STATE OF NORTH CAROLINA

Department of Health and Human Services
Division of Health Service Regulations
Office of Emergency Services

EMS System Modification Application

Updated January-1-2012

EMS System Modification Application Instructions

The following instructions should assist you in completing the NCOEMS EMS System Modification application. You only need to send in the completed section(s) listed on the **Content Information** page that pertains to your modification along with any required attachment(s). Please contact your regional specialist should you need assistance in completing this application.

1. Section I. EMS System Information:

a. Must be filled out for **all** System Modifications and must be updated in CIS as information changes. This is system information and not Provider.
b. This page is formatted to be completed electronically and saved for future use.
c. The System Modification document is to be completed and submitted by the county System Administrator.

2. Section II. NEW EMS Provider Application:

a. SECTION II.A. This section is for a NEW EMS Provider application. It encompasses licensed and non-licensed Provider applicants. This is strictly Provider information.
b. SECTION II.B. This section allows for detailed information as to how the Provider will function within the system. A map or written narrative of service area is required and all information asked for must be addressed for application to be approved.

Section II. C. Provider Name or Ownership Change Only:

a. SECTION II C. When the name or ownership of the provider changes, completion of a new EMS Provider License application is required as per rule 10A NCAC 13P .0206(b).
b. This section is for a provider who is requesting a name or ownership change only and all information that was submitted in the original application is still current.
c. Required Endorsements: County Manager, System Administrator, Medical Director, and Provider Administrator.

3. Section III. The Addition of Current Licensed or Non-Licensed EMS Provider(s) to the EMS System:

a. This section is for a licensed or non-licensed EMS Provider currently functioning in one system and is requesting to function in another EMS system.
b. If changes are required for any areas of the current EMS System application, these must be included as attachments to be added in the original application.

4. Section IV. Modifying the Level of Care for Current Licensed or Non-Licensed Provider(s) participating within the EMS System.

a. Any Provider within a system who is requesting to modify their current level of care must complete this section. This can be either an increase or decrease in level of care.
b. If an increase in level of care, a new roster must be included with application.
c. If changes are required for any area of the current EMS System application, these must be included as attachments to be added to the original application.

5. Section V. The Deletion of a Current Licensed or Non-Licensed EMS Provider(s) or Non Traditional Practice Setting in the EMS System:

a. Signatures of System, Provider, and or Hospital Administrator representative are required.
b. Documentation is required to explain how service will be provided in the area that the deleted Provider served.

6. Section VI. EMD Center Information and Application:

a. This section must be completed for all initial EMD Centers, additions, deletions, and changes/updates in the current EMDPRS and EMD con-ed.

Note: Please be prepared to present documentation or other information supporting your answer."

7. Section VII. Medical Oversight:

a) Section VII A. If changes are made in protocols, medications, policies, or procedures for the EMS System, completion of this section along with supporting documentation is required. **If an EMS System or Provider would like to change or add a protocol to the existing NCCEP Patient Care Treatment Protocols, the EMS System Medical Director must contact the NCOEMS Medical Director for approval before development of the additional protocol(s). Approval letter from the NCOEMS Medical Director and the OEMS is required before implementation of changes.**

b) Section VII.B. If the system adds an Assistant Medical Director or changes System Medical Director, **even if interim**, this section is required. This section provides all the mandatory NCCEP requirements. If a Medical Director or Assistant Medical Director is deleted, only name is required.

8. Section VIII. Endorsements:

a. This section clarifies whose signatures are required based on sections that are being modified and must be sent with any modification submission. **Note: The County Manager's signature is not required, when through written delegation or resolution, the system administrator has been delegated authority to act on behalf of the county.**

A completed application with all required attachments must be submitted to the appropriate regional office. Modifications that require approval must be submitted at least 30 days and receive notification from the OEMS prior to implementation. Incomplete applications are subject to be returned or may result in delayed approval. Further inquiries are to be directed to the appropriate regional office. All system modification applications must be approved by the county EMS System Administrator.

Note: Please be prepared to present documentation or other information supporting your answer."

