MINNESOTA
OFFICE OF EMERGENCY
MEDICAL SERVICES

Ambulance License Application Form

Enclosed are instructions and forms to apply for a new ambulance service license or to change a current level of service in the State of Minnesota.

If you are seeking one of the following services, contact your EMS Specialist, and proceed no further with this application:

- **Transfer of ownership of a license**
- **Any changes to the Primary Service Area**
- **Relocation of the base of operations**

For technical assistance in completing this application, please contact the appropriate EMS Specialist from the Office of Emergency Medical Services staff personnel list. OEMS staff can be reached at info.oems@state.mn.us or by calling 651-201-2800.

All application materials and applicable fees must be mailed to:

Office of Emergency Medical Services
335 Randolph Ave
Saint Paul, MN 55102

An application received by the OEMS is reviewed initially for completeness by staff. The application is considered complete when all information and documentation has been received as required by Minnesota Statute and Administrative Rule governing ambulance operations in Minnesota. Official notice will be published in the ***Minnesota State Register*** and appropriate newspapers as required by statute. The applicant will be billed for all notices published. The OEMS will forward copies of the **Notice of Completed Application and, if applicable, Notice of Order for Hearing** to appropriate agencies as required by statute.

Carefully review Minnesota Statutes, Section 144E.11, wherein the requirements and process for ambulance license applications are described.

Enclosures:

- Fee Statement
- Instructions and Application: Part I
- Instructions and Application: Part II
- Primary Service Area Requirements
- OEMS Staff Directory

Minnesota Ambulance Service License Application Fee Statement

The initial application fee for a license to operate an ambulance service or to offer a new type of ambulance service is **$150.00.**

The fee must accompany the enclosed application.

Attach a check or money order made payable to "Treasurer, State of Minnesota" to this application.

Upon approval of a new license, an additional fee for each vehicle will be assessed.

Applications must have payment submitted to be considered COMPLETE.

Minnesota Ambulance Service License Application Instructions: Part I

Provide all information requested by this application form, making sure to sign the last page. Incomplete applications will be returned. The review and decision by the Office of Emergency Medical Services (OEMS) will be made based on information provided in this application. If you have questions regarding this application form, please contact OEMS staff for assistance.

1. Service Name and Information

- The service name must be the public business name.
    - This will be the name visible to the public on the issued license and ambulance vehicles.
- All correspondence from the OEMS will be mailed to the provided mailing address.
- *Manager* – This is the person to contact at the business phone number. This person must be familiar with the general management and operation of the entire service.

2. Contact Information

- Provide the business phone number and fax number (if applicable) of management during normal business hours. Provide an alternate phone number if necessary, and pager number (optional.) Include area codes with all numbers. Please include an email for service management. The OEMS uses email for important communications.

3. Base of Operations

- Provide the street address for the base of operation. This must ***not*** be a post office box number.

4. Type of Service

- Check the type of service for the proposed license.
- A Minnesota based and licensed ambulance service must apply for a new license to provide a new type of service (e.g., to change type of service from basic to advanced life support, etc.).

5. Type of Operation

- Check the type of operation that best describes who is, or will, be responsible for operating this ambulance service. Check one box only.

6. Volunteer Status

- Check the box that describes the volunteer status of the employees. A volunteer ambulance attendant is defined as a person making less than $6000 per year from their services on the ambulance and whose livelihood does not depend on the volunteer pay. “Mix Paid/Volunteer” includes a service with at least one person paid along with volunteers.

7. Ownership

- Provide the name of the person, partnership, association, corporation, or unit of government applying for this ambulance license. If this entity is incorporated within the State of Minnesota, give the official corporate name.
- Provide the address to direct correspondence specifically for the owner of the service. (e.g., city, government offices, corporation, etc.).
- Check the appropriate box that describes the legal status of the applicant identified as the owner. (e.g., a city fire department would check "city").

8. Substations

- List locations (if applicable) that are distinct from the base of operation and from which additional vehicles, personnel and equipment will operate. These must also be a street address, not a PO box number.

9. Medical Director(s)

An ambulance service is required to have a Minnesota licensed physician medical director.

