Reset Form

APPLICATION FOR EMS TRAINING INSTITUTION CERTIFICATION

State Form 54424 (R2 / 3-15)

INDIANA DEPARTMENT OF HOMELAND SECURITY
EMERGENCY MEDICAL SERVICES COMMISSION
302 West Washington Street, Room E239
Indianapolis, IN 46204

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

NOTE: 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 of any provisions, standards, or requirements may be cause for suspension or revocation.

ADDRESS EACH OF THE FOLLOWING ITEMS IN NARRATIVE FORM.

A. Submit agreement(s) of affiliation with clinical and internship facilities.
B. Provide evidence of effective ratio of supervisory personnel to students during clinical phases of the program.
C. Provide evidence that you have liability insurance for all students.
D. Submit curriculum requirements for **EACH** level of course you plan to teach.
E. Describe how you provide adult education techniques to all affiliated instructors.
F. Describe your procedures to evaluate all affiliated instructors.
G. Describe the type of EMS Course conducted. (Classroom, online, hybrid, and how you will meet & verify curriculum requirements.)
H. Submit a signed copy of the medical director approval form, listing your affiliated instructors.
I. Describe the in-course standards and criteria by which the instructor is to determine successful completion of the didactic and clinical portions of the course. Include the following:
   1. Attendance requirements and absentee policies.
   2. Testing procedures.
   3. Number and scope of in-course tests.
   4. Didactic pass/fail grade average and criteria.
   5. Provision for make-up test and classes.
   6. Minimal age for enrollment.
   7. Policies to provide reasonable accommodations pursuant to the American with Disabilities Act.
   8. Describe your screening and evaluation process for acceptance into any certified training program.

IF CERTIFIED AT ALS LEVEL, ALSO SUBMIT THE FOLLOWING ITEMS.

A. Submit verification of student access to emergency patients for clinical phases of the course(s). (Facility agreements, schedule, etc.)
B. Submit written approval from administration and medical staff. *(Must indicate each department participating.)*
C. Describe your orientation to hospital personnel who will be directly involved in training or operation aspects of ALS.
D. Name and list qualification of your:
   1. Medical Director 2. Program Coordinator 3. Instructional Staff (*include Preceptors*)
E. Submit a copy of your CoAEMSP annual reports.

Type of application *(check one)*
☐ New ☐ Renewal ☐ Upgrade / Additional

Level of certification *(check all that apply)*
☐ Basic ☐ Advanced Life Support

Type of training offered *(check all that apply)*
☐ EMR ☐ EMT ☐ Advanced EMT ☐ Paramedic

Common operating name of training institution	County	Certification number

Legal name of institution *(as filed with the Indiana Secretary of State)*

Mailing address *(number and street, city, state, and ZIP code)*

Street address *(if different from the mailing address)*

Business telephone number	Business fax number	E-mail address
( )	( )	

Name of training institution official	E-mail address	Daytime telephone number
		( )

Signature of training institution official	Date (*month, day, year*)

Name of person responsible for day-to-day business	E-mail address	Daytime telephone number
		( )

Signature of person responsible for day-to-day business	Date (*month, day, year*)

Name of medical director	E-mail address	Daytime telephone number
		( )

Address *(number and street, city, state, and ZIP code)*	Indiana license number

Signature of medical director	Date (*month, day, year*)

AFFIRMATION

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 regarding Training Institutions in 836 IAC 4-1 and agree to strictly adhere to them.

Signature of training institution official	Date (*month, day, year*)