EMS SYSTEM MODIFICATION APPLICATION

CONTENT INFORMATION AND SELECTION

Application Date: Proposed Implementation Date:

Descriptive Title:

This modification involves: **(Check all boxes that apply, complete appropriate sections, and attach any required documentation.)**

Check Section

☐ **I. EMS System Information**
(Section must be completed for any modification)

☐ **II. New EMS Provider Application:**
☐ **Licensed Provider** ☐ **Non-licensed Provider**
(Complete sections I, II and VIII)

☐ **II. C. Provider Name or Ownership Change Only**
☐ **Licensed Provider** ☐ **Non-licensed Provider**
(Complete sections I, II (C) and VIII)

☐ **III. The Addition of Current Licensed or Non-Licensed EMS Provider(s) to the EMS System**
(Complete sections I, III, and VIII)

☐ **IV. Modifying the Level of Care for of Current Licensed or Non-Licensed Provider(s) participating Within and or outside the EMS System**
(Complete sections I, IV, and VIII)

☐ **V. Deletion of any System Provider or Non Traditional Practice Setting:**
☐ **Licensed Provider** ☐ **Non-Licensed Provider** ☐ **Non Traditional Practice Setting**
(Complete sections I, V, and VIII)

☐ **VI. EMD Center Information and Application:**
☐ **Addition** ***or*** ☐ **Deletion to an EMS System**
(Complete sections I, VI, and VIII)

☐ **VII. Medical Oversight:**
☐ **A. Protocol, Medication, Polices or Procedure or Peer Review Committee Modification**
(Complete sections I, VII (A), and VIII)

☐ **B. System Medical Director or Assistant Modification and Requirements**
(Complete sections I, VII (B), and VIII)

☐ **VIII. Endorsements**

Note: Please be prepared to present documentation or other information supporting your answer."

EMS System Information

1. **Must be filled out for <u>all</u> System Modifications. This is system and not Provider information.**
2. **This page is formatted to be completed electronically and saved for future use.**
3. **The System Modification Document is to be completed and submitted to the NCOEMS by the county System Administrator**.
4. **If any of the below information has changed, please update in CIS data base prior to submission and highlight below what is new.**

EMS System: **Level of System:** ☐ **EMT-B** ☐**EMT-I** ☐**EMT-P**
Number of Modifications:
Descriptive Title: **Proposed Implementation Date:**

County Manager: **County:**

Co. Manager Address:

Phone: Fax Number: Email Address:

Pager: Mobile:

Contact Person: **Title:**

Phone: Fax Number: Email Address:

Pager: Mobile:

Mailing Address:

City: State: Zip:

Medical Director:

Phone: Fax Number: Email Address:

Pager: Mobile:

Mailing Address:

City: State: Zip:

RAC Affiliation:

Completed application must be submitted to the appropriate regional office. Modifications that require approval must be submitted at least **<u>30 days</u>** and receive notification from the OEMS prior to implementation. Further inquiries are to be directed to the appropriate regional office. **All system modification applications must be approved by the county EMS System Administrator.**

<u>WESTERN</u>
Western Regional EMS Office
3305 16th Ave. S.E.
Suite 302
Conover, NC 28613
828-466-5548 Office
828-466-5651 Fax

<u>CENTRAL</u>
Central Regional EMS Office
801 Biggs Drive
2717 Mail Service Center
Raleigh, NC 27699-2717
919-855-4678 Office
919-715-0498 Fax

<u>EASTERN</u>
Eastern Regional EMS Office
404 St. Andrews Street
Greenville, NC 27834
252-355-9026 Office
252-355-9063 Fax

<u>Note:</u> Please be prepared to present documentation or other information supporting your answer."

II. New EMS Provider Application

1. **SECTION II. A. This section is for a NEW EMS Provider application. It encompasses licensed and non-licensed Provider applicants. This is strictly Provider information.**
2. **SECTION II. B. This section allows for detailed information as to how the Provider will function within the system. A map or written narrative of service area is required.**
3. **SECTION II. C. This section is for a Provider who is requesting a name or ownership change only and all information that was submitted in the original application is still current.**
4. **Required Endorsements: County Manager, System Administrator, Medical Director, and Provider Administrator.**

A. Provider Information:

Application Type: ☐ Licensed ☐ Non-Licensed

Legal Name of Provider

Mailing Address:

City: State: Zip:

Physical Address of Base of Operation or where the provider will offer point to point patient transport within the system:

City: State: Zip:

Provider Number: System Affiliation:
(Regional Specialist will enter for Initial applicants, if Applicable.)