- Provide the name, address, phone number, and email of the physician medical director(s) with whom the service has a written agreement to provide medical direction. The agreement with the Medical Director must include statements that the physician will:

    - Approve standards for training and orientation of personnel.
    - Approve standards on upgrading and purchasing equipment.
    - Establish all standing orders for the provision of adult and pediatric patient care.
    - Establish triage, treatment, and transportation protocols for adult and pediatric patients.
    - Participate in the development of an internal quality assurance program.
    - Establish written procedures for administration of medications.
    - Assure annual skill verification of ambulance personnel.

- If applying for license as an advanced or advanced-specialized ambulance service, submit with this application a copy of all appropriate documentation including standing orders, contract for services, and a statement from the physician medical director stating in detail precisely what equipment will be carried on licensed vehicles. Copies of these documents must be maintained in a license file with other required documentation. It is necessary to require copies of this documentation to assure adequate

information for the OEMS review of initial license of advanced service. All such statements must be maintained in the licensee's files for inspection by the OEMS EMS Specialist after a license is issued.
- State whether the physician(s) has been trained in Advanced Cardiac Life Support and/or Advanced Trauma Life Support.
- State whether the medical director volunteers his/her services.

10. Affiliated Medical Institution/Base Hospital

- If the ambulance service is affiliated with a medical institution / base hospital provide the name, address, phone number, email, and administrator's name for the affiliated medical institution.

11. Mutual Aid Agreements

- Ambulance services must provide documentation of one local mutual aid agreement (Minnesota Statute 144E.101 Subd. 12(a). It is suggested, but not required, that a mutual aid agreement be established with at least one "advanced" ambulance service, if possible, for possible intercept and for potential disaster situations.
- Provide the name, EMS #, and location of the base of operation for at least one neighboring service (Minnesota-licensed), with a written agreement to provide back-up coverage. This back up coverage agreement is required. Copies of these agreements must be submitted with the application.
- If the applicant / service has any pre-arranged mutual aid agreements allowed under 144E.101 Subd. 12(b) (commonly known as 12/24-hour agreements), copies of those agreements must be submitted with the application.

12. Response Times

- Estimate the maximum response time at maximum allowable speeds to the most distant part of the proposed primary service area (MR 4690.3400.) The initial designation of a primary service area is based in part on the anticipated maximum response time to the most distant boundary. Provide as an estimate of the average response times for all runs.
- If this application is for "specialized" license, specify travel times within the requested PSA. If travel times are not applicable (e.g., fixed wing aircraft or helicopters), enter not applicable.

13. Population to be Served

- Provide up-to-date census information for persons residing within the boundaries of the requested primary service area and an estimate of the number of visitors to the area on an annual basis. The EMS regional program or community health service agency may be of assistance in providing this information.

14. Utilization

- Estimate the number of each type of run anticipated by the proposed service in the next 12-month period.
- If applying for an advanced license, estimate each type of run even if all calls will have advanced response.
- Specialized advanced or specialized basic transports are made according to a pre-arranged schedule (patient transfers during which care was offered or provided).

15. Revenue and Cash Contributions

If exact financial data is not available, estimate as accurately as possible. Current license holders applying for a different level of service must provide financial projections for the new type of service, not the current level of service.

- Estimate the total operating revenues from each of the following sources during the next twelve-month period:

  Annual from operations: include patient fees for services and third-party payments from all sources of insurance, including public, private, and self-pay.

  Annual non-operating revenue: include all revenues received which are not directly related to the provision of a specific service to a particular individual. Revenues include grants, gifts, donations, subsidies, reimbursement for volunteer training, contracts, interest payments.

16. Revenue Sources

- Estimate of the percentage of revenue from the various sources that will be used to operate the service. Use whole numbers only.

17. Non-Cash Contribution

- State, regional, and local planning efforts can be enhanced if officials are aware that the public is contributing to ambulance services. The estimated cash value of donated contributions to the proposed service are reported here. Do not include contributions or costs already included in item 16.

  Volunteer staffing: If the service will be staffed by volunteers, use at least the minimum wage multiplied by the number of hours volunteer staff is on active call. By law, a licensee must always have at least two persons available. Also include donated time for training, medical direction, and administration.

  Equipment, vehicles, facilities, space: If the service will pay no rent for its use of a base of operation or substation, include an estimate of the value of this space from the donating source (city, hospital, etc.). Provide estimates of other non-cash contributions to the service for major items of equipment (radios, pagers, defibrillator, etc.) and vehicles received during the first year of service.

