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 FORM
(for New Providers only)

Provision of Medical Control Fee: **$2,500**
Medical Control Compliance per Unit: **$500**

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 board, list names of all partners, board members 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 Event(s)
- ☐ 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 AND EMERGENCY OPERATIONS

Does applicant agree to provide mutual aid and emergency medical services at the request of ICEMA's EMS Administrator, or designee, in accordance with ICEMA policy?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

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: _____

Sub-station:
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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

Does applicant employ sufficient personnel adequately trained and available to deliver ambulance service of good quality at all times in the operating area? ☐ Yes ☐ No

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

Does applicant affirm that all EMS personnel have and will continue to have applicable licenses, permits, and certificates (i.e., California Driver's License, California Ambulance Drivers Permit, Medical Examiner's Certificate, current CPR card, current EMT or ICEMA EMT-P card and State of California Licensure)? ☐ Yes ☐ No

11. CALIFORNIA HIGHWAY PATROL (CHP) FORMS

CHP Form 360A - Emergency Ambulance Non-Transferable License

Is provider a privately owned company? ☐ Yes ☐ No

Level of Service: ☐ ALS ☐ BLS ☐ Exempt

If yes, attach a photocopy of the current license issued by the Commissioner of the California Highway Patrol.

CHP Form 299 - Ambulance Inspection Reports

Check if there is an attached copy of the most recent ambulance inspection report by the California Highway Patrol for each vehicle listed in Item 9.

☐ ALS
☐ Exempt
☐ Not Applicable

CHP 301 - Special Vehicle Identification/Permits

Check if there is an attached copy of the most recent ambulance inspection report by the California Highway Patrol for each vehicle listed in Item 9.

☐ ALS
☐ Exempt
☐ Not Applicable

12. COMMUNICATION EQUIPMENT

Are all units equipped with communication equipment per ICEMA Reference #5040 - Radio Communication Policy? ☐ Yes ☐ No

13. EQUIPMENT AND SERVICE

Does applicant own, or have under your control, required equipment to adequately conduct an EMS service in the service area which meet the requirements established by the California Vehicle Code, and that you own or have access to suitable and safe facilities for maintaining equipment in a clean, sanitary and mechanically sound condition? ☐ Yes ☐ No

14. AFFIRMATION OF EQUIPMENT

Does applicant affirm that each vehicle and its appurtenances conform to all applicable provisions of the San Bernardino Ambulance Ordinance and the California Administrative Code? ☐ Yes ☐ No

15. INDEMNIFICATION

Does applicant certify that as a condition of ICEMA's Provision of Medical Care, that you agree to appear and defend all action against ICEMA arising out of exercises of said Provision of Medical Care, and shall indemnify, defend and save ICEMA, its officers, employees and agents harmless of and from all claims, demands actions or causes of action of every kind and description resulting or indirectly, arising out of, or in any way connected with the exercise of the Provision of Medical Care unless there is a conflict of interest?
☐ Yes ☐ No

16. LIABILITY INSURANCE

ICEMA liability insurance requirements for ALS service providers are as follows:

- Comprehensive General in the sum of $5,000,000 per occurrence
- Vehicle liability in the sum of $5,000,000 per occurrence
- Professional liability of EMS services in the sum of $5,000,00 per occurrence
- Worker's Compensation - statutory amount with $250,000 for employers liability

Provider must provide the following:

- Evidence that ICEMA, its officers, officials employees and volunteers are additionally insured with respect to operations performed
- Evidence that insurance policies contain a provision that a 30-day notice will be given to ICEMA prior to cancellation
- Public providers must show evidence of liability protection in the form of copies of insurance policies official action of its governing body or other legal documents
- Evidence of Worker's Compensation insurance

17. FEES

Provision of Medical Control	$2,500.00
Medical Control Compliance per Unit	$500.00

Application will not be processed without payment of fees, as established by ordinance or approved fee resolution as incorporated.

18. APPLICATION MAP (FOR NEW APPLICANTS ONLY)

Attach a map and outline the area for which you will provide ALS service.

19. 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