NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
EMERGENCY HEALTH SYSTEMS
STATE OF NEBRASKA

Emergency Medical Service Application

Complete and return this application and all supporting documentation to one of the following:

Email (preferred method):
DHHS.EMSLicensing@nebraska.gov

Fax: (402) 742-2322

Department of Health and Human Services
Office of Emergency Health Systems
PO Box 95026
Lincoln, Nebraska 68509-5026

SECTION A1 – LICENSE TYPE: Select the level of licensure for which you are applying.

☐ Basic Life Support

☐ Advanced Life Support –
Must provide a copy of your Mid-Level Practitioner Controlled Substance Registration (DEA Number) or a copy of your completed application for a Mid-Level Practitioner Controlled Substance registration.
*The DEA Number must be issued to the service **NOT** the Physician Medical Director's number.*

SECTION A2 – TRANSPORT TYPE:

☐ Transport Service

☐ Non-Transport Service – Must provide a written transport agreement with a licensed EMS Service.

SECTION B – SERVICE INFORMATION

Legal EMS Service Name:

EMS Service Contact Name: | EMS Service Contact Phone:

EMS Service Contact E-Mail Address:

Primary Physical Station Address: Street/Route: | City: | State: | Zip:

Mailing Address: Street/Route: | City: | State: | Zip:

Submit a list of all station locations, if multiple, by using this form found below:
http://dhhs.ne.gov/OEHS%20Program%20Documents/EMS%20Multiple%20Sites%20Form.pdf

SECTION C – OWNER/APPLICANT INFORMATION

Owner Name:

Owner Type:
☐ Sole Proprietorship ☐ Partnership
☐ Limited Liability Company (1 member) ☐ Limited Liability Company (2 or more members)
☐ Corporation ☐ Governmental Unit (City/County/State/U.S.)
☐ Other (Please list):

Address: Street/Box/Route: | City: | State: | Zip:

Phone #: | Fax #:

E-Mail Address:

FOR SOLE PROPRIETORSHIP OWNERS – if applicant has both a SSN and A#, report both

Applicant Social Security Number:

Alien Registration Number, if applicable:

Has the sole proprietor ever been convicted of a misdemeanor or a felony? Yes ◯ No ◯

If yes convicted of a misdemeanor or a felony, the applicant must submit:

- A copy of the court record related to all misdemeanor and felony convictions that includes the statement of charges and final disposition.
- If the conviction(s) occurred in a state other than Nebraska, submit an explanation of the events leading to the conviction (what, when, where, why) and a summary of actions taken to address the behaviors or actions related to the conviction; and
- A letter from the applicant's probation officer addressing the terms and current status of the probation, if the applicant is currently on probation.

SECTION D – PHYSICIAN MEDICAL DIRECTOR (PMD) INFORMATION

PMD Legal Name: | License Number:

Physical Address: Street/Box/Route: | City: | State: | Zip:

Phone Number: | Fax Number:

E-Mail Address:

PMD Signature:

SECTION E – DOCUMENTATION

Provide a list of the names, license numbers, and licensure levels of the members/employees of the service.

Provide a completed Physician Medical Director Authorization (page 3 of this document).

Has this service modified or are using alternate protocols from the Nebraska Emergency Medical Service Protocols? Yes ○ No ○

IF YES, provide a copy of your modified protocols signed by your Physician Medical Director.

Will this service be utilizing a glucose monitor? Yes ○ No ○

IF YES, provide a copy of your current Clinical Laboratory Improvement Amendments (CLIA) certificate or a copy of the submitted 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 38-130 3A-E 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:

- ☐ This service meets the standards outlined in 172 NAC 12, Section 12-004; and
- ☐ This service **has not** provided emergency medical services in the State of Nebraska prior to submitting this application; **OR**
- ☐ 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 license.

Print Name: _____

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

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

- ☐ A citizen of the United State; or
- ☐ An alien lawfully admitted into the United States who is eligible for 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.

The Department:

- May request additional information as needed;
- Requires any documents written in a language other than English to 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.

Physician Medical Director Authorization

Service Name	License Number

- 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 Chapter 12.

- I attest that I have experience in, and knowledge of, emergency care of acutely ill or traumatized patients and I am familiar with the design and operation of local, regional, and state emergency medical service systems.

- I have approved and signed the following as required:
  a. Infection Control Policy
  b. Quality Assurance Program
  c. Equipment List
  d. Backup Response Plan

☐ I adopt the complete set of the Nebraska EMS Model Protocols as posted on the Emergency Medical Services website (dhhs.ne.gov/ems) 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 am aware that I am responsible for any adverse action that may arise due to these changes;

OR

☐ I have adopted and implemented custom EMS protocols as of the date of my signature.

Signature of PMD	Printed Name of PMD	Date