Other Contributions: Provide the estimated value of donated supplies, publicity, insurance, and other contributions for which no cash is received.

18. Average Patient Charges

- Provide average patient charges for each type of service listed. Standard charges are acceptable provided it is a meaningful estimate of the average charge made per patient. If charges vary dependent on type of service provided, estimate the average charge per patient for each type of service listed and explain fully on an attached sheet.
- Use definitions for the three categories of service described in number 14 above. If uniform charges are made regardless of the type of service provided, the average charge will be the same for each category of service provided. If more convenient, attach a standard charge sheet for the service.

19. Expenses

- Provide total estimated annual operating expenses in each of the following categories:

  Personnel: Includes all employee salaries, fringe benefits and training costs. This also includes nominal stipends paid to volunteers.

  Capital Related: Includes depreciation computed for the purchase of reusable equipment (ambulances, radio, pagers), the cost of purchasing, renting, and improving buildings, interest expense on capital-related items, etc.

  Estimated Uncollectible Accounts: Includes losses from service charges which were uncollectible, due to bad debts or lack of third-party reimbursement.

  Vehicle Operations: Gasoline, repairs, tires, licenses, etc.

  All other expenses: Includes non-vehicle license fees, insurance, equipment maintenance and repairs, consumable supplies, rent payments, taxes, etc.

20. Method of Accounting

- Indicate the method of accounting used by the service.

21. Personnel

- Provide the name and phone numbers of individuals responsible for the following:
  - **On-Site Inspection:** A person available during the day that can be located for an on-site inspection of the service by an OEMS representative.
  - **Training:** A person responsible for maintaining current ambulance personnel training records.

22. Radio Communications

Pursuant to 144E.103 Subd. 5 ambulance services are required to have a two-way radio capable of communicating with the licensee's communications base and all points in the licensee's primary service area (MR 4690.2000.)

23. Current Personnel Roster

- Provide the number of attendants and drivers on the service roster who possess current registration / certification at one of the stated levels of training.
- Provide a copy of a current roster including the name and certification level (Minnesota EMR, EMT, AEMT or Paramedic) card # and the expiration date of the card. If qualified personnel have not yet been identified, provide a plan for hiring or training personnel. A roster form is provided for completion, or you may attach a separate roster containing the applicable information.

24. Vehicles

- List each vehicle to be licensed as an ambulance. If vehicle(s) have not been acquired, list the specifications proposed for vehicles.

25. Certification of Accuracy

- Sign the application or it will be considered incomplete and returned. OEMS staff will determine whether an ambulance license application is complete. The decision may be to accept an application or to request additional information.

Application Requirements – Part II

A complete application must address each of the following four criteria found in Minnesota Statutes 144E.11, subdivision 6. Address each statutory requirement separately, attach the corresponding documentation, and record the attachment in the table provided at the end of the application.

1. Letters of Support

- **Statute:** The recommendations or comments of the governing bodies of the counties, municipalities, community health directors as defined under MS 145A.09 Subd. 2, and emergency medical services system designated under MS 144E.50, in which this service would be provided.
    - **Explanation:** Submit written recommendations or comments in support of this application from the governing bodies of the counties, municipalities, community health directors and emergency medical services systems in which this service will be provided. Letters of support can be submitted as part of the application or directly to the OEMS. Please note that for purposes of license application review by the OEMS, only official letters from governing bodies of counties, municipalities, community health directors, and regional emergency medical services systems (144E.50) meet this statutory requirement.

2. Deleterious Effects on the Public Health Caused by Duplication of Service

- **Statute:** The deleterious effects on the public health from duplication, if any, of ambulance service that would result from granting this license (MS 144E.11 Subd. 6(2)).
    - **Explanation:** List providers of ambulance service whose state-designated PSA overlaps with your proposed PSA. Document fully how duplication of service will be a positive benefit for providers and consumers in the PSA requested.
- If other providers do not comment on / or object to the application, the applicant has the duty of demonstrating that the duplication in service will not create deleterious competition.

3. Effect on Public Health

- **Statute:** The estimated effect of the proposed service, or expansion in PSA on the public health.
    - **Explanation:** Document fully how the proposed new service or proposed change in license will:
        - benefit in a positive way the health status (mortality, morbidity) of the population to be served.
        - affect any specific health problems of the population to be served.
        - provide a more positive public health benefit in the proposed or current PSA than is now available.

