STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Interim Director

MARTA E. JENSEN
Interim Administrator

TRACEY D. GREEN, MD
Chief Medical Officer

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

INITIAL PERMIT APPLICATION

Application for permit as:

☐ Commercial Ambulance ☐ Air Ambulance ☐ Volunteer Ambulance ☐ Fire-Fighting Agency

☐ Industrial ☐ BLS ☐ ILS ☐ ALS

Instructions: This form must be fully completed and mailed to the State EMS Program 4150 Technology Way, Suite 101, Carson City, NV 89706, with the appropriate application fee. Please print in or type.

1. Trade name or fictitious name of proposed ambulance service:_____

2. Name of applicant:_____
(Last) (First) (Middle)

Mailing Address:_____
(Street / P.O. Box) (City) (State) (Zip) (Phone)

3. Name of Service Coordinator:_____
(Last) (First) (Middle)

Mailing Address:_____
(Street / P.O. Box) (City) (State) (Zip) (Phone)

4. Corporate or Partnership name:_____

5. Resident Agent of Corporation:_____

6. Registered and legal owner of ambulance units (attach extra sheet if necessary):_____

7. Is this a: ☐ Partnership ☐ Corporation or ☐ Sole Proprietor engaged in the business to provide ambulance services of any type.

List below officers, directors, partners, etc. (attach extra sheet if necessary)

Name	Address	Percent of ownership in business

8. Describe all units proposed to be used by Applicant (attach extra sheet if necessary)

	1	2	3	4	5	6
Make						
Model/Type						
Year						
Model #						
Chassis VIN #						
Colors						
Insignia / Name / or Monogram						
FAA #						
Other						
# of Litter Spaces						
2 -Way Radio Dispatch freq.						
EMS Radio Channels Yes or No						
Call #						
Vehicle License #						
Specify: 2 or 4-Wheel Drive						
Specify: Fixed or Rotary Wing						

9. Address and description of main location of ambulance service: _____

10. Address and description of any substation(s): _____

    1. _____

    2. _____

    3. _____

    4. _____

    5. _____

11. Address and description of radio base station locations: _____

    _____

12. Has the applicant ever been issued a Permit for Ambulance or Air-Ambulance Service in any other state? ☐ Yes ☐ No

13. Has the applicant ever had a permit for Ambulance or Air-Ambulance Service revoked or suspended in any other state? ☐ Yes ☐ No

14. The following must accompany the application:

    1. A complete set of fingerprints for each Applicant. **If this is a corporation, partnership, or sole proprietor engaged in the business to provide ambulance services of any type**; a set of fingerprints for each of the persons named under #7 must be provided.

    2. **If this is a corporation, partnership, or sole proprietor engaged in the business to provide ambulance services of any type**; a statement of financial worth of the Applicant Service for Commercial Ambulance or Air-Ambulance Services.

    3. **If this is a Volunteer Service**; proof of the Applicants volunteer status verified by the local Board of County Commissioners.

    4. A schedule of fees to be charged to patients for services provided.

    5. Fee in the amount of $200.00, pursuant to NAC 450B.700 (4).

    6. A current set of agency protocols as per NAC 450B.505 (2)

15. I hereby certify that all the Attendants, Air-attendants, or Trainees of the Applicant Service are licensed in the appropriate category by the State Division of Public and Behavioral Health- State EMS Program or its duly authorized agent. I further certify that all statements made in this application are true and understand that any misstatements of facts contained herein or attached hereto may cause denial of issuance or revocation or suspension of a Permit for operation of the said Applicant Service in the State of Nevada.

Signature:_____ Title:_____
(Blue ink)

Please print:_____ Date:_____
Name

Statement of Volunteer Ambulance Service

I, _____, _____, hereby certify that
(Name) (Title or Position)

_____ Ambulance Service is

a Volunteer group providing ambulance service in _____ County.

Signed: _____
(Name)

_____
(Title)

Subscribed and sworn to before me this _____ day of _____,_____.

NOTARY PUBLIC, IN AND FOR
_____ COUNTY, NEVADA

STATEMENT OF FINANCIAL WORTH
FOR
COMMERCIAL AMBULANCE AND AIR-AMBULANCE SERVICES

Name of Service:_____

D.B.A.:_____

Address:_____

Amount of annual payroll: $_____ # Attendants: _____ # other: _____

Bank with:

1. Name:_____ Checking ☐ Loan ☐

   Address:_____ Savings ☐ Payroll ☐

2. Name:_____ Checking ☐ Loan ☐

   Address:_____ Savings ☐ Payroll ☐

Assets:

Real property			$ _____
Equipment and supplies			$ _____
Vehicles			$ _____
Cash on hand			$ _____
Cash in Bank			$ _____
Accounts receivable			$ _____
Estimated income	per month $_____	Annual	$ _____
		Total	$ _____

Liabilities:	per month		annual
Equipment:	$ _____		$ _____
Vehicles:	$ _____		$ _____
Accounts payable:	$ _____		$ _____
Operating expenses:	$ _____		$ _____
Other:	$ _____		$ _____
		Total	$ _____
		Total Net Worth	$ _____

Signed:_____, Title:_____

(Blue ink)

Address:_____ Phone:_____

Emergency Contact Information

The 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.

