Reset Form

APPLICATION FOR AIR AMBULANCE SERVICE PROVIDER CERTIFICATION

State Form 55590 (3-15)

INDIANA DEPARTMENT OF HOMELAND SECURITY
EMERGENCY MEDICAL SERVICES COMMISSION
302 West Washington Street, Room E239
Indianapolis, IN 46204
Telephone: 1-800-666-7784

INSTRUCTIONS: 1. *Please type or print clearly. Complete all items and questions, attach additional pages as necessary.*
2. *Submit this form with all attachments, listing number and title of each item to the above address.*
3. *Upon receipt this form will be treated as a public record.*

Type of Air Ambulance: *(Please check one that applies.)* ☐ Fixed-Wing ☐ Rotocraft		
Common operating name of organization	County	Certification number
Legal name of organization *(As filed with the Indiana Secretary of State.)*		
Address *(number and street, city, state, and ZIP code)*		
Mailing address *(if different) (number and street, city, state, and ZIP code)*		
Business telephone number ( )	24-hour contact telephone number ( )	Business fax number ( )
Name of Medical Director		Title
Daytime telephone number ( )	E-mail address	
Name of Chief Executive Officer		Title
Daytime telephone number ( )	E-mail address	
Name of Day to Day Operations Manager		Title
Daytime telephone number ( )	E-mail address	
Name of Training Officer		Title
Daytime telephone number ( )	E-mail address	
Name of Data Collection Agent		Title
Daytime telephone number ( )	E-mail address	

A. COMMUNICATIONS

If operating on frequencies licensed by other organizations, list appropriate expiration dates below, and attach letters of authorization from licensed organization.

1. Submit a list of all on-board medical communications equipment.
2. If initial application, submit copy of FCC license.
3. If renewal application, give FCC license expiration dates for all that apply:
   ☐ Radio equipment required under 14CFR part 135 ____/____/____ ☐ IHERN ____/____/____
4. Dispatch Method:
   ☐ Central Dispatch ☐ Provider Dispatch ☐ Other *(explain)* _____

B. OPERATIONAL INFORMATION

(Attach additional pages if necessary.)

1. Does your organization provide emergency medical service twenty-four (24) hours, seven (7) days a week?
   ☐ Yes ☐ No

2. Define Base of Operations and primary and secondary response area.

3. Submit a copy of the F.A.A. Part 135 Operation Specifications Table of Contents Part A and Operations Specification 14 CFR Part 135 *(Flight minimums)*.
4. Describe your organization's area-wide plan to provide safety education and to coordinate rotocraft ambulance service with ground emergency medical service organizations, law enforcement, mutual aid back-up systems, and central dispatch when available *(rotocraft organizations only).*
5. List the address for the location where your organization's records are kept. *(number and street, city, state, and ZIP code)*
6. List any waivers granted to the provider by the Emergency Medical Services Commission.

C. MANPOWER

1. Describe your organization's staffing patterns for air-medical crew and pilots.
2. Provide a listing of all personnel and their qualifications by category:
   (List must include all that regularly serve as pilots and air-medical personnel.)

D. TRAINING

1. Describe the organization's plan to ensure annual continuing education for air-medical personnel on air transportation problems and flight physiology.

E. VEHICLES

1. Submit a listing of all aircraft to include aircraft type and identification numbers.
2. If initial application, submit an Emergency Medical Services Commission vehicle application for each aircraft.
3. Submit F.A.A. Part 135 Operations Specification Part D85, Aircraft Listing.
4. Submit a copy of the Certificate of Insurance for all aircraft including effective and expiration dates and the amount of coverage.
5. Describe procedures for checking electric and mechanical equipment, medical care equipment, and vehicle integrity.

F. ATTACHMENTS

(Only original signatures will be accepted.)

- PROTOCOLS – Submit copy of current protocols, signed and dated by the Medical Director. If a renewal application, submit a letter signed and dated by the Medical Director stating that there have been no changes in the protocols since the previous application. If protocols have changed, submit copies of the changes signed and dated by the Medical Director.
- MEDICAL DIRECTOR APPROVAL FORM – Submit form, signed and dated by the Medical Director.
- PERSONNEL ROSTER – Submit roster, signed and dated by organization CEO and Medical Director.
- MEDICATIONS – Submit a list of any and all medications and solutions, including amounts, dosages and method of storage, approved and signed by the Medical Director. Submit a list of all on-board life support equipment.
- SUPERVISING HOSPITAL APPROVAL – Submit a letter, signed and dated by the Administrator of Supervising Hospital, listing personnel and affirming that the supervising hospital has reviewed the competency of the ALS personnel and grants them affiliation.
- CONTRACT – Submit a copy of the contract with the supervising hospital; or interdepartmental memo, if hospital based; or a letter signed and dated by the Administrator of the supervising hospital stating that the existing contract is still in effect. Contract must include detailed descriptions of how the hospital will provide continuing education, medical control, audit and review, liaison and direction for supply of medications and solutions, and safety and survival programs and education.

Disclosure of this information is mandatory. Failure to provide any information may prevent this application from being approved. Misrepresentation of information, failure to comply and maintain compliance with, and/or violation provisions, standards, or requirements may be cause for suspension or revocation.

This is to affirm that all statements contained in this application are true to the best of my knowledge. I hereby affirm that I have read and do understand the State of Indiana official rules and regulations for air ambulances and agree to strictly adhere to them.

Signature of Chief Executive Officer	Date signed *(month, day, year)*

Printed or typed name of provider