4. Costs Associated with Change in Service

- **Statute:** Whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, or expansion in primary service area.

- **Explanation:** Describe how the benefits of the proposed new service or change in license outweigh the cost of providing the service. Provide any documentation that clarifies costs associated with a proposed licensing upgrade.

Requirements for Primary Service Area Description

The OEMS has the duty to examine each application from an EMS system-wide perspective. The OEMS must determine whether granting a new or upgraded license is in the best interest of the public health based upon the evidence contained in the record, and other applicable evidence including various court decisions that have been interpreted and applied to the ambulance licensing law.

Minnesota Rules, part 4690.3400 describes the requirements for initial designation of a PSA. Describe your **proposed** PSA using the township and range number (i.e., T110NR24W), or if not changing a current state designated PSA, submit a copy of your current PSA as part of the application. If providing a description, use **whole sections** within townships in your PSA. **Do not** use popular township names or describe partial sections within townships. Also, submission of a map showing PSA boundaries would be helpful. Mark on the map the base of operation location with a B and any substation locations with an S.

Neighboring services wishing to clarify existing overlapping PSAs or engage in a process to redefine existing PSA boundaries should contact an EMS Specialist to begin the Summary Approval process outlined in MS 144E.07, and do **NOT** proceed with this application.

Required Criteria for a Specialized Ambulance Service License Application

A prospective licensee must obtain a license to provide a new type or types of service (Minnesota Statutes 144E). An application must be completed on a form provided by the OEMS. This application form is part of this packet.

- **OEMS Application Form - Part I:** Application form Part I is described above, but special attention must be made to the following required documentation:

  Agreement with Medical Director. This agreement must include statements that the physician will:

  - Approve standards for training and orientation of personnel.
  - Approve standards for purchasing equipment and supplies that impact patient care.
  - Establish all standing orders for the provision of adult and pediatric patient care.
  - Approving written triage, treatment, and transportation guidelines for adult and pediatric patients.
  - Participate in the development of an internal quality improvement program.
  - Provide written procedures for the administration of medications.
  - Assure an annual skills verification of each person on the roster. (MS 144E.265)

A medical director's agreement is required even if an arrangement has been made to have nurses or physician assistants from the hospital provide staffing for interfacility transports.

Protocols: Protocols (adult and pediatric) must be submitted as part of the application. For advanced services these protocols must include a list of narcotics that have been approved for use in the ambulance, and the policy for disposal and storage.

Mutual Aid Agreements: Mutual Aid Agreements are typically not required of specialized services, but it is recommended that an agreement with another licensed service be available for back-up in case of service unavailability or a disaster situation.

Personnel Roster: If available a roster must be submitted. If qualified personnel have not yet been identified, provide a plan for hiring or training personnel. Personnel identified on the roster must meet requirements of MS 144E.101 subdivision 11. If personnel are not EMTs and / or Paramedics, documentation must be submitted that indicates that all attendants are trained to use all the equipment in the ambulance.

Schedule of Services. A specialized license is one that provides basic or advanced ambulance services and is different from an "emergency" basic or advanced ambulance service in that it restricts its operation to specific hours of the day (it may identify daytime operations only), specific segments of the population (such as transfers from one health care facility to another or services by air), or certain types of medical conditions (cardiac care services, neo-natal services). The most common type of specialized service is for advanced specialized ambulance service that provides inter-facility transfers beginning from a designated health care facility. A schedule of operations must be submitted with the application that details any provision of care that does not fall under the normal standard of care provided by an emergency ambulance provider. A schedule may include, but is not limited to:

- the use of registered nurses rather than EMTs or paramedics as attendants. (If using nurses from the hospital, a copy of the agreement between the ambulance service and hospital should be submitted)
- use of prepackaged equipment
- neo-natal services only.

Any provision of the rules may be waived or changed as part of a schedule. To request a waiver or variance to any part of the MN Rules 4690, the applicant must explain how the proposed change will benefit the public health.

- **OEMS Application Form - Part II:** Part II of the license application requires that four specific criteria in MS 144E be addressed. These criteria are a very important part of the application process and are used by the OEMS to make a final decision.

- **Complete Application / Decision from the OEMS**. The OEMS will decide on whether the ambulance license application is complete and begin the public review process. After it is determined that an application is complete, the public review process usually takes from two to four months, including the

OEMS final decision. This assumes a “non-controversial” public process. If a decision to approve the license is made, a successful inspection must occur prior to beginning the operation of the service.

