Georgia Department of Public Health

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000 Main Form

CLASSIFICATION

1 (Select One)	☐ New	☐ Anniversary	☐ Renewal	☐ Revision
2 Type of License: (***Select all that apply***)	☐ First Responder	☐ Ground Ambulance	☐ Neonatal	☐ Air Ambulance
3 Service Delivery Contract	☐ Yes	☐ No	***(If service Delivery Contract then omit 22-24)***	

OWNERSHIP

4 (Select One)	☐ Individual	☐ Partnership	☐ Corporation	☐ Private Hospital
	☐ State Government	☐ County Government	☐ City Government	☐ Hospital Authority

5a Name of Owner:		**5**b Email Address:	
6a Owner Street Address or P.O. Box:			**6**b Business Phone:
7a City:	**7**b State:	**7**c Zip Code:	**7**d Fax Number:
8a Authorized Agent:		**8**b Email Address:	
9a Street Address or P.O. Box:			**9**b Business Phone:
10a City:	**10**b State:	**10**c Zip Code:	**10**d Fax Number:
11a Registered Agent if a Corporation		**11b** Email Address:	
12a Street Address or P.O. Box:			**12b** Business Phone:
13a City:	**13b** State:	**13c** Zip Code:	**13d** Fax Number:

BASIC QUALIFICATIONS

14 Has the owner or any party to this application had any certification or license revoked or had any other disciplinary actions levied from any state or federal agency? ☐ **Yes** ☐ **No**

**** If "yes," attach documentation explaining the circumstances.***

15 Has the owner or any party to this application ever been convicted of a felony by this or any other state or federal court? ☐ **Yes** ☐ **No**

**** If "yes," attach documentation explaining the circumstances.***

16 Is the owner or any party to this application currently in any pending matter referred to in the preceding two items? ☐ **Yes** ☐ **No**

**** If "yes," attach documentation explaining the circumstances.***

17a Doing Business as:	**17b** License Number

Name of Service(s):	Type of Service :	License Number:	Level of Care:
18a	**FIRST RESPONDER**	**18b**	**18c**
19a	**GROUND AMBULANCE**	**19b**	**19c**
20a	**NEONATAL**	**20b**	**20c**
21a	**AIR AMBULANCE**	**21b**	**21c**

22 Types and Number of Personnel Employed				
EMTs: **22a**	Intermediates: **22b**	Advanced EMTs: **22c**	Cardiac Technicians: **22d**	Paramedics: **22e**
23 Types and Number of Vehicles	First Responder: **23a**	Ground Ambulance: **23b**	Neonatal: **23c**	Air Ambulance: **23d**
24 Total Number of Vehicles: _____				

BASE LOCATION

25a Base Location – Street Address:			**25b** County:
26a City:	**26b** State: **Georgia**	**26c** Zip Code:	**26d** Zoned Provider:
27a Director:		**27b** Email Address:	
28a Business Phone:	**28b** Emergency Phone:	**28c** Fax Number:	**28d**. Additional Locations? ☐ **Yes** ☐ **No**

ADDITIONAL LOCATION(S) MUST BE RECORDED ON FORM GA-EMS 1000 – SUPPLEMENTAL

INFECTIOUS DISEASE EXPOSURE CONTROL

29a. Name of Direct Contact:		**29b.**Email Address:	
30a Street Address:			
31a City:	**31b** State:	**31c** Zip Code:	**31d** 24-Hour Contact Number:

COMMUNICATION

32a Agency or Company Name:		**32b** Name of Contact Representative:	
33a Email Address:		**33b** Business Phone:	**28c** Fax Number:
34a Street Address:			**34b** Emergency Phone:
35a City:	**35b** State:	**35c** Zip Code:	**35d** County

CERTIFICATION

I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE, AND THAT I WILL NOTIFY THE OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA IN WRITING OF ANY CHANGE IN MY EMPLOYMENT AGENCY, HOME OR MAILING ADDRESS, TELEPHONE NUMBER OR EMAIL ADDRESS. I UNDERSTAND THAT ANYONE WHO MAKES FALSE STATEMENTS TO THE DEPARTMENT MAY BE SUBJECT TO CRIMINAL PROSECUTION UNDER OFFICAL CODE OF GEORGIA SECTION 16-10-20; AND, THAT FALSE STATEMENTS MAY FURNISH GROUNDS FOR THE DENIAL OR REVOCATION OF A LICENSE.

