NOVEMBER 1981

Status Report with Updated Data

for

COMPREHENSIVE PLAN

for

EMERGENCY MEDICAL SERVICES, 1981.

* ABRIDGED 1980 EDITION *

STATE OF INDIANA

EMERGENCY MEDICAL SERVICES COMMISSION

315 STATE OFFICE BUILDING

INDIANAPOLIS, INDIANA 46204

TABLE OF CONTENTS

** ABRIDGED EDITION **

FORWARD TO THE NOVEMBER 1981 STATUS REPORT

for the

COMPREHENSIVE PLAN FOR EMERGENCY MEDICAL SERVICES (1980)

Since the adoption of the Comprehensive Plan for Emergency Medical Services on March 21, 1980, much progress has been made toward development of an EMS system that is responsive to the needs of all Indiana residents. As detailed in Section V of this update, of the Plan's 142 activities, 88 have been accomplished or are in progress. Because of these accomplishments, and because needs of the State and the regions will change, and new needs will be identified, the State EMS Plan will undergo a major revision and update in 1983. The 1983 edition of the Plan will present not only a State-wide overview, but will also represent the unique needs of each region of the State through an aggregation of Regional EMS Plans prepared by the Regional Coordination Centers (RCC's).

However, with the progress that has been made, and with the RCC's developing Regional EMS Plans , there are at least two reasons why an update is necessary now. First, it provides a status report on each activity of the Plan, which will allow evaluation of the Plan's implementation. Secondly, this volume includes an updated data base containing current figures pertaining to EMS resources which will assist Regional Coordination Centers and others in their planning and evaluation efforts.

This abridged edition contains Sections I,III, IV and V of the Comprehensive Plan. Section I has been updated to include the newest revisions to both the rules and regulations and the enabling legislation. Section V has also been revised to indicate the current (November 1981) status of each activity. As with the 1980 abridged edition, readers are referred to the complete Comprehensive Plan for Emergency Medical Services for additional information.

Philip K. Martin
Executive Director

INTRODUCTION

The State of Indiana Comprehensive Plan for Emergency Medical Services is intended to provide direction in developing a network of effective, cooperative and comprehensive emergency medical service systems across the State.

The "systems approach" to emergency medical services development has been endorsed by the lead agency in EMS for the State, the Indiana Emergency Medical Services Commission. An EMS system is defined by the Department of Health, Education and Welfare as:

> "A system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occuring as a result of the patient's condition or because of natural disasters or similar situations)."*

The EMS system consists of the following components as a minimum:

1. Manpower
2. Training
3. Communication
4. Transportation
5. Facilities
6. Critical Care Units
7. Public Safety Agencies
8. Consumer Participation
9. Accessibility to Care
10. Transfer of Patients
11. Coordinated Medical Recordkeeping
12. Public Information and Education
13. Evaluation
14. Disaster Linkage
15. Mutual Aid Agreements

In this plan, Management of the EMS system is considered to be a 16th component. Also, because of their similarity, Facilities and Critical Care Units have been combined.

The Plan outlines a means for establishing EMS regions for planning and a method of designating regional entities which have the resources and the authority from the Commission to plan, develop, and direct regional EMS systems throughout the State. To insure the appropriateness and region-wide support of these "Regional Coordination Centers" (RCC's), they will be structured so as to include providers, consumers, etc., in their management structure. The RCC's then, will identify specific objectives for their respective regions while utilizing the state-wide Goal, Sub-Goals and Objectives of this Plan as guidelines for system development. The Objectives to be addressed state-wide are subject to modification during all phases of the planning process and in subsequent updates of the Indiana Comprehensive Plan for Emergency Medical Services.

The regional EMS system plans, developed by the Regional Coordination Centers should include (at a minimum) all components contained in Section III and the Sub-Goals and Objectives contained in Section IV. Due to differing local needs and resources, the State EMS Plan does not identify every possible goal, objective and activity that may be necessary to achieve a complete EMS system in the State. However, those that Section IV does contain are recognized as priorities by the EMS Commission for the Regional Coordination Centers.

*Emergency Medical Services Program Guidelines, DHEW, August 1979

PREFACE

The Emergency Medical Services Commission, created by Indiana Code 16-1-39, is charged with promoting "the establishment and maintenance of an effective system of emergency medical services..." Pursuant to the provisions of this act, the State of Indiana Comprehensive Plan for Emergency Medical Services has been developed. The adoption by the Emergency Medical Services Commission of this plan represents the culmination of months of intensive development and the labors of many individuals and agencies.