Part I - Application for License to Operate an Ambulance Service in Minnesota

Check all that apply:

☐ **INITIAL LICENSE (Any level)**

☐ **CHANGE IN TYPE OF SERVICE (BLS to ALS or ALS to Part-time ALS)**

☐ **RELOCATION OF BASE OF OPERATIONS TO NEW MUNICIAPLITY OR TOWNSHIP (if required under MS 144E.15)**

☐ **EXPANSION OF PSA**

1. Service Name

Service Name		
Business Address		
City	**State**	**Zip**
Manager		

2. Phone Numbers

Daytime
Alternate / Pager
Fax
Email

3. Base of Operation

Address or location		
City	**State**	**Zip**
County		

4. Type of license(s) being requested

☐ **Basic Ambulance**

☐ **Basic Ambulance Specialized**

☐ **Basic Ambulance Specialized (Air)**

☐ **Advanced Ambulance**

☐ **Advanced Ambulance Specialized**

☐ **Advanced Ambulance Specialized (Air)**

☐ **Part-time Advanced Ambulance**

5. Type of Operation

☐ **Fire**

☐ **Hospital**

☐ **Police**

☐ **Private**

☐ **Other Public Service**

☐ **Other**

6. Volunteer Status

☐ **All Volunteer**[1] ☐ **Mix Paid/Volunteer** ☐ **All Paid**

7. Ownership

Owner Name		
Business Address		
City	**State**	**Zip**
Owner Email		**Phone**

Ownership Type

☐ **County** ☐ **U.S. PHS** ☐ **Other Nonprofit**
☐ **City** ☐ **Federal** ☐ **Partnership**
☐ **City/County** ☐ **Nonprofit Corporation** ☐ **For Profit Corporation**
☐ **Hospital** ☐ **Individual** ☐ **Tribe**

License Owned by a Licensed Health Care Facility ☐ **Yes** ☐ **No**

8. Substations

List substation location(s) where vehicles, personnel or equipment will be located (substations must be within the primary service area.)

Address or location			
City	**State**	**Zip**	**County**

Address or location			
City	**State**	**Zip**	**County**

Address or location			
City	**State**	**Zip**	**County**

[1] Volunteer ambulance attendant is defined as a person making less than $6,000 per year from their services to the ambulance and show livelihood does not depend on the volunteer pay.

9. Medical Directors

Physician's Name		
Address		
City	State	Zip
Email		Phone

Has the physician been trained in Advanced Cardiac Life Support? ☐ **Yes** ☐ **No**

Has the physician been trained in Advanced Trauma Life Support? ☐ **Yes** ☐ **No**

Does the physician volunteer their services as medical director? ☐ **Yes** ☐ **No**

10. Affiliated Medical Institution/Base Hospital (if any)

Institution Name and Address		
City	State	Zip
Hospital Administrator		
Email		Phone

11. Mutual Aid

List current written agreements with Minnesota licensed service(s) to provide back-up coverage for ambulance service. Submit a copy of each agreement submitted with this application.[2]

Mutual Aid Service		EMS Number
City	State	Zip

Mutual Aid Service		EMS Number
City	State	Zip

Mutual Aid Service		EMS Number
City	State	Zip

[2] Agreement must be current, signed, and reviewed at least every 24 months. Attach additional sheets if necessary.

12. Response Times

Estimate the maximum and average response times from the base of operations or substation(s) to the most distant point within your primary service area.

Maximum Response Time		**Minutes (most distant point)**
Average Response Time		**Minutes**

List the maximum distance from your base of operations or substation to the most distant point in your primary service area:

	Miles

13. Population to be Served

Provide the estimated population of residents and visitors in your primary service area (scheduled services need not answer).

Residents		**Visitors**	

14. Utilization

Provide estimates for each type of ambulance run anticipated in the next twelve months.

Basic Runs	
Basic Specialized Runs	
Advanced Runs	
Advanced Specialized Runs	
Total Runs (All Types)	

15. Revenue and Cash Contributions

Estimate the total operating revenue from all sources for the 12 months:

Annual from operations (fees for services, third party payment, etc.	**.00**
Annual non-operating revenues (subsidies, gifts, grants, contracts, interest, etc.)	**.00**
Total Revenue and Cash Contributions	**.00**

16. Revenue Sources

Estimate the approximate percentage of revenue and cash contributions received from each of the following sources (these should total 100%). Round to the nearest **whole** percentage.

