



**Oklahoma State Department of Health**

Protective Health Services  
Emergency Systems/EMS Division  
1000 N.E. 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
Telephone: (405) 271-4027  
Fax: (405) 271-4240



**INSTRUCTIONS  
FOR THE  
COMPLETION  
OF  
OKLAHOMA'S  
STANDBY  
EMERGENCY MEDICAL  
RESPONSE AGENCY  
INITIAL APPLICATION FORMS**



## Application Direction

Please type or print all information, except where a signature is required.

### Section 1 – Type of Application

- Enter the date of the application.
- Enter the application purpose.
- Enter the agency license number if submitting an application amendment, survey, or renewal.

### Section 2 – Business Information

- Enter the name of your agency including city, state and zip code.
- Enter the mailing address of your agency including city, state and zip code.
- Enter the physical address of your agency including city, state and zip code.
- Enter the records retention address (address of where the agency records are located) (city, state, & zip code)
- Enter the business telephone number and an emergency telephone number.
- Enter the name of the person who will be a point of contact for the application.
- Enter an email that the point of contact will be able to access to receive correspondence for the Department.
- Enter the days and times of the agencies operations. Please include the days and times that records will be available for an unannounced inspection review. (310:641-15-18 (a) – (c))

### Section 3 – Owner’s Information (310:641-15-3 (h))

- Enter the name of the agency owner (You must also complete and submit the ownership supplementary form)

### Section 4 – Level of Care (310:641-15-10 (a))

- Both Standby Event and Pre-Hospital agencies are to have at least one person of the responding personnel certified or licensed by the Department.

### Section 5 – Type of Owner (310:641-15-3 (j))

- Enter the type of ownership for the agency.

### Section 6 – Type of Operation

- Enter the type of operation for the agency.

### Section 7 – Communication Policy (310:641-15-3 (j) (10))

- Agency Dispatch
  - Enter the agency phone number that dispatch will contact to dispatch a call by phone.
  - Enter who the call will be received by (i.e. crew members, agency dispatcher).
- Other Dispatch
  - Enter the agency that is providing dispatch to the agency.
  - Enter the phone number the agency providing dispatch for the agency.
- Radio System
  - Enter the type of two way radio communication maintained by the agency.
  - Enter the frequency being used for dispatch if applicable.

(NOTE: The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. The communication plan must be compliant with Local, State and Federal communication plans. The agency must complete and submit a statement stating the agency has a communication policy as part of this application.)

### Section 8 – Medical Director 310:641-15-3-(j) (7)

- Enter the name of you medical director. Indicate the type of license (MD or DO).
- Enter the telephone number of where the medical director can be reached.
- Enter the address of where the medical director can receive correspondence by mail.
- Enter the medical director’s State license number, OBNDD number and Specialty.
- Enter the hospital or place the medical director is on staff.

(NOTE: All Emergency Medical Response Agencies must have a physician medical director. Copies of the medical director’s state license, OBNDD registration, letter of agreement and CV must be submitted with this application. A statement on how the agency will maintain quality assurance documentation on the medical director’s involvement with the quality assurance process must be submitted with this application.)



### Section 9 – EMRA Council or Board (310:641-15-3 (j) (3))

- If the EMRA has a council or board a Supplement form must be completed and submitted with this application.

### Section 10 – Coordination with other certified or licensed agencies (310:641-15-3 (l))

- EMS agencies responsible for the event location when the event is within a licensed ambulance service area or approved area for prehospital emergency medical response agencies.
- The applicant will need to have documents available for inspection showing the coordination with other agencies. The EMS-EMRA Provider Agreement form is included with this application and can be used to meet this requirement.

### Section 11 – Records Requirement Information (310:641-15-22)

- All of the items on this checklist are required to be kept in your records for regulatory inspections. The items on the right column are items that must be sent with your application. An example of how the EMRA applicant will maintain regulatory compliance will be required at the time of the initial site inspection. (See “Other Requirements” below for more information.)

### Section 12 – Quality Assurance Plan (310:641-15-3- (j) (9) (C))

- The agency must develop and submit a quality assurance plan. The plan must show how the medical director will be involved with review of patient care as outlined in the plan. The plan must include at least review of patient care refusals, air ambulance utilization, airway management interventions, time sensitive medical, time sensitive trauma, cardiac arrests and a random review of portion of all remaining patient care reports.

