Air Ambulance Trauma Verification 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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

(This page intentionally left blank.)

Application Instruction Checklist

When your application for EMS Air Ambulance Verification License is received by the Department of Health, 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, renewal or provisional.

- **New**—First time requesting:
  An Air Ambulance Service License with Trauma Verification, and your agency currently holds accreditation by a nationally recognized and department approved air ambulance accreditation entity.
  Or;
  Trauma Verification on a current Air Ambulance Service License, and your agency currently holds accreditation by a nationally recognized and department approved air ambulance accreditation entity.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of an Air Ambulance Service with Trauma Verification.
- **Amended**—Request the addition or elimination of information on the Air Ambulance Service license with Trauma Verification.
- **Renewal**—Renew an Air Ambulance Service License with Trauma Verification.
- **Provisional—**If a non-licensed Air Ambulance Service seeking Trauma Verification is ineligible to attain accreditation because it lacks a history of operation a provisional license, for no longer than two years, may be requested.

☐ **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/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Legal Owner/Operator 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.

Agency Name: Enter the agency name as advertised on signs or Web site.

Address of Primary Base of Operation: Enter the address of the primary base of operation, including city, state, zip code and county.

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

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

☐ **2. Agency Specific Information:**
Level of care provided on a 24-hour basis: Check which one applies to you.

Requested response area: Refer to the State Air Medical Service Plan.

Organization Type: Please check the one organization that best applies to your organization.

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

Personnel Status: Check whether paid or volunteer and number of EMS personnel that are paid or volunteer.

☐ **3. Contact Information:**
Contact person:
Enter the name, phone number, and email address of the person who is able to answer questions about agency licensing, vehicle licensing, and agency personnel association issues. Include a Washington State DOH credential number, if applicable.

☐ **4: Supervision:**
Enter name of the County Medical Program Director and their credential number and the MPDD/Agency Physician and their credential number.

☐ **5. 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 of agency, previous service credential number, effective date of ownership change and physical address.

Emergency Medical Vehicles: Provide year, make and model, tail number, actual address of aircraft, Rotary or Fixed Wing air ambulance, and FAA Registration number.

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

☐ **6. Statements and Signatures:**
The agencies 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.

License Requirements:

Thank you for applying for an EMS air ambulance license in Washington State. Please complete the following:

- ☐ Complete and submit the application for licensure, with original signature and date.
- ☐ Provide copies of the following current and valid documentation issued by the Federal Aviation Administration (FAA) as stated in WAC 246-976-320(2)(b):
  - Air Taxi Registration (OST Form 4507) showing the effective date of FAA registration and exemption under 14 C.F.R. 298.
  - Air Carrier Certification authorizing common carriage under 14 C.F.R. 135, including Operations Specifications (FAA Form 8430-18) authorizing aeromedical helicopter or fixed-wing air ambulance as applicable to the agency.
  - Certificate of Registration (AC Form 8050-3) for each air ambulance operated by the agency.
  - Standard Airworthiness Certificate (FAA Form 8100-2) for each air ambulance operated.
- ☐ Provide a certificate of insurance establishing current and valid public and passenger liability insurance coverage for the air ambulance service.
  - A copy of the insurance coverage policy, or
  - An ACCORD certificate of insurance, or
  - A letter from a licensed insurer verifying the required insurance will be in place within the applicant agency at the time the license is issued.
- ☐ Provide a certificate of insurance establishing current and valid professional and general liability insurance coverage for the air ambulance service.
  - A copy of the professional and general liability insurance coverage policy, or
  - An ACCORD certificate of insurance, or
  - A letter from a licensed insurer verifying the required insurance will be in place within the applicant agency at the time the license is issued.
- ☐ Provide proof of the air ambulance service's current accreditation status and a copy of the current accreditation report by a nationally recognized and department approved air ambulance accreditation entity.
- ☐ Provide a copy of the service's mission statement and identify the scope of care provided by the service. See WAC-246-976-320.
- ☐ If you are applying for a provisional license in accordance with WAC 246-976-320 (3)(b), please provide proof that you applied for accreditation.

(This page intentionally left blank.)

