2016-2018
NORTH DAKOTA LICENSE RENEWAL APPLICATION
ADVANCED LIFE SUPPORT GROUND AMBULANCE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 53887
7/2016

Name of ALS Ground Ambulance Service	License Number

Where as, the above-named ambulance service provides emergency medical care and uses publicly or privately owned vehicles upon the streets or highways of this state for the transportation of persons who are sick, injured, wounded, or otherwise incapacitated or helpless, and holds itself to the public, or to its employees, for such a service or regularly provides such a service.

Where as, the above-named ambulance service will provide services which meet the standards of Chapter 23-27 of the North Dakota Century Code, and regulations promulgated by the State Health Council governing advanced life support ground ambulance service.

Application is hereby made to operate as an advanced life support ground ambulance service until midnight October thirty-first of the year 2018.

This license is nontransferable and substation ambulances may not operate independently outside the primary license holder. Substation ambulances must display the name of the headquarter ambulance on all vehicles. A licensing fee is required for each substation licensure in addition to the headquarter ambulance licensure fee.

The license fee of $50.00 plus $50.00 for each substation is enclosed and made payable to:

North Dakota Department of Health.

Signature	Date

DEMS OFFICE USE ONLY	
License Number	
Date Issued	
Substations	
Amount Due	
Approved by	
Processed by	Process Date

STATE USE ONLY
Date Received
Amount Received
Cash MO Check Number _____

Name of ALS Ground Ambulance Service		License Number
Mailing Address of Service		
City	State	ZIP Code
Physical Address of Service		
City	State	ZIP Code
County	Region	
Medical Director		
Squad Leader		
Contact Person (if different)		
Squad leader and contact person must be listed on the service roster.		
Agency E-mail Address		
Day Telephone Number	Evening Telephone Number	Fax Number

TYPE OF CONTROL

Governmental	☐ County	☐ Municipal	☐ County and City	☐ Tribal	☐ Federal
Non-profit	☐ Corporation		☐ Association		
For-profit	☐ Individual		☐ Partnership		☐ Corporation
Is your corporation / partnership / association listed as "In Good Standing" with the North Dakota Secretary of State?				☐ Yes	☐ No

MILL LEVY

Does the service have a mill levy in place?	☐ Yes	☐ No
If yes: Number of mills	Amount Received	
Other tax money received		

OWNERSHIP

Name of Exact Ownership of Service				
Check one:	☐ Hospital Based	☐ Fire Based	☐ Private / Independent	☐ Government / Non-Fire Entity

Name of ALS Ground Ambulance Service	License Number

STAFFING

Check one:	☐ Volunteer		☐ Paid	☐ Combination
Paid Staff	☐ Not Applicable	☐ Up to 3	☐ 4 to 5	☐ 6 or more
Paid staff implies payments to individuals greater than $10,000 per year.				
Does your service maintain a written call schedule meeting minimum staffing as required per NDAC 33-11-01.2?	☐ Yes	☐ No		
Does your substation(s) maintain a written call schedule meeting minimum staffing as required per NDAC 33-11-01.2?	☐ Yes	☐ No	☐ N/A	

VEHICLE AND LIABILITY INSURANCE CARRIERS

Name of Vehicle Insurance Company			
Agent Name	Agent Address		
City		State	ZIP Code
Name of General Liability Insurance Company			
Agent Name	Agent Address		
City		State	ZIP Code

Name of ALS Ground Ambulance Service	License Number

DISPATCH INFORMATION: ALS GROUND AMBULANCE

List information for all agencies that dispatch your service.					
Name of dispatching agency					
Location (City)			Contact Phone Number		
☐ Emergent			☐ Non-emergent		
Type of dispatching agency:					
☐ County	☐ State Radio	☐ Hospital	☐ City / Law Enforcement		
☐ Other (Explain)					
How are personnel notified?	☐ Pager	☐ Radio	☐ Telephone	☐ Other (Explain)	

Name of dispatching agency					
Location (City)			Contact Phone Number		
☐ Emergent			☐ Non-emergent		
Type of dispatching agency:					
☐ County	☐ State Radio	☐ Hospital	☐ City / Law Enforcement		
☐ Other (Explain)					
How are personnel notified?	☐ Pager	☐ Radio	☐ Telephone	☐ Other (Explain)	

Name of dispatching agency					
Location (City)			Contact Phone Number		
☐ Emergent			☐ Non-emergent		
Type of dispatching agency:					
☐ County	☐ State Radio	☐ Hospital	☐ City / Law Enforcement		
☐ Other (Explain)					
How are personnel notified?	☐ Pager	☐ Radio	☐ Telephone	☐ Other (Explain)	

List any areas of improvement or concerns regarding the operational functionality of the dispatching system. DEMS would like to use this information to continue to build the cooperative relationship between EMS personnel / agencies and dispatch.

Name of ALS Ground Ambulance Service	License Number

☐ Check here if you have updated your vehicle roster online. If so you may leave this page blank.

VEHICLE ROSTER INFORMATION: ALS GROUND AMBULANCE

Unit Number (Radio)					☐ Primary Vehicle	☐ Backup Vehicle
Make					Year	VIN Number
Ambulance Cell Phone Number						Mileage

Unit Number (Radio)					☐ Primary Vehicle	☐ Backup Vehicle
Make					Year	VIN Number
Ambulance Cell Phone Number						Mileage

Unit Number (Radio)					☐ Primary Vehicle	☐ Backup Vehicle
Make					Year	VIN Number
Ambulance Cell Phone Number						Mileage

Unit Number (Radio)					☐ Primary Vehicle	☐ Backup Vehicle
Make					Year	VIN Number
Ambulance Cell Phone Number						Mileage

Unit Number (Radio)					☐ Primary Vehicle	☐ Backup Vehicle
Make					Year	VIN Number
Ambulance Cell Phone Number						Mileage

Name of ALS Ground Ambulance	License Number

AMBULANCE PERSONNEL ROSTER: ALS GROUND AMBULANCE

☐ Check here if you have updated your personnel roster online. If so you may leave this page blank.

NOTE: State ID numbers are required. Application will be rejected if this information is not provided. If you are listing new members, you must include EMS registration forms or ALS licensure forms.

First Name	Last Name	State ID Number	Provider Level

Name of ALS Ground Ambulance Service	License Number

AMBULANCE PERSONNEL ROSTER, CON'T: ALS GROUND AMBULANCE

First Name	Last Name	State ID Number	Provider Level

Name of ALS Ground Ambulance Service	License Number

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Total Number of Vehicles in Service

Please make copies if additional pages are needed.

Please place an "X" in boxes if stocked.

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Mounted ambulance cot with retaining straps				
Stretchers with retaining straps. Vehicle design dictates quantity.				
Piped oxygen system - with appropriate regulator and flow meter, or two "E" size bottles for minimum oxygen supply with regulator and flow meter				
Portable oxygen unit with carrying case. To include one "D" size bottle with another "D" bottle in reserve				
Three nasal cannula, three non-rebreather oxygen masks in adult and pediatric sizes, and three sets of oxygen supply tubing				
Suction wall mounted and portable capable of achieving 400 mm/hg 4 seconds or less, w/catheters in adult sizes, rigid and soft				
Bag valve mask resuscitation units in infant, child and adult sizes with appropriate sized face masks or pocket masks with oxygen inlet in infant, child and adult sizes				
Spine boards - one full size and one half size - with retaining straps				
Head to board immobilization device				
Commercial fracture splints usable for open and closed fractures or padded boards usable for pediatric and adult patients				
Hot packs - four minimum				
Cold packs - four minimum				
Activated Charcoal				
Obstetrical Kit - disposable or sterile				
Soft roller self adhering bandages - five yards (4.75 meters) long - twelve minimum				
Sterile burn sheets - two minimum				
Triangular bandages - three minimum				
Sterile gauze pads - four inches (10.16 centimeters) by four inches - twenty five minimum				
Trauma dressing - approximately 10 inches by thirty six inches - two minimum				
Nasopharyngeal airways in adult and child sizes - one set minimum				
Oral airways in adult and child sizes - one set minimum				
Sterile occlusive dressings - approximately three inches by nine inches				
Tape - assorted sizes - four rolls minimum				
Blunt Shears - two minimum				
Lower extremity traction splint				
Disposable gloves - small, medium and large - one box each min.				
Bedpan, emesis basin and urinal - single use or sterilizable; one each minimum				
Distilled water or saline solution - one gallon minimum				
Flashlights - two minimum				

Name of ALS Ground Ambulance Service	License Number

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Total Number of Vehicles in Service

Please make copies if additional pages are needed.

Please place an "X" in boxes if stocked.

Item	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Reflectorized flares for securing scene - three sets minimum				
Red biohazard bags - three minimum				
Cervical collars - small, medium and large one each minimum				
Two blankets, two pillows, four sheets and four towels.				
Tubiculcidal disinfectant product				
Fire extinguisher - dry chemical, mounted, five pound (2.27 Kg) minimum				
Intravenous fluid holder - cot mounted or ceiling hook				
Stethoscope with adult and pediatric capabilities				
Blood pressure manometer with cuff size in large adult, adult, child and infant				
Endotracheal airway equipment - pediatric and adult				
Manual cardiac monitor defibrillator with pediatric capabilities				
IV therapy equipment - catheters, tubing, solution - pediatric and adult				
Syringes and needles - assorted sizes				
Glucose measuring device				
Nebulizer with tubing				
Alcohol swabs / betadone swabs				
Twenty-five triage tags				
Pulse oximeter				
ECG supplies, paper, electrodes, defibrilator pads				
1- sharps container less than 1/2 full				
VHF radio with capabilities of meeting EMS standards as determined by the department				
Portable radio capable of reaching law enforcement & hospitals				
Personal protection equipment, such as mask, non-absorbant gown, protective eyewear - four each minimum				
Biological fluid cleanup kit				
Reflective vest - minimum of two				
Pediatric backboard				
Pediatric traction splint				
Appropriate pediatric reference material				
Magill forceps: one adult, one pediatric				
Written treatment protocols				
Narcotic				
Antidysrhythmic				

