



2022-2024
NORTH DAKOTA LICENSE RENEWAL APPLICATION
ADVANCED LIFE SUPPORT GROUND AMBULANCE
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 EMERGENCY MEDICAL SYSTEMS
 SFN 53887 (09-2022)



Legal Name of ALS Ground Ambulance Service	License Number
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Whereas, the above-named ambulance service provides emergency medical care and uses publicly or privately owned vehicles upon the streets or highways of this state for the transportation of persons who are sick, injured, wounded, or otherwise incapacitated or helpless, and holds itself to the public, or to its employees, for such a service or regularly provides such a service.

Whereas, the above-named ambulance service will provide services which meet the standards of Chapter 23-27 of the North Dakota Century Code, and regulations governing advanced life support ground ambulance service.

Application is hereby made to operate as an advanced life support ground ambulance service until midnight October thirty-first of the year 2024.

This license is nontransferable and substation ambulances may not operate independently outside the primary license holder. Substation ambulances must display the name of the headquarter ambulance on all vehicles. A licensing fee is required for each substation licensure in addition to the headquarter ambulance licensure fee.

The license fee of \$50.00 plus \$50.00 for each substation is enclosed and made payable to:
North Dakota Department of Health and Human Services.

Send completed and signed forms with payment to:



Department of Health and Human Services
 Emergency Medical Services
 1720 Burlington Dr - Ste A
 Bismarck ND 58504-7736

Signature	Date
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EMS OFFICE USE ONLY	
License Number	
Date Issued	
Substations	
Amount Due	
Approved by	
Processed by	Process Date

STATE USE ONLY		
Date Received		
Amount Received		
Cash	MO	Check Number _____

Legal Name of ALS Ground Ambulance Service		License Number
Mailing Address of Service		
City	State	ZIP Code
Physical Address of Service (911-assigned address)		
City	State	ZIP Code
County		
Medical Director	Contact Number	
Squad Leader	24-hour Number	
Contact Person (if different than Squad Leader)	24-hour Number	
Squad leader and contact person must be listed on the service roster.		
Agency E-mail Address		
Day Telephone Number	Evening Telephone Number	Fax Number

OWNERSHIP

Name of Exact Ownership of Service (e.g. City of Oakes, Altru Health, etc.)	
Check one: <input type="checkbox"/> Hospital-Based <input type="checkbox"/> Fire-Based <input type="checkbox"/> Private (For Profit or Non-Profit) <input type="checkbox"/> Government / Non-Fire Entity	

TYPE OF OWNERSHIP (check only one)

Governmental	<input type="checkbox"/> County	<input type="checkbox"/> District	<input type="checkbox"/> City	<input type="checkbox"/> Tribal	<input type="checkbox"/> Federal
Non-profit	<input type="checkbox"/> Corporation		<input type="checkbox"/> Association		
For-profit	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership		<input type="checkbox"/> Corporation	
Is your corporation / partnership / association listed as "In Good Standing" with the North Dakota Secretary of State? (https://firststop.sos.nd.gov/search/business)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
* You will not be licensed unless you are in good standing.					

MILL LEVY

Does the service have a mill levy in place?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what entity levies the tax?			
City	County	Ambulance District	Fire District

Legal Name of ALS Ground Ambulance Service	License Number
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STAFFING

Check one:	<input type="checkbox"/> Non-Compensated (Receive NO pay)	<input type="checkbox"/> Paid (Receive on-call and/or hourly wage)	<input type="checkbox"/> Combination
Number of Paid Staff	<input type="checkbox"/> Not Applicable		
	Full-time (>30 hr/week)	Part-time hourly (<30 hr/week)	Part-time on-call
Paid staff implies any payment, no matter the amount, to personnel for providing response to emergency calls			
Please attach a written call schedule (most recent month) as required per NDAC 33-11-01.2-09. The schedule must reflect the levels of recognition/certification/licensure for each individual on the schedule.			
Do you notify your PSAP when your substation(s) is/are available as required per NDAC 33-11-01.2-07?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

VEHICLE AND LIABILITY INSURANCE CARRIERS

Name of <u>Vehicle</u> Insurance Company			
Agent Name		Agent Address	
City		State	ZIP Code
Name of <u>General Liability</u> Insurance Company			
Agent Name		Agent Address	
City		State	ZIP Code

Legal Name of ALS Ground Ambulance Service	License Number
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COMMUNICATION INFORMATION: ALS GROUND AMBULANCE SERVICE

List information for all agencies that dispatch your ambulance service.