Phone Number: ( ) Fax Number: ( ) Email:

Provider Administrative Contact: Title:

Phone Number: ( ) Fax Number: ( ) Email:

Pager Number: ( ) Mobile Number: ( )

Does the service area within which you will be providing ambulance service have an existing ambulance franchise ordinance as stated in G.S. 153A-250? ☐ Yes ☐ No **If yes, signature of the county manager on this application serves as franchise approval to operate within the system.**

Application must be signed by the county manager granting approval to operate within the service area.

B. Mandatory Information Requirements:

☐ 1. Attach an 8 ½ x 11 map or a written narrative indicating the approved service area within the system, to include square miles. Explain the Provider's role within the overall system.

☐ 2. Indicate proposed primary level of **licensed** operation:
☐ EMT ☐ EMT-I ☐ EMT-P ☐ Convalescent ☐ Air Medical

☐ 3. Indicate proposed type of **Non-licensed** operation:
☐ Medical Responder ☐ First Responder ☐ Fire ☐ Rescue ☐ Law ☐ Industrial ☐ Other

☐ 4. Provide written narrative explaining the following:
a. How will the public access the Provider? _____
b. Describe the hours of operation. If the Provider will not be providing services 24 / 7, then a procedure must be developed that will ensure coverage is provided to the citizens 24 / 7. _____

Note: Please be prepared to present documentation or other information supporting your answer."

☐ 5. Provide written narrative explaining the following:
a. The type of radio communication to be used by the new provider. . _____
b. How communication will be maintained with the hospital. _____
c. If using the State VIPER Network, provide a copy of the Highway Patrol VIPER Authorization form. Is this attached? ☐ Yes ☐ No
d. Provide copy of FCC license and call sign or approval letter if provider uses radio under the authority of another with this application. Is this attached? ☐ Yes ☐ No.

☐ 6. Will the new Provider have representation as part of the EMS Peer Review Committee? ☐ Yes ☐ No
If yes, provide new EMS Peer Review Committee membership. If no, explain the process in which Information regarding medical review is obtained. _____

☐ 7. Will on-line medical control be provided by a facility other than those currently listed in system application. ☐ Yes ☐ No If yes, give name of facility. _____

☐ 8. Attach a personnel roster to include name, EMS Level, and last four digits of their social security number or state-issued P number.

☐ 9. Provide a brief narrative explaining how many vehicles, the type, and the level of care in which you will be operating within the system. _____
For example: 3 EMT-P ground units, 1 EMT-P Non-Transport ,etc.

☐ 10. Will the new Provider be using the current equipment/medication checksheets and the vehicle maintenance forms as in the County EMS System application? ☐ Yes ☐ No If no, provide copies of new forms that will be used.

☐ 11. Provide a brief narrative explaining the following:
a. How the cleaning and maintaining of equipment and vehicles will be done. _____
b. Assurance that supplies and medications are not used beyond the expiration date and are stored in a temperature controlled atmosphere according to manufacture's specifications. _____

☐ 12. Has the new Provider's employees completed an emergency vehicle operations course, if required by the EMS System Plan?
☐ Yes ☐ No

☐ 13. What method will the new Provider be using to collect and electronically submit data within 24 hours?_____

☐ 14. What EMS Educational Institution is responsible for continuing education and record keeping for the new Provider? (name of institution and title of person responsible_____)

☐ 15. A copy of the current OEMS approved system plan was submitted to (name) on (date. _____)

☐ 16. Has the new provider's employees been made aware of any requirements imposed by the System?
☐ Yes ☐ No

For licensed Provider(s) and EMT-I and EMT-P non-licensed Provider(s) only:

This application serves as intent to apply for an ambulance / vehicle permit and or license. Initial Provider license applicants must coordinate with the appropriate OEMS Regional Specialist to schedule the inspection of the proposed vehicles.

Note: Please be prepared to present documentation or other information supporting your answer."

