



## 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



Oklahoma State  
Department of Health

# INSTRUCTIONS FOR THE COMPLETION OF OKLAHOMA'S STRETCHER AID VAN INITIAL APPLICATION FORM

**August 2016**

Rev. 8/16



## Emergency Systems/EMS Division Stretcher Aid Van Application Instructions

### APPLICATION FORM

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.

#### Section 2 – Business Information

- Enter the name of your agency
- 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 will be kept) including city, state and zip code.
- Enter the business telephone number and an emergency telephone number.
- Enter the days and times of the agency's operations. Please include the days and times that records will be available for an unannounced inspection review.
- Enter yes if you agency will maintain substations. Complete and submit the Stretcher Aid Van substation form with you application. (Note: All substations must be contiguous to the licensed service area. A separate license will be required for any area that is not contiguous to the licensed area.) **(310:641-17- 2 (h))**

#### Section 3 – Owner's Information (310:641-17-2 (g))

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

#### Section 4 – Level of Care (63 O.S. § 1-2503 (25) and (26))

"Stretcher aid van patient" means any person who is or will be transported in a reclining position on a stretcher or gurney, who is medically stable, nonemergent and does not require any medical monitoring equipment or assistance during transport."

#### Section 5 – Type of Owner

- 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

- 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 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 and also documentation that a screening process is in place to ensure a request for the transport of a stretcher aid van patient will meet the agency's capability, capacity, and licensure requirements.



## Emergency Systems/EMS Division Stretcher Aid Van Application Instructions

### **Section 8 – Licensed Service Area and compliance with existing sole-source ordinances (63 O.S. § 1-2503 (25) and (26))**

Stretcher aid van services shall only be permitted and approved by the Commissioner in emergency medical service regions, ambulance service districts, or counties with populations in excess of 300,000 people. Notwithstanding the provisions of this paragraph, stretcher aid van transports may be made to and from any federal or state veterans facility

Please provide documents that verify the service area meets the statutory population limits, and include documents showing the applicant has addresses or is compliant with any sole-source ordinance.

### **Section 9 – EMS Council or Board**

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

### **Section 10 – Records Requirement Information (310:641-17-18)**

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

### **Section 11 – Response Plan (310:641-17-2 (g) (7))**

- The agency must develop a response plan for providing and requesting mutual aid. The plan must address how the agency will provide and receive disaster assistance in accordance with local and regional plans and local communications plans.

### **Section 12 – Owner Signature (310:641-17-2 (3))**

- 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**

- **Confidentiality Policy**(310:641-17-2 (g) (8)) – This is a statement ensuring confidentiality of all documents and communications regarding protected patient health information.
- **Business Plan**(310:641-17-2 (j)) – This is a plan that includes a financial disclosure statement showing evidence of the ability to sustain the operation for at least one (1) year.
- **Proofs of Insurance** – provide proofs of current insurance policies:
  - Vehicle Liability (\$1,000,000)
  - General or Professional Liability (\$1,000,000)
  - Worker’s Compensation

<continued>



## Emergency Systems/EMS Division Stretcher Aid Van Application Instructions

### Included Forms

- **Ownership & Control Interest Disclosure** – Complete all sections that apply to the ownership of your Stretcher Aid Van Service. Sign and notarize the form on Section 9.
- **Personnel Roster** – List all personnel for your agency 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 agency. Enter any additional equipment in the blank space on the form.
- **Substations** – Check "yes" if your agency will maintain substations. Complete and submit the substation form with you application. If this information is available as a print-out from your service, you may submit that print-out. (310:641-15-9)

### Department Application Procedures

After submitting your Stretcher Aid Van application, it will be reviewed by Department staff for completeness, accuracy and legibility. You will be contacted if the application is incomplete or additional information is required. Once complete, 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 license will be mailed to the address of record. Information regarding your Emergency Medical Response Agency package may be obtained by calling (405) 271-4027.

**The license application can be denied for any of the reasons detailed in 310:641-17-5 and 17-6.**



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## Stretcher Aid Van Application READ "Instruction Booklet" for Details

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

Date of Application \_\_\_\_\_ Purpose: Initial \_\_\_\_ Amended \_\_\_\_ Update \_\_\_\_ License No: \_\_\_\_\_

### SECTION 2 – BUSINESS INFORMATION

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

Mailing Address: \_\_\_\_\_

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

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

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

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

Email Address: \_\_\_\_\_ Phone Number \_\_\_\_\_

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

Will your agency have substation(s)? Yes \_\_\_ No \_\_\_ (If Yes, please fill out and attach the SAV substation form.)