Verification Requirements

☐ Provide a detailed narrative on each of the following in accordance with WAC 246-976-395 (3):

a. Dispatch Plan
b. Response Plan (include station locations and system status management)
c. Type of Transport (emergency, inter-facility, or both)
d. Tiered Response and Rendezvous Plan
e. Back-up Plan to Respond including how the applicant agency will continue patient transport if a vehicle is disabled
f. Interagency Relations
g. How the applicant's agency proposal avoids inefficient duplication of resources/services as outlined in the State Air Medical Service Plan
h. How the applicant agency will meet the specific needs as outlined in the State Air Medical Service Plan
i. How the applicant agency will maintain consistency with the approved EMS regional plan including patient care procedures
j. Ability to meet vehicle and equipment requirements
k. Ability to meet staffing requirements
l. How the agency applicant meets the following Trauma Training Program requirements:
    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.
m. Participation in regional EMS council meetings and compliance with Regional Quality Improvement initiatives.

(This page intentionally left blank.)

Washington State Department of HEALTH

Date Stamp Here

Air Ambulance Trauma Verification License Application

This is for: ☐ New ☐ Change of Ownership ☐ Amendment

☐ Renewal License # _____ ☐ Provisional

Check One

☐ Association ☐ Limited Partnership ☐ Sole Proprietor

☐ Corporation ☐ Municipality (City) ☐ State Government Agency

☐ Federal Government Agency ☐ Municipality (County) ☐ Tribal Government Agency

☐ Limited Liability Company ☐ Non-Profit Corporation ☐ Trust

☐ Limited Liability Partnership ☐ Partnership

1. Demographic Information

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

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

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

2. Agency Specific Information

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

Requested response area (as identified in the regional plan): _____

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	

Personnel Status

Are your EMS personnel primarily: (check one) ☐ Paid ☐ Volunteer

Number of EMS personnel that are: ___ Paid ___ Volunteer

Number of EMS personnel certified at each level: ___ EMR ___ EMT ___ AEMT ___ PARA

___ RN ___ Other, _____

3. Contact Information

Contact Person Name	WA State DOH Credential # (if applicable)
Email Address	Phone (enter 10 digit #)

4. Supervision

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

5. 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 Name of Service	Previous Service Credential #	Effective Date of Change

Emergency Medical Aircraft

Please provide the following information for all aircraft to be licensed. Aircraft location is the address in which the aircraft is physically located. Indicate the type of aircraft(s): Fixed Wing; Rotary Wing (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.

Please review WAC 246-976-320 to ensure your vehicles meet all requirements. See our website for the complete EMS and Trauma Care System Rules.

Station Name and Physical address of aircraft base			
City	State	Zip Code	County

Aircraft Information

☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing
FAA Registration Number	FAA Registration Number	FAA Registration Number

Station Name and Physical address of aircraft base			
City	State	Zip Code	County

Aircraft Information

☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing
FAA Registration Number	FAA Registration Number	FAA Registration Number

Station Name and Physical address of aircraft base			
City	State	Zip Code	County

Aircraft Information

☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing
FAA Registration Number	FAA Registration Number	FAA Registration Number

Station Name and Physical address of aircraft base			
City	State	Zip Code	County

Aircraft Information

☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing
FAA Registration Number	FAA Registration Number	FAA Registration Number

Station Name and Physical address of aircraft base			
City	State	Zip Code	County

Aircraft Information

☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing	☐ Fixed wing ☐ Rotary Wing
FAA Registration Number	FAA Registration Number	FAA Registration Number

Signature

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 State Air Medical Plan and Regional Plan.
2. This air ambulance service meets the minimum requirements provided in WAC-246-976-320 (Air Ambulance Services).
3. Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols;
4. Our service meets all FAA regulations;
5. Our service will comply with department approved pre-hospital triage procedures.

Signature of Owner/Operator | Date

Print Name of Owner/Operator | Print Title

EMS Credentialing
PO Box 47877
Olympia, WA 98507
360.236.4700

Regional Council Review and Comment

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

EMS Agency 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

(This page intentionally left blank.)

RCW/WAC and Online Web Site 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