II C. Provider Name or Ownership Change Only:

1. **When the name or ownership of the provider changes, completion of a new EMS Provider License application is required as per rule 10A NCAC 13P .0206(b).**
2. **This section is for a provider who is requesting a name or ownership change only and all information that was submitted in the original application is still current.**
3. **Required Endorsements: County Manager, System Administrator, Medical Director, and Provider Administrator.**

Application Type (Please check one) : ☐ Licensed ☐ Non Licensed

Current Legal Name of Provider Proposed Legal Name of Provider

Mailing Address:

City: State: Zip:

Physical Address of Base of Operation or where the provider will offer point to point patient transport within the system:

City: State: Zip:

Provider Number: System Affiliation:

Phone Number: ( ) Fax Number: ( ) Email:

Provider Administrative Contact: Title:

Phone Number: ( ) Fax Number: ( ) Email:

Pager Number: ( ) Mobile Number: ( )

If there is an existing ambulance franchise ordinance as stated in G.S. 153A-250, have the appropriate changes been approved?

☐ Yes ☐ No **If yes, signature of the county manager on this application serves as franchise approval of name change.**

☐ Have personnel and facilities been provided with information regarding the Provider's new name in the system? ☐ Yes ☐No

Note: Please be prepared to present documentation or other information supporting your answer."

III. The Addition of Current Licensed or Non-Licensed EMS Provider(s) To the EMS System

1. **This section is for a licensed or non-licensed EMS Provider currently functioning in one system and requesting to function in another EMS system.**
2. **If changes are required for any areas of the current EMS System application, these must be included as attachments to be added in the original application.**
3. **Required Endorsements: County Manager, System Administrator, Medical Director, and Provider Administrator.**

IF THIS PROPOSAL INVOLVES MORE PROVIDERS, ATTACH ADDITIONAL PAGES FOLLOWING THE SAME FORMAT

A. Proposed Provider(s)

Provider Name Is the information listed in the CIS data base correct? ☐ Yes ☐ No If no, please update.

Provider Number: License Number ☐ Non-licensed
(Regional Specialist will enter for applicants, if Applicable.)

Phone: ( ) Fax: ( )

Contact Person Title:

Phone: ( ) Pager: ( ) Mobile: ( )

Mailing Address

Physical Address of Base of Operation or where the provider will offer point to point patient transport within the system:

City: State: Zip:

B. Mandatory Information Requirements:

☐ 1. Attach an 8 ½ x 11 map or a written narrative indicating the approved service area within the system, to include square miles. Explain the Provider's role within the overall system.

☐ 2. Indicate proposed primary level of **licensed** operation:
☐ EMT ☐ EMT-I ☐ EMT-P ☐ Convalescent ☐ Specialty Care ☐ Air Medical

☐ 3. Indicate proposed level and type of **Non-licensed** operation:
☐ Medical Responder ☐ First Responder ☐ Fire ☐ Rescue ☐ Law ☐ Industrial ☐ EMT-I ☐EMT-P ☐Other

☐ 4. Provide written narrative explaining the following:
a. how will the public access the Provider? _____
b. describe the hours of operation. If the Provider will not be providing services 24 / 7, then a procedure must be developed that will ensure coverage is provided to the citizens 24 / 7. _____

☐ 5. Provide written narrative explaining the following:
a. The type of radio communication to be used by the new provider. . _____
b. How communication will be maintained with the hospital. _____
c. If using the State VIPER Network, provide a copy of the Highway Patrol VIPER Authorization form. Is this attached? ☐ Yes ☐ No
d. Provide copy of FCC license and call sign or approval letter if provider uses radio under the authority of another with this application. Is this attached? ☐ Yes ☐ No.

Note: Please be prepared to present documentation or other information supporting your answer."

☐6. Will the new Provider have representation as part of the EMS Peer Review Committee? ☐ Yes ☐ No
If yes, provide new E MS Peer Review Committee membership. If no, explain the process in which information regarding medical review is obtained. _____

☐ 7. Will on-line medical control be provided by a facility other than those currently listed in system application. ☐ Yes ☐ No If yes, give name of facility._____

☐ 8. Attach a personnel roster to include name, EMS Level, and last four digits of their social security and or state-issued P number.

