D H E C

PROMOTE PROTECT PROSPER

Catherine B. Templeton, Director

Promoting and protecting the health of the public and the environment

Application for New License Check Off Sheet

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

- ☐ Type or print legibly the information for ALL eight (8) sections: Leave no section(s) blank. (Reg 61-7: Sec 401.A)
- ☐ 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 (61-7 Sec 401.A.12 and § 40-43-83)
- ☐ Include a copy of agency's drug list, on letterhead signed and dated by the Medical Control Physician and EMS Director. (Reg 61-7: Sec 402.D)
- ☐ Include a statement on letterhead signed and dated by medical control adapting the 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.D)
- ☐ If fingerstick BGLs are preformed, complete the Clinical Laboratory Improvement Amendments (CLIA) Certificate Of Waiver (COW) and mail the application to SC DHEC: CLIA Program, Attn: Lakeshia Wright, 2600 Bull Street, Columbia, SC 29201
- ☐ Include a copy of DEA license, if applicable. (Reg 61-7: Sec 401.A.11)
- ☐ Include a copy of Medical Control Physician Change or Update Form. (Reg 61-7: Sec 402.E)
- ☐ Include a copy of the Medical Control's South Carolina Board of Medical Examiners License
- ☐ Complete and return the SMARTT System Enrollment Form.
- ☐ Complete and return the SMARTT Contact Enrollment Form.

Select the method for EMS Electronic Data Submission, and follow the corresponding process to begin Data Submission:

- ☐ PreMIS Web App: We will use the PreMIS Web Application at no cost. The PreMIS Web App does not require configuration or testing. Therefore, you may begin immediately after completion of enrollment and training. Contact Victor Grimes grimesve@dhec.sc.gov or (803) 545-4262 for access to the application and additional training resources. All Crewmembers need to complete their paperwork prior to coming off shift. All PCRs should be entered and completed within 72 hours of the incident.
- ☐ PreMIS Import: We will use a Commercial Software at the Agency's cost. Commercial EMS field Collection Software must be NEMSIS Gold Compliant as listed at www.nemsis.org at the EMS Agency's cost. Contact Jeff Robertson jrobertson@emspic.org to establish and account and instructions for Software File Testing. Please note that all PCRs should be imported into PreMIS within 72 hours of the incident. It is the responsibility of the agency to ensure that all imports are successful.

D H E C
PROMOTE PROTECT PROSPER

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

SECTION I — SERVICE INFORMATION Official Use Only: License No: _____

New 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: _____ Assistant Director: _____ ☐ n/a

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

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

Email Address: _____ Email Address: _____

License Applied For: ☐ Ground Ambulance ~~Report~~ ☐ EMT - First Responder

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, Flight Mechanics, and 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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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	Official Use Only 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	Official Use Only 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 for 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 unit 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 will 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

Medical Control Physician

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

Section VIII

1. **Service Information**

Service Name _____

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

Gender: ☐ Male ☐ Female

Race: (Select)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race

Ethnicity: (Select)
☐ Hispanic or Lantino
☐ Not Hispanic or Lantino

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 Attended a Medical Control Workshop ☐ 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

Medical Control Physician

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

Section VIII

1. **Service Information**

Service Name _____

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

Gender: ☐ Male ☐ Female

Race: (Select)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race

Ethnicity: (Select)
☐ Hispanic or Lantino
☐ Not Hispanic or Lantino

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 Attended a Medical Control Workshop ☐ 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