EMS TRAINING INSTITUTION LICENSURE APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 60909 (03/2021)

Incomplete applications will be returned. Application must include payment of $75 payable to: ND Department of Health.

Date			
Training Institution	Business Telephone Number		
Address	City	State	ZIP Code
Program Director	Home Telephone Number		
Address	City	State	ZIP Code
E-Mail Address	ND EMS Number		
Medical Director	Telephone Number		
Address	City	State	ZIP Code
E-Mail Address	ND License Number		
Contact Person	Telephone Number		
Address	City	State	ZIP Code
E-Mail Address	ND License Number		

STATEMENT OF ACCURACY

I hereby affirm and declare that the information in this document is true and correct and that any fraudulent entry may be considered sufficient cause for rejection and revocation. I further agree to notify the ND State Department of Health - Division of Emergency Medical Systems immediately if any changes occur.

Signature	Date

APPLICATION CHECKLIST – Sign application and mail with all required items to the address below.

- ☐ Completed Application Form
- ☐ Copy of Institution's Student Policy Book
- ☐ Copy of Institution's Instructor Policy Book
- ☐ Student Application Form
- ☐ $75 Fee Payable to: North Dakota Department of Health

When all completed application materials are received, you will be contacted to set up a verification visit by DEMS. Prior to this visit it is recommended to review the EMS Training Institution Guidebook to make all necessary preparations.

For State Use Only:

Date Received
Amount Received
☐ Cash ☐ MO ☐ Check Number _____

For DEMS Use Only:

License Number
Date Application Received
Site Visit Date
Date License issued

NORTH Dakota | Health
Be Legendary.

Division of Emergency Medical Systems
1720 Burlington Dr • Bismarck ND 58504-7736
701-328-2388 • 701-328-0357 (f) • dems@nd.gov • health.nd.gov

Training Institution License Number

OWNERSHIP OF TRAINING INSTITUTION

Name	Telephone Number		
Address	City	State	ZIP Code
Name	Telephone Number		
Address	City	State	ZIP Code
Name	Telephone Number		
Address	City	State	ZIP Code

OFFICERS

Name	Title
Name	Title
Name	Title
Name	Title

INSTRUCTORS - List only the instructors that are currently licensed as a ND Instructor/Coordinator or Continuing Education Coordinator (CEC) and affiliated with the institution at the time of application.

Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number

Training Institution License Number

MEDICAL DIRECTOR AGREEMENT: EMS TRAINING INSTITUTION

This form must be completed with each training institution licensure renewal application or any time there is a change or addition of medical directors. A current medical director agreement must always be on file for each training institution.

PHYSICIAN MEDICAL DIRECTOR

First Name		Last Name		MI
Address		City	State	ZIP Code
Telephone Number	ND License Number		Expiration Date	
Name of Training Institution			Training Institution Number	

I, the above-named physician, agree to function as Physician Medical Director for the above-named EMS Training Institution. As Medical Director I agree that I will be directly involved in the development of course curricula and evaluate and approve all courses offered by this Training Institution. I also agree to oversee the Quality Improvement / Quality Assurance program developed by the Training Institution.

The expiration date of this agreement will coincide with the expiration date of the Training Institution or may be terminated upon written notification by the Training Institution or by myself to the Division of Emergency Medical Systems.

Medical Director Signature	Date

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

☐ Remove previous medical director ☐ Add additional medical director

Training Institution License Number

PROGRAM DIRECTOR AGREEMENT: EMS TRAINING INSTITUTION

This form must be completed upon training institution licensure or anytime there is a change in program director.

First Name	Last Name	MI

Address	City	State	ZIP Code

Telephone Number	ND EMS Number	Expiration Date

Name of Training Institution	Training Institution Number

I, the above-named professional, agree to function as Program Director for the above-named Training Institution. As Program Director I understand that I am responsible for ensuring compliance with all rules and regulations regarding training institution licensure requirements for the above-named training institution. It is my duty to maintain updated information with the Division of Emergency Medical Systems including updating the contact information as needed.

The expiration date of this agreement will coincide with the expiration date of the training institution or may be terminated upon written notification to the Division of Emergency Medical Systems.

Program Director Signature	Date

Training Institution License Number

HOSPITAL ADMINISTRATION SUPPORT AGREEMENT: EMS TRAINING INSTITUTION

Facility	Telephone Number		
Address	City	State	ZIP Code
ND License Number	Expiration Date		
Name of Training Institution		Training Institution Number	

As administrator of the above-named hospital I support the above-named EMS Training Institution and agree that the students enrolled in the EMS programs at this facility may do their clinical training skills required at this hospital. The nursing unit supervisor will assign a preceptor to directly supervise and advise each student. I reserve the right to terminate this agreement by submitting a written notice to the Division of Emergency Medical Systems as well as to the named EMS Training Institution.

The expiration date of this agreement will coincide with the expiration date of the Training Institution or may be terminated upon written notification by the Training Institution or by myself to the Division of Emergency Medical Systems.

Hospital Administrator Signature	Date
Program Director Signature	Date

Training Institution License Number

AMBULANCE SERVICE SUPPORT AGREEMENT: EMS TRAINING INSTITUTION

Ambulance Service	License Number		
Address	City	State	ZIP Code
ND License Number	Expiration Date		
Name of Training Institution		Training Institution Number	
Ambulance Service Director			

As director of the above-named ambulance service I agree to provide a clinical setting for EMS programs conducted by the above-named EMS Training Institution. I understand that the EMS programs conducted by the Training Institution will involve students observing and participating in all aspects of patient care as carried out by this service while under supervision. The ambulance clinical experience will be under direct supervision of a field preceptor assigned by this ambulance service with overall coordination by the Training Institution Program Director and the medical director of stated institution. I reserve the right to terminate this agreement by submitting a written notice to the Division of Emergency Medical Systems as well as to the named EMS Training Institution.

The expiration date of this agreement will coincide with the expiration date of the Training Institution or may be terminated upon written notification by the Training Institution or by myself to the Division of Emergency Medical Systems.

Service Director Signature	Date
Program Director Signature	Date