36 Owner's Name:	
37a. Signature:	**37b.**Date:
38 Authorized Agent's Name:	
39a. Signature:	**39b.** Date:

Georgia Department of Public Health

Schedule A

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000

INSURANCE INFORMATION

Name of Service	License Number(s)	License Type	Base Location
1a	**1b**	MEDICAL FIRST RESPONDER	**1c**
2a	**2b**	GROUND AMBULANCE	**2c**
3a	**3b**	NEONATAL	**3c**
4a	**4b**	AIR AMBULANCE	**4c**

5 Vehicle Identification Number (s) of Vehicles (s) Insured:

1.		**11.**	
2.		**12.**	
3.		**13.**	
4.		**14.**	
5.		**15.**	
6.		**16.**	
7.		**17.**	
8.		**18.**	
9.		**19.**	
10.		**20.**	

6 Policy Number(s):

7a Amount of Coverage: (must be equal to or in excess of $1,000,000 CSL)

7b Date of Effective Coverage:

Person:	**Accident:**	**Property:**	**Month/Day/Year** **to** **Month/Day/Year**

The undersigned further certifies, as an agent for the company, that the above information is true and correct and if the insurance is terminated for any reason (canceled, revoked, expired, etc.) the company or its agent will within ten (10) calendar days, provide written notice to the Department at the address listed below.

Georgia Department of Public Health
Office of Emergency Medical Services and Trauma
2600 Skyland Drive, Lower Level
Atlanta, Georgia 30319

7a Printed Name of Insurance Agent or Insurance Representative:

7b Insurance Company Providing Coverage:

8a Signature of Insurance Agent or Insurance Company Representative:

8b Date:

8c Business Phone:

9 Address: Street City State Zip Code

10a Service Owner or Authorized Agent's Name

10b Title:

11a Service Owner or Authorized Agent's Signature

11b Date:

Georgia Department of Public Health

Schedule B

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000

Medical Director Agreement

EMS PROVIDER INFORMATION

Name of Service	License Number(s)	License Type	County
1a	**1b**	MEDICAL FIRST RESPONDER	**1c**
2a	**2b**	GROUND AMBULANCE	**2c**
3a	**3b**	NEONATAL	**3c**
4a	**4b**	AIR AMBULANCE	**4c**

MEDICAL DIRECTOR INFORMATION

5a Name of Medical Director:	**5**b Email Address:		
6a Street Address or P.O. Box:			**6**b Business Phone:
7a City:	**7**b State:	**7**c Zip Code:	**7**d Fax Number:
8a Area of Specialty:			**8b** Georgia License Number:

AGREEMENT

I am a physician licensed to practice medicine in Georgia and have agreed to serve as the Medical Director for the above-identified EMS Provider. This contract is valid for a maximum of twenty five (25) months from the date of signing and must be renewed in conjunction with the license renewal.

As Medical Director, I will provide medical direction and training in conformance with O.C.G.A. 31-11, Department Rules and Regulations, and Policies established by the Office of Emergency Medical Services and Trauma. I have read and do hereby affirm that I understand and will abide by all requirements contained therein.

If I should decide to relinquish my role as Medical Director, I will notify the Department of Public Health (DPH), Office of Emergency Medical Services and Trauma (address below), and the EMS Provider in writing not less than ten (10) calendar days prior to the termination of the agreement.

Georgia Department of Public Health
Office of Emergency Medical Services and Trauma
2600 Skyland Drive - Lower Level
Atlanta, Georgia 30319

SIGNATURES

9 Owner or Authorized Agent:	
10a Signature:	**10b** Date:
11 EMS Medical Director:	
12a Signature:	**12b** Date:

Georgia Department of Public Health

Schedule C

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000

Pharmaceutical Agreement

EMS PROVIDER INFORMATION			
Name of Service	License Number(s)	License Type	County
1a	**1b**	MEDICAL FIRST RESPONDER	**1c**
2a	**2b**	GROUND AMBULANCE	**2c**
3a	**3b**	NEONATAL	**3c**
4a	**4b**	AIR AMBULANCE	**4c**

PHARMACY INFORMATION			
5a Name of Pharmacy:			**5b** Georgia License Number:
6a Street Address or P.O. Box:			**6**b Business Phone:
7a City:	**7**b State:	**7**c Zip Code:	**7**d Fax Number:
8 Email Address:			

AGREEMENT

This is an agreement between the above listed agencies relative to the control, procurement, handling, and accountability of drugs and intravenous fluids (IVs). Attached to this document are copies of all appropriate agreements and contracts between the above-mentioned EMS Provider and Georgia Licensed Pharmacy or Wholesaler and a list of pharmaceutical agents approved for use, and related policies established and signed by the Medical Director of the licensed emergency medical service provider ("EMS Medical Director"). This agreement will be valid for a maximum of twenty five (25) months from the date of signing and must be renewed in conjunction with the license renewal, prior to the expiration of the twenty five (25) months.