Name of ALS Ground Ambulance Service	License Number

CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Item *Please make copies if additional pages are needed.* **Please place an "X" in boxes if stocked.**	**Unit Number(s)**			
	UNIT #	UNIT #	UNIT #	UNIT #
Anticholinergen parasympatholic				
Opiod antagonist				
Coronary vasodialator, antiaginal				
Antianxiety				
Caloric				
Alkalinizer				
Broncodilator, adrenergic IV or SQ, also handheld or nebulized				
Anticonvulsant				
Meconium aspirator adaptor				
Laryngoscope w/ straight blade sizes 0, 1, 2, 3, & 4 and curved blade sizes 2, 3, & 4				
Stylettes: one pediatric, one adult				

Additional Equipment (not required by DEMS)

Infant / child car seat				

Name of ALS Ground Ambulance Service	License Number

SUBSTATION LICENSE

Please Note: Leave this area blank if your service does not have substations. If the substation ambulance is located within headquartered service area (city limits), substation licensure does not apply. Substations must display headquartered ambulance services name on all units. For each licensure only one roster is permissible. The listed contact person must be registered under the service's personnel roster.

Substation 1

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

Substation 2

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

Substation 3

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

Substation 4

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

Substation 5

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

Substation 6

Location of Substation (city)		
Physical Address		ZIP Code
Unit Number(s)	Contact person of substation	

MEDICAL DIRECTOR AGREEMENT: ALS GROUND AMBULANCE

INSTRUCTIONS: This form must be completed with each ambulance licensure renewal application or at any time a change or addition of medical director is made. All ALS personnel license applications, etc. must be signed by the medical director on record or they will be returned. A current medical director agreement must be on file for each service at all times.

PHYSICIAN MEDICAL DIRECTOR

First Name	Last Name	MI

Street Address / PO Box	City

State	ZIP Code	Telephone Number

ND License Number	Expiration Date

Name of ALS Ground Ambulance Service

Ambulance Service License Number

I, the above-named physician, agree to function as Physician Medical Director for the above-named ambulance service, it's associated substation units and/or quick response unit(s). As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service and any associated substation(s) and/or quick response unit(s). The emergency medical services personnel working either as volunteers or as compensated employees for these services are acting as my designated agents when providing patient care. It is my duty to assure that a system for quality improvement / quality assurance is developed and implemented. I will provide input on training issues and provide online medical direction when necessary.

The expiration date of this agreement will coincide with the expiration date of the ambulance license or may be terminated upon written notification by the listed ambulance service or by myself to the Division of Emergency Medical Systems.

☐ Remove previous medical director from service roster.

☐ Add to service roster as additional medical director.

Medical Director Signature	Date

SQUAD LEADER AGREEMENT: ALS GROUND AMBULANCE

INSTRUCTIONS: This form may be completed electronically or by hand. This form must be completed upon ambulance licensure or anytime there is a change in squad leader. A current squad leader agreement must be on file for each service at all times.

SERVICE SQUAD LEADER

First Name		Last Name	MI
Street Address / PO Box		City	
State	ZIP Code	Telephone Number	
ND EMS Number			
Name of Ambulance Service			

I, the above-named EMS professional, agree to function as Squad Leader for the above-named Ambulance Service, its associated substation units and/or Quick Response Unit(s). As Squad Leader I understand that I am responsible for ensuring compliance with all rules and regulations in regards to ambulance licensure requirements for the above named ambulance service and its associated substation(s) and/or Quick Response Unit(s). It is my duty to maintain updated service information with the Division of Emergency Medical Systems including updating the service address and contact information as well as the service personnel and vehicle rosters as needed.

The expiration date of this agreement will coincide with the expiration date of the ambulance or may be terminated upon written notification to the Division of Emergency Medical Systems.

☐ Remove previous Squad Leader from service roster.

☐ Maintain previous Squad Leader on service roster, changing status to 'service member'.

New Squad Leader Signature	Date
Outgoing Squad Leader Signature (If applicable)	Date
Other Authorized Signature (If outgoing squad leader signature is unavailable.)	Date

Name of ALS Ground Ambulance Service	License Number

MUTUAL AID AGREEMENT: ALS GROUND AMBULANCE

List ambulance services that this service has formal written agreements with for mutual aid. If no agreements have been made, leave this area blank.

Service	City

List Quick Response Units that this service has agreements with or collaborates with on emergency calls.

QRU	City

I hereby affirm that all information entered on this license application is true and correct to the best of my knowledge. I understand that any fraudulent entries may be sufficient cause for rejection or revocation of agency licensure.

I further agree to notify the North Dakota Department of Health Division of Emergency Medical Systems immediately if any changes in status occur. I agree that this ground ambulance service completes a trip ticket for each call and submits the required data to the Division of Emergency Medical Systems with the standards set by the North Dakota Department of Health as well as meeting all other requirements for ambulance licensure as outlined in Chapter 23-27 of the North Dakota Century Code.

Signature	Date

Click here to print completed form. ☐Sign and mail with payment to the address be

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF ACCOUNTING
600 E. BOULEVARD AVE. DEPT 301
BISMARCK, ND 58505-0200