☐ 9. Provide a brief narrative explaining how many vehicles, the type, and the level of care in which you will be operating within the system. ***For example: 3 EMT-P ground units, 1 EMT-P Non-Transport, and 1 SCT ground and 1 SCT air medical unit.***_____

☐10. Provide a brief narrative explaining the following:
a. How the cleaning and maintaining of equipment and vehicles will be done. _____
b. Assurance that supplies and medications are not used beyond the expiration date and are stored in a temperature controlled atmosphere according to manufacture's specifications. _____

☐11. Will the new Provider be using the current equipment/medication checksheets and the vehicle maintenance forms as in the County EMS system application? ☐ Yes ☐ No If no, provide copies of new forms that will be used.

☐12. Has the new Provider's employees completed an emergency vehicle operations course as required by the EMS System Plan? ☐ Yes ☐ No

☐13. What method will the new Provider be using to collect and electronically submit data within 24 hours?_____

☐14. What EMS Educational Institution is responsible for continuing education and record keeping for the new Provider? (name of institution and title of person responsible_____)

☐ 15. Has the new provider been made aware of System Requirements and their role in the System? ☐ Yes ☐ No

☐ 16. Have personnel and facilities been provided with information regarding on-line medical control and the new Provider's role in the system? ☐ Yes ☐ No

☐ 17. Has the new provider's employees been made aware of any requirements imposed by the System? ☐ Yes ☐ No

Note: Please be prepared to present documentation or other information supporting your answer."

IV. Modifying the Level of Care for Current Licensed or Non-Licensed Provider(s) participating within the EMS System

1. **Any Provider within a system who is requesting to modify their current level of care must complete this section. This can be either an increase or decrease in level of care.**
2. **If an increase in level of care, a new roster must be included with application.**
3. **If changes are required for any area of the current EMS System application, these must be included as attachments to be added to the original application.**
4. **Required Endorsements: County Manager, System Administrator, Medical Director, and Provider Administrator.**

A separate sheet must be completed for EACH PROVIDER participating in this EMS System program modification.

Provider Name: Is the information listed in the CIS data base correct? ☐ Yes ☐ No If no, please update.

Provider Number: License Number: ☐ Non-Licensed

Provider Mailing Address:

City: State: Zip:

Contact Person: Title:

Phone: ( ) Pager: ( ) Mobile: ( )

1. Indicate CURRENT Operational level: ☐ MR ☐ EMT ☐ EMT-I ☐ EMT-P ☐ Air Medical

2. Indicate PROPOSED Operational level: ☐ EMT ☐ EMT-I ☐ EMT-P ☐ Air Medical

3. Roster in CIS must be current with appropriate staffing requirements for proposed level: ☐ Yes ☐ No

4. PROPOSED # of vehicles to be permitted: Non-Transporting

Mandatory Information Requirements:

☐1. If there is a change in the current service area, attach an 8 ½ x 11 map or a written narrative indicating the approved service area within the system, to include square miles. Explain the Provider's role within the overall system. _____

☐2. If there is a change, provide a written narrative explaining the following:
a. How will the public access the Provider? _____
b. Describe the hours of operation. If the Provider will not be providing services 24 / 7, then a procedure must be developed that will ensure coverage is provided to the citizens 24 / 7. _____

☐3. Will the Provider have representation as part of the EMS Peer Review Committee? ☐ Yes ☐ No If yes, provide the new EMS Peer Review Committee membership. If no, explain the process in which information regarding medical review is obtained. _____

☐4. Will on-line medical control be provided by a facility other than those currently listed in system application. ☐ Yes ☐ No If yes, give name of facility._____

☐5. Will the Provider be using the current equipment/medication checksheets and the vehicle maintenance forms as in the County EMS system application? ☐ Yes ☐ No If no, provide copies of new forms that will be used.

☐ 6. Does the new level of care require a change in the continuing education? ☐ Yes ☐ No If yes, What teaching institution is responsible for education? _____

Note: Please be prepared to present documentation or other information supporting your answer."

☐ 7. Addition /changes made in medications, policies, or procedures for the EMS System or Medical Director requires completion of Section VII, Medical Oversight. This information is to be attached to this modification. An approval letter from the NCOEMS Medical Director and the OEMS is required prior to implementation.

☐8. Have personnel and facilities been provided with information regarding on-line medical control and the new Provider's role in the system? ☐ Yes ☐ No

Note: Please be prepared to present documentation or other information supporting your answer."

