STEVE SISOLAK
Governor

RICHARD WHITLEY, MS
Director

LISA SHERYCH.
Administrator

ISHAN AZZAM, Ph.D., M.D.
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Emergency Medical Systems Program
4150 Technology Way, Suite 101
Carson City, Nevada 89706
Telephone (775) 687-7590 • Fax (775) 687-7595
http://dpbh.nv.gov/Reg/Emergency_Medical_Systems_(EMS)/

Agreement Renewal

Check Level of Service: ☐ Basic ☐ Intermediate ☐ Advanced

Name of Ambulance, Air Ambulance, or Fire-fighting Agency

Mailing Address of Agency

Phone Number of Agency Fax Number of Agency

E-Mail Address of Agency

Service or Agency Contact Person

Title

Approval is effective so long as the service or agency is operated as set forth in this agreement and is in compliance with Nevada Revised Statues and Nevada Administrative Code 450B. Approval is rescinded by the Division of Public and Behavioral Health for cause or on written request of the operating service or agency.

NEVADA STATE EMS PROGRAM ONLY

Date Received:_____
Approved:_____
Denied:_____
Denial Letter Sent:_____
Registered #:_____

Date Reviewed:_____
Documents Received:

_____ Attendant List
_____ Agreement Renewal Cover
_____ Physician Director Agreement
_____ Hospital(s) Agreement
_____ Service Agreement
_____ Mechanical Safety Statement
_____ Variance Review
_____ Current Rate Schedule
_____ Verification of Protocol
_____ Permitted Services Info
_____ Permit and Vehicle Fees

All Permitted Agencies

Once you have completed your review of all required documentation, the agency EMS Coordinator and the agency Medical Director must sign the bottom of this form attesting to the accuracy of the information provided.

Please forward the updated packet to the Carson City Office. If you have any questions about any of the required documentation, or changes, please contact your EMS Representative.

Checklist

- ☐ Agreement Renewal Cover Letter
- ☐ Ambulance Service Agreement
- ☐ Physician Director Agreement
- ☐ Hospital Agreement
- ☐ Permitted Services Information
- ☐ Verification of Current Protocols
- ☐ Current Rate Schedule
- ☐ Vehicle Log (With Corrections If Necessary)
- ☐ Certification of Vehicle Mechanical Safety
- ☐ Attendant List

Please make sure you have all this information on file for Site Audit Review when requested.

EMS Coordinator (printed name)	Medical Director (printed name)
EMS Coordinator (signature)	Medical Director (signature)

VERIFICATION OF CURRENT PROTOCOLS

Pursuant to NAC 450B.505 (2):

2. The medical director of a service or fire-fighting agency shall:

(a) Establish medical standards which:

(1) Are consistent with the national standard which is prepared by the National Highway Traffic Safety Administration of the United States Department of Transportation as a national standard for the level of service for which a permit is issued to the service or an equivalent standard approved by the Administrator of the Division and which are approved by the board;

(2) Are equal to or more restrictive than the national standard prepared by the National Highway Traffic Safety Administration of the United States Department of Transportation or an equivalent standard approved by the Administrator of the Division an adopted by the state emergency medical system; and

(3) Must be reviewed and maintained on file by the Division or a physician active in providing emergency care who is designated by the Division to review and make recommendations to the Division.

(b) Direct the emergency care provided by any certified person who is actively employed by the service.

Date of Protocols currently in use:_____

Medical Director who initiated Protocols:_____

Current Protocols on file:_____

If the current Medical Director is NOT the Medical Director who initiated your protocols, please have the current Medical Director sign below indicating they have read and is in agreement with the protocols in use.

_____ _____

Medical Director (Print) Medical Director (Signature)

_____

Date

_____ _____

Agency Representative (Print) Agency Representative (Signature)

_____

Date

CERTIFICATION OF MECHANICAL SAFETY REQUIRED FOR PERMIT RENEWAL

Pursuant to NAC 450B.580(1), Each ambulance or agency's vehicle must be maintained in safe operating condition, including all of its engine, body and other operating parts and equipment. The Division shall periodically, at least every 12 months, **require the holder of a permit to certify** that the holder has had each ambulance, air ambulance or agency's vehicle under his or her control inspected by a professional mechanic who has found it to be in safe operating condition. In the case of an air ambulance, maintenance must be in accordance with Federal Aviation Administration rules, 14 C.F.R. Parts 43, 91 and 135, as applicable, which are hereby adopted by reference and are available without charge from the United States Department of Transportation, 1200 New Jersey Avenue, S.E., Washington, D.C. 20590. The holder shall mail a copy of the certificate to the Division with each application for the renewal of a permit or upon request of the Division.

I certify that each ambulance, air ambulance or agency's vehicle listed under this permit has been inspected by a professional mechanic who has found it to be in safe operating condition.