The EMS Commission, by statute, is the lead agency in the development and maintenance of the system, both through this plan and through the establishment of quality standards (both regulatory and recommended). However, operational decisions should remain at the provider level, and should function within a regional system for optimal patient care. Individual regions throughout the state should define and further refine regional EMS System plans to fit the specific needs of their area, consistent with, and within the conceptual framework of the State Plan.

The State Plan consists of nine discrete sections which when taken together will provide direction to all concerned parties in the development of a comprehensive system of emergency medical services in Indiana.

Section I, Organization for EMS Planning and Implementation, presents a thorough description of the organizational structure of the State EMS Commission, its authority, and its relationship to other groups and agencies.

Section II, Planning Information, divided into two subsections: EMS Resources and Description of Program Area. EMS Resources lists all existing available EMS resources (facilities, manpower, equipment, etc.) for which data is currently obtainable. It is similar to Section I in that it is to be viewed as a point of reference as the comprehensive system is developed. Description of the Program Area is a compilation of various natural and man-made features of Indiana.

Section III, EMS System Components and Affecting EMS Commission Regulatory Standards, also contains two subsections, which are presented concurrently, rather than sequentially. Coupled with each explanatory definition of a system component is a citation of the EMS Commission Rules and Regulations affecting it. If none exists, this is so noted.

Section IV, Program Objectives and Implementation, is comprised of the overall system sub-goals for each component, the objectives necessary to meet those sub-goals, and the specific activities required by the identified entities to implement the system.

Section V, Implementation Schedule, is the time-table for plan and system implementation. By presenting a quantified listing of when actions are to be undertaken, direction is given to those entities responsible for them. This will also facillitate periodic review and measurement of system development.

Section VI, Program Resource and Commitment Summary, matches all agencies and entities involved in development and implementation of the plan, with the specific actions for which they are responsible.

Section VII, Budget Schedule, details by specific action the EMS Commission's financial obligation to system development and implementation.

Section VII, Appendix, contains data and elements supportive of the entire plan, including the approved Communications Plan and the IHERN Manual.

The overall outline of the plan was endorsed by the EMS Commission in September 1979, and represents a systems approach to Emergency Medical Services planning and implementation. The Plan contains all sections and components recommended by both the Departments of Transportation and Health, Education and Welfare in accordance with Section VII, Standard 11 of the Highway Safety Act of 1966 and the EMS Act of 1973. The reasons this format was deemed appropriate are threefold.

First and foremost, it is practical. As the state and regions strive to plan and implement EMS systems, they will need to know: What man-made (auto-accidents, nuclear) and natural (snow, floods, etc.) dangers exist; what resources are currently available to respond to these dangers (facilities, manpower, equipment, etc.) and within what context (terrain, roads, climate, rules and regulations) they will function. Also state-wide program objectives need to be clearly spelled out, as does identification of who is responsible for implementing these objectives.

Secondly, by using a format acceptable to the Department of Transportation, the state will be able to continue receiving and utilizing Department of Traffic Safety monies for current component implementation, and in the future apply for different and/or additional funding for projects.

Finally, if any of the identified regions see the need for, and wish to apply for DHEW grant funds, the necessary data will be available to them, already in an appropriate format.*

Michael A. Lanning
Planning Director

* On September 30, 1981, the DHHS EMS Program was discontinued and federal EMS monies were "transferred" into the Preventative Health and Health Services Block Grant.

The EMS Commission is currently working closely with the Board of Health to assure that the EMS section of the State Health Plan is consistent with the EMS needs of the State as identified by the Commission.

1. ORGANIZATION FOR EMS PLANNING AND IMPLEMENTATION

1.0. AUTHORITY

1.1. Evolution of State Involvement in Indiana EMS.

State government involvement in the provision of emergency medical services began as a direct result of the passage of the Federal Highway Safety Act of 1966 which established a number of highway safety standards and provided formula grants for the State's use in implementing the various aspects of the standards. One of those standards, Standard 11, speaks to the provision of emergency medical services in order to reduce accidental death and disability.

In 1967 Governor Rodger D. Branigan, by Executive Order assigned the implementation of Standard 11 to the Indiana State Board of Health and requested that they work in cooperation with the Indiana Department of Traffic Safety, the agency charged with administering the Governor's Highway Safety Program. The State Board of Health established a number of E.M.S. advisory committees and immediately began to work on an E.M.S. Plan. The first plan was published in 1968 and a second plan was published in 1973.

During that period of time State Board of Health was able to assign two staff positions and a secretarial position to assist the Department of Traffic Safety. The State Board of Health and staff were able to develop a number of Federal grant applications for local communities to assist in the purchase of ambulances, emergency medical care equipment and related communications systems.