V. The Deletion of Current Licensed, Non-Licensed EMS Provider(s), and Non Traditional Practice Settings in the EMS System

1. **Signatures of System and Provider or Hospital Administrator representative are required.**
2. **Documentation is required to explain how service will be provided in the area that the deleted Provider served unless a Non Traditional Practice Setting.**
3. **Required Endorsements: *County Manager, System Administrator, Provider and /or Hospital Administrator**

IF THIS PROPOSAL INVOLVES MORE PROVIDERS, ATTACH ADDITIONAL PAGES FOR EACH PROVIDER.

Provider Name:

Provider Number: License/Approval Number: Expiration Date:

Last Date of Provider service

☐ **Provide documentation of how the service area will be covered 24 hours a day and state reason for deletion.**

☐ **If deleted Provider is not functioning in another EMS System, please attach the original copy of their Provider license.**

****

For Non-Traditional Practice Setting(s)
<u>Deletion only</u>:

If a Non-traditional practice setting is deleted, this section is required.

Last Date of Service: _____ Reason for deletion. _____ (Complete* in lieu of signature page)

_____* _____*
Facility Administrator Signature **Date**
Type/print name

_____* _____*
System Medical Director Signature **Date**
Type/print name

_____* _____*
System Administrator Signature **Date**
Type/print name

<u>Note:</u> Please be prepared to present documentation or other information supporting your answer."

Section VI. EMD CENTER INFORMATION AND APPLICATION

1. **This section must be completed for all initial EMD Centers, additions, deletions, and changes/updates in the current EMDPRS. Verification from the EMD Medical Director is required. EMD centers must be operational 24 hours a day; 7 days a week.**
2. **Required Endorsements: County Manager, System Administrator, EMD Center Director, and Medical Director. If deleting an EMD Center, see Section C.**

☐ **Addition**

Legal Name of EMD Center Licensee:

Mailing Address:

City: State: Zip Code: -

Physical Location:

Service Area:

City: State: Zip Code: -

Provider Number:

System Affiliation:

Phone Number: Fax Number: Email:

Provider Administrative Contact: Title:

Phone Number: Fax Number: Email:

Pager Number: Mobile Number:

A. Emergency Medical Dispatch (EMD) Program

For initial EMD programs provide all the following and complete other applicable sections:

☐ The EMDPRS card set version number _____ and license number _____ approved by the medical director. Indicate whether the system has adopted the minimum standard EMDPRS as defined in the NCCEP document or has chosen to develop its own EMDPRS. _____ Please provide assurance that the EMDPRS will be reviewed annually, and discuss the mechanism by which changes will be made. Example**:** EMDPRS will be reviewed every January or as changes occur throughout the year._____

☐ If the EMDPRS is developed locally, please provide complete copy of card set and assurance that the EMDPRS will be reviewed annually, and discuss the mechanism by which changes will be made.

☐ Provide list of EMD personnel including last four digits of social security number or state-issued P number that hold a current credential by the **NCOEMS.**

☐ Provide documentation of how continuing education will be provided. List the following: Name of the EMS Educational Institution: _____. Name of the credentialed EMD instructor:_____. The person who will be responsible for keeping track of the EMD personnel continuing education._____

☐ Verification from Medical Director stating approval of continuing education for EMD. (signed letter or signature of medical director on this application will suffice)

☐ Provide the FCC call sign and expiration date of the center that will be utilizing the EMD program.

☐ Attach new peer review committee listing indicating EMD representative.

Note: Please be prepared to present documentation or other information supporting your answer."

B. For Modifications to a Current EMD Program:

Check appropriate boxes and provide the required documentation.

Is the information listed in the CIS data base correct? ☐ Yes ☐ No If no, please update.

☐ Change in EMD version and license number; **provide copy of the front of the new card set showing version and license number.** When will new card version be in service? Date:_____

☐ If the EMDPRS is developed locally, please provide a complete copy of card set and assurance that the EMDPRS will be reviewed annually.

☐ Is the EMD center roster current as listed in CIS data base? Yes☐ If no, must explain._____

☐ How will personnel be updated on new card set? Explain _____

☐ Provide signed letter or signature on this application from Medical Director approving new card set.

☐ Change in location or ☐ addition of location.