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
<input type="checkbox"/> Emergent	<input type="checkbox"/> Non-emergent
How are personnel notified? <input type="checkbox"/> Pager <input type="checkbox"/> Radio <input type="checkbox"/> Telephone <input type="checkbox"/> Other (Explain)	

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
<input type="checkbox"/> Emergent	<input type="checkbox"/> Non-emergent
How are personnel notified? <input type="checkbox"/> Pager <input type="checkbox"/> Radio <input type="checkbox"/> Telephone <input type="checkbox"/> Other (Explain)	

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
<input type="checkbox"/> Emergent	<input type="checkbox"/> Non-emergent
How are personnel notified? <input type="checkbox"/> Pager <input type="checkbox"/> Radio <input type="checkbox"/> Telephone <input type="checkbox"/> Other (Explain)	

Who do you contact for on-line medical control?	Receiving Facility	Medical Director	Other
How do you contact on-line medical control?	Radio	Mobile Telephone	

Ambulance Services NOT providing data are ineligible for licensure per NDAC 33-11-01.2-10(5)

What software (ePCR) does your agency use to create patient care reports and collect data? (example: ESO, Health EMS, etc.)

Legal Name of ALS Ground Ambulance Service	License Number
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Check here if you have updated your vehicle roster online. If so you may leave this page blank.

VEHICLE ROSTER INFORMATION: ALS GROUND AMBULANCE

Unit Number (Assigned by State Radio)					<input type="checkbox"/> Primary Vehicle
Make			Year	VIN Number	
Ambulance Cell Phone Number				Mileage	

Unit Number (Assigned by State Radio)					<input type="checkbox"/> Primary Vehicle
Make			Year	VIN Number	
Ambulance Cell Phone Number				Mileage	

Unit Number (Assigned by State Radio)					<input type="checkbox"/> Primary Vehicle
Make			Year	VIN Number	
Ambulance Cell Phone Number				Mileage	

Unit Number (Assigned by State Radio)					<input type="checkbox"/> Primary Vehicle
Make			Year	VIN Number	
Ambulance Cell Phone Number				Mileage	

Unit Number (Assigned by State Radio)					<input type="checkbox"/> Primary Vehicle
Make			Year	VIN Number	
Ambulance Cell Phone Number				Mileage	

Legal Name of ALS Ground Ambulance Service	License Number
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CHECKLIST OF REQUIRED EQUIPMENT: ALS GROUND AMBULANCE

Total Number of Vehicles in Service

<p><i>Please make copies if additional pages are needed.</i></p> <p>Item Please place an "X" in boxes if stocked.</p>	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Mounted ambulance cot with retaining straps				
Stretchers with retaining straps. Vehicle design dictates quantity.				
Piped oxygen system - with appropriate regulator and flow meter, or two "E" size bottles for minimum oxygen supply with regulator and flow meter				
Portable oxygen unit with carrying case. To include one "D" size bottle with another "D" bottle in reserve				
Three nasal cannula, three non-rebreather oxygen masks in adult and pediatric sizes, and three sets of oxygen supply tubing				
Suction wall mounted and portable capable of achieving 400 mm/hg 4 seconds or less, w/catheters in adult sizes, rigid and soft				
Bag valve mask resuscitation units in infant, child and adult sizes with appropriate sized face masks or pocket masks with oxygen inlet in infant, child and adult sizes				
Spine boards - one full size and one half size - with retaining straps				
Head to board immobilization device				
Commercial fracture splints usable for open and closed fractures or padded boards usable for pediatric and adult patients				
Hot packs - four minimum				
Cold packs - four minimum				
Activated Charcoal				
Obstetrical Kit - disposable or sterile				
Soft roller self adhering bandages - five yards (4.75 meters) long - twelve minimum				
Sterile burn sheets - two minimum				
Triangular bandages - three minimum				
Sterile gauze pads - four inches (10.16 centimeters) by four inches - twenty five minimum				
Trauma dressing - approximately 10 inches by thirty six inches - two minimum				
Nasopharyngeal airways in adult and child sizes - one set minimum				
Oral airways in adult and child sizes - one set minimum				
Sterile occlusive dressings - approximately three inches by nine inches - 2 minimum				
Tape - assorted sizes - four rolls minimum				
Blunt Shears - two minimum				
Lower extremity traction splint				
Disposable gloves - small, medium and large - one box each min.				
Bedpan, emesis basin and urinal - single use or sterilizable; one each minimum				
Distilled water or saline solution - one gallon minimum				
Flashlights - two minimum				

