Maryland Institute for Emergency Medical Services Systems
Office of Commercial Ambulance Licensing & Regulation
653 West Pratt Street
Baltimore, MD 21201-1536
Office: (410) 706-8511 - Fax: (410) 706-8552

Commercial Ambulance Services

SPECIALTY CARE TRANSPORT (SCT) APPLICATION

Company Name:

For Office Use Only

Date Application Received ___/___/___

Date Equipment Inspected ___/___/___

Date Licenses Issued ___/___/___

CAREFULLY READ THE INSTRUCTIONS AND COMPLETE ALL AREAS.

Ensure all boxes are checked and the required documents included with the application submission.

SUBMIT THE REQUIRED INFORMATION AND DOCUMENTS: *Check if COMPLETE*

- ☐ Completely answer all questions
- ☐ Sign and date the Certification on the last page
- ☐ Submit the original application electronically
- ☐ Submit legible copies of Governmental Identification for all those listed on application
- ☐ Submit completed application along with the following attachments:
- ☐ **Signed SCT Medical Director Agreement and supporting documentation.** Your company and the SCT medical director must engage in a Medical Director Agreement. This document must be signed by the SCT medical director acknowledging the responsibilities required under COMAR Title 30. A copy of this agreement is attached to this packet.
- ☐ Executed assistant SCT Medical Director delegation as applicable.
- ☐ Copy of approved **Medical Director's Standing Orders** with supporting documentation for SCT transport and the program in general
- ☐ **Completed vehicle list** and supporting documentation as applicable.
- ☐ Completed and **Approved SCT Medication List.**
- ☐ Completed **SCT Nursing Personnel List**.
- ☐ ____ Number of SCT equipment sets (indicate total number in space provided)
- ☐ Ensure all current personnel are appropriately affiliated with your service.
- ☐ Fee(s) in the form of a check made payable to "MIEMSS/SOCALR." Refer to SOCALR fee schedule (see appendix) for current licensing fees.
  - SCT service fee
  - New vehicle licensing fees as applicable.
- ☐ Sign and date the Application

COMPANY INFORMATION

Name of Commercial Ambulance Service (*registered with the Maryland DAT*): *SOCALR may **not** issue a license to an applicant whose name is confusingly similar to another doing business in Maryland*		
SCT Medical Director		
Name: (Last, First)	Maryland Physician License #: ****MUST ATTACH COPY OF LICENSE****	
Address:	Federal DEA License #: ****MUST ATTACH COPY OF LICENSE****	
City, State, Zip Code:	Email Address: ****REQUIRED****	
Telephone Number:	Cell Telephone Number:	Fax Number:
Hospital Program Affiliation:		
Has the Medical Director approved and signed the Medical Director Agreement? ☐ No ☐ Yes ****MUST BE ATTACHED****		
Associate SCT Medical Director		
Name: (Last, First)	Maryland Physician License #: ****MUST ATTACH COPY OF LICENSE****	
Address:	Federal DEA License #: ****MUST ATTACH COPY OF LICENSE****	
City, State, Zip Code:	Email Address: ****REQUIRED****	
Telephone Number:	Cell Telephone Number:	Fax Number:
Hospital Program Affiliation:		
Has the Medical Director approved and signed the Medical Director Agreement? ☐ No ☐ Yes ****MUST BE ATTACHED****		

Specialty Care Transport Vehicle List					
Designation Number:	Year / Make / Model:	VIN Serial Number:	Tag #	Inspection Cert. Date	To Be Licensed As:
1.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
2.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
3.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
4.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
5.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
6.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit
7.					☐ ALS w/ SCT Upgrade ☐ Dedicated SCT Unit

1. If vehicle is an addition to the fleet, submit new vehicle application and fee.
2. In accordance with COMAR 30.09.06.02D, only dedicated SCT units may be marked with the words “Specialty Care Transport”, “Specialty Care Ambulance”, “Mobile Intensive Care” or similar words implying, in the judgment of SOCALR, that the ambulance is licensed as an SCT commercial ambulance.

SPECIALTY CARE TRANSPORT - NURSING PERSONNEL LIST				
Employee Full Legal Name (PRINTED)	Type of Health Care License(s)	License #(s)	State(s) Licensed	Certification or License Expiration Date(s)
1	☐ RN ☐ NP ☐ COMPLETED MIEMSS BASE STATION COURSE DATE ____________________ **OR** ☐ CURRENTLY LICENSED EMS PROVIDER ☐ EMT-B ☐ CRT ☐ EMT-P			
2	☐ RN ☐ NP ☐ COMPLETED MIEMSS BASE STATION COURSE DATE ____________________ **OR** ☐ CURRENTLY LICENSED EMS PROVIDER ☐ EMT-B ☐ CRT ☐ EMT-P			
3	☐ RN ☐ NP ☐ COMPLETED MIEMSS BASE STATION COURSE DATE ____________________ **OR** ☐ CURRENTLY LICENSED EMS PROVIDER ☐ EMT-B ☐ CRT ☐ EMT-P			
4	☐ RN ☐ NP ☐ COMPLETED MIEMSS BASE STATION COURSE DATE ____________________ **OR** ☐ CURRENTLY LICENSED EMS PROVIDER ☐ EMT-B ☐ CRT ☐ EMT-P			

Attach additional pages as required

SPECIALITY CARE TRANSPORT (SCT) APPROVED MEDICATION LIST					
Medication trade name	Medication generic name	Indication	Dose	Route	Minimum amount to be carried[2]
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					

Attach additional pages as required

1. List of medications in addition to those required by the Maryland Medical Protocols for EMS Providers must be approved by the service's SCT Medical Director. The medications and list shall be carried on board the ambulance when in service for an SCT transport.
2. Sufficient quantities of medications shall be carried to care for the patient for the longer of one hour or two times the estimated time of transport.

Printed Name of Medical Director:	Date:
Signature:	

Owner Certification	
By my signature below I hereby affirm under the penalties of perjury that; (a) There has been no attempt for the purpose of obtaining or attempting to obtain a license, to knowingly and willfully: (i) Falsify, conceal, or omit a material fact, (ii) Make any false, fictitious, incomplete, or fraudulent statements or representations, (iii) Make or use any false writing document, or entry knowing the same to contain any false, fictitious, fraudulent statement, and (b) The signer is authorized by the commercial ambulance service identified on the application to sign the application form to execute the sworn statement.	
Name of Applicant: (Last, First)	Title:
Signature:	Date:

SPECIALTY CARE TRANSPORT (SCT) MEDICAL DIRECTOR AGREEMENT

I, the undersigned physician, acknowledge that I have received and reviewed copies of the: (a) Commercial Ambulance Services regulations (COMAR 30.09); (b) Emergency Medical Services Operational Programs regulations (COMAR 30.03) and; (c) "Maryland Medical Protocols for Emergency Medical Providers", which is a document incorporated by reference in Title 30. I further attest that I meet the qualifications of a Specialty Care Transport (SCT) Commercial Ambulance Service Medical Director as stated in COMAR 30.09.14.02D including;

a) Qualifications as set forth in COMAR 30.03.03,
b) Educational experience in the care of the types of critically ill patients the service will transport,
c) Board certification in an appropriate specialty, and
d) Current active practice within a hospital clinical setting.

and agree to serve as a Specialty Care Transport Medical Director for

____ upon its licensure as a(n) _______________
(Name of ambulance service)

commercial ambulance service in accordance with the requirements of COMAR 30.09.

Furthermore, I agree to assume the following physician responsibilities as outlined in COMAR 30.03.03, including:

(a) Medical direction for the specialty care transport service,
(b) Medical direction to the commercial ambulance service's personnel related to specialty care transport,
(c) Medical oversight of patient care, (COMAR 30.03.03C (1) (a)).
(d) Approve, participate in and provide medical expertise for the commercial ambulance service in:
  (i) A comprehensive quality assurance plan covering all aspects of EMS patient care (COMAR 30.03.03C(1)(b)(i));
  (ii) Standard operating procedures for the EMS operational program under the "Maryland Medical Protocols for Emergency Medical Providers" (COMAR 30.03.03C(1)(b)(ii));
  (iii) Credentialing of EMS providers (COMAR 30.03.03C(1)(b)(iv));
  (iv) Review and approval of medical equipment used by the commercial ambulance service (COMAR 30.03.03C(1)(b)(v)); and
  (v) All aspects of the commercial ambulance service operations which impact patient care, including planning, development and operations (COMAR 30.03.03C(1)(b)(vi)).
(e) Timely approval of applications to MIEMSS for licensure and certification and renewal of licensure and certification for all EMS providers affiliated with the above named commercial ambulance service, (COMAR 30.03.03C91)(c)).
(f) Provision of training as required in specialty care transport, and provider training including:
  (i) remedial and continuing educational programs (COMAR 30.03.03C(1)(iii)); and
  (ii) skills review which meets the provider recertification and relicensing requirements (COMAR 30.09.07.02E(2))
(g) Use of consulting physicians when appropriate,
(h) Participation in the development and implementation of any patient care guidelines required for interfacility transport of critically ill patients including those guidelines to be followed by nursing personnel,
(I) In collaboration with nursing personnel, direction of the appropriate transport team configurations required for patients,

I agree to notify the State Office of Commercial Ambulance Licensing and Regulation of any change in address or telephone number and to notify the State Office of Commercial Ambulance Licensing immediately upon termination of my status as Medical Director for the above named service, as required in COMAR 30.09.

I acknowledge that all medical direction to the EMS providers of the above named commercial ambulance service, shall be in accordance with the "Maryland Medical Protocols for Emergency Medical Services Providers" (COMAR 30.03.03.02).

<table>
<tr><td colspan="2">Printed Name of Medical Director:</td><td>Date:</td></tr>
<tr><td colspan="3">Signature:</td></tr>
<tr><td>Maryland Physician License #:

MUST ATTACH COPY OF LICENSE</td><td colspan="2">Federal DEA License #:

MUST ATTACH COPY OF LICENSE</td></tr>
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