Note: Annual updating of the EMDPRS is required per 10A NCAC 13P .0407(b)

C. For Deletion of EMD Center:

Complete information listed below:

Legal Name of EMD: _____

Provider Number: _____

System Affiliation: _____

Last Date of Service: _____

Reason for deletion: _____

Note: Please be prepared to present documentation or other information supporting your answer."

VII. MEDICAL OVERSIGHT

1. **SECTION VII A. If changes are made in protocol, medications, policies, or procedures or peer review committee for the EMS System, completion of this section along with supporting documentation is required. This information is to be sent to the appropriate regional office and not directly to the NCOEMS Medical Director. If an EMS System would like to change or add to the existing NCCEP Patient Care Treatment Protocols, the Medical Director must contact the NCOEMS Medical Director for approval before development of the additional protocol(s). Approval letter from the NCOEMS Medical Director and NCOEMS is required before implementation of changes.**

2. **SECTION VII B. If the system adds an Assistant Medical Director or changes System Medical Director, even if interim, this section is required. Include verification that all mandatory NCCEP requirements are met. If a Medical Director or Assistant Medical Director is deleted, only the name is required. County letter of appointment is required.**

3. **Required Endorsements: System Administrator and Medical Director (for protocol changes only).**

4. **Section I. and VIII. Completion and submission required with any change in this section.**

A. Protocol, Medications, Policies, or Procedures Modification or Peer Review Committee

For a detailed listing of the protocols, policies, and procedures as required by the North Carolina College of Emergency Physicians, refer to the OEMS web page at www.ncems.org.

Have any changes occurred to the written treatment protocols, medications, policies or procedures or peer review committee?
☐ **Yes** ☐ **No** If yes: check all the below that apply and send to the appropriate regional office. **Do not send to the NCOEMS Medical Director.**

Provide written approval letter from the System Medical Director for any proposed changes and list what changes are being made.

☐ Attach one paper copy and one electronic copy of the proposed written treatment protocols. All changes should reflect the current NCCEP guidelines.

☐ Attach one paper copy and one electronic copy of the proposed change in polices.

☐ Attach one paper copy and one electronic copy of the proposed change in procedures.

☐ Attach one paper copy and one electronic copy of the proposed medications changes and list quantities carried on each unit per level.

☐ Attach one paper copy of the proposed change in peer review committee.

Note: Approval letter must be received from OEMS prior to implementation.

Note: Please be prepared to present documentation or other information supporting your answer."

B. Medical Director Modification

1. **The Medical Director for an EMS System shall be responsible for items listed in 10A NCAC 13P .0403 (a) (1) – (9), (b), and (c).**
2. **If the system adds an Assistant Medical Director or changes System Medical Director <u>even if interim</u>, this section is required. Include verification that all the mandatory NCCEP requirements are met. If a Medical Director or Assistant Medical Director is deleted, only name is required. When approved, System will need to have new Medical Director establish a profile and or update CIS with new information.**

☐ Add { ☐ Delete Name: }

☐ System Medical Director ☐ Assistant Medical Director ☐ Interim

Name:

Home: ( ) Work: ( ) Pager: ( )

Mobile: ( ) Email:

Mailing Address: ☐ Home ☐ Work
City: State: Zip:

1. **<u>If an addition, please include all the following documentation:</u>**

☐ Letter of appointment from county official. This is required for Medical Director and Assistant Medical Director.

☐ Document verifying the NCCEP requirements. (See table at bottom of page)

☐ Complete the NCCEP Medical Director's Course within the first year of appointment. Date of course:_____ In subsequent years, attend 1 or more of 3 NC EMS Medical Director meetings scheduled by the NC OEMS annually.

☐ Documentation of the Medical Directors' responsibilities and job description. Attach contract if applicable.

☐ Letter from new Medical Director that he/she approves of protocols, policies, medications, procedures, equipment to be carried on vehicles.

☐ Letter of approval from Medical Director stating approval of continuing education plan, if applicable.

☐ Letter of approval for the EMD center and card version, if applicable.

☐ Updated EMS Peer Review Committee list indicating new Medical Director as member, if applicable.

☐ Medical Director must complete profile in CIS data base.

