RECOGNITION OF SUPPLEMENTAL FIRST RESPONDER STATUS APPLICATION

Instructions and approval process:

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

This shall include letters of support from the First Responder PSAR(s) and Chief Elected Official(s) for the affected geographic area (include as attachments).

Upon receipt, OEMS shall review the application for completeness.

OEMS shall forward requests for information to the applicant within thirty (30) business days of receipt of the application. The applicant shall forward such requested information to OEMS within ten (10) business days.

In the event requested information is not submitted within the required period of time, the application shall be considered to be withdrawn without prejudice.

OEMS shall render a decision on the application within ten (10) business days upon being deemed complete.

The applicant and affected first responder PSAR(s) shall receive written notification of such decision. OEMS shall notify the appropriate regional council(s) upon approval of any supplemental first responder.

If you have questions or need assistance, contact your Regional EMS Coordinator. OEMS contact information can be found on the Contact Us page of the OEMS website.

PROVIDER INFORMATION

1. Official legal Name of Service: _____

2. Business Address: _____

_____

3. Mailing Address: _____

_____

4. Telephone Numbers:
   Business: _____
   Emergency: _____
   Fax: _____

5. Chief Executive Officer:
   Name: _____
   Title: _____
   Telephone (work) _____
   Telephone (home) _____
   Telephone (cell) _____
   Email: _____

6. Contact Person
   Name: _____
   Title: _____
   Telephone (work) _____
   Telephone (home) _____
   Telephone (cell) _____
   Email: _____

EFFECT OF PROPOSED ASSIGNMENT

Please provide a narrative description of how the supplemental first responder service will function. Include at least the following information:

1) how the *Supplemental First Responder Recognition* will improve patient care in the primary service area to be served. Attach additional pages if necessary
2) how the supplemental first responder organization will interact with the assigned first responder organization.

Name of current First Responder Primary Service Area Responder (PSAR):

_____

Narrative:

GEOGRAPHIC COVERAGE

This section of the application must detail the boundaries of the geographic area which will be covered by this supplemental assignment. Please provide both a narrative description and a map of the geographic boundaries to be covered. If available, please also provide GPS coordinates.

HISTORICAL RESPONSE TIME DATA

This section must detail historical response time data, including activation & response time (see definitions below) for the preceding 12 months. Please provide the name of the EMS dispatch agency that will activate supplemental first responder personnel and a description of the communications equipment (i.e. radios, pagers, etc.) to be used. If response time data for the preceding 12 months exists, please provide it on the following page. If activation time data for the preceding twelve months does not exist, please describe the plan for collecting such data in the future.

Name of EMS Dispatch Agency: _____

Telephone: _____ Email: _____

Description of communications equipment that will activate supplemental first responder personnel:

DATE RANGE: From: _____ To: _____

ACTIVATION TIME = the measure of time, in minutes, from notification by dispatch to the supplemental first responder organization that an emergency exists, to the beginning of the response of supplemental first responder personnel.

RESPONSE TIME = the total measure of time, in minutes, from notification by dispatch to the supplemental first responder organization that an emergency exists, to arrival at the patient's side.

ACTIVATION TIME		
TIME IN MINUTES	TOTAL RESPONSES	% OF RESPONSES
1-2		
2-3		
3-4		
>4		
TOTAL RESPONSES FOR PREVIOUS 12 MONTHS		100%

RESPONSE TIME		
TIME IN MINUTES	TOTAL RESPONSES	% OF RESPONSES
< or = 4		
4-5		
5-6		
6-7		
7-8		
>8		
TOTAL RESPONSES FOR PREVIOUS 12 MONTHS		100%

INITIAL APPLICATION FOR EMS SPONSOR HOSPITAL

1. Name of EMS Organization: _____

2. Mailing Address: _____
   Phone:_____Fax: _____

3. Name of Chief/CEO and Title: _____

4. Chief/CEO Phone:_____Email: _____

I understand and agree that the skill(s) for which we are authorized is contingent upon sponsor hospital medical control and compliance with Section 19a-179-12 of the Regulations which govern the delivery of prehospital emergency medical services.

_____ _____
Chief/CEO Signature Date

TO BE COMPLETED BY SPONSOR HOSPITAL

Name of Sponsor Hospital: _____

Address: _____

EMS Medical Director_____Phone:_____
E-mail:_____Fax: _____

EMS Coordinator:_____Phone:_____
E-mail:_____Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form).

