D H E C

PROMOTE PROTECT PROSPER

Catherine B. Templeton, Director

Promoting and protecting the health of the public and the environment

Application for Renewal License Check Off Sheet

Initial each box and attach to application prior to mailing packet.

- ☐ Type or print legibly the information for ALL nine (9) sections: Leave no section(s) blank. (Reg 61-7: sec 401.A)
- ☐ CIS reflects the most accurate information of the service address, mailing address, primary and secondary contact information, employee roster with legal name(s), vehicle(s) and location of station(s).
- ☐ Include a copy of agency's liability and malpractice insurance policy with vendor's contact information. (Reg 61-7: Sec 401.A.10)
- ☐ Include a copy of Non-Dispensing Pharmacy Outlet Permit (61-7Sec401.A.12and §4D-43-B3)
- ☐ Include a copy of agency's drug list, on letterhead signed and dated by Medical Control.(Reg 61-7: sec 402.D)
- ☐ Include a statement on letterhead signed and dated by medical control adapting the 2010 SC State Protocols and Procedures. Or, include protocols and procedures on CD labeled with name of agency, month/year, and the words "Protocols/Procedures" (Reg 61-7: sec 402.0)
- ☐ Include a copy of agency's Clinical Laboratory Improvement Amendments (CLIA) Certificate Of Waiver (COW) If finger stick BGLs are preformed.
- ☐ Include a statement on letter head signed by mutual aid agreement agency, if applicable. (Reg 61-7: sec 403.C)
- ☐ Include a copy of agency's DEA license state and federal, if applicable. (Reg 61-7: sec401.A.11)

OFFICIAL USE ONLY:

- ☐ SMARTT Systems Compliance _____ % of _____ weeks to-date.
- ☐ Last PreMIS Processed Import ____/____/____ 24 Hour 48 Hour 72 Hour Delayed: ____/____
- ☐ Last PreMIS Recorded Date ____/____/____
- ☐ Charting Software: PreMIS Other: _____

Reviewed ___/___/_____ Initials: _____ Comments: _____

_____

☐ Mail application packet and contents to:

SC DHEC: Division of EMS and Trauma
Attn: EMS Inspectors
2600 Bull Street
Columbia, SC 29201

D H E C
PROMOTE PROTECT PROSPER

Application for Service Provider's License
Division of EMS & Trauma

SECTION I — SERVICE INFORMATION License No: _____

Renewal Applications Only

Name of Service: _____

Physical Address: _____

City: _____ County: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Business Phone: (____) _____ Fax: (____) _____ Emergency Phone: (____) _____

Owner of Service: _____

☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital
☐ Government ☐ Fire Dept ☐ Rescue Squad

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

EMS Director: _____ EMS Assistant: _____ ☐ n/a

Work Phone: (____) _____ Work Phone: (____) _____

Mobile Phone: (____) _____ Mobile Phone: (____) _____

Email Address: _____ Email Address: _____

License Category Applied For: ☐ Ground Ambulance ☐ EMT First Responder
[EMS Reg. 61-7 pp. 7–9]

Type of Organization: ☐ Hospital Based ☐ Industry ☐ Fire Dept.
☐ Rescue Squad ☐ County Government
☐ Private Provider ☐ City Government

Level of Service: ☐ EMT-Basic ☐ Advanced EMT ☐ EMT-Paramedic ☐ Nurse

Services Offered: ☐ Non-Emergent Transport ☐ 911 Response with Transport ☐ 911 Response without Transport
☐ HazMat ☐ Paramedic Intercept ☐ Rescue

This is to certify that all information in this application is accurate and complete.

_____ _____
Signature of Person in Charge Date

SECTION II Employee/Member Information

This roster must include all employees associated with ambulance duties including drivers, pilots, RNs, and Flight Mechanics, etc. ☐ Yes ☐ No

Employee/Volunteer Contact Information			Certification Level	SC Cert. Number	Expiration MM/YR
Last Name, First Name	Address	Phone #			

SECTION II Employee/Member Information

Employee/Volunteer Contact Information			Certification Level	SC Cert. Number	Expiration MM/YR
Last Name, First Name	Address	Phone #			

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SECTION II Employee/Member Information

Employee/Volunteer Contact Information			Certification Level	SC Cert. Number	Expiration MM/YR
Last Name, First Name	Address	Phone #			

SECTION III - Vehicle Information

Vehicle Identification Number	Year	DHEC Permit Number	License Tag Number	Make	Fuel Type	Unit Type

1. Truck Modular - KKK
2. Van - KKK
3. Van Modular - KKK
4. Non-Transporting
5. MCI Bus
6. Other

SECTION III - Vehicle Information

Vehicle Identification Number	Year	DHEC Permit Number	License Tag Number	Make	Fuel Type	Unit Type

1. Truck Modular - KKK
2. Van - KKK
3. Van Modular - KKK
4. Non-Transporting
5. MCI Bus
6. Other

SECTION IV - Vehicle Locations and Type

	Primary Units			Backup Units		
Must Include Station Name, Street Location and Phone Number or each Station	**Number Basic Units**	**Number Intermediate Units**	**Number Advanced Units**	**Number Basic Units**	**Number Intermediate Units**	**Number Advanced Units**
☐ Headquarters						
☐ Substations						

SECTION V - Additional Operational Information

Insurance Information:

☐ Attach a copy of Certificate of Insurance from vendor

Name of Insurance Company: _____

Name of Agent: _____

Phone Number: _____

Mailing Address of Agent: _____

City, State, Zip: _____

Types of Coverage: ☐ Liability ☐ Property Damage ☐ Medical Malpractice

Limits of Coverage: Malpractice: $_____ Liability: $_____

Radio Information:

