



**Application for Licensure
as an Emergency
Medical Service**

State of Nebraska
 Department of Health and Human Services
 Division of Public Health – Licensure Unit
 PO Box 94986 – Lincoln, Nebraska 68509-4986

SECTION A – License Type Select the level of licensure for which you are applying.

<input type="checkbox"/>	Basic Life Support – Transport Service	<input type="checkbox"/>	Advanced Life Support – Transport Service
<input type="checkbox"/>	Basic Life Support – Non Transport Service	<input type="checkbox"/>	Advanced Life Support – Non Transport Service

SECTION B – Service Information

Service Name:			
Physical Address:	Street/Box/Route:		
	City:	State:	Zip:
Phone #:		Fax #:	
Service Contact Name:			Phone #:
E-Mail Address:			
Alternate Contact Name:			Phone #:
E-Mail Address:			

SECTION C – Owner/Applicant Information

Owner Name:				
Owner Type:	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/>	Partnership
	<input type="checkbox"/>	Limited Liability Company (1 member)	<input type="checkbox"/>	Limited Liability Company (2 or more members)
	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Governmental Unit (City/County/State/U.S.)
	<input type="checkbox"/>	Other (Please list):		
Address:	Street/Box/Route:			
	City:	State:	Zip:	
Phone #:		Fax #:		
E-Mail Address:				
If owner type is sole proprietorship, provide the owner's social security number:				

SECTION D – Physician Medical Director (PMD) Information			
PMD Name:		License Number:	
Physical Address:	Street/Box/Route:		
	City:	State:	Zip:
Phone #:		Fax #	
E-Mail Address:			
SIGNATURE OF PHYSICIAN MEDICAL DIRECTOR			

SECTION E – Documentation		
Provide a list of the names, license numbers and licensure levels of the members/employees of the service.		
Provide a description or map of your service area.		
Provide a completed Physician Medical Director Authorization (pages 4-8 of this document).		
Does this service own or lease an ambulance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IF NO , provide a copy of your written transport agreement with a licensed emergency medical service.		
Has this service modified the Nebraska Emergency Medical Service Protocols?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IF YES , provide a copy of your modified protocols signed by your Physician Medical Director.		
Is this service applying for an Advanced Life Support Service license?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IF YES , provide a copy of your Mid-Level Practitioner Controlled Substance registration or a copy of your completed application for a Mid-Level Practitioner Controlled Substance registration. <i>The controlled substance registration number must be issued to the service. The service cannot use the Physician Medical Director's number.</i>		
Will this service be utilizing a glucose monitor?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IF YES , provide a copy of your current Clinical Laboratory Improvement Amendments (CLIA) certificate or a copy of your completed application for a CLIA certificate.		

SECTION F – Attestation

This section is to be completed by the owner(s)/applicant(s). For purposes of this application as outlined in 172 NAC 12, Section 12-003.02, Item 1i (1) to (5), that would be:

- *The owner or owners if the applicant is a sole proprietorship, a partnership, or a limited liability company that has only one member; or*
- *Two of its members if the applicant is a limited liability company that has more than one member; or*
- *Two of its officers if the applicant is a corporation; or*
- *The head of the governmental unit having jurisdiction over the emergency medical service if the applicant is a governmental unit; or*
- *If the applicant is not an entity described above, the owner or owners or if there is no owner, the chief executive officer or comparable official.*

Subsection 1 – I attest as follows:

Check each box in acknowledgement.

- That the service meets the standards outlined in 172 NAC 12, Section 12-004; and
- That this service **has not** provided emergency medical services in the State of Nebraska prior to submitting this application; **OR**
- That this service **has** provided emergency medical services in the State of Nebraska prior to submitting this application. Number of days services were provided: _____

The Department may assess an administrative penalty in the amount of \$10 per day, not to exceed a total of \$1,000 for practice without a credential.

Print Name: _____

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Complete Subsection 2 only if the owner is a sole proprietorship.

Subsection 2 – For the purposes of Neb. Rev. Stat. §38-129, I attest that I am:

Check the appropriate box below.