5. At what level is the above organization licensed/certified or authorized?

Supplemental First Responder ☐ First Responder ☐

6. What BLS skills is this organization authorized to perform? *(check all appropriately)*

Aspirin (EMT and above)	Yes ☐	No ☐
Continuous Positive Airway Pressure (CPAP) (EMT and above)	Yes ☐	No ☐
Glucometer (EMT and above)	Yes ☐	No ☐
Epinephrine Auto injector (EMT and above)	Yes ☐	No ☐
Naloxone (Narcan®) Intranasal and/or Autoinjector (EMR and above)	Yes ☐	No ☐
Twelve Lead ECG Acquisition and Transmission (EMT and above)	Yes ☐	No ☐

7. Are you utilizing the current statewide EMS Protocols? Yes ☐ No ☐

If applicable please identify any additional protocols you are utilizing in addition to the Statewide EMS Protocols _____

_____

If no, please indicate what protocols you are using: _____

_____

The above EMS Organization has complied with all conditions as set forth by this sponsor hospital for the requested level of care, but not limited to, initial provider training. Therefore, on behalf of the Sponsor Hospital we agree to provide medical control in accordance with Section 19a-179-12 of the Regulations of Connecticut State Agencies which govern the delivery of pre-hospital emergency medical services.

Medical Director Print	Signature	Date
EMS Coordinator	Signature	Date

If no historical data exists, describe plan for collecting and maintaining activation & response time data. Note: This page may be copied if additional space is needed.

STAFFING PLAN

Please describe below the hours of operation & staffing plan to assure response coverage. Note: This page may be copied if additional space is needed.

DISPATCH POLICY AND PROTOCOLS

Please describe below, or provide a copy as an attachment, approved dispatch protocols that describe chief complaints, situations or types of EMS incidents that will result in the dispatch of the supplemental first responder. In the space provided below describe the methodology for periodically reviewing (at least annually) and/or amending the supplemental first responder dispatch protocols.

PERSONNEL ROSTER

Please provide the following information for each full-time/part-time employee/member to be utilized by the applicant. **Note:** This page may be copied if additional space is needed.

NAME	CERTIFICATION LEVEL	CERTIFICATION/ LICENSURE #	EXPIRATION DATE

VEHICLE INFORMATION

The requested information shall be provided for *each* vehicle to be operated by the applicant service as a "supplemental first responder" vehicle. Do not include privately owned vehicles. **Note:** This page may be copied if additional space is needed.

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

CERTIFICATES OF MALPRACTICE AND MEDICAL LIABILITY INSURANCE

In accordance with CGS 19a-180, the following shall be the required limits for licensure and/ or certification:

(1) for damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident at least one million dollars,
(2) for damage to property at least fifty thousand dollars, and
(3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars.

In lieu of the limits set forth in subdivisions (1) to (3), inclusive, of this subsection, a single limit of liability shall be followed as follows:

(A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and
(B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars.

ATTACHMENTS REQUIRED:

Attach Certificates of Malpractice and Medical Liability Insurance verifying the minimum insurance requirements outlined above.

SIGNATURE PAGE

The Chief Executive Officer of each applicant supplemental first responder service must sign this page as an express condition for recognition to operate as a supplemental first responder.

_____
(Name of applicant service)

I do hereby warrant and certify that the above-named EMS provider organization shall carry out its responsibilities as a supplemental first responder in accordance with Section 19a-179-4(a) of the Regulations of Connecticut State Agencies. Specifically, the above-named service shall provide at least the following at the scene of each EMS call to which it responds:

1. One Emergency Medical Responder (EMR) who is certified in accordance with section 19a-179-16(a) of the Regulations of Connecticut State Agencies.

2. A two-way radio compatible with the supplemental first responder dispatcher.

3. Bandaging material and dressings sufficient to control hemorrhage.

4 Oropharyngeal or mouth-to-mouth airways in infant, child and adult sizes. Such airways shall be non-rigid and non-metal in construction.

5. Portable oxygen administration apparatus with a thirty (30) minutes supply of oxygen (at seven (7) liters per minute flow rate), which is operable totally detached from the parent vehicle. Such oxygen administration unit shall be capable of accepting attachment to a nasal cannula, mouth/nose oxygen mask or as enrichment feed to a forced ventilation unit.

And, all First Responder vehicles listed in the Vehicle Information section of this application shall be equipped in compliance with the equipment standards published annually by the Commissioner pursuant to CGS 19a-177. The most current standard can be found on the Communications & Reference Documents page of the OEMS website.

All information provided within this application is, to the best of my knowledge, true and correct.

_____ _____
Date Chief Executive Officer Signature