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

Initial Contact Person

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 Service Medical Director for_____ service 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 emergency medical technicians 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

PRE-HOSPITAL EMERGENCY CARE ENDORSEMENT
HOSPITAL AGREEMENT

The _____ Hospital of _____, Nevada agrees to the following provisions relative to the operations of _____ _____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 magnetic tape or digital disc. 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 Nevada State Health 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 Service / Air Ambulance Service / Fire-Fighting Agency of _____, Nevada agrees to the following provisions relative to operations of Basic, Intermediate or Advanced Ambulances, Air Ambulances or Agency Vehicles:

1. When an ambulance providing advanced emergency care is in operation, it must be staffed by two licensed attendants per NRS 450B and as per permit level requirements.
    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 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 implement local 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 Nevada State Division of Public and Behavioral Health of any change in the status of this Agreement.

_____ _____

Service Representative (Print) Service Representative (Signature)

_____

Title

_____

Mailing Address City State Zip Code

_____ _____

Phone Number Date

CERTIFICATION OF MECHANICAL SAFETY REQUIRED FOR PERMIT

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 _____

CURRENT RATE SCHEDULE

Pursuant to NRS 450B.235:

1. Each public and private owner of an ambulance shall file his or her schedule of rates with the health authority. Any change in a schedule of an ambulance must be filed before the change becomes effective.

2. The health authority shall keep each schedule of rates or changes filed with it for at least 3 years after the schedule has been superseded or otherwise become ineffective.

LETTER OF EXPLANATION

The physician director and the signatory representative of the requesting agency or organization of the proposed service shall attach a "Letter of Explanation" to this application, addressed to the Manager Nevada State EMS Program, detailing the following:

1. Manpower – Should be described in terms of their prior training and experience, affiliation with the type of ambulance or rescue service (i.e., fire department, private, hospital-based, etc.) Agency must also provide a separate agency roster to the Division.

2. Training – How will the continuing education be conducted? How will sufficient clinical experience be assured?

3. Radio Communications – What communications capabilities will exist between ambulance attendants and physician? Is there direct radio communications between personnel and physician on a 24-hour basis? Are any portions of the emergency response area without EMS radio communications coverage?

4. Dispatch – How is service dispatched on a 24-hour per day basis?

5. Citizen Access – How will citizens summon the service?

6. Transportation:

   a) Ambulance Service Only:
   Will the service unit transport the patient? If not, who will be responsible for transportation? Are the emergency transport vehicles adequate in size and design to accommodate the equipment and supplies appropriate to the level of endorsement, in addition to the regular complement of equipment?

   b) Firefighting Agency Only:
   Who will be responsible for transportation of the patient? List services which to be called or used.

   c) Air Ambulances Only:
   What arrangements have been made for transporting patients from the airport to the receiving hospital? Who will provide ground transportation of the patient?

7. Geographic Area - Will the operation of this service or agency be limited to a specific geographic area or site? What geographic area or site will be served by this service or agency?

8. Equipment / Supplies – List the equipment and supplies which will be carried for Intermediate or Advanced life support use including the specific drugs and fluids proposed to be carried, along with protocols.

9. Record Keeping Critique System – Describe the record keeping system that will be utilized and the manner and frequency of critique sessions that will be held for physician-ambulance attendant review of specific cases to insure quality care was provided.

This Letter of Explanation will be an important consideration in approval or rejection of the proposed service unit.

NEVADA STATE EMS PROGRAM ONLY

Date Received:_____
Approved:_____
Denied:_____
Denial Letter Sent:_____
Registered #:_____

Date Reviewed:
Documents Received:
_____ Permit Application
_____ Statement of Volunteer Ambulance Service
_____ Statement of Financial Worth
_____ Emergency Contact Information
_____ Physician Director Agreement
_____ Hospital(s) Agreement
_____ Pre-Hospital Service Agreement
_____ Mechanical Safety
_____ Current Protocols
_____ Current Rate Schedule
_____ Letter of Explanation
_____ Permit Fees