INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
(909) 388-5823 FAX: (909) 388-5825

PROVISION OF MEDICAL CONTROL INFORMATION UPDATE FORM

1. PROVIDER INFORMATION

Name: ______________________________

Doing Business As: ______________________________

Address: ______________________________

Mailing Address: ______________________________

Business Phone: ____________________ Fax: ____________________

2. ADMINISTRATION/STAFFING

Fire Chief/CEO: ____________________ E-mail: ____________________

EMS Coordinator: ____________________ E-mail: ____________________

Medical Director: ____________________ E-mail: ____________________

If a corporation, joint venture, partnership or limited partnership, list names of all partners, and/or names of corporate officers, their permanent addresses and their percentage of participation in the business. ☐ Not Applicable

Name	Mailing Address	Position (i.e., Board Member, Partner, President)	% of Participation

3. TYPE OF SERVICE, LEVEL OF SERVICE(S), AND NUMBER OF AMBULANCES

Check the type of service to be provided.

- ☐ First Responder
- ☐ Ground Ambulance Transport
- ☐ Paid Fire Department
- ☐ Volunteer Fire Department
- ☐ Law Enforcement
- ☐ Special Events
- ☐ Other

If Other is marked, describe type of service: ____

Check the level of service(s) to be provided and the number of ambulances in each category.

Level of Service	# of Units
☐ Advanced Life Support (ALS)	______________
☐ Basic Life Support (BLS)	______________
☐ Specialty Care Transport (SCT)	______________

4. HOURS OF SERVICE

- ☐ 24 hours per day, 365 days per year
- ☐ Other

If other, please specify: ____

5. OPERATING AREA(S)/BOUNDARIES

List the operating area(s) as specified in the EMS Plan. Include exclusive operating area(s).
☐ Not Applicable

EOA #s: ____

6. MUTUAL AID AGREEMENTS

List the names of ambulance providers the organization has a written Mutual Aid Agreement to provide coverage in times of shortages.

____

____

____

____

7. LOCATION OF AMBULANCE STATIONS

List the location of ambulance stations. If additional space is needed, attach a separate page.

Main Station:
Address: ____________________

Sub-station:
Address: ____________________

Sub-station:
Address: ____________________

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Address: ____________________

Sub-station:
Address: ____________________

8. AMBULANCE UNITS

Provide a complete list of ambulance units that will operated. If additional space is needed, attach a separate page.

Unit #	Year/Make	License #	Mileage - Odometer Reading	Level of Service
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
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				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT

9. SECONDARY VEHICLES

In order to utilize a secondary vehicle, list and define primary functions of any secondary patient transport vehicles or response units (i.e., bikes, supervisor units, boats, ATV, or other transport capable vehicles).

Unit #	Year/Make	License #	Mileage - Odometer Reading	Level of Service
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT
				☐ ALS ☐ BLS ☐ SCT

10. PERSONNEL/NUMBER OF EMPLOYEES

List the number of employees/volunteers below:

Type	Full-time	Part-time	Volunteer	Expiration Date
AEMT				
EMT				
EMT-P				
MICN				

List of employees/volunteers and the expiration date of their certification, accreditation or license. If additional space is needed, attach a separate page.

Name	Certification, Accreditation or License #	Expiration Date

11. SIGNATURE FOR SUBMISSION

This form is to be signed and verified by the owner/applicant/officer, or in a partnership, by each partner. In the case of a corporation the signature of an authorized officer and the accompanying corporation seal are required. Add signature page as needed.

The above information and statements are true and correct to the best of my knowledge.

______________________________	______________________________
Applicant/Owner/Officer Signature	Applicant/Owner/Officer Signature
______________________________	______________________________
Print Name	Print Name
____________________	____________________
Date	Date