Third party payment (Medicare, Medicaid, Private Insurance)	**%**
Patient charges (direct payment method)	**%**
Community Health Service subsidy	**%**
Other public subsidy or grant	**%**
Private grants, personal gifts	**%**
Training reimbursement	**%**
Other – specify	**%**
Total	**%**

17. Non-Cash Contributions

Estimate the financial value of in-kind contributions for the next 12 months:

Volunteer staffing (including medical director)	**.00**
Equipment, vehicles, facilities, space	**.00**
Other contributions (supplies, publicity, insurance, etc.)	**.00**
Total Annual Contributions	**.00**

18. Average Patient Charges

Provide the expected patient charge for the first 12 months of service:

ALS average patient charge (including scheduled)	**.00**
BLS average patient charge (including scheduled)	**.00**
Special transportation average patient charge (non-medical)	**.00**

19. Expenses

Provide estimated annual operating expenses for the next 12 months at the level of service specified by this application:

Personnel (salary and fringe)	**.00**
Capital-related (depreciation, interest on loans, etc.)	**.00**
Estimated uncollectible accounts	**.00**
Vehicle operations	**.00**
All other expenses	**.00**
Total Annual Expenses	**.00**

20. Method of Accounting

☐ **Accrual** ☐ **Cash** ☐ **Other, specify_____**

21. Personnel

Provide the names and telephone number for individuals responsible for the following:

On-site Inspection by the OEMS:

Name	**OEMS #**	**Phone**
Email		**Mobile**

Training and Continuing Education for Personnel:

Name	**OEMS #**	**Phone**
Email		**Mobile**

22. Radio Communications

	Initial here attesting that vehicles are equipped with 2-way communication devices in accordance with MR 4690.2000.

23. Personnel Roster

List the number of personnel on the service roster with current registration / certification at the following levels. List the highest level for each employee.

	Volunteer[3]	**Paid**
Emergency Medical Technician		
Advanced Emergency Medical Technician		
Paramedic		
Emergency Medical Responder		
Other (RN, MD, PA)		
Total number active on roster		

[3] Volunteer ambulance attendant is defined as a person making less than $6,000 per year from their services to the ambulance and whose livelihood does not depend on the volunteer pay.

Current Active Roster

The current active roster must include the full name, current certification / registration level, Minnesota OEMS number, and expiration date for each member of the service. All active personnel with an expired registration / certification are NOT able to work on an ambulance; there is no grace period for persons on the active roster for a licensed ambulance service. ***Do not submit copies of cards with this roster.***

Name (Last / First / MI)	Qualification (EMR, EMT, AEMT, Paramedic)	OEMS#	Expiration Date	Paid / Volunteer

24. Vehicles

List current or expected vehicle(s) to operate the proposed service. Add additional rows or pages as needed.

VIN #	Year	Make	Model	Unit #	Box Manufacturer	Chassis Remount (Y/N)

- **VIN #**
- **Year:** year vehicle was manufactured
- **Make:** make of the vehicle (e.g., Chevrolet, Ford, etc.)
- **Model:** Chassis model (E350, ProMax 2500, etc.). If other than ground vehicle, list type (fixed wing, rotor wing, etc.)
- **Unit #:** unit number assigned to vehicle by the ambulance service.
- **Box Manufacturer:** maker of the patient compartment
- **Chassis Remount:** Yes or No

25. Attestation

I attest that the information contained in this application and its attachments is true and correct to the best of my knowledge.

Signature of company officer or legally authorized official **Date**

Title **Phone**

Required Documentation

Attachments listed must be submitted with any application for a new service. Attachments may vary depending upon the specific application and type of service. The application process will not begin until the application is complete. Allow an ample amount of time for the entire license process to be completed. Use the following checklist to ensure you have attached the required documentation. Please list **ALL** attachments in the table below.

- ☐ **Medical Direction Agreements**
- ☐ **Guidelines / Protocols for Adult and Pediatric Patients**
- ☐ **Mutual Aid Agreements**
- ☐ **Personnel Roster**
- ☐ **Application Part II documents**
- ☐ **Completed Table of Attachments**

Attachments

Add rows to table as needed.

Number	Name