



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

Licensing Application

CAREFULLY READ AND COMPLETE THE APPLICATION IN ITS ENTIRETY
Required supporting documentation must be included with application submission.

Submit the application to: SOCALR@miemss.org OR

Maryland Institute for Emergency Medical Services Systems
State Office of Commercial Ambulance Licensing and Regulation
653 West Pratt Street, Room 313
Baltimore, Maryland 21201-1536

For Office Use Only

Date Application Received ___/___/___

Date Ambulance(s) Inspected ___/___/___

Date Licenses Issued ___/___/___

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

This application is to be completed to obtain licensure from the Maryland Institute of Emergency Medical Services Systems (MIEMSS) as a Specialty Care Transport (SCT) service in Maryland. A commercial ambulance service must be licensed at the advanced life support (ALS) level prior to submitting this application. Further information regarding commercial ambulance licensing and regulations can be found at: (<http://www.miemss.org/home/commercial-ambulance>)

1. Complete and return the following documents for processing (Incomplete applications will be returned):

Completed *Specialty Care Transport Service Application*

Completed *Specialty Care Transport Nursing Personnel List*

Completed *Specialty Care Transport Approved Medication List*. This list must be approved by the service Medical Director and the State Medical Director.

Executed *Specialty Care Transport Medical Director Agreement(s)* and supporting documentation for each SCT Medical Director retained by the service.

Executed *Owner's Certification*.

2. Submit payment. The non-refundable service licensing fee for Specialty Care Transport is **\$500.00**, and must be paid upon application submission. SOCALR **DOES NOT** accept checks as a form of payment. For your convenience, SOCALR has adopted the ability to receive funds via ACH transfer, which offers an efficient payment process to all of our customers, and consequently, more efficient application processing. There are no transaction fees associated with this process, and it requires only a few easy steps for one-time setup. Beginning on February 1, 2018, all payments to SOCALR must be made via ACH, wire transfer, or credit card. Credit card payments may be made by contacting SOCALR at 410-706-8511.

Upon receipt, applications are reviewed for completion. All service SCT Medical Directors, and SCT Medication Lists must be approved by the State EMS Medical Director. Medical Directors must also attend an SCT Medical Director Orientation. SOCALR will contact the service to schedule this orientation upon approval of the SCT Medical Director. Upon completion of Medical Director Orientation, all SCT equipment will be inspected by SOCALR representatives prior to licensure as an SCT service.

SPECIALTY CARE TRANSPORT SERVICE APPLICATION

Commercial Ambulance Service Name:

Person to contact regarding this application:

Name:

Phone:

Email:

SCT Medical Director

Name:

Address:

Phone:

Cell:

Email:

SCT Coordinator

Name:

Licensure Level:

Paramedic

RN

Other:

Phone:

Cell:

Email:

SPECIALTY CARE TRANSPORT NURSING PERSONNEL LIST

(A printout listing identical information will be accepted in lieu of completing this section)

Employee Full Legal Name (PRINTED)	Type of Health Care License(s)	License #(s)	State(s) Licensed	Certification or License Expiration Date(s)
	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				
2	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				
3	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				
4	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				
5	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				
6	RN NP			
Completed: COMPLETED MIEMSS BASE STATION COURSE (Date: _____); OR CURRENTLY LICENSED EMS PROVIDER (CHECK: EMT CRT Paramedic)				

Attach additional pages as required

SPECIALTY CARE TRANSPORT MEDICAL DIRECTOR AGREEMENT

I, the undersigned physician, acknowledge that I have received and reviewed a copy of the Commercial Ambulance Services regulations (COMAR 30.09). I further attest that I meet the qualifications of a Specialty Care Transport Commercial Ambulance Service Medical Director as stated in COMAR 30.09.14.02(D), 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.

I agree to serve as Specialty Care Transport Medical Director for upon its licensure as a Specialty Care Transport 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 30.09.14, including:

- a) Use of consulting physicians when appropriate,
- b) 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,
- c) In collaboration with nursing personnel, direction of the appropriate transport team configurations required for patients,
- d) Provision of training as required in Specialty Care Transport, and
- e) Participation in a quality assurance program as described in COMAR 30.09.14.02(D).

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 Specialty Care Transport Medical Director for the above named service, as required in COMAR 30.09.14.

Please affix copies of:

- Current Maryland physician license
- Current CV
- Board certification(s)
- Updated QA/QI Plan in accordance with COMAR 30.09.14.02D.

(SCT Medical Director's Printed Name)

(SCT Medical Director's Signature)

(Date)

Owner's 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.

(Printed Name)

(Title)

(Signature)

(Date)