Washington State Department of Health

EMS Agency Verification and Vehicle License Application Packet

Contents:

In order to process your request:

Mail your application and other documents to:

EMS Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instructions Checklist

When your application for EMS Service Verification and Vehicle License Application is received by the Department of Health (DOH), it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

Indicate type of application—new, change of ownership, amended or renewal.

- **New**—First time requesting: An EMS Service and Trauma Verification or Trauma Verification on a EMS Service and Vehicle License.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the from the sale of an agency.
- **Amended**—Request the addition or elimination of information on the EMS Service Verification and Vehicle License. For example, a 'Change of Response Area', 'Rural Services Approval' or 'Level of Care,' etc.
- **Renewal**—Renew EMS Service Verification and Vehicle License. Enter your current agency license number.

☐ **Indicate service type:** Ambulance (transport), or Aid Service (non-transport).

☐ **Check the level of care provided:** Check which one applies to you.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **1: Demographic Information:**
Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/EMS Service Name: Enter the owner's name as it appears on the UBI/Master Business License.

Legal Owner/EMS Service Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax number.

Email and Web Address: Enter the owner's email and Web addresses, if applicable.

EMS Service Verification Name: Enter the name as advertised on signs or Web site. For example, 'Fire District #99,' 'Woodbridge Fire and Rescue,' etc.

Service Physical Address: Enter the physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the phone and fax number.

Mailing Address: Enter the mailing address, if different than physical address.

☐ **2. Specific Information:**
Organization Type: Please check the one organization that best applies to your service.

Response Information: Provide a number for each EMS activity. **Primary response**, first out/first alarm. **Secondary response**, responding at primary service's request, 2nd out alarm. First time applicants need not provide this information.

☐ **3. Personnel Status:**
Indicate your EMS Service staffing model, see definitions below.

Paid: All staff are compensated

Volunteer: All staff are volunteer

Combination: A combination of any of the following:

Some staff are paid

Some staff are volunteer and receive some form of nominal compensation

Some staff are volunteer and receive no compensation

List the total number of Paid, Volunteer, Advanced First Aid (AFA) personnel, and the total number of Non-Medically Trained Driver (NMTD). NMTD are persons who do not hold a EMS certification issued by the Department of Health.

You must provide a copy of your current roster from EMS Certification online. If you need assistance please contact EMS credentialing 360-236-4859.

☐ **4. EMS Supervisor Information:** Enter the name, phone number, and email address of the EMS Supervisor who is able to answer questions about licensing, vehicle licensing, and personnel association issues. Include a Department of Health credential number, if applicable.

☐ **5. Supervision:** Enter name of the County Medical Program Director and their Department of Health credential number.

☐ **6. Additional Information:**
Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, LLC members or manager, partners, etc. Attach additional completed pages if you need more space.

Change of Ownership Information: If applicable, list the previous legal owner name, previous name, previous service credential number, effective date of ownership change and physical address.

☐ **7. Emergency Medical Vehicles:** Provide year, make and model, license plate number, actual address of vehicle, AMB or AID, and VIN. Attach additional completed pages if you need more space.

☐ **8. General Operation:** Provide information regarding the organization's general operation. Attach additional completed pages if you need more space.

☐ **9. Rural Attestation:** Complete this section if you are operating with approval, or requesting approval as a rural service with non-medically trained drivers as shown in RCW 18.73.150. The representative must read the affirmation statement thoroughly to ensure the provision of this section are understood. Then, print and sign name and enter the date.

☐ **10. Signatures:** The representative must read the affirmation statement thoroughly to ensure the provisions of this section are understood. Then, print and sign name and enter the date.

Washington State Department of Health

Verification Requirements

- ☐ Check with the Regional EMS Council to assure that the need for an additional service exists. If the response area is saturated with the maximum services, the application will not be consistent with the Regional EMS Plan.
- ☐ Provide a map of response area.

  Note: Maps of Response Areas are available in the respective Regional EMS and Trauma Care Office and plans are posted on the **website**. The minimum and maximum number of verified services by type and the distribution by response areas are specified in the approved regional EMS plans.

- ☐ Complete the application including the following:

  Note: For renewal only complete sections 1-6

  1. Dispatch Plan
  2. Response Plan (include station locations and system status management)
  3. Response Area
  4. Type of Transport (emergency or inter-facility)
  5. Tiered Response and Rendezvous Plan
  6. Back-up Plan to Respond
  7. Interagency Relations
  8. A detailed explanation of how the applicant's proposal avoids unnecessary duplication of resources/services as outlined in the Approved Regional Plan "Needs and Distribution of Services" provisions
  9. A detailed explanation of how the service will meet the specific needs as outlined in the Approved Regional Plan

- ☐ Include evidence of current liability insurance coverage to include professional, general and motor vehicle

  Provide a copy of the liability insurance coverage policy, an ACCORD certificate of insurance, or a letter from a licensed insurer verifying the required insurance will be in place for the service at the time verification goes into effect.

- ☐ Provide a detailed narrative on each of the following:

  a. Consistency with the Approved Regional Plan and Patient Care Procedure

  b. Vehicles and Equipment

  c. Sufficient Staffing Levels

d. Trauma Training Program

1. How the service's present Certified EMS Personnel have been, or will be, trained so they have the necessary understanding of Department-approved Medical Program Director (MPD) protocols.
2. How the service will assure that its personnel understand their obligation to comply with the MPD protocols.
3. How the service will assure that its personnel will maintain currency with the protocols whenever they are revised.
4. How the service will address numbers 1-3 for new personnel as they join the organization.

e. Participation and compliance with Regional Quality Improvement.