Radio Frequencies ☐ UHF Tx: _____ _____ _____ _____

☐ VHF Rx: _____ _____ _____ _____
Dispatch Hospital Other Other

If using Frequencies other than VHF attach a list of each individual frequency:

Each unit can communicate with:

☐ Company Base ☐ Fire Department ☐ Law Enforcement ☐ Hospital ☐ EMS

☐ Emergency Operations Center Other (Specify): _____

Does each vehicle have a cell phone? ☐ Yes ☐ No

Is a dispatch log maintained and available for inspection containing the date, time call received, type of call, and time unit is enroute? ☐ Yes ☐ No

How is your agency dispatched?
☐ 911
☐ Self Dispatched
☐ Third Party Vendor (specify): _____

Non-emergent Phone Number: (_____) _____

SECTION VI - Contact Information

Training Officer:

Name: _____ Office Phone: _____

Mobile Phone: _____ Email: _____

Forms Control Officer:

Name: _____ Office Phone: _____

Mobile Phone: _____ Email: _____

Fleet Manager*: _____ Office Phone: _____

Mobile Phone: _____ Email: _____

*** Note:** the personnel responsible for preparing unit(s) for permit inspection(s)

Mutual Aid Agreements: Please check if applicable: ☐ Yes ☐ No
Please include a copy of any mutual aid agreements that your service may have concerning non-disaster related agreements. Example: A non-emergent transport service has a mutual aid agreement with the local 911 service to provide emergency response within a given area or nursing home/residential care facility.

Controlled Substances: Please check if applicable: ☐ Yes ☐ No
If your service carries any controlled substances or have them listed in your protocols, please provide a copy of your South Carolina State Controlled Substance Registration. (This is the South Carolina equivalent to the DEA License)

SECTION VII

The Ryan White Comprehensive Aids Resources Emergency Act of 1990

Indicate below the name of the person who will serve as your designated officer. If your designated officer changes, you must notify the department in writing with the name of the new designated officer within five (5) days of the change.

Infection Control Officer

Name: _____

Phone: _____ E-mail: _____

☐ Please include a copy of the company's exposure control plan in accordance with OSHA 1910.1030

Section VIII

1. How many vehicle(s) are fully equipped to the:
   a. EMT -Basic level? _____
   b. Advanced EMT level? _____
   c. Paramedic level? _____
2. What is the number of permitted vehicle(s) in your fleet? _____
3. What is the total number of calls that your service was dispatched to during the last six (6) months? _____
4. What is the total number of call that your service responded to during the last six (6) months? _____
5. What is the average number of calls your service runs per DAY?

   Answer from number 4: _____ ÷ 6 months = _____ ÷ 30 days

   Emergent or Non-Scheduled _____ + Non-Emergent or Scheduled _____ =_____

Ambulance Services:

6. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the Paramedic level and staffed with at least one (1) Paramedic and one (1) EMT-Basic? _____
7. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the AEMT level and staffed with at least one (1) AEMT and one (1) EMT-Basic? _____
8. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the EMT-Basic level and staffed with at least one (1) EMT-Basic and one (1) non-certified driver? _____

EMT First Responder Services:

9. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the Paramedic level and staffed with at least one (1) Paramedic? _____
10. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the AEMT level and staffed with at least one (1) AEMT? _____
11. What is the total number of calls that your service responded to during the last six (6) months where the unit was fully equipped to the EMT-Basic level and staffed with at least one (1) EMT-Basic? _____

I hereby certify that the above statements are true and correct to the best of my knowledge.

EMS Director Signature: _____ Date: _____/ _____/ _____

Medical Control Physician

South Carolina Department of Health and Environmental Control
Division of EMS and Trauma
Renewal Medical Control Physician Form

Section IX

1. **Service Information**

Service Name _____ SC DHEC License Number _____

Service Mailing Address _____

City/State/Zip Code _____

Telephone Number _____ FAX Number _____

2. **Medical Control Physician Information**

☐ Primary ☐ Assistant

_____
Name Med Control Physician SC Lic.#

_____
E-Mail Address

_____
Mailing Address

_____
City/State/Zip

( ) _____ ( ) _____
Telephone Number Emergency Number

☐ Primary ☐ Assistant

_____
Name Med Control Physician SC Lic.#

_____
E-Mail Address

_____
Mailing Address

_____
City/State/Zip

( ) _____ ( ) _____
Telephone Number Emergency Number

Statement of Understanding & Authorized Signatures:
I have read and understood the duties & responsibilities of the Medical Control Physician as outlined in Regulation 61-7 § 402 (A through G) and § 44-61-130. Of the EMS law also included on this form. Further, If my EMS service has a State-Approved In-Service Training program, I accept full responsibility for the program and understand that I may not waive anyone from the State recertification examination until I have attended a State-Approved EMS Medical Control Workshop. If I have not already attended a Medical Control Physician Workshop, I understand that I must attend the next available workshop within the next twelve (12) months in order to remain as Medical Control Physician for the above EMS service.

☐ I have ☐ I have not
Attended a Medical Control Workshop

☐ I have ☐ I have not
Attended a Medical Control Workshop

_____
Signature Primary Med Control Physician/Date

_____
Signature ASSISTANT Med Control Physician/Date

I understand that I must Notify the SCDHEC Division of EMS & Trauma of any change in Medical Control, Drug List, and/or Standing Orders/Protocols within ten (10) days (Regulation 61-7 ,§ 402 E)

_____
Signature EMS Director/Date