Please answer the following information:

1. Hold current license to practice medicine or osteopathy in North Carolina. **(Where is copy of license held for OEMS Inspection)** ☐
2. Have endorsement indicating a working relationship with the local physician community (i.e. Hospital staff, local medical society, or emergency physician's group) ☐
3. Preferably hold board certification or be board prepared in Emergency Medicine and completion of an EMS Fellowship. When this is not feasible, the medical director must at least hold board certification or be board prepared in a clinical specialty that represents the broad patient base the EMS system serves. Board certification must be obtained within 5 years after successful completion of residency training. **(List Board Certification Specialty)** ☐
4. Maintain BC/BP as mentioned in above with a board, approved by the American Board of Medical Specialties or the American Osteopathic Association. ☐
5. Maintain an active clinical practice. **(Where)** ☐
6. Have education or experience in out-of-hospital emergency care. **(Give Explanation)** ☐
7. Have participated, or possess equivalent experience, in the resuscitation of adult and pediatric patients that suffer acute illness or traumatic injury. **(Explain)** ☐
8. Possess knowledge of federal, state, and local laws and regulations regarding EMS ☐ **Yes**
9. Maintain appropriate medical liability coverage. **(Statement to this fact will suffice)** ☐
10. Maintain involvement in local, regional, state, or national EMS organizations. **(How)** ☐
11. Be exempt from item 1-3 above if the medical director was appointed prior to January 1, 2002. Those directors who do not meet the qualifications in item 1-3 must maintain current certification in a standardized adult trauma resuscitation course, a standardized adult cardiac resuscitation course, and a standardized pediatric acute resuscitation course. **(Provide copies of certification for verification)** ☐

<u>Note:</u> Please be prepared to present documentation or other information supporting your answer."

☐ For Assistant Medical Director:

When approved, System will need to have new Assistant Medical Director establish a profile and or update CIS with new information.

☐ Add { ☐ Delete Name: } ☐ Interim

Name:

Home: ( ) Work: ( ) Pager: ( )

Mobile: ( ) Email:

Mailing Address: ☐ Home ☐ Work

City: State: Zip:

☐ Letter of appointment from county official.

☐ Attach list of clearly defined and written responsibilities or tasks assigned by the Medical Director.

☐ Complete the NCCEP Medical Director's Course within the first year of appointment. Date of workshop:

☐ Updated EMS Peer Review Committee list indicating new Assistant Medical Director as member, if Applicable.

☐ Assistant Medical Director must complete profile in CIS data base.

Please answer the following information:

Assistant Medical Director Requirements
1. Hold a current license to practice medicine or osteopathy or be credential by the NCOEMS as an EMS Physician Assistant or EMS Nurse Practitioner. ☐
2. Work under the direction of the EMS system medical director or the EMS specialty care transport program medical director. ☐
3. In subsequent years, attend 1 or more of 3 NC EMS Medical Director meetings scheduled by the NC OEMS annually.

Note: Please be prepared to present documentation or other information supporting your answer."

VIII. ENDORSEMENTS

Please type or print the name and title under each required signature. If additional signatures are required, attach an extra copy of this sheet.

We, the undersigned, have reviewed this **EMS SYSTEM MODIFICATION APPLICATION** and all attachments. We fully approve, support, and endorse this modification with a thorough involvement and understanding of our respective roles and responsibilities in maintaining an EMS System in the State of North Carolina pursuant to the rules of the North Carolina Medical Care Commission.

_____ _____
System Medical Director Date
Type/print name

_____ _____
EMS System Administrator Date
Type/print name

_____ _____
County Manager (see note below) Date
Type/print name

_____ _____
County Manager, Outside of Service Area (if applicable) Date
Type/print name

_____ _____
Provider Administrator (if applicable) Date
Type/print name

_____ _____
Provider Administrator (if applicable) Date
Type/print name

_____ _____
Hospital/Facility Representative (if applicable) Date
Type/print name

_____ _____
Other (if applicable) Date
Type/print name

Note: The County Manager's signature is not required, when through written delegation or resolution, the system administrator has been delegated authority to act on behalf of the county. If the county manager or system administrator has changed since last submission, a new letter from the county is required.

For NCOEMS Use Only

Date Received NCOEMS_____

Regional Specialist Signature_____

Note: Please be prepared to present documentation or other information supporting your answer."