The State Board of Health then recognized that the implementation of any state E.M.S. plan was hampered by the lack of legislative authority. Several pieces of legislation were introduced to develop requirements for quality standards for the provision of emergency medical services but the bills met the firm opposition of the many volunteer providers and funeral directors in the State of Indiana who were fearful that any proposed standards would necessitate their ceasing care. Of primary concern was the lack of the availability of training.

Early in 1973, with the assistance of the Department of Traffic Safety, pilot training programs were developed in Lafayette, Richmond and Terre Haute through the auspices of Indiana Vocational Technical College. The pilot projects were successful, and a state-wide project was written to develop training programs, through Ivy Tech, for the entire State; and the State Board of Health began a program of voluntary testing and certification, although still without legislative support.

On May 25, 1973, several representatives of concerned medical organizations met with the newly elected Governor Otis R. Bowen, M.D., a family physician from Bremen, a small community in rural North Central Indiana. They asked the Governor to consider the possibility of establishing a state-wide emergency medical services system and as a result, on July 23, 1973, with the support of 15 co-sponsoring organizations, a one-day Governor's Conference on Emergency Medical Services was conducted. The conference was attended by over 700 persons with a variety of interests in pre-hospital emergency health care. The meeting was divided into

five separate sessions: Services and Facilities; Records and Data Retrieval; Manpower, Education and Training; Transportation and Equipment; and Communications. Each group developed a series of recommendations and filed them in the conference report prepared for the Governor. Conference attendees passed a resolution requesting that an emergency medical services state advisory committee be established as a commission to promulgate rules and policies on emergency medical services with implementation by the State Board of Health and to develop a comprehensive report to the Governor. As a result of the recommendations, a committee was established and chaired by an Executive Assistant to the Governor with representatives from both parties of the House and Senate, E.M.S. providers and health care officials, which drafted legislation for introduction.

Early in 1974 the legislation was introduced as part of the Administration's legislative package. With the support of the Governor's office and strong bi-partisan support of both houses, the 1974 Session of the Indiana General Assembly passed Senate Enrolled Act #151 which amended Title 16 of the Indiana Code by adding a new section, 39, regarding the provision of emergency medical service. The Act established the E.M.S. Commission (an agency reporting directly to the Governor), assigned the Commission certain E.M.S. systems duties and responsibilities and also assigned the Commission the responsibility to develop quality standards for purpose of certification of ambulance services, vehicles, equipment, communications systems, personnel, and operational procedures.

Membership of the Commission was as follows: four persons who are representatives of the public-at-large, one from a duly organized volunteer fire department which provides ambulance service, one from a full-time municipal or police department which provides ambulance service, one person who provides private ambulance service, one who operates hospital emergency medical service facilities, one licensed physician, one licensed nurse or emergency medical technician, and one representative from Indiana law enforcement agencies. Thus, the inclusion of the participants in an E.M.S. system, both in the committee that drafted the bill and on the regulatory Commission established by the bill, did much to diffuse the past opposition to legislative efforts. In 1980, the General Assembly changed the membership of the Commission by deleting one member representing the public-at-large, splitting the Registered Nurse and EMT positions, changing the hospital emergency medical service facility member to the Chief Executive Officer of a hospital that provides emergency ambulance service, and adding one emergency paramedic and one emergency physician; thereby increasing Commission membership to thirteen.

The Commission first met in May 1974 and, as required by the Act, developed a series of recommended quality standards for certification of emergency ambulance service. These recommendations and a State-of-the-art report were presented to the Governor on January 1, 1975, and a copy was mailed to every member of the General Assembly. The Commission then asked for comments and recommendations from both the Governor and the members of the General Assembly. The Governor made several suggestions which were incorporated in the standards and, hearing no adverse comments from members of the General Assembly, the quality standards were promulgated on June 1, 1975, with a mandatory compliance date of January 1, 1978.

Thus, all those who then provided emergency ambulance service and all potential providers had two and one-half years to review the standards and to make whatever changes were necessary to continue providing emergency medical services.

The act requires all persons, firms, corporations, etc. who provide emergency ambulance service as a part of their regular course of doing business, either paid or volunteer, to meet certification standards promulgated by the Commission. The Commission's staff was successful in securing through the Public Health Service, D.H.E.W., a four-year grant to train ambulance personnel, effective July 1, 1975. Fourteen major hospitals, one in each of the State's economic planning and development regions, had been identified in 1974 and agreed to serve as a focal point for training, communications, and data collection. As a result of the four-year public health service project, there were 248 free E.M.T. classes conducted in the various local communities of the state under the auspices of the fourteen "Regional Hospitals". At the same time, an equivalent number of courses were conducted by other hospitals and the various campuses of Indiana Vocational Technical College.

