



Washington State Department of

Health

Office of EMS and Trauma Systems

P.O. Box 1099

Olympia, WA 98507-1099

360.236.2845

<http://www.doh.wa.gov/hsqa/emstrauma/>

EMS Agency Verification and Vehicle License Application Packet

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Important Information:

The attachments referred to below are available on our Web site at <http://www.doh.wa.gov/hsqa/emstrauma>. Please click on "Licensure Processes." If you are unable to access the information via the Internet, please contact our office.

Review Washington Administrative Code ([WAC](#)) [246-976-260 through 390](#) to assure your service meets all licensure and verification requirements.

Review the excerpts of the Regional Plan and Patient Care Procedures (PCPs) to assure your service will operate consistently with them.

Complete the attached application. If your service is seeking verification in more than one region, an application will be needed for each region. The Department of Health (DOH) will obtain the Regional Council recommendation.

Please allow at least 90 days for DOH to process your application.

If you have any questions, please contact 1-800-458-5281, extension 1.

In order to process your request:

Return Completed Applications to:

Department of Health
Office of EMS and Trauma Systems
PO Box 1099
Olympia, WA 98504-1099

Send a copy of the complete application to the Regional EMS Council in whose area the service is applying for response area assignment.

Plans for applying electronically are underway but this is not an option at this time.



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Application Checklist and Instructions

Indicate type of application: New, change of ownership, or Amendment.

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

Check One:

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

Section #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.

Facility Name: Enter the facility name as advertised on signs or Web site.

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

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

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

Section #2: Facility Specific Information:

Level of Care Provided on a 24-hour basis: Check which one applies to you.

Requested response area: Identified in the regional plan.

Site Type: Please check the one applicable site type.

Response Information: Provide number for each EMS activity. 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.

Application Checklist and Instructions (continued)

Section #3: Key Individuals:

Contact Person: Provide name, WA State DOH credential # if applicable, and email address.

Section #4: Supervision:

County Medical Program Director: Provide name of director. (County medical program director or MPD delegated supervising physician).

Section #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 sheet, if necessary.

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

Emergency Medical Vehicles:

Indicate service(s) providing extrication equipment. Provide year, make and model, license plate number, actual address of vehicle, AMB or AID, VIN number, and if there is variance for extrication equipment.

Emergency Medical Services Personnel:

Indicate personnel in your organization who will be providing emergency care, aid or transportation, showing their highest EMS qualification (EMT, paramedic, etc.) Include all EMS personnel who are full or part-time. Attach additional sheets if needed.

Signature:

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

Regional Council Review and Comment:

Send this form along with a copy of your completed application to the Regional EMS Council in whose area the service is applying for response area assignment.



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Date Stamp Here

EMS Agency Verification and Vehicle License Application

This is for: New Change of Ownership Amendment

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

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | |

1. Demographic Information

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

Mailing Address

City	State	Zip	County
------	-------	-----	--------

Phone# ()	Fax# ()
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Email Address	Web Address:
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Facility/Agency Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip	County
------	-------	-----	--------

Facility Phone# ()	Fax# ()
---------------------------	----------------

Mailing Address (If different than physical address)

City	State	Zip	County
------	-------	-----	--------

2. Service Specific Information

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

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

SITE TYPE (check one only)

- | | | |
|--|---|--|
| <input type="checkbox"/> City Fire Department | <input type="checkbox"/> Fire District | <input type="checkbox"/> Municipal (city/county) |
| <input type="checkbox"/> City/Fire District Combined | <input type="checkbox"/> Hospital District | <input type="checkbox"/> Private Volunteer Association |
| <input type="checkbox"/> EMS District | <input type="checkbox"/> Industrial Fire Department | <input type="checkbox"/> Search & Rescue |
| <input type="checkbox"/> Federal Fire Department | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> 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	<input type="text"/>	Transports Primary/Secondary	<input type="text"/>
Secondary Responses	<input type="text"/>	Inter-facility Transports Only	<input type="text"/>

Personnel Status

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

Number of EMS personnel that are: _____ Paid _____ Volunteer

3. Key Individuals

Contact Person Name

WA State DOH Credential # (if applicable)

Email Address

4. Supervision

Name of County Medical Program Director

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 #	Title

Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Service	Previous Service Credential #	Effective Date of Ownership Change
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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 70.168).

Please review WAC 246-976-260 through 390 to ensure your vehicles meet all requirements. WAC 246-976-300 requires all licensed vehicles to carry extrication equipment. A variance from this requirement may be requested, and if approved, the extrication equipment must be available within 10 minutes. To request a variance, indicate the name of the agency(s) providing extrication equipment below and enter 'Yes' in the appropriate column.

Service(s) providing extrication equipment: _____

Year	Make and Model	License Plate Number	Actual Address of Vehicle (if different from page 1)	Choose One (✓)		Vehicle Identification Number (VIN)	Variance For extraction equipment (Yes or No)
				AMB	AID		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							

Note: When adding, removing, or changing the location of licensed vehicles, it is always necessary to notify the Department of the change(s). The Vehicle Changes Application is available at: <http://www.doh.wa.gov/hsga/emstrauma/licproc.htm>.

Emergency Medical Services Personnel

List all personnel in your organization who will be engaged in providing emergency care, aid or transportation, showing their highest EMS qualification (EMT, Paramedic, etc.). Include all EMS personnel who are full or part-time. Attach additional sheets if needed.

Keep a copy of this document on file for inspection by the Department of Health.

Name/Credential#	*AFA	FR	EMT	IV Tech	AW Tech	IV/AW Tech	ILS Tech	ILS/AW Tech	PM
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
Please total each column:									

- Legend:**
- *AFA = Advanced First Aid
 - FR = First Responder
 - EMT = Emergency Medical Technician
 - IV Tech = Intravenous Therapy Technician
 - AW Tech = Airway Technician
 - IV/AW Tech = IV and Airway Technician
 - ILS Tech = Intermediate Life Support Technician
 - ILS/AW Tech = ILS and Airway Technician
 - PM = Paramedic

* Advanced First Aid is not a level of certification regulated by the Department of Health.

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 Regional Plan and pre-hospital patient care procedures.
2. The vehicles identified on Page 2 meet the minimum equipment requirements for the level and type of trauma verification requested by our service.
3. We meet the minimum staffing requirements for verification as identified on Page 4.
4. Our certified EMS personnel utilize DOH approved Medical Program Director (MPD) protocols.
5. We maintain current liability insurance coverage (**copy attached**).

Signature of Owner/Operator

Date

Print Name

Print Title



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EMS Agency Verification and Vehicle License Application Regional Council Review and Comment

Service Name _____

Level of care provided on a 24-hour basis: BLS ILS ALS
 Ambulance (transport) Aid Service (non-transport)

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

Regional Council Review and Comment

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