### Section 13 – Protocols (310:641-15-3- (j) (9))

- Enter the type of protocol that will be used by the applicant.
- If your organization desires to use the State protocols, please indicate in a letter your intent of using the protocols as is. The letter must be signed by the agency director and agency medical director.
- If your organization desires to use the State protocols with changes, please indicate in a letter your intent of using the protocols with changes. The letter must be signed by the agency director and agency medical director. If you are removing protocols from the State protocols you may include the protocols removed on the letter. If you are adding protocols that are not included in the State protocol you must submit the protocol(s) with supporting evidence based documents.
- If your agency desires to use agency specific protocols, please submit the entire protocol to the Department for approval. If your agency specific protocols differ from the State protocols you must submit the supporting evidence based documents with you protocol(s).
- The agency specific protocol must include a letter signed by the agency director and agency medical director.
- In addition to any type of protocol intent letter, you must also complete and submit an Authorized Procedure List (APL).

### Section 14– Response Plan (310:641-15-3 (j) (11))

- The agency must develop a plan that addresses how the agency will provide and receive disaster assistance in accordance with local and regional plans and local communications plans if it were to enter the incident command system. The response plan may include, but not be limited to:
  1. Describe how the standby EMRA will receive and respond to requests for service at the location.
  2. Describe how the agency will request transport services.
  3. In the event of a disaster or other ICS event -
    - A. How will the agency integrate into the locations disaster plan? (Will the standby EMRA have medical command, or will medical command rest with the venue or responding agencies?)
    - B. How will the agency be utilized by the responding agencies? (How will the standby EMRA be integrated with other responders?)
    - C. How will the agency support the responding agencies? (Will the SB EMRA be in a leadership role, or support role and be integrated with the other responders)
    - D. How will the agency be integrated into the responding agencies response?  
Will members of the SB EMRA become part of the responder teams/units?  
Will the SB EMRA be provided a specific task (triage, treatment, or transport assignments) within the ICS structure?



**Section 15– Owner Signature (310:641-15-22 (j))**

- Print the license owner’s name in the space provided.
- Print the license owner’s title in the space provided.
- Enter the date in the space provided.
- The license owner must sign in the space provided.
- The signature must be verified by a notary public.

**Other Requirements:**

**Governmental Support (310:641-15-3 (k))**

- If the applicant is providing care to the public on public property, then letters of governmental support and documents verifying coordination with local ambulance services are required for that agency to have the authority to provide care at that setting.
- If the agency is providing care to the public in a business or establishment open to the public on private property, then letters of governmental support are not required.

**Communication Plan** - The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. The communication plan must be compliant with Local, State and Federal communication plans.

**Response Plan**– See Section 14 above.

**Confidentiality Policy** – This is a statement ensuring confidentiality of all documents and communications regarding protected patient health information.

**Medical Director**

- Copy of Medical Director’s OK State Medical license
- Copy of Medical Director’s OBND Registration
- Copy of Medical Director’s Curriculum Vitae
- Signed letter from Medical Director agreeing to offer medical direction to the EMRA

**Included Forms:**

**Ownership & Control Interest Disclosure** – Complete all sections that apply to the ownership of your EMRA. Sign and notarize the form on Section 9.

**EMS-EMRA Coordinating Agreement** – As part of the requirements for certification, the EMRA must coordinate with other licensed and certified agencies that respond to the location you are providing Standby services for. (see 15-3 (l)) This does not have to be submitted with the application, but must be documented in the event of an inspection or investigation. This may also be included in your response plan.

**Personnel Roster** – List all personnel for your EMRA who drive, pilot and/or provide patient care. Include the EMR Certificate Number and Expiration date for EMR’s; the Oklahoma EMS license number and Expiration date for EMT’s or higher or list non-medical personnel who drive as “driver.”

**Equipment List** – check to indicate all equipment from the “Suggested Equipment List” that you will have for your EMRA. Enter any additional equipment in the blank space on the form.

**Approved Procedures List** – Check each box to indicate the procedures used at your agency—including procedures at scopes of practice above the EMR level if you will have EMS individuals working at higher levels. **Include** a signed letter from the Medical Director and Agency Director stating that you accept the Oklahoma State Protocols either “as-is” or “with changes”, where you will include or attach an outline of the changes.