During the period between June 1975 and January 1, 1978, the Commission staff worked with local units of government, primarily on a county-wide basis to assist in the development of modern services, and the Governor made available in excess of $3 million through the Highway Safety Program, for the upgrading, if necessary, of ambulances, on-board emergency health care equipment, mobile communications, and hospital-to-hospital and hospital-to-ambulance communications.

Currently, there are over 12,000 state certified emergency medical technicians in the State. There are 344 certified services at the basic life support level operating 765 ambulances. All hospitals have common communications capability with all ambulances. As the basic life support system began to develop, it soon became apparent that the provision of care in the field beyond the capabilities of the training of emergency medical technician was necessary. In 1975 the General Assembly passed new legislation regarding the provision of advanced life support. It also amended Title 16 by adding Chapter 40. The advanced life support legislation charged the Commission with the responsibility of developing quality standards for the certification and provision of advanced life support, both intermediate and paramedic, in the State.

Currently 45% of the population of the state of Indiana is served by paramedic ambulance service providers. There are in excess of 340 certified paramedics in the State of Indiana, all of whom have completed the Department of Transportation's Emergency Medical Technician-Paramedic training program, who have successfully passed a rigorous state written examination, and who function under the medical control of a physician medical director through a sponsoring hospital.

Therefore, significant progress has been made toward the goal of the 1974 General Assembly which stated that the legislation was enacted for the purpose of "promoting the establishment and maintenance of an effective system of emergency medical service including the necessary equipment, personnel and facilities to insure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered".

1.2 State Legislation. The Second Regular Session of the 98th Indiana General Assembly (1974) amended Section I, IC 1971, 16-1 by adding a new chapter concerning emergency medical services for the State of Indiana. In doing so, the General Assembly declared that the provision of emergency medical services is a matter of vital concern affecting the public health, safety and welfare of the people of the State.

The amendment was enacted for the purpose stated in the enabling legislation:

"...to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment personnel, and facilities to insure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered."

The Act provided for the creation of the Indiana Emergency Medical Services Commission. Pursuant to the 1980 amendment to the Act, the Commission is composed of thirteen members who are involved in all aspects of emergency medical services including the public-at-large. Of the thirteen members appointed by the Governor, one is from a duly organized volunteer fire department which provides ambulance service, one from a full time municipal fire or police department which provides ambulance service, one from a private ambulance service, one state certified emergency paramedic, one emergency physician, one chief executive officer of a hospital that provides ambulance service, one registered nurse, one who possesses an unlimited license to practice medicine in the State of Indiana, one certified emergency medical technician, one from an Indiana law enforcement agency, and three who are representatives of the public-at-arge and who are not in any way related to providing emergency medical services. To insure that the Commission is non-artisan in nature, it is further stipulated that not more than seven members of the Commission can be from the same political party.

As defined in the Act, the EMS Commission is responsible for:

1. Developing and promoting a state-wide progrm for providing emergency medical services in cooperation with state, regional and local public and private organizations, agencies, and persons.
2. The program shall include but not be limited to:
   a. preparation of state, regional and local emergency ambulance plans;
   b. provision of consultative services to state, regional, and local organizations and agencies in developing and implementing emergency ambulance service programs;
   c. promotion of a state-wide system of emergency medical care and treatment centers by developing minimum standards, procedures and guidelines in regard to personnel, equipment, supplies, communication facilities and the location of such centers;
   d. promotion of training programs for personnel engaged in the provision of emergency medical care and treatment, and programs for the education of the general public in first aid techniques;
   e. promotion of the coordination of emergency communications, resources, and procedures throughout the state and the development of, in cooperation with interested state regional and local public and private agencies, organizations, and persons, an effective and comprehensive communications system.
3. Regulation, inspection and certification of emergency services, facilities, communications, and operational procedures of those personnel engaged in providing emergency medical services as defined in the Act.

4. Adoption and promulgation of such necessary rules and regulations to implement an approved system of emergency medical services.

1.3. COMPLEMENTARY STATE AGENCIES: In addition to the EMS Commission, there are complementary state agencies which indirectly act on behalf of the EMS system development in Indiana.

1.3.1. The Division of Traffic Safety, Indiana Department of Highways: The DTS which has statutory authority to administer the Governor's Highway Safety Program, has been involved in EMS planning as outlined in the requirements established by the National Highway Traffic Safety Administration and the Federal Highway Administration, Department of Transportation as set forth in the Highway Safety Program Manual.

Since 1968, in excess of 5 million dollars in funding for implementation of various progrms for emergency medical services development has been available through the IDTS. 186 grantees have received funds (usually 70% of purchase price) for 185 ambulances, 179 mobile ambulance to hospital radios, 46 Hospital Base Radios and 60 heavy and power extrication tools.

The Division of Traffic Safety has also in the past funded the staff positions of Communications Director, Transportation Director, Planning Director, and 2 clerical/typists.

The DTS has been responsible for the past development of a comprehensive highway safety plan of which there is an EMS component. This authority was established by the Highway Safety Act of 1966, whose Standard 11 required that states develop standards and policies for development of state-wide programs of EMS. Since that time, financial aid has been provided to many political sub-divisions throughout Indiana to develop such a state-wide system.

1.3.2. The State Health Planning and Development Agency (SHPDA): The SHPDA of the Indiana State Board of Health is the agency established for health planning and resources development in Indiana. This State Agency has the authority to carry out the intent of Public Law 93-641 (and amended by 96-74), the National Health Planning and Resources Development act of 1974. This authority was reinforced under Executive Order 6-76; issued by the Governor of the State of Indiana.

All health planning activities in Indiana are coordinated by the state agency. The EMS planning activities have been addressed in the State Health Plan (SHP), and reflect primarily all planning and implementation efforts which have been accomplished by the EMS Commission and the three Health Systems Agencies in Indiana.

The coordination of planning and implementation of emergency medical services throughout Indiana will continue between the State Board of Health and the EMS Commission.

1.3.3. The State Health Coordinating Council (SHCC): The SHCC is an advisory body responsible for the final development of a State Health Plan (SHP) for Indiana. Included in the SHP as a health care service is the provision for emergency medical services to the citizens of Indiana.

1.3.4. The Indiana Department of Civil Defense: The Department of Civil Defense was created by Public Law 110. This legislation charged the agency:

> "...to provide for the common defense and protect the public peace, health, and safety, and to preserve the lives and property of the people of the state."

Included in this provision is a disaster management system to encompass all aspects of pre-disaster preparedness as well as operational and post-disaster preparedness. One element included in civil defense planning within the statute is the provision for emergency transportation preparedness in the event of a disaster. Additionally, each local or interjurisdictional agency must prepare and update a disaster emergency plan for its designated area.

The requirement in the statute facilitates the need to integrate emergency medical services within disaster planning efforts of the Department of Civil Defense.

1.3.5. Other Agencies: There are several agencies recognized for their role in emergency medical services on a state-wide basis. Some of the agencies involved state-wide are:

-Indiana Hospital Association
-Indiana State Medical Association
-Indiana Volunteer Firefighters Association
-American Heart Association (Indiana Affiliate)
-American Red Cross
-Indiana State Police
-American College of Emergency Physicians
-Emergency Department Nurses Association

1.4. Regional and Local Agencies: A variety of regional and local agencies are involved directly and indirectly in planning and implementating EMS Systems throughout the State.

1.4.1. Regional Coordination Centers for Emergency Medical Services: As called for in Objective 15.1 of the State EMS Plan (see section IV, Program Objectives and Implementation), the Commission began its Regional Coordination Center (RCC) program in October 1980.

RCCs have the authority and responsibility to coordinate and plan the development of EMS systems state-wide. They do so while receiving the input and support of the various EMS participants in their regions. To date, there are RCCs in seven of the State's ten EMS regions. They are:

Northwest Regional Coordination Center (219) 886-4777
c/o Methodist Hospital of Gary
600 Grant Street
Gary, Indiana 46402

Battle Ground Region EMS Council (317) 362-2800
c/o Montgomery County Culver Union Hospital
306 Binford Street
Crawfordsville, Indiana 47933

Northeastern Indiana EMS, Inc. (219) 458-2197
3024 Fairfield Avenue
Fort Wayne, Indiana 46807

Southwest Indiana EMS (812) 424-5571
Regional Coordination Center
Court Building, Room 420
123 North West Fourth Street
Evansville, Indiana 47708

Wyandotte Regional Coordination Center (812) 283-2368
c/o Clark County Memorial Hospital
Post Office Box 69
Jeffersonville, Indiana 47130

Central Indiana EMS Council (317) 875-5641
1717 West 86th Street, Suite 400
Indianapolis, Indiana 46260

North Central Indiana EMS Regional Coordination Center (219) 288-8311
c/o South Bend Osteopathic Hospital
2515 East Jefferson Boulevard
South Bend, Indiana 46615