Agency Representative (Print) _____ Agency Representative (Signature) _____

Title _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Date _____

PRE-HOSPITAL EMERGENCY CARE ENDORSEMENT
HOSPITAL AGREEMENT

The _____ Hospital of _____ (city/state) agrees to following provisions relative to the operations of _____ the _____ Service / Agency on a continuing basis for a period of 1 year:

1. Provide 24-hour physician or registered nurse supervision of the hospital emergency department. Physician must be present or able to be present in the emergency department within 30 minutes.
2. Provide voice radio communication capability on a 24-hour basis, for medical direction of pre-hospital emergency care.
3. All communications shall be recorded on tapes or discs. These recordings will be retained in the custody of the hospital for at least 90 days, if the tapes or discs are not retained at a regional dispatch center or the Nevada Shared Radio System.
4. Allow EMS personnel the opportunity to participate in continuing education, i. e., didactic, practical and clinical sessions of a structured nature.
5. Include the report of pre-hospital emergency care in the medical record of the hospital for each patient.

It is further agreed that this hospital will immediately notify the Division of Public and Behavioral Health of any change in the status of this agreement.

_____ _____
Hospital Administrator (Print) Hospital Administrator (Signature)

_____
Title

_____
Mailing Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number Date

PRE-HOSPITAL EMERGENCY CARE ENDORSEMENT
SERVICE AGREEMENT

The _____ Ambulance Agency / Air Ambulance Agency / Fire-Fighting Agency of _____, (city/state) agrees to the following provisions relative to operations of Basic, Intermediate or Advanced Ambulances, Air Ambulances or Agency Vehicles:

1. Maintain adequate numbers of attendants who are licensed to provide 24-hour, 7 day a week operation of the ambulance service /fire-fighting agency or;
   a) If an air ambulance, maintain an adequate number of registered nurses and pilots to provide 24-hour, 7 day a week operation.
2. Report to the Division any traffic accident or incident reportable to the Federal Aviation Administration.
3. Provide continuing education appropriate for the level of endorsement as required by the Medical Director or the Division of Public and Behavioral Health.
4. Develop and maintain standards to assure compliance with Board of Health regulations for:
   a) Documentation and reporting of patient care provided.
   b) Submit information required by the National Emergency Medical Services Information System.
   c) Use of the EMS radio system to obtain medical direction on administration of pre-hospital emergency care.

It is further agreed that this agency will immediately notify the Division of Public and Behavioral Health of any change in the status of this Agreement.

Agency Representative (Print)	Agency Representative (Signature)
Title	
Mailing Address	City / State / Zip Code
Phone Number	Date

PERMITTED AGENCY INFORMATION

Agency Name: _____

Coordinator: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Email: _____

EMERGENCY CONTACT INFORMATION

Initial Contact: _____

Phone Number: _____ Fax Number: _____

Cell Phone Number: _____ Pager Number: _____

Email: _____

Secondary Contact: _____

Phone Number: _____ Fax Number: _____

Cell Phone Number: _____ Pager Number: _____

Email: _____

MEDICAL DIRECTOR INFORMATION

Medical Director: _____

Phone Number: _____ Fax Number: _____

Email: _____

DISPATCH CENTER INFORMATION

Dispatch Center: _____

Phone Number: _____ Fax Number: _____

Dispatch Frequency: _____

Primary ER: _____

SERVICE DETAIL

Permit Number:_____ Permit Level: _____

Number of Vehicles: Transport:_____ Non-Transport:_____

Substations: _____

_____

VARIANCE REVIEW

Please list any variances that your agency is working under:

_____

_____

_____

Reason for variance:

_____

_____

_____

Date Board of Health variance was granted: _____

If more than 3 years old, do you wish to renew the variance?_____Yes ____No

If yes, please provide a letter requesting renewal of the variance, including an explanation of the need for the variance.

Emergency Contact Information

The Nevada State EMS Program is compiling a list of emergency contact information regarding services and agencies throughout the state to aid in mobilization in the event of mass casualty incident. Please provide contact information.

Name of Ambulance Agency, Air Ambulance Agency or Fire-fighting Agency

Initial Contact Person

Name	Title
Phone Number	Fax Number
Cell Phone Number	Pager Number
E-Mail Address	

Secondary Contact Person

Name	Title
Phone Number	Fax Number
Cell Phone Number	Pager Number
E-Mail Address	

Dispatch Center

Agency Name	
Phone Number	Fax Number

PHYSICIAN DIRECTOR AGREEMENT

I,_____M.D./D.O.,
a physician licensed to practice medicine in Nevada, do hereby agree to serve as the agency Medical Director for_____
on a continuing basis for a period of one (1) year. I further agree to notify the agency, Division of Public and Behavior Health of any change in status of this Agreement at least 30 days prior to any change as per NAC 450B.505 6 (a).

It is understood that I will be responsible for

a) Establishment, implementation and evaluation of medical standards for pre-hospital emergency care provided by this agency.

b) Confirm proficiency levels for personnel of the service.

It is further understood that I may also establish or approve:

a) Medical protocols and policies for this agency.

b) Educational programs within the service that is consistent with state standards.

c) Medical standards for dispatch procedures for this agency.

d) Standing orders that direct emergency care prior to initiating contact with a physician.

e) A system of medical quality improvement for this agency.

f) Suspension of a licensed attendant from duty within the agency pending review and evaluation by the Division.

_____ _____
Agency Medical Director (Print) Agency Medical Director (Signature)

_____
Mailing Address

_____ _____ _____
City State Zip Code

_____ _____
Phone Number E-Mail Address

_____
Date