**Oklahoma State Department of Health  
Emergency Systems / EMS Division**

**Department Application Procedures**

After submitting your Emergency Medical Response Agency package, it will be reviewed by Department staff for completeness, accuracy and legibility. You will be contacted if the package is incomplete or additional information is required. Once the application is complete and reviewed, an EMS Administrator will then be assigned to conduct an initial inspection of your files, equipment and facility. Upon receipt of the EMS Administrators inspection report your Emergency Medical Response Agency Certificate will be mailed to the address of record. Information regarding your Emergency Medical Response Agency package may be obtained by calling (405) 271-4027.

(NOTE: For a list of records that must be maintained by the Standby Emergency Medical Response Agency refer to the 310:641-15-22



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Standby Emergency Medical Response Agency Application Checklist

Date application received: \_\_\_\_\_

Date complete application received: \_\_\_\_\_

Reason for package: Initial \_\_\_ Amended \_\_\_ Update \_\_\_ Other \_\_\_\_\_

Agency Name: \_\_\_\_\_

Please check each item:

1.  \$50 Initial EMRA application fee (310:641-15-3 (j) (13))
2. Address
  - Business Address
  - Physical Address
  - Record Retention Address
3.  Hours of Operation
4.  Emergency Phone Number  Business Phone Number
5.  Statement of ownership (310:641-15-3 (j) (1))
6.  Copies of contracts (310:641-15-3 (j) (8))
7.  Level of Care (310:641-15-3 (k) (2))
8. Medical Director (310:641-15-3 (h) (7))
  - Letter of agreement
  - Physician contact information w/address
  - Resume/CV
  - State Lic. # \_\_\_\_\_
  - OBNDD #: \_\_\_\_\_
9.  Personnel Roster (310:641-15-10)
10. Protocols (310:641-15-3 (h) (9))
  - Type (as is, with changes, agency)
  - Signed Letter (Medical Director, agency director )
  - Authorized Procedure List
  - Protocol changes
  - QA Plan
11.  Governmental Endorsement (if applicable) (310:641-15-3 (k))
12.  EMS Agency Coordination (310:641-15-3 (l) and (m))
13.  Communication plan (310:641-15-3 (j) (10))
14.  Response plan (310:641-15-3 (j) (11))
15.  Confidentiality policy (310:641-15-3 (j) (12))
16.  List of Equipment (310:641-15-11)
17. Insurance (310:641-15-2 (j) (4)-(6))
  - General Liability Insurance
  - Vehicle Liability Insurance
  - Workers Compensation Insurance

Scheduled for Inspection: \_\_\_ Date: \_\_\_\_\_ (or attach Aspen Report)



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## EMRA Standby Application

READ "Instruction Booklet" for Details

### SECTION 1 – TYPE OF APPLICATION (Print or Type)

Date of Application \_\_\_\_\_ Purpose: \_\_\_\_\_ Initial \_\_\_\_\_ Amendment \_\_\_\_\_ License No: \_\_\_\_\_

### SECTION 2 – BUSINESS INFORMATION

Service Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
City State Zip Code

Physical Address: \_\_\_\_\_  
City State Zip Code

Record Retention Address: \_\_\_\_\_  
City State Zip Code

Business Telephone: \_\_\_\_\_ Emergency Telephone: \_\_\_\_\_

Fire Chief / Director / Administrator / Coordinator / CEO Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

County: \_\_\_\_\_ Coverage Area includes (city(ies) or county(ies)) \_\_\_\_\_

Hours of Business Operation (Include days and times): \_\_\_\_\_

### SECTION 3 – OWNER'S INFORMATION

Name: \_\_\_\_\_ (Complete Ownership Supplementary Form)

### SECTION 4 – LEVEL OF CARE

The highest level of care that will be available on all requests for service.

Emergency Medical Responder \_\_\_\_\_

Basic Life Support \_\_\_\_\_

Intermediate Life Support \_\_\_\_\_

Advanced Life Support \_\_\_\_\_

Paramedic Life Support \_\_\_\_\_

### SECTION 5 – TYPE OF OWNER

Governmental City \_\_\_\_\_  
Governmental County \_\_\_\_\_  
Governmental Federal \_\_\_\_\_  
Governmental Tribal \_\_\_\_\_  
Private (Not For Profit) \_\_\_\_\_  
Private (For Profit) \_\_\_\_\_  
Board or Trust (Other) \_\_\_\_\_  
522 Board or Trust \_\_\_\_\_  
(Title 18 or 19)

### SECTION 6 – TYPE OF OPERATIONS

Fire Based \_\_\_\_\_  
Law Enforcement \_\_\_\_\_  
Hospital \_\_\_\_\_  
3<sup>rd</sup> Party (Not Fire or Police) \_\_\_\_\_  
Private \_\_\_\_\_  
Other: \_\_\_\_\_

### SECTION 7 – PUBLIC ACCESS AND DISPATCH

#### Agency Dispatch

Agency phone number where calls are received: ( ) - . The call is received by: \_\_\_\_\_

#### Other Dispatch

Agency providing dispatch: \_\_\_\_\_ Phone number for agency providing dispatch: ( ) - .

#### Radio System (How are you dispatched?)

Cell Phone? \_\_\_\_\_ VHF? \_\_\_\_\_ UHF? \_\_\_\_\_ 700Mhz \_\_\_\_\_ 800Mhz \_\_\_\_\_ What Freq? \_\_\_\_\_

Does the agency applicant have a communication policy that addresses receiving and dispatching emergency and non-emergency calls that is State and Federal compliant? Yes \_\_\_\_\_ No \_\_\_\_\_ (You must include a communication policy statement-see instructions.)

### SECTION 8 – MEDICAL DIRECTOR

Name: \_\_\_\_\_ MD: \_\_\_\_\_ DO: \_\_\_\_\_ Telephone Number: ( ) - .

Address: \_\_\_\_\_  
Mailing Address City State Zip Code

State License Number: \_\_\_\_\_ OBNDL Number: \_\_\_\_\_ Specialty: \_\_\_\_\_

On Staff Where: \_\_\_\_\_

(Copies of the Medical Director's State License, OBNDL Registration, Letter of Agreement and CV must be submitted with this application)

**SECTION 9 – EMRA COUNCIL OR BOARD**

Do you have an EMRA Council or Board? Yes \_\_\_ No \_\_\_

If yes, complete the EMRA Ownership & Control Interest Disclosure included with this application.

**SECTION 10 – Supporting/Coordinating EMS Agency (see 15-3(I))**

EMS Agency Name: \_\_\_\_\_

(Proof of coordination with a sponsoring EMS Agency is not required for the initial application, but should be available for inspection (see Section 11))

**SECTION 11 – RECORDS REQUIREMENT INFORMATION – (Checklist for Required Information):**

The below items must be kept in your records for regulatory inspections.

The below items must be sent in with your Initial Application. They also must be kept in your records for regulatory inspections. See Instructions for more specific information

- Call log (Rule Compliant)
- Vehicle Maintenance Reports
- Staffing Patterns and Schedules
- Records of In-Service Training / CE's
- Operational Protocols
- Compliance with OSHA Requirements
- Personnel State Licenses
- Personnel Proof of EVOC
- OSHA Compliant Exposure Control Plan
- Data Submission to OKEMSIS
- Electronic or Paper Run Reports
- Personnel CPR Certifications
- ICS Training (100, 200 and 700)
- EMS Agency(ies) (Section 10)

- Copies of Contacts for Equipment & Services(if applicable)
- Governmental Letter(s) of Support (if applicable)
- EMRA Personnel Roster (form attached)
- Confidentiality Policy
- Communications Policy
- Medical Director forms (Section 8)
- Quality Assurance Plan (Section 12)
- Patient Care Protocols with APL (Section 13)
- Response Plan (Section 14)
- Auto Liability Insurance (\$1,000,000.00)
- Proof of Workers' Compensation
- Professional Liability Insurance (\$1,000,000.00)

All records listed above will be reviewed during regulatory inspections.

At the time of your initial site inspection you must be able to show an example of how the records will be maintained.

**SECTION 12 – QUALITY ASSURANCE PLAN**

The agency must develop and submit a quality assurance plan. Be sure that your plan includes the following:

- Patient Care Refusals       Air Ambulance Utilization       Airway Management Interventions
- Time Sensitive Medical       Time Sensitive Trauma       Cardiac Arrests Interventions
- Random Patient Care Report Review

**SECTION 13 – PROTOCOLS**

What type of protocols does the applicant wish to utilize?

- State Protocol (as is)       State Protocol (with changes)       Agency Specific Protocol

(You must complete and submit the Authorized Procedure List (APL) (Included) and a Protocol intent letter. Both must be signed by agency director and medical director-noting protocol changes if applicable. If the Protocols are Agency specific, you must provide the full Protocols.

**SECTION 14 – RESPONSE PLAN**

The agency must develop a response plan for providing and requesting mutual aid. The plan must address how the agency provide and receive disaster assistance in accordance with local and regional plans and local communications plans. (You must submit the plan with this application.) (See instructions for more information)

**SECTION 15 - OWNER SIGNATURE**

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Signed before this \_\_\_\_\_ day of \_\_\_\_\_. My Commission Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Notary Public



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## STANDBY EMERGENCY MEDICAL RESPONSE AGENCY OWNERSHIP & CONTROL INTEREST DISCLOSURE

Print or type all information

### SECTION 1 – ENTITY (required)

Name of Entity: \_\_\_\_\_ DBA: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code County

### SECTION 2 – TYPE OF ENTITY (required)

- \_\_\_\_\_ Government Ownership (City State Federal Tribal) – Give Description: \_\_\_\_\_
- \_\_\_\_\_ Sole Proprietorship. List name of owner: \_\_\_\_\_
- \_\_\_\_\_ Partnership. List partners: \_\_\_\_\_
- \_\_\_\_\_ Corporation. Name of corporation: \_\_\_\_\_
- \_\_\_\_\_ Corporation Documentation must be submitted with this form
- \_\_\_\_\_ Disclosing entity receives money from, or contracts with, a '522' District (Article X) Complete Section 6
- \_\_\_\_\_ Disclosing entity receives money from or contracts with, an Ambulance Service District (Title 19) Complete Section 7.
- \_\_\_\_\_ Other (Specify): \_\_\_\_\_

### SECTION 3 – INDIRECT OWNERSHIP (If applicable)

List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

NAME	ADDRESS
_____	_____
_____	_____

### SECTION 4 – MORTGAGEE (If applicable)

List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

NAME	ADDRESS
_____	_____
_____	_____

### SECTION 5 – CORPORATION OFFICERS / DIRECTORS (If applicable)

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors. Additional names can be included on a separate piece of paper if necessary.

CORPORATION OFFICERS NAME	TITLE	ADDRESS
_____	_____	_____
_____	_____	_____

  

CORPORATION DIRECTORS NAME	TITLE	ADDRESS
_____	_____	_____
_____	_____	_____

**SECTION 6 – ‘522’ EMS DISTRICT BOARD (If applicable)**

If the disclosing entity is a ‘522’ District Board, or received money from a ‘522’ District Board, list the names, titles and addresses of the officers and directors. Give meeting dates and times.

522 District Board Name \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**MEETINGS:** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_

What is the amount of millage for this District? \_\_\_\_\_ Valuation of this District: \_\_\_\_\_

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contact or contracts to provide ambulance services with this form.

**SECTION 7 – OTHER OWNERSHIP OR CONTROLLING INTERESTS (If applicable)**

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board (Title 19), a city, a county, a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Ownership %: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Ownership %: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**MEETINGS:** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_

What is the amount of millage for this District? \_\_\_\_\_ Valuation of this District: \_\_\_\_\_

**IF TITLE 19:**

Name of Title 19 District: \_\_\_\_\_

What is the amount of tax for the District?: \_\_\_\_\_ Amount collected by the District?: \_\_\_\_\_

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contract(s) to provide ambulance service to this form.

**SECTION 8 – FELONY STATEMENT (required)**

Has any owner, principal, officer, or director been convicted of a felony?

Yes No If yes, please indicate details on a separate piece of paper.

**SECTION 9 – VERIFICATION STATEMENT (required)**

I understand that false or misleading representation on this statement may be prosecuted under applicable State laws.

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date



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EMS-EMRA PROVIDER AGREEMENT (Standby EMRA)

APPLICANT (Standby EMRA Agency)

I, \_\_\_\_\_ do hereby and on behalf of
\_\_\_\_\_ (Emergency Medical Response Agency)
organization agree to abide by and follow Regulations and Rules set forth by State of Oklahoma in full and
without exception or omission.

(Printed Name)

(Signature)

(Title)

(Date)

COORDINATING EMS AGENCY

I, \_\_\_\_\_ do hereby and on behalf of the
\_\_\_\_\_ (EMS Agency) agree to the rules set forth
by the State of Oklahoma and cooperate with the above named EMRA organization. I (we) do agree to
provide transportation as for all ambulance patients requested from the above named EMRA organization.

(Printed Name)

(Signature)

(Title)

(Date)



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## EMRA PERSONNEL ROSTER

**Instructions:** List all personnel associated with the ambulance service or emergency medical response agency that drive, pilot and/or provide patient care. Please list the names in alphabetical order. Please type or print only.