### SECTION 3 – OWNER'S INFORMATION

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

### SECTION 4 – LEVEL OF CARE

By statute and regulation, the Stretcher aid van is limited to transporting a patient "who is or will be transported in a reclining position on a stretcher or gurney, who is medically stable, nonemergent and does not require any medical monitoring equipment or assistance during transport." (63 O.S. § 1-2503 (26))

### 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
- Title 19 District Board

### SECTION 6 – TYPE OF OPERATIONS

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

### SECTION 7 – Communication Policy

#### 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 policy statement which will also include your screening process (see instructions.))

**SECTION 8: Licensed Service Area and compliance with existing sole-source ordinances.**

**300,000 Population Minimum - EMS Region \_\_\_\_\_ Ambulance Service District \_\_\_\_\_ County \_\_\_\_\_**

**Does a sole-source ordinance exist in the identified Region, District, or County? \_\_\_\_\_**

**\*Include documentation showing compliance with existing sole source ordinances.**

**SECTION 9: – EMS COUNCIL OR BOARD**

Do you have an EMS Council or Board? Yes \_\_\_ No \_\_\_ If yes, complete the Ownership Disclosure Form.

**SECTION 10: – RECORDS REQUIREMENT INFORMATION – (Checklist for Required Information):**

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

- Record of patient transport
- Call log (Rule Compliant)
- Vehicle Maintenance Reports
- License or credential file
- Personnel State License or certification
- Personnel Proof of EVOC or defensive Driving course
- Personnel CPR Certifications
- ICS Training (100, 200 and 700)
- Records of In-Service Training / CEU
- Staffing Patterns and Schedules
- Operational Protocols
- Compliance with OSHA Requirements
- Mutual Aid Plan (Local & Regional Compliant)
- Electronic or Paper Run Reports
- Data Submission to OKEMIS

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

- Certificate of Vehicle Insurance (\$1,000,000.00)
- Workers' Compensation Program Verification\*
- Professional Liability Insurance (\$1,000,000.00)
- Sole Source Compliance Documentation (See Section 8)
- Copies of Contacts for Equipment & Services
- Map and Description of Coverage Area (Population specific)
- Business Plan(See Instructions)
- Confidentiality Policy(See Instructions)
- Communications Policy(See Section 7)
- Screening Process (See Section 7)
- Response Plan (See section 11)
- Equipment Checklist

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 11: – 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.)

**SECTION 12: - 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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Stretcher Aid Van Agency Application Checklist

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

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

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

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

Please check each item:

1. \_\_\_\_\_ Fee Paid      Amount \$ \_\_\_\_\_      (310:641-17-2 (g) (9))  
    \_\_\_\_\_ Substations      \_\_\_\_\_ Units
2. Addresses  
    \_\_\_\_\_ Business Address  
    \_\_\_\_\_ Physical Address  
    \_\_\_\_\_ Record Retention Address
3. \_\_\_\_\_ Hours of Operation
4. \_\_\_\_\_ Emergency Phone Number      \_\_\_\_\_ Business Phone Number
5. \_\_\_\_\_ Ownership documentation      (310:641-17-2 (g) (1))
6. \_\_\_\_\_ Copies of contracts      (310:641-17-2 (g) (5))
7. \_\_\_\_\_ Personnel Roster      (310:641-17-8)
8. \_\_\_\_\_ Compliance with Sole Source      (310:641-17-2 (h))
9. \_\_\_\_\_ Communication policy      (310:641-17-2 (g) (6))
10. \_\_\_\_\_ Business Plan      (310:641-17-2 (j))
11. \_\_\_\_\_ Response plan      (310:641-17-2 (g) (7))
12. \_\_\_\_\_ Confidentiality policy      (310:641-17-2 (g) (8))
13. \_\_\_\_\_ List of Equipment      (310:641-17-10)
14. \_\_\_\_\_ Description Service Area/Map      (63 O.S. § 1-2503 (25))
15. Insurance      (310:641-17-2 (g) (2)-(4))  
    \_\_\_\_\_ General Liability Insurance  
    \_\_\_\_\_ Vehicle Liability Insurance  
    \_\_\_\_\_ Workers Compensation Insurance
16. \_\_\_\_\_ Business plan      (310:641-17-2 (j))

