



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
Emergency Medical Systems Program  
4150 Technology Way, Suite 101  
Carson City, Nevada 89706  
Telephone (775) 687-7590 • Fax (775) 687-7595  
[http://dpbh.nv.gov/Reg/Emergency\\_Medical\\_Systems\\_\(EMS\)/](http://dpbh.nv.gov/Reg/Emergency_Medical_Systems_(EMS)/)

**Agreement Renewal**

Check Level of Service:  Basic  Intermediate  Advanced

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Name of Ambulance, Air Ambulance, or Fire-fighting Agency

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Mailing Address of Agency

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Phone Number of Agency

Fax Number of Agency

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E-Mail Address of Agency

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Service or Agency Contact Person

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Title

Approval is effective so long as the service or agency is operated as set forth in this agreement and is in compliance with Nevada Revised Statutes and Nevada Administrative Code 450B. Approval is rescinded by the Division of Public and Behavioral Health for cause or on written request of the operating service or agency.

**NEVADA STATE EMS PROGRAM ONLY**

Date Received: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Approved: \_\_\_\_\_

Documents Received:

Denied: \_\_\_\_\_

\_\_\_\_\_ Attendant List

Denial Letter Sent: \_\_\_\_\_

\_\_\_\_\_ Agreement Renewal Cover

Registered #: \_\_\_\_\_

\_\_\_\_\_ Physician Director Agreement

\_\_\_\_\_ Hospital(s) Agreement

\_\_\_\_\_ Service Agreement

\_\_\_\_\_ Mechanical Safety Statement

\_\_\_\_\_ Variance Review

\_\_\_\_\_ Current Rate Schedule

\_\_\_\_\_ Verification of Protocol

\_\_\_\_\_ Permitted Services Info

\_\_\_\_\_ Permit and Vehicle Fees

**All Permitted Agencies**

Once you have completed your review of all required documentation, the agency EMS Coordinator and the agency Medical Director must sign the bottom of this form attesting to the accuracy of the information provided.

Please forward the updated packet to the Carson City Office. If you have any questions about any of the required documentation, or changes, please contact your EMS Representative.

**Checklist**

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Agreement Renewal Cover Letter              |
| <input type="checkbox"/> | Ambulance Service Agreement                 |
| <input type="checkbox"/> | Physician Director Agreement                |
| <input type="checkbox"/> | Hospital Agreement                          |
| <input type="checkbox"/> | Permitted Services Information              |
| <input type="checkbox"/> | Verification of Current Protocols           |
| <input type="checkbox"/> | Current Rate Schedule                       |
| <input type="checkbox"/> | Vehicle Log (With Corrections If Necessary) |
| <input type="checkbox"/> | Certification of Vehicle Mechanical Safety  |
| <input type="checkbox"/> | Attendant List                              |

Please make sure you have all this information on file for Site Audit Review when requested.

\_\_\_\_\_  
EMS Coordinator (printed name)

\_\_\_\_\_  
Medical Director (printed name)

\_\_\_\_\_  
EMS Coordinator (signature)

\_\_\_\_\_  
Medical Director (signature)

# VERIFICATION OF CURRENT PROTOCOLS

Pursuant to NAC 450B.505 (2):

2. The medical director of a service or fire-fighting agency shall:

(a) Establish medical standards which:

(1) Are consistent with the national standard which is prepared by the National Highway Traffic Safety Administration of the United States Department of Transportation as a national standard for the level of service for which a permit is issued to the service or an equivalent standard approved by the Administrator of the Division and which are approved by the board;

(2) Are equal to or more restrictive than the national standard prepared by the National Highway Traffic Safety Administration of the United States Department of Transportation or an equivalent standard approved by the Administrator of the Division and adopted by the state emergency medical system; and

(3) Must be reviewed and maintained on file by the Division or a physician active in providing emergency care who is designated by the Division to review and make recommendations to the Division.

(b) Direct the emergency care provided by any certified person who is actively employed by the service.

Date of Protocols currently in use: \_\_\_\_\_

Medical Director who initiated Protocols: \_\_\_\_\_

Current Protocols on file: \_\_\_\_\_

**If the current Medical Director is NOT the Medical Director who initiated your protocols, please have the current Medical Director sign below indicating they have read and is in agreement with the protocols in use.**

\_\_\_\_\_  
Medical Director (Print)

\_\_\_\_\_  
Medical Director (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative (Print)

\_\_\_\_\_  
Agency Representative (Signature)

\_\_\_\_\_  
Date

# CERTIFICATION OF MECHANICAL SAFETY REQUIRED FOR PERMIT RENEWAL

Pursuant to NAC 450B.580(1), Each ambulance or agency's vehicle must be maintained in safe operating condition, including all of its engine, body and other operating parts and equipment. The Division shall periodically, at least every 12 months, **require the holder of a permit to certify** that the holder has had each ambulance, air ambulance or agency's vehicle under his or her control inspected by a professional mechanic who has found it to be in safe operating condition. In the case of an air ambulance, maintenance must be in accordance with Federal Aviation Administration rules, 14 C.F.R. Parts 43, 91 and 135, as applicable, which are hereby adopted by reference and are available without charge from the United States Department of Transportation, 1200 New Jersey Avenue, S.E., Washington, D.C. 20590. The holder shall mail a copy of the certificate to the Division with each application for the renewal of a permit or upon request of the Division.

**I certify that each ambulance, air ambulance or agency's vehicle listed under this permit has been inspected by a professional mechanic who has found it to be in safe operating condition.**

\_\_\_\_\_  
Agency Representative (Print)

\_\_\_\_\_  
Agency Representative (Signature)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

**PRE-HOSPITAL EMERGENCY CARE ENDORSEMENT**  
**HOSPITAL AGREEMENT**

The \_\_\_\_\_ Hospital  
of \_\_\_\_\_ (city/state) agrees to  
following provisions relative to the operations of \_\_\_\_\_ the  
\_\_\_\_\_ Service / Agency on a continuing basis for a  
period of 1 year:

1. Provide 24-hour physician or registered nurse supervision of the hospital emergency department. Physician must be present or able to be present in the emergency department within 30 minutes.
2. Provide voice radio communication capability on a 24-hour basis, for medical direction of pre-hospital emergency care.
3. All communications shall be recorded on tapes or discs. These recordings will be retained in the custody of the hospital for at least 90 days, if the tapes or discs are not retained at a regional dispatch center or the Nevada Shared Radio System.
4. Allow EMS personnel the opportunity to participate in continuing education, i. e., didactic, practical and clinical sessions of a structured nature.
5. Include the report of pre-hospital emergency care in the medical record of the hospital for each patient.

It is further agreed that this hospital will immediately notify the Division of Public and Behavioral Health of any change in the status of this agreement.

\_\_\_\_\_  
Hospital Administrator (Print)

\_\_\_\_\_  
Hospital Administrator (Signature)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

**PRE-HOSPITAL EMERGENCY CARE ENDORSEMENT**  
**SERVICE AGREEMENT**

The \_\_\_\_\_ Ambulance Agency / Air Ambulance Agency / Fire-Fighting Agency of \_\_\_\_\_, (city/state) agrees to the following provisions relative to operations of Basic, Intermediate or Advanced Ambulances, Air Ambulances or Agency Vehicles:

1. Maintain adequate numbers of attendants who are licensed to provide 24-hour, 7 day a week operation of the ambulance service /fire-fighting agency or;
  - a) If an air ambulance, maintain an adequate number of registered nurses and pilots to provide 24-hour, 7 day a week operation.
2. Report to the Division any traffic accident or incident reportable to the Federal Aviation Administration.
3. Provide continuing education appropriate for the level of endorsement as required by the Medical Director or the Division of Public and Behavioral Health.
4. Develop and maintain standards to assure compliance with Board of Health regulations for:
  - a) Documentation and reporting of patient care provided.
  - b) Submit information required by the National Emergency Medical Services Information System.
  - c) Use of the EMS radio system to obtain medical direction on administration of pre-hospital emergency care.

It is further agreed that this agency will immediately notify the Division of Public and Behavioral Health of any change in the status of this Agreement.

\_\_\_\_\_  
Agency Representative (Print)

\_\_\_\_\_  
Agency Representative (Signature)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

**PERMITTED AGENCY INFORMATION**

Agency Name: \_\_\_\_\_

Coordinator: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Initial Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Email: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Email: \_\_\_\_\_

**MEDICAL DIRECTOR INFORMATION**

Medical Director: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

**DISPATCH CENTER INFORMATION**

Dispatch Center: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dispatch Frequency: \_\_\_\_\_

Primary ER: \_\_\_\_\_

**SERVICE DETAIL**

Permit Number:\_\_\_\_\_ Permit Level: \_\_\_\_\_

Number of Vehicles: Transport:\_\_\_\_\_ Non-Transport:\_\_\_\_\_

Substations: \_\_\_\_\_

\_\_\_\_\_  
**VARIANCE REVIEW**

Please list any variances that your agency is working under:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for variance:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date Board of Health variance was granted: \_\_\_\_\_

If more than 3 years old, do you wish to renew the variance?\_\_\_Yes \_\_\_No

If yes, please provide a letter requesting renewal of the variance, including an explanation of the need for the variance.

## Emergency Contact Information

The Nevada State EMS Program is compiling a list of emergency contact information regarding services and agencies throughout the state to aid in mobilization in the event of mass casualty incident. Please provide contact information.

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Name of Ambulance Agency, Air Ambulance Agency or Fire-fighting Agency

### Initial Contact Person

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Name

Title

---

Phone Number

Fax Number

---

Cell Phone Number

Pager Number

---

E-Mail Address

### Secondary Contact Person

---

Name

Title

---

Phone Number

Fax Number

---

Cell Phone Number

Pager Number

---

E-Mail Address

### Dispatch Center

---

Agency Name

---

Phone Number

Fax Number

## PHYSICIAN DIRECTOR AGREEMENT

I, \_\_\_\_\_ M.D./D.O.,  
a physician licensed to practice medicine in Nevada, do hereby agree to serve as the agency  
Medical Director for \_\_\_\_\_  
on a continuing basis for a period of one (1) year. I further agree to notify the  
agency, Division of Public and Behavior Health of any change in status of this Agreement at  
least 30 days prior to any change as per NAC 450B.505 6 (a).

It is understood that I will be responsible for

- a) Establishment, implementation and evaluation of medical standards for pre-hospital emergency care provided by this agency.
- b) Confirm proficiency levels for personnel of the service.

It is further understood that I may also establish or approve:

- a) Medical protocols and policies for this agency.
- b) Educational programs within the service that is consistent with state standards.
- c) Medical standards for dispatch procedures for this agency.
- d) Standing orders that direct emergency care prior to initiating contact with a physician.
- e) A system of medical quality improvement for this agency.
- f) Suspension of a licensed attendant from duty within the agency pending review and evaluation by the Division.

\_\_\_\_\_  
Agency Medical Director (Print)

\_\_\_\_\_  
Agency Medical Director (Signature)

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Date