Agency Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person Providing the Information: \_\_\_\_\_ Title: \_\_\_\_\_

Name (Last, First and Middle Initial)	Level of License	SSN
Address	OK License Number & expiration date	Full/Part Time

1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name (Last, First and Middle Initial)	Level of License	SSN
---------------------------------------	------------------	-----

Address

OK License Number  
& expiration date

Full/Part Time

11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



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## STANDBY Emergency Medical Response Suggested Equipment List (310:641-15-12)

Required equipment	Equipment removed per 15-12 (b)
Universal precaution kits- BSI (Body Substance Isolation)	( (b) In the event the medical control physician does not approve procedures or interventions requiring this equipment, the minimum equipment list may be modified for the applicant.)
CPR (Cardiopulmonary Resuscitation)	
<ul style="list-style-type: none"> <li>• CPR valve mask, CPR mouth barrier device (BSI)</li> <li>• AED (Automated External Defibrillator) (adult and pediatric capability)</li> </ul>	
Airway Management	
<ul style="list-style-type: none"> <li>• Oral airways (complete set)</li> <li>• BVM (Bag Valve Mask) (adult, pediatric, infant)</li> <li>• Oxygen system (portable, with two (2) adult, pediatric and infant masks, and 2 adult nasal cannulas)</li> <li>• Suction device (battery or manual powered) (portable) (one (1) bulb syringe not in OB kit)</li> </ul>	
Wound Management	
<ul style="list-style-type: none"> <li>• Sterile dressings and bandages (burn sheets, 4"x4", 6"x8" or "8"x10", 2" or larger roller bandages 3"x8" occlusive, triangular bandages,</li> <li>• Adhesive tape, strips and patches (minimum 1" width)</li> <li>• Scissors</li> </ul>	
Fracture management	
<ul style="list-style-type: none"> <li>• Splints (adult and pediatric extremity splints, adult traction splint)</li> <li>• Cervical collars (assorted sizes)</li> <li>• Long spine board</li> </ul>	
Vital Signs	
<ul style="list-style-type: none"> <li>• Stethoscope / Blood pressure cuff (adult, pediatric and infant sizes)</li> <li>• Instant cold packs</li> <li>• Blanket(s)</li> <li>• Notebook / Clipboard / Pencil/ Patient care reports</li> <li>• Digital thermometer</li> <li>• Copy of protocols (electronic or paper)</li> <li>• <u>With medical director approval – Glucometer</u></li> </ul>	
<ul style="list-style-type: none"> <li>• <del>With medical director approval – Glucometer</del></li> </ul>	



## Authorized Procedure List

Agency Name:	Date:
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Agency Director Signature:	Date:
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Medical Director Signature:	Date:
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Airway	EMR Scope of Practice	EMT Scope of Practice	I/85 Scope of Practice	AEMT Scope of Practice	Paramedic Scope of Practice
Airway Assessment					
Oxygen Therapy--Nasal Cannula					
Oxygen Therapy--Non Rebreather Mask					
Oxygen Therapy-Partial Rebreather Mask					
Oxygen Therapy-Simple Face Mask					
Oxygen Therapy-Venturi Mask					
Oxygen therapy-Humidifiers					
Airway Obstruction Management					
Head Tilt-Chin lift					
Jaw Thrust					
Modified Jaw Thrust					
BLS Artificial Ventilation					
Pulse Oximetry Application/Interp					
BVM					
Airway-Nasal					
Airway-Oral					
Demand Valve-Manual Triggered Ventilation					
Airway-Laryngeal Mask					
Intubation-Orotrachael					
Intubation-Nasal Trachael					
Airway Dual Lumen					
Airway Supraglottic					
Suctioning-Upper Airway					
Suctioning-Tracheobronchial					
Obstruction-Direct laryngoscopy					
Non-Invasive Postive Pressure Ventilation					
End Tidal-Co2 Monitoring					
Wave-Form Capnography					
Impedance Threshold Device					
Automated Transport Ventilator (ATV)					
Chest decompression--Needle					
Cricothyrotomy--Percutaneous					
Cricothyrotomy--Surgical					
Gastric Decompression--NG Tube					
Gastric Decompression--OG Tube					
Stoma/Tracheostomy Management					