Washington State Department of Health

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EMS Service Verification and Vehicle License Application

This is for: ☐ New ☐ Change of Ownership ☐ Amendment
☐ Renewal License # _____

Service Type: ☐ Ambulance (transport) ☐ Aid Service (non transport)

Level of care provided - Check only one: ☐ BLS ☐ ILS ☐ ALS

Check One

☐ Association
☐ Corporation
☐ Federal Government Agency
☐ Limited Liability Company
☐ Limited Liability Partnership
☐ Limited Partnership
☐ Municipality (City)
☐ Municipality (County)
☐ Non-Profit Corporation
☐ Partnership
☐ Sole Proprietor
☐ State Government Agency
☐ Tribal Government Agency
☐ Trust

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
Legal Owner/EMS Service Name	
Mailing Address	

City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address:	

Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Specific Information

Organization Type: (check one only)

☐ City Fire Department	☐ Fire District	☐ Municipal (city/county)
☐ City/Fire District Combined	☐ Hospital District	☐ Private Volunteer Association
☐ EMS District	☐ Industrial Fire Department	☐ Search & Rescue
☐ Federal Fire Department	☐ Law Enforcement	☐ Other_____

Response Information

Please provide the number for each EMS activity listed below, for your last full calendar year (if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information):

Primary Responses		Transports Primary/Secondary	
Secondary Responses		Inter-facility Transports Only	

3. Personnel Status

Please submit your current roster from the Department of Health EMS Certification Online.

Staffing Model: ☐ Paid ☐ Volunteer ☐ Combination

Number of EMS personnel that are: ____Paid ____Volunteer

Number of personnel non-credentialed that are:____AFA (Advanced First Aid) ____Non-Medically Trained Drivers

4. EMS Supervisor Information

EMS Supervisor	WA State DOH Credential # (if applicable)
Email Address	Phone (enter 10 digit #)

5. Supervision

Name of County Medical Program Director	WA State DOH Credential #
Name of MPDD/Agency Physician	WA State DOH Credential #

6. Additional Information

Legal Owner Information–attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone (enter 10 digit #)	Title

Change of Ownership Information

Previous Name of Legal Owner	Previous Service Credential #
Previous Name of Service	Effective Date of Change

7. Emergency Medical Vehicles

Please provide the following information for all vehicles to be licensed. Vehicle location is the address in which the vehicle is physically located. Indicate the type of vehicle(s):
AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030 and consistent with RCW 70.168).
See our website for the complete EMS and Trauma Care System Statutes.

Physical address of vehicle

City	State	Zip Code	County

Vehicle Information

Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	

Physical address of vehicle

City	State	Zip Code	County

Vehicle Information

Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	
Year	Make and Model	☐ AMB ☐ AID
License Plate Number	VIN	

8. General Operation

Please describe the general operation of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. For more information on agency and vehicle licensing see website.

Provide an explanation of your:

1. Dispatch plan _____

_____

2. Response plan _____

_____

3. Response area _____

_____

4. Type of transport - please circle one: Emergency, Interfacility, Both, or N/A.

5. Tiered response and rendezvous _____

_____

6. Back-up plan to respond (may not apply to agencies doing interfacility transports only) _____

_____

_____

Note: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach additional completed pages if you need more space.

9. Rural Service Attestation:

To be completed by agencies with non-medically trained ambulance drivers

I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. We have verified that each non-medically trained driver is at least 18 years of age.
2. We have performed a Washington State Patrol background check and have verified that each non-medically trained driver has no reported offenses.
3. We have verified that each non-medically trained driver holds a valid driver's license with no restrictions.

Signature of Owner/Operator _____ Date _____

Print Name _____ Print Title _____

10. Signatures

I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. We operate in a manner that is consistent with the Washington State Triage tools; EMS and Trauma Care Council Regional Plan, pre-hospital Patient Care Procedures, and department approved County Operating Procedures.
2. Our current certified EMS personnel are familiar with and utilize a Department of Health approved Medical Program Director (MPD) patient care protocols.
3. The vehicles identified on page three meet the minimum equipment requirements for the level and type of trauma verification requested by our service.
4. We meet the minimum staffing requirements as identified on page four.
5. We maintain current liability insurance coverage.
6. In accordance with RCW 43.70.490, our certified EMS personnel are adequately trained in and familiarized with techniques, procedures, and protocols for best handling situations in which persons with particular disabilities are present at the scene of an emergency.

Signature of Owner/Operator | Date

Print Name | Print Title

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Washington State Department of Health
EMS Credentialing
PO Box 47877
Olympia, WA 98507
360.236.4700

Regional Council Review and Comment

This portion to be completed by the service applying for licensure and mailed to the department with your completed application packet.

EMS Service Name _____

Address: _____

Contact Person _____

Phone (enter 10 digit #): _____ Date: _____

Level of care provided on a 24-hour basis: ☐ BLS ☐ ILS ☐ ALS

☐ Ambulance (transport) ☐ Aid Service (non-transport) ☐ Air Ambulance

The signature below is required in accordance with **WAC 246-976-390**. Please note that only DOH may approve licensure and verification of services.

This portion to be completed by the Regional Council Representative and returned to the department.

Does this application for verification appear to be consistent with the Regional Plan?

☐ Yes
☐ No Attach documentation to explain a "No" answer.

_____
Regional EMS Council Representative

_____
EMS Region

_____
Signature Date

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Emergency Medical Services and Trauma System, RCW 18.71

Emergency Medical Services and Trauma System, RCW 18.73

Emergency Medical Services and Trauma System, WAC 246-976

Online

Emergency Medical Services and Trauma System web page