2016-2018
NORTH DAKOTA LICENSE RENEWAL APPLICATION
AIR AMBULANCE

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 53889 (7/2016)

Select Level of Licensure Requested (check one)	☐ BLS Air Ambulance	☐ ALS Air Ambulance	☐ Critical Care Air Ambulance
Name of Air Ambulance Service			License Number

Where as, the above-named ambulance service provides emergency medical care and uses publicly or privately owned aircraft in the airspace 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 air ambulance service.

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

This license is nontransferable and a licensing fee of $50.00 is required at time of submission and must be made payable to: **North Dakota Department of Health.**

Send completed and signed forms with payment to:

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

Signature	Date

DEMST 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 Air 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 your 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 Air 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.				

AIRCRAFT AND LIABILITY INSURANCE CARRIERS

Name of Aircraft 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 Air Ambulance Service	License Number

DISPATCH INFORMATION: AIR 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 Air Service	License Number

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

VEHICLE ROSTER INFORMATION: AIR AMBULANCE

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Sat Phone Number	☐ Multi Engine
Year	Make	Hours

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Sat Phone Number	☐ Multi Engine
Year	Make	Hours

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Sat Phone Number	☐ Multi Engine
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Year	Make	Hours

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Sat Phone Number	☐ Multi Engine
Year	Make	Hours

Name of Air Ambulance Service	License Number

AMBULANCE PERSONNEL ROSTER: AIR 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 Air Ambulance Service	License Number

AMBULANCE PERSONNEL ROSTER, CON'T: AIR AMBULANCE

First Name	Last Name	State ID Number	Provider Level

Name of Air Ambulance Service	License Number

CHECKLIST OF REQUIRED EQUIPMENT: AIR AMBULANCE

Total Number of Vehicles in Service

			Item *Please make copies if additional pages are needed.* **Please place an "X" in boxes if stocked.**	Unit Number(s)			
				UNIT #	UNIT #	UNIT #	UNIT #
Critical Care	ALS	BLS	Patient litter or stretcher				
			Stethoscope				
			Blood pressure cuff with aneroid gauge				
			Manual suction with assorted rigid and soft catheters				
			One set of oropharyngeal airways				
			One set of nasopharyngeal airways				
			Oxygen administration system, including a protective pressure gauge, a non-gravity dependent flowmeter, supply tubing, a non-rebreather mask and a nasal cannula. The unit must be capable of achieving an oxygen delivery flow rate of at least 15 liters per minute for one hour.				
			Mouth-to-mask artificial ventilation device with supplemental oxygen inlet port such as a pocket mask, suitable for use on infant through adult patients. This may be replaced with bag valve mask devices with masks for infant, child and adult patients.				
			A suction unit capable of providing free airflow of at least 20 liters per minute and achieving a minimum of 300 millimeters of mercury vacuum within four seconds. Must include an assortment of soft and rigid catheters in both pediatric and adult sizes.				
			Intravenous equipment and supplies for both pediatric and adult patients.				
			Two intravenous bag holders with straps				
			Endotracheal intubation equipment and supplies for both pediatric and adult patients				
			Cardiac monitor-defibrillator and supplies with pediatric and adult capabilities				
			A drug box / bag that contains drugs that have been ordered by the medical director of the ambulance service				
			Equipment and supplies necessary to provide level of care as ordered by medical director				
			Transport ventilator				
			Intravenous infusion pump				

MEDICAL DIRECTOR AGREEMENT: AIR AMBULANCE

INSTRUCTIONS: This form must be completed with each ambulance licensure application or at any time a change or addition of medical directors 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 Air Ambulance Service			
Ambulance Service License Number			

I, the above-named physician, agree to function as Physician Medical Director for the above-named air ambulance service. As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service. 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.

Medical Director Signature	Date

If this is a change in medical director check one of the boxes below:

- ☐ Remove previous medical director from service roster.
- ☐ Add to service roster as additional medical director.

SQUAD LEADER AGREEMENT: AIR 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. 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. 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.

Squad Leader Signature	Date

If this is a change in squad leader, complete the section below:

- ☐ 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
Title (if other than squad leader)	Telephone Number

Name of Air Ambulance Service	License Number

MUTUAL AID AGREEMENT: AIR 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 below.

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