<b>Cardiac-Circulation</b>	<b>EMR Scope of Practice</b>	<b>EMT Scope of Practice</b>	<b>I/85 Scope of Practice</b>	<b>AEMT Scope of Practice</b>	<b>Paramedic Scope of Practice</b>
CPR					
AED					
Mechanical CPR Device					
Multi-Lead Cardiac Monitor Application &/or Transmission					
Multi-Lead Cardiac Monitoring (interpretive)					
Single- Lead Cardiac Monitoring (interpretive)					
Manual Defibrillation					
Cardioversion-Electrical					
Carotid Massage					
Transcutaneous Pacing-Manual					
Internal pacing-monitor only					
Ventricular assist device					
Hypothermia therapy					

<b>Immobilization</b>	<b>EMR Scope of Practice</b>	<b>EMT Scope of Practice</b>	<b>I/85 Scope of Practice</b>	<b>AEMT Scope of Practice</b>	<b>Paramedic Scope of Practice</b>
C-Collar					
CID (Cervical Immobilization)					
Short Board					
Vest Type Extrication Device					
Long Board					
Manual					
Rapid Manual Extrication					
Extremity Stabilization					
Vest Type Extrication Device					
Traction Splint					
Mechanical Patient Restraint					
Emergency moves for endangered patients					
Pelvic Splint					



<b>Medication Administration - Routes</b>	<b>EMR Scope of Practice</b>	<b>EMT Scope of Practice</b>	<b>I/85 Scope of Practice</b>	<b>AEMT Scope of Practice</b>	<b>Paramedic Scope of Practice</b>
Inhalation					
Oral					
Sublingual					
Nasogastric					
Intranasal					
Intramuscular					
Subcutaneous					
Intraosseous					
Auto-injector					
IV Push					
IV Bolus					
IV Piggyback					
Indwelling Catheters					
Implanted Central IV Ports					
Rectal					
Ophthalmic					
Topical					
Transdermal					
Buccal					

<b>Miscellaneous Skills</b>	<b>EMR Scope of Practice</b>	<b>EMT Scope of Practice</b>	<b>I/85 Scope of Practice</b>	<b>AEMT Scope of Practice</b>	<b>Paramedic Scope of Practice</b>
Hemorrhage control-direct pressure					
Hemorrhage control-tourniquet					
Shock Treatment					
Lifting and Moving Patients					
Helmet Removal (Sports)					
Helmet Removal (Motorcycle)					
Child-Birth					
Blood-glucose monitoring					
Automated BP					
Manual BP					
Eye irrigation					
Eye irrigation-morgan lens					
Urinary catheterization					
Venous Blood Sampling					
Central line-monitoring					
Intraosseous Initiation					
IV-maintain of non-medicated fluids					
IV-maintain of medicated fluids					
IV Initiation-Peripheral					
Thrombolytic therapy-monitoring					



Formulary	EMR Scope of Practice	EMT Scope of Practice	I/85 Scope of Practice	AEMT Scope of Practice	Paramedic Scope of Practice
Albuterol-Proventil- Ventolin (patient's prescription)					
Albuterol-Proventil- Ventolin (agency supplied)					
Assist with Patient Prescription Beta Agent					
Aspirin					
Activated Charcoal					
Adenosine					
Amiodarone					
Atropine Sulfate					
Calcium Chloride					
Dextrose (D50)					
Dextrose (D25)					
Diazepam					
Diltiazem					
Diphenhydramine					
Dopamine					
Duodote Auto Injector					
Epinephrine 1:1000					
Epinephrine 1:10,000					
Epinephrine Auto injector					
Etomidate					
Fentanyl					
Glucagon					
Glucose					
Haloperidol					
Hydralazine					
Hydroxocobalamin					
Ipratropium Bromide					
Labetalol					
Lidocaine					
Lidocaine 2% Intravascular					
Lidocaine Viscous Gel					
Lorazepam					
Magnesium Sulfate					
Methylprednisolone					
Midazolam					
Morphine Sulphate					
Hydromorphone					
Narcan (Naloxone)					
Nitrous Oxide					
Metered Dose Nitroglycerin-patient's prescription					
Metered Dose Nitroglycerin- agency supplied					
Nitroglycerin Tablets-patient's prescription					
Nitroglycerin-Tablets agency supplied					
Nitroglycerin-IV Infusion					
Nitroglycerin-Ointment					
Norepinephrine					
Ondansetron					
Phenylephrine 2%					
Pralidoxime Chloride					
Sodium Bicarbonate					

