

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services



MOBILE INTENSIVE CARE UPGRADE APPLICATION

INSTRUCTIONS

This application is to be completed fully by the applicant. Please do not leave required fields blank, enter "N/A" if it does not apply. You are strongly encouraged to contact your <u>Regional EMS Coordinator</u> for any assistance you may require in completing this application. Please review Connecticut General Statutes and <u>Regulations of Connecticut State Agencies</u> governing Mobile Intensive Care Service prior to completing this application.

The Office of Emergency Medical Services (OEMS) shall review the application for completeness. It shall be the sole responsibility of the OEMS to deem the application complete. Requests for additional information shall be forwarded to the applicant within thirty (30) days of the receipt of the application. The applicant shall provide such requested additional information within ten (10) business days of the receipt of such request.

Once deemed complete by OEMS, the application will be forwarded to the affected Regional Council(s) for review and recommendation. The Regional Council(s) shall have forty (40) days after receipt of the application to forward a recommendation to the OEMS. The OEMS shall render a decision on the application within ten (10) business days after receipt of the Regional Council(s) recommendation.

NOTE: Local EMS Planning is the responsibility of the municipality. Any affected municipality should be included in discussions regarding modifying EMS resource deployment or system design.

The following must be included in your application submission:

- 1. This completed application;
- 2. A letter of support from the municipal chief elected official in which the applicant is requesting;
- 3. A list of currently certified personnel trained to the new level of authorization;
- 4. A copy of the clinical care protocols for this new level of authorization (electronic copy is acceptable);
- 5. A copy of the sponsor hospital quality assurance plan for this new level of authorization;
- 6. A list of EMS organizations you currently have written mutual aid agreements that will assist in providing uninterrupted 24/7/365 coverage at the requested level.

Submit the original application (including all required attachments) to the address below, to the attention of the Regional EMS Coordinator.

Please remember to retain a copy for your records.

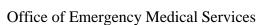
Department of Public Health Office of Emergency Medical Services 410 Capitol Avenue, MS#12EMS PO Box 340308 Hartford, CT 06134-0308 (860) 509-7975



PROVIDER INFORMATION

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH





MOBILE INTENSIVE CARE UPGRADE APPLICATION

Legal Name of Service:			
Business Address:			
Person completing this form: Title:			
Primary Telephone:Email:	Seconda	ary Telephone: _	
CURRENT LEVEL OF CERTIFICATION/LI	ICENSE (che	eck all that apply	<u>):</u>
Check what level of service you currently hold:			
First Responder			
Basic Ambulance			
Mobile Intensive Care - Advanced			
Mobile Intensive Care - Paramedic			
LEVEL REQUESTING			
Check level of authorization your	Is there a P	SAR currently	If "yes" enter name
organization is requesting (check all that apply)	assigned at	that level?	of PSAR
Basic Ambulance	YES	NO	
Mobile Intensive Care – Advanced	YES	NO	

How will you schedule the members of your organization who are trained at this new level to assure 24-hour coverage? Provide narrative (use extra sheets if needed).

YES

NO

FOR OFFICE OF EMS USE ONLY

F	OR OEMS USE ONLY	
DATE RCVD:	RC REVIEW COMPLETE:	
DEEMED COMPLETE DATE:	OEMS DIRECTOR SIGNATURE	

Mobile Intensive Care - Paramedic



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ATTACHMENTS (REQUIRED)

All attachments must be clearly numbered and referenced.

Example: "See ATTACHMENT 1 – MUNICIPAL LETTER OF SUPPORT"

ATTACHMENT 1 – MUNICIPAL LETTER OF SUPPORT.

A letter of support from the municipal CEO supporting the application.

ATTACHMENT 2 – ROSTER OF CURRENTLY CERTIFIED/LICENSED PERSONNEL.

List should include first/last name, certification/license number and expiration date for each person trained to the requested level.

ATTACHMENT 3 – COPY OF THE SPONSOR HOSPITAL CLINICAL CARE PROTOCOLS.

An electronic copy is acceptable.

ATTACHMENT 4 – COPY OF THE SPONSOR HOSPITAL QUALITY ASSURANCE PLAN FOR THE REQUESTED LEVEL.

An electronic copy is acceptable.

ATTACHMENT 5 – LIST OF MUTUAL AID AGREEMENTS.

All EMS organizations you currently have written mutual aid agreements with (copies of the agreements are acceptable).



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SPONSOR HOSPITAL INFORMATION AND TREATMENT PROTOCOLS

Sponsor Hospital EMS Medical Director (print)	Signature	Date
Sponsor Hospital EMS Clinical Coordinator (print)	Signature	Date
We, the undersigned acknowledge the and collectively, we agree to sponsor responsibilities described in Regulation Mobile Intensive Care Services.	the applicant at the requested leve	on has been reviewed in its entirety, l of care. We accept the
Have the Protocols been made avail	able to the authorized staff membe	ers of you organization? Yes No
Title of Sponsor Hospital Protocols: Revision Date:		
(If the mailing address of the Medical Direction please include it on an attachment to this for		erent than the hospital mailing address,
		Fax:
E-Mail:	Fa	X:
Medical Director:		none:
Name of Sponsor Hospital:Address:		



Title

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



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SIGNATURE PAGE FOR CHIEF EXECUTIVE OFFICER OR OTHER AUTHORIZED AGENT

I, the undersigned, acknowledge that the information provided within this application is current and accurate. I understand and agree that the approval of this upgrade is contingent upon the continuance of medical direction and compliance with the Connecticut General Statutes and Regulations of Connecticut State Agencies governing the delivery of emergency medical services.

| Name (print) | Signature |

Date