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



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STRETCHER AID VAN OWNERSHIP & CONTROL INTEREST DISCLOSURE

Print or type all information

SECTION 1 - ENTITY

Name of Entity: DBA:
Address: City State Zip Code County

SECTION 2 - TYPE OF ENTITY

Government Ownership (City, State or Federal) - Give Description:
Sole Proprietorship. List name of owner:
Partnership. List partners:
Corporation. Name of corporation:
Disclosing entity received money from, or contracts with, a '522' District (Article X);
Give '522' district name:
Disclosing entity received money from or contracts with, an 'Ambulance Service' District (Title 19);
Give 'Ambulance Service' district name:
Other (Specify):

SECTION 3 - INDIRECT OWNERSHIP

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.

Table with 2 columns: NAME, ADDRESS

SECTION 4 - MORTGAGEE

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).

Table with 2 columns: NAME, ADDRESS

SECTION 5 - CORPORATION OFFICERS / DIRECTORS

CORPORATION OFFICERS

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

Table with 3 columns: OFFICERS NAME, TITLE, ADDRESS

CORPORATION DIRECTORS

Table with 3 columns: DIRECTORS NAME, TITLE, ADDRESS

**SECTION 6 – FELONY STATEMENT**

Has any owner, principal, officer, or director been convicted of a felony?  
Yes \_\_\_\_ No \_\_\_\_ . If yes, please indicate details on a separate peace of paper.

**SECTION 7 – ‘522’ EMS DISTRICT BOARD**

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.

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 8 – OTHER OWNERSHIP OR CONTROLLING INTERESTS**

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:**

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 9 – VERIFICATION STATEMENT**

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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### Stretcher Aid Van Equipment List (310:641-17-10)

Required Equipment	List Additional Equipment here
<ul style="list-style-type: none"><li><input type="checkbox"/> Universal precaution kits- BSI (Body Substance Isolation gowns, gloves, eye protection, and masks)</li><li><input type="checkbox"/> Latex or equivalent gloves separate from BSI kits.</li><li><input type="checkbox"/> One pair of scissors or shears.</li><li><input type="checkbox"/> One each pediatric and adult size bag-valve mask resuscitators.</li><li><input type="checkbox"/> One suction unit (portable or vehicle mounted) which is capable of delivering adequate suction to clear the airway, with wide-bore tubing (one quarter inch) (1/4"), and rigid and soft catheters for the types of patients the agency transports.</li><li><input type="checkbox"/> Oral airways pediatric and adult sizes.</li><li><input type="checkbox"/> Extra blankets, sheets, pillow cases.</li><li><input type="checkbox"/> Two (2) five (5) pound fire extinguishers, secured, with one (1) accessible to the driver and one (1) accessible to the patient care attendant,</li><li><input type="checkbox"/> AED (Automated External Defibrillator) (adult and pediatric capability)</li><li><input type="checkbox"/> One elevating gurney with locking equipment.</li><li><input type="checkbox"/> If the agency transports children, then the agency is required to provide a child restraint system.</li></ul>	



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## STRETCHER AID VAN 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.

### 310:641-17-8. Stretcher aid van staffing

- (a) Each stretcher aid van service shall be staffed by a minimum of two (2) persons.
- (b) The patient shall be accompanied by a minimum of:
  - (1) an attendant that has a current Oklahoma Emergency Medical Responder certification and maintains current BLS certification and
  - (2) the driver shall hold a valid Oklahoma driver's license, possess a current BLS certification, and have completed an agency defensive driving course that includes driving a vehicle similar to a stretcher aid van.

For the employees that are not certified or licensed by the Department, please describe their level of license as "driver".

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.		

Oklahoma State Department of Health  
Protective Health Services / Emergency Systems

ODH Form  
(Rev. 8/16)

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

9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Signature \_\_\_\_\_

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



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### Stretcher Aid Van List of Substations

Do you have units positioned at locations other than the mailing address of record? YES \_\_\_ NO \_\_\_

If, yes please list the address and physical location, if different from the address of the units. Make additional copies of this page if necessary.

(NOTE: If the substation is not contiguous to your licensed service area a separate license will be required)

Substation Name or Number	Address	City, ZIP	Phone Number at Sub-station