The pharmacy entering into this Agreement agrees to supply drugs and/or IVs to the EMS Provider in accordance with O.C.G.A. §26-4-116. A wholesaler entering into this Agreement agrees to distribute drugs and/or IVs to the above-referenced EMS Provider in accordance with O.C.G.A. §16-13-72 and GA. Comp. r. & Regs. r. 480-7-.03(5) of the Rules of the State Board of Pharmacy. A pharmacy/wholesaler is also required to abide by the policies of the State Office of Emergency Medical Services and Trauma (OEMS) and the EMS Medical Director's instructions. The drugs and IVs approved for use will be treated as standard ward inventory, as defined by the Rules of the State Board of Pharmacy (Chapter 480-13). In the event that there are any local policies developed related to the procurement, control, storage, handling, accountability, and/or administration of pharmaceuticals, which conflict with the GA. Comp. r. & Regs. r. 511-9-2 of the Rules of the Department of Public Health (DPH) and the policies established by the State Office of Emergency Medical Services, as amended, the DPH rules and OEMS shall be followed, unless the local policies are more stringent. Copies of this agreement shall be maintained by the pharmacy or Wholesaler, EMS Medical Director and EMS Provider. The original will be given to the DPH and OEMS.

If for any reason this contract is cancelled or otherwise changed at any time, the Pharmacy and licensed EMS provider shall notify OEMS in writing no later than ten (10) days prior to such change or cancellation.

SIGNATURES		
9a Pharmacy Representative:	**9b** Owner or Authorized Agent:	**9c** EMS Medical Director:
10 Title:		
11a Signature:	**11b** Signature:	**11c** Signature:
12a Date:	**12b** Date:	**12c** Date:

GA-EMS 1000
Schedule D

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Verification of Lawful U.S. Residency for License Application

O.C.G.A. Section 50-36-1(e)(2)

As part of my application for licensure from the Georgia Department of Public Health, I hereby swear, under oath, that I am:

[*Check <u>one</u> of the following*]

(1) _____ A citizen of the United States;

(2) _____ A legal permanent resident of the United States;

or

(3) _____ A qualified alien or non-immigrant under the Federal Immigration and Nationality Act. The alien number assigned to me by the United States Department of Homeland Security or other federal immigration agency is Alien Number _____.

I also swear that I am eighteen years of age or older, and that I have provided at least one secure and verifiable identity document with this affidavit, as required by O.C.G.A. Section 50-36-1(e)(1). The secure and verifiable document is my_____
_____
_____.

The original "secure and verifiable document" was shown to the notary public, and a true copy of the document is attached to my application with this affidavit.

In making these representations, I understand that any person who knowingly and willfully makes a false statement in an affidavit on any matter within the jurisdiction of state government shall be guilty of a violation of O.C.G.A. Section 16-10-20 and face criminal penalties authorized by that statute.

Subscribed and sworn before me this _____
day of _____, 20_____.

_____
Signature of Applicant

_____
Printed Name Of Applicant

_____
Notary Public

My Commission Expires _____

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document for proof of or documentation of identity, that document will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

Georgia Department of Public Health

Schedule E

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000

PERSONNEL INFORMATION

Name of Service(s)	License Number(s)	License Type	Location(s)
1a	**1b**	MEDICAL FIRST RESPONDER	**1c**
2a	**2b**	GROUND AMBULANCE	**2c**
3a	**3b**	NEONATAL	**3c**
4a	**4b**	AIR AMBULANCE	**4c**

5a **Full Name** (As it appears on Georgia License)	**5b** **Level of Licensure EMT-I-A-CT-P or OTHER**	**5c** **Georgia License Number**	**5d** **Georgia License Expiration Date**	**5e** **Employment Status**	**5f** **CPR Expiration Date**	**5g** **ACLS Expiration Date**

ADDITIONAL PERSONNEL INFORMATION MUST BE RECORDED ON FORM GA-EMS 1000(a) – ADDENDUM

SIGNATURES	
6a Owner's Name:	**6b** Authorized Agent's Name:
7a. Signature & Date:	**7b.** Signature & Date:

Georgia Department of Public Health

Schedule F

EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION

GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

GA-EMS 1000

VEHICLE INFORMATION

Name of Service	License Number(s)	License Type	County
1a	**1b**	MEDICAL FIRST RESPONDER	**1c**
2a	**2b**	GROUND AMBULANCE	**2c**
3a	**3b**	NEONATAL	**3c**
4a	**4b**	AIR AMBULANCE	**4c**

5a Vehicle License Type (Indicate Grd AMB or MFR or NEO or Air AMB)	**5b** Year	**5c** Type	**5d** Make	**5e** Manufacturer's Vehicle Identification Number (VIN)	**5f** Service Unit/Call Number (FAA "N" number for Air Ambulance)	**5g** State EMSVID Number	**5h** Status A= Addition C= Current D= Delete

ADDITIONAL VEHICLE INFORMATION MUST BE RECORDED ON FORM GA-EMS 1000(b) – ADDENDUM

SIGNATURES

6a Owner's Name:	**6b** Authorized Agent's Name:
7a. Signature & Date:	**7b.** Signature & Date: