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
Inspection Application Packet

NEONATAL SERVICE INFORMATION

Company Name:

For Office Use Only

Application Received ___/___/___

Equipment Inspected ___/___/___

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 Medical Director Agreement.** Your company and the medical director must engage in a Medical Director Agreement. This document must be signed by the EMS operational program medical director acknowledging the responsibilities required under COMAR Title 30. A copy of this agreement is attached to this packet.
- ☐ **Approved Neonatal Medication List.**
- ☐ Ensure all current personnel are appropriately affiliated with your service.
- ☐ 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*

Neonatal 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 Neonatal 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****

Primary Perinatal / Neonatal Referral Center		
Name of Contact Person:	Title:	Office Number:
Email Address:		Cellphone Number:
Street Address:		Suite/Apt. Number:
City, State, Zip Code:		Fax Number:
Secondary Perinatal / Neonatal Referral Center		
Name of Contact Person:	Title:	Office Number:
Email Address:		Cellphone Number:
Street Address:		Suite/Apt. Number:
City, State, Zip Code:		Fax Number:
Third Perinatal / Neonatal Referral Center		
Name of Contact Person:	Title:	Office Number:
Email Address:		Cellphone Number:
Street Address:		Suite/Apt. Number:
City, State, Zip Code:		Fax Number:

Licensed Neonatal Transport Units					
Designation Number:	Year / Make / Model:	VIN Serial Number:	Tag #	Inspection Cert. Date	Location
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Neonatal Transport Personnel List

Only list those personnel not already listed on the general Personnel List . If some or all of these individuals are hospital employees, you may attach a list provided by the hospital.

Employee Full Legal Name (PRINTED)	Work Time * <20 hr/wk or >20 hr/week (Circle one)	Type of Health Care License or Certification (Circle what applies)	Health Care Certification or License #	State or states Licensed	Certification or License Expiration Date
1	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
2	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
3	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
4	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
5	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
6	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
7	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
8	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
9	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
10	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
11	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
12	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
13	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
14	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
15	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
16	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
17	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
18	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
19	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
20	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
21	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
22	<20 hrs >20 hrs	EMT-B CRT EMTP RN NP			
23	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
24	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			
25	<20 hrs >20 hrs	EMT-B CRT EMT-P RN NP			

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:

NEONATAL 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 Neonatal Commercial Ambulance Service Medical Director as stated in COMAR 30.09.12.02D(2) and agree to serve as a Neonatal Medical Director for

_____ upon its licensure as a(n) NEONATAL

(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 neonatal service,
(b) Medical direction to the commercial ambulance service's personnel related to neonatal care,
(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 neonatal care, 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)).

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).

Printed Name of Medical Director:	Date:
Signature:	
Maryland Physician License #:	Federal DEA License #: