferred 24/7 Monitoring)

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	<input type="checkbox"/>	DENIED	<input type="checkbox"/>
TRANSPORT:	APPROVED	<input type="checkbox"/>	DENIED	<input type="checkbox"/>
BLS:	APPROVED	<input type="checkbox"/>	DENIED	<input type="checkbox"/>
ALS:	APPROVED	<input type="checkbox"/>	DENIED	<input type="checkbox"/>

REASON:

STATE BOARD OF HEALTH SIGNATURE: _____

Alabama EMS Agency/Provider Topography

Organizational Mission

		Fire	Law Enforcement	EMS	Hospital	Air Medical	Other
Business Structure	County	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	City (includes towns)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	For Profit Corporation (includes partnerships, LLCs, and sole proprietorships)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Non-Profit Organization (includes non-profit associations and non-profit corporations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Federal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Military	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tribal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Initial Application Only

List all active personnel in alphabetical order,
or attach roster with information requested below.

*For Air Ambulance Services, list only State Licensed EMSP.

	Name (print) Last, First MI Alphabetical order	EMS License Level	EMS License Number	Employment Status Full, P.T., Vol.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				

	Name (print) Last, First MI Alphabetical order	EMS License Level	EMS License Number	Employment Status Full, P.T., Vol.
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67				
68				
69				
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				
80				
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95				
96				
97				
98				
99				
100				

I certify that the above listed information is true and correct to the best of my knowledge, that this licensed service will provide EMS coverage 24 hours a day, 7 days a week, and that appropriately licensed personnel will be on each run as provided for in the Emergency Medical Services Rules.

Signature of Applicant: _____ Date: _____