NORTH Dakota
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2022-2024
NORTH DAKOTA LICENSE RENEWAL APPLICATION
AIR AMBULANCE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EMERGENCY MEDICAL SYSTEMS
SFN 53889 (09-2022)

Select Level of Licensure Requested (check one)	☒ BLS Air Ambulance	☐ ALS Air Ambulance	☐ Critical Care Air Ambulance
Name of Air Ambulance Service			License Number

Whereas, the above-named air ambulance service provides emergency medical care and uses publicly or privately owned aircraft in the airspace 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 air ambulance service will provide services which meet the standards of Chapter 23-27 of the North Dakota Century Code, and regulations governing air ambulance service.

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

This license is nontransferable and a licensing fee of $50.00 is required at time of submission and must be made payable to: **North Dakota Department of Health and Human Services.**

Send completed and signed forms with payment to:

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

Signature	Date

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 _____

Name of Air Ambulance Service		License Number
Mailing Address of Service		
City	State	ZIP Code
Physical Address of Service		
City	State	ZIP Code
Attach a separate page listing aircraft not based at agency headquarters. Please list the registration number, base location, and city of each aircraft.		
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 your 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: ☐ Hospital-Based ☐ Fire-Based ☐ Private (For Profit or Non-Profit) ☐ Government / Non-Fire Entity

TYPE OF OWNERSHIP (check only one)

Governmental	☐ County	☐ District	☐ City	☐ Tribal	☐ Federal
Non-profit	☐ Corporation		☐ Association		
For-profit	☐ Individual		☐ Partnership		☐ 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) * You will not be licensed unless you are in good standing.				☐ Yes	☐ No

MILL LEVY

Does the service have a mill levy in place?	☐ Yes	☐ No
If yes, what entity levies the tax? ☐ City ☐ County ☐ District		

Name of Air Ambulance Service	License Number

STAFFING

Check one: ☐ Non-Compensated (Receive NO pay) ☐ Paid (Receive on-call and/or hourly wage) ☐ Combination

Number of Paid Staff: ☐ Not Applicable ☐ Full-time (>30 hr/week)

☐ Part-time hourly (<30 hr/week) ☐ Part-time hourly (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? ☐ Yes ☐ No ☐ N/A

AIRCRAFT AND LIABILITY INSURANCE CARRIERS

Name of Aircraft Insurance Company			
Agent Name	Agent Address		
City	State	ZIP Code	
Name of General Liability Insurance Company			
Agent Name	Agent Address		
City	State	ZIP Code	

Name of Air Ambulance Service	License Number

COMMUNICATION INFORMATION: AIR AMBULANCE SERVICE

List information for all agencies that dispatch your air ambulance service.

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
☐ Emergent	☐ Non-emergent
How are personnel notified? ☐ Pager ☐ Radio ☐ Telephone ☐ Other (Explain)	

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
☐ Emergent	☐ Non-emergent
How are personnel notified? ☐ Pager ☐ Radio ☐ Telephone ☐ Other (Explain)	

Name of PSAP/dispatching agency	
Location (City)	Contact Phone Number
☐ Emergent	☐ Non-emergent
How are personnel notified? ☐ Pager ☐ Radio ☐ Telephone ☐ 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

Air 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.)

Name of Air Service	License Number

☐ Check here if you have updated your vehicle roster online. If so you may leave this page blank.

VEHICLE ROSTER INFORMATION: AIR AMBULANCE

☐ Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
☐ Rotor Wing	Sat Phone Number	☐ Multi Engine

Year	Make	Hours

Base Location	City

Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
Rotor Wing	Sat Phone Number	☐ Multi Engine

Year	Make	Hours

Base Location	City

Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
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Year	Make	Hours

Base Location	City

Fixed Wing	Registration Number (Tail Number)	☐ Single Engine
Rotor Wing	Sat Phone Number	☐ Multi Engine

Year	Make	Hours

Base Location	City

Name of Air Ambulance Service	License Number

AMBULANCE PERSONNEL ROSTER: AIR AMBULANCE

☐ Check here if you have updated your personnel roster online. If so you may leave this page blank.

NOTE: State ID numbers are required. Application will be rejected if this information is not provided. If you are listing new members, you must include EMS registration forms or ALS licensure forms.

First Name	Last Name	State ID Number	Provider Level

Name of Air Ambulance Service	License Number

AMBULANCE PERSONNEL ROSTER, CON'T: AIR AMBULANCE

First Name	Last Name	State ID Number	Provider Level

Name of Air Ambulance Service	License Number

CHECKLIST OF REQUIRED EQUIPMENT: AIR AMBULANCE

Total Number of Aircraft in Service

Please make copies if additional pages are needed.

Item

Please place an "X" in boxes if stocked.

			Item	Unit Number(s) UNIT #	UNIT #	UNIT #	UNIT #
Critical Care	ALS	BLS	Patient litter or stretcher				
			Stethoscope				
			Blood pressure cuff with aneroid gauge				
			Manual suction with assorted rigid and soft catheters				
			One set of oropharyngeal airways				
			One set of nasopharyngeal airways				
			Oxygen administration system, including a protective pressure gauge, a non-gravity dependent flowmeter, supply tubing, a non-rebreather mask and a nasal cannula. The unit must be capable of achieving an oxygen delivery flow rate of at least 15 liters per minute for one hour.				
			Mouth-to-mask artificial ventilation device with supplemental oxygen inlet port such as a pocket mask, suitable for use on infant through adult patients. This may be replaced with bag valve mask devices with masks for infant, child and adult patients.				
			A suction unit capable of providing free airflow of at least 20 liters per minute and achieving a minimum of 300 millimeters of mercury vacuum within four seconds. Must include an assortment of soft and rigid catheters in both pediatric and adult sizes.				
			Intravenous equipment and supplies for both pediatric and adult patients.				
			Two intravenous bag holders with straps				
			Endotracheal intubation equipment and supplies for both pediatric and adult patients				
			Cardiac monitor-defibrillator and supplies with pediatric and adult capabilities				
			A drug box / bag that contains drugs that have been ordered by the medical director of the ambulance service				
			Equipment and supplies necessary to provide level of care as ordered by medical director				
			Transport ventilator				
			Intravenous infusion pump				

MEDICAL DIRECTOR AGREEMENT: AIR AMBULANCE

INSTRUCTIONS: This form must be completed with each ambulance licensure application or at any time a change or addition of medical directors 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 Air Ambulance Service

Air Ambulance Service License Number

I, the above-named physician, agree to function as Physician Medical Director for the above-named air ambulance service. As Medical Director I understand that I am responsible for all patient care standards associated with the above named air ambulance service. The emergency medical services personnel working either as volunteers or as compensated employees for this service 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 online 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

If this is a change in medical director check one of the boxes below:

☐ Remove previous medical director from service roster.

☐ Add to service roster as additional medical director.

SQUAD LEADER AGREEMENT: AIR 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 air ambulance service. 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 air ambulance service. 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 aircraft rosters as needed.

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

Squad Leader Signature	Date

If this is a change in squad leader complete the section below:

☐ Remove previous Squad Leader from service roster.

☐ 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

Name of Air Ambulance Service	License Number

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 air ambulance service completes an electronic patient care report for each call and submits the required data to the Division of 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 air ambulance licensure as outlined in Chapter 23-27 of the North Dakota Century Code.

Signature	Date

Print completed form.
Sign and mail with payment to the address below.

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