- A citizen of the United States; or
- An alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
- A nonimmigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

SECTION G – For Office Use Only

Inspector Name:				Inspection Date:		
Inspection Results (Inspection Report Attached)	Yes	No	Board Approval	Yes	No	Date:
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	



**Nebraska Board of
Emergency Medical Services**

**Physician Medical Director
Authorization**

Physician Medical Director Authorization Service Acknowledgment

Service Name

License Number

This service acknowledges the authorities of the Physician Medical Director (PMD) as stated in Nebraska Emergency Medical Services (EMS) Practice Act and the Nebraska Rules and Regulations Title 172 Chapters 11 and 12.

Physician Medical Director Adoption

- I acknowledge my authorities and responsibilities as Physician Medical Director (PMD) as stated in Nebraska Emergency Medical Services (EMS) Practice Act and the Nebraska Rules and Regulations Title 172 Chapters 11 and 12.
- I adopt the following documents as required by Nebraska EMS Practice Act and the Nebraska Rules and Regulations Title 172 Chapters 11 and 12.
 - a. Infection Control Plan
 - b. Quality Assurance Plan
 - c. Equipment List
 - d. Back-up Response Plan
- Additional Authorization is required for additional skills and medications for the Emergency Medical Responder (EMR) and Emergency Medical Technician (EMT)
- I adopt the complete set of the Nebraska EMS Model Protocols as posted on the Emergency Medical Services website on the date of my signature as the official protocols for the service named above; **OR**
- I adopt the Nebraska EMS Model Protocols as posted on the Emergency Medical Services website on the date of my signature with modifications. I have reviewed the modified protocols and a signed copy of each modified protocol is included with this application. I am aware that I am responsible for any adverse action that may arise due to these changes; **OR**
- I do not adopt the Nebraska EMS Model Protocols. I have provided a signed copy of the protocols that the above named service will follow along with documentation outlining how they differ from the Nebraska EMS Model Protocols.

Signature of PMD

Printed Name of PMD

Date

AUTHORIZATION FOR ADDITIONAL SKILLS AND MEDICATIONS

Emergency Medical Responders (EMR)

I authorize the following added skills and medications for Emergency Medical Responders (EMR) that have the appropriate approved training and listed on the attached ***Additional Skills Roster – EMR***.

(Check All That Apply)

<input checked="" type="checkbox"/>	PMD Approved Skills – Medications For The EMR
<input type="checkbox"/>	Application Of Devices To Immobilize The Spine
<input type="checkbox"/>	Application Of Devices To Immobilize Extremities
<input type="checkbox"/>	Administer By Protocol Aspirin
<input type="checkbox"/>	Administer By Protocol Epinephrine 1:1000 By Auto Injector

Emergency Medical Technicians (EMT)

I authorize the following added skills and medications for Emergency Medical Technicians that have the appropriate approved training and listed on the attached ***Additional Skills Roster – EMT***

(Check All That Apply)

<input checked="" type="checkbox"/>	PMD Approved Skills – Medications For the EMT
<input type="checkbox"/>	Glucometer
<input type="checkbox"/>	Dual Lumen Airway – Combitube
<input type="checkbox"/>	Supraglottic Airway – King Airway
<input type="checkbox"/>	Impedance threshold device
<input type="checkbox"/>	Monitor ONLY an established IV of Normal Saline, Lactated Ringer, D5W
<input type="checkbox"/>	Establish Peripheral IV Access And Monitor IV Fluids Of Normal Saline, Lactated Ringer, D5W
<input type="checkbox"/>	Administer by protocol Epinephrine 1:1000 by auto injector
<input type="checkbox"/>	Administer by protocol Albuterol by nebulizer

I Authorize The Above Checked Additional Skills – Medications As Indicated For The Individuals As Listed On The Additional Skills Roster.

Service Name: _____

Signature Physician Medical Director: _____

Printed Name of Physician Medical Director: _____

Date: _____

ADDITIONAL SKILLS ROSTER – EMT

The Following **Emergency Medical Technicians** (EMT) Are Authorized
For the Added Skills and Medications As Indicated Below

Name	Airway		Intravenous		Medications				
	Impedance Threshold Device	CPAP	Glucometer	Dual Lumen Combitube	Supraglottic King Airway	Monitor Only	Start & Monitor	Albuterol By Nebulizer	Epi-Auto Injector
<i>Example: John Doe</i>	X	X	X	X	X	X	X	X	X