Legal Name of ALS Ground Ambulance Service	License Number
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CHECKLIST OF REQUIRED EQUIPMENT, CONT.: ALS GROUND AMBULANCE

Total Number of Vehicles in Service

<p><i>Please make copies if additional pages are needed.</i></p> <p>Item Please place an "X" in boxes if stocked.</p>	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
Reflectorized flares for securing scene - three per set minimum				
Red biohazard bags - three minimum				
Cervical collars - small, medium and large one each minimum				
Two blankets, two pillows, four sheets and four towels.				
Tuberculocidal disinfectant product				
Fire extinguisher - dry chemical, mounted, five pound (2.27 Kg) minimum				
Intravenous fluid holder - cot mounted or ceiling hook				
Stethoscope with adult and pediatric capabilities				
Blood pressure manometer with cuff size in large adult, adult, child and infant				
Endotracheal airway equipment - pediatric and adult				
Manual cardiac monitor defibrillator with pediatric capabilities				
Glucose measuring device				
Nebulizer with tubing				
Alcohol swabs / betadone swabs				
Pulse oximeter				
Twenty-five triage tags				
ECG supplies, paper, electrodes, defibrillator pads				
1- sharps container less than 1/2 full				
IV therapy equipment - catheters, tubing, solution - pediatric and adult				
Syringes and needles - assorted sizes				
Personal protection equipment, such as mask, non-absorbant gown, protective eyewear - four each minimum				
VHF radio with capabilities of meeting EMS standards determined by the department				
Portable radio capable of reaching law enforcement and hospitals				
Biological fluid cleanup kit				
Reflective vest - minimum of two				
Pediatric backboard				
Pediatric traction splint				
Appropriate pediatric reference material				
Magill forceps: one adult, one pediatric				
Written treatment protocols				
Narcotic				
Antidysrhythmic				

Legal Name of ALS Ground Ambulance Service	License Number
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CHECKLIST OF REQUIRED EQUIPMENT, CONT.: ALS GROUND AMBULANCE

Item <i>Please make copies if additional pages are needed.</i> Please place an "X" in boxes if stocked.	Unit Number(s)			
	UNIT #	UNIT #	UNIT #	UNIT #
	Anticholinergen parasympatholic			
Opiod antagonist				
Coronary vasodialator, antiaginal				
Antianxiety				
Caloric				
Alkalinizer				
Broncodilator, adrenergic IV or SQ, also handheld or nebulized				
Anticonvulsant				
Meconium aspirator adaptor				
Laryngoscope w/ straight blade sizes 0, 1, 2, 3, & 4 and curved blade sizes 2, 3, & 4				
Stylettes: one pediatric, one adult				

Additional Equipment (not required by DEMS)

Infant / child car seat				
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Legal Name of ALS Ground Ambulance Service	License Number
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Substation License

Please Note: Leave this area blank if your service does not have substations. Substations must display headquarter ambulance service name on all units. Only one roster is allowed for each licensure. The contact person must be on the service's personnel roster.

Substation 1

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

Substation 2

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

Substation 3

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

Substation 4

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

Substation 5

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

Substation 6

Location of Substation (city)	
Physical Address (911-assigned address)	ZIP Code
Unit Number(s)	Contact Person of Substation

MEDICAL DIRECTOR AGREEMENT: ALS GROUND AMBULANCE

INSTRUCTIONS: This form must be completed with each ambulance licensure renewal application or at any time a change or addition of medical director is made. All ALS personnel license applications, etc. must be signed by the medical director on record or they will be returned. A current medical director agreement must be on file for each service at all times.

PHYSICIAN MEDICAL DIRECTOR

First Name		Last Name		MI
Street Address / PO Box			City	
State	ZIP Code	Telephone Number		
ND License Number			Expiration Date	
Name of ALS Ground Ambulance Service				
Ambulance Service License Number				

I, the above-named physician, agree to function as Physician Medical Director for the above-named ambulance service, its associated substation units and/or quick response unit(s). As Medical Director I understand that I am responsible for all patient care standards associated with the above named ambulance service and any associated substation(s) and/or quick response unit(s). The emergency medical services personnel working either as volunteers or as compensated employees for these services are acting as my designated agents when providing patient care. It is my duty to assure that a system for quality improvement / quality assurance is developed and implemented. I will provide input on training issues and provide on-line medical direction when necessary.

The expiration date of this agreement will coincide with the expiration date of the ambulance license or may be terminated upon written notification to the Department of Health and Human Services Emergency Medical Systems by the listed ambulance service or myself.

Medical Director Signature	Date
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If this is a change in medical director check one of the boxes below:

<input type="checkbox"/> Remove previous medical director from service roster.
<input type="checkbox"/> Add to service roster as additional medical director.

SQUAD LEADER AGREEMENT: ALS GROUND AMBULANCE

INSTRUCTIONS: This form may be completed electronically or by hand. This form must be completed upon ambulance licensure or anytime there is a change in squad leader. A current squad leader agreement must be on file for each service at all times.

SERVICE SQUAD LEADER

First Name		Last Name	MI
Street Address / PO Box		City	
State	ZIP Code	Telephone Number	
ND EMS Number			
Name of Ambulance Service			

I, the above-named EMS professional, agree to function as Squad Leader for the above-named Ambulance Service, its associated substation units and/or Quick Response Unit(s). As Squad Leader I understand that I am responsible for ensuring compliance with all rules and regulations in regards to ambulance licensure requirements for the above named ambulance service and its associated substation(s) and/or Quick Response Unit(s). It is my duty to maintain updated service information with the Department of Health and Human Services Emergency Medical Systems including updating the service address and contact information as well as the service personnel and vehicle rosters as needed.

The expiration date of this agreement will coincide with the expiration date of the ambulance or may be terminated upon written notification to the Department of Health and Human Services Emergency Medical Systems.

Squad Leader Signature	Date
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If this is a change in squad leader, complete the section below:

<input type="checkbox"/> Remove previous Squad Leader from service roster.	
<input type="checkbox"/> Maintain previous Squad Leader on service roster, changing status to 'service member'.	
New Squad Leader Signature	Date
Outgoing Squad Leader Signature (If applicable)	Date
Other Authorized Signature (If outgoing squad leader signature is unavailable.)	Date
Title (if other than Squad Leader)	Telephone Number

Legal Name of ALS Ground Ambulance Service	License Number
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MUTUAL AID AGREEMENT: ALS GROUND AMBULANCE

List Quick Response Units that this service has agreements with or collaborates with on emergency calls.

QRU	City

I hereby affirm that all information entered on this license application is true and correct to the best of my knowledge. I understand that any fraudulent entries may be sufficient cause for rejection or revocation of agency licensure.

I further agree to notify the North Dakota Department of Health and Human Services Emergency Medical Systems immediately if any changes in status occur. I agree that this ground ambulance service completes an electronic patient care report for each call and submits the required data to the Department of Health and Human Services Emergency Medical Systems with the standards set by the North Dakota Department of Health and Human Services as well as meeting all other requirements for ambulance licensure as outlined in Chapter 23-27 of the North Dakota Century Code.

Signature	Date
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Print completed application.
Sign and mail with payment to the address below.



Department of Health and Human Services
Emergency Medical Services
1720 Burlington Dr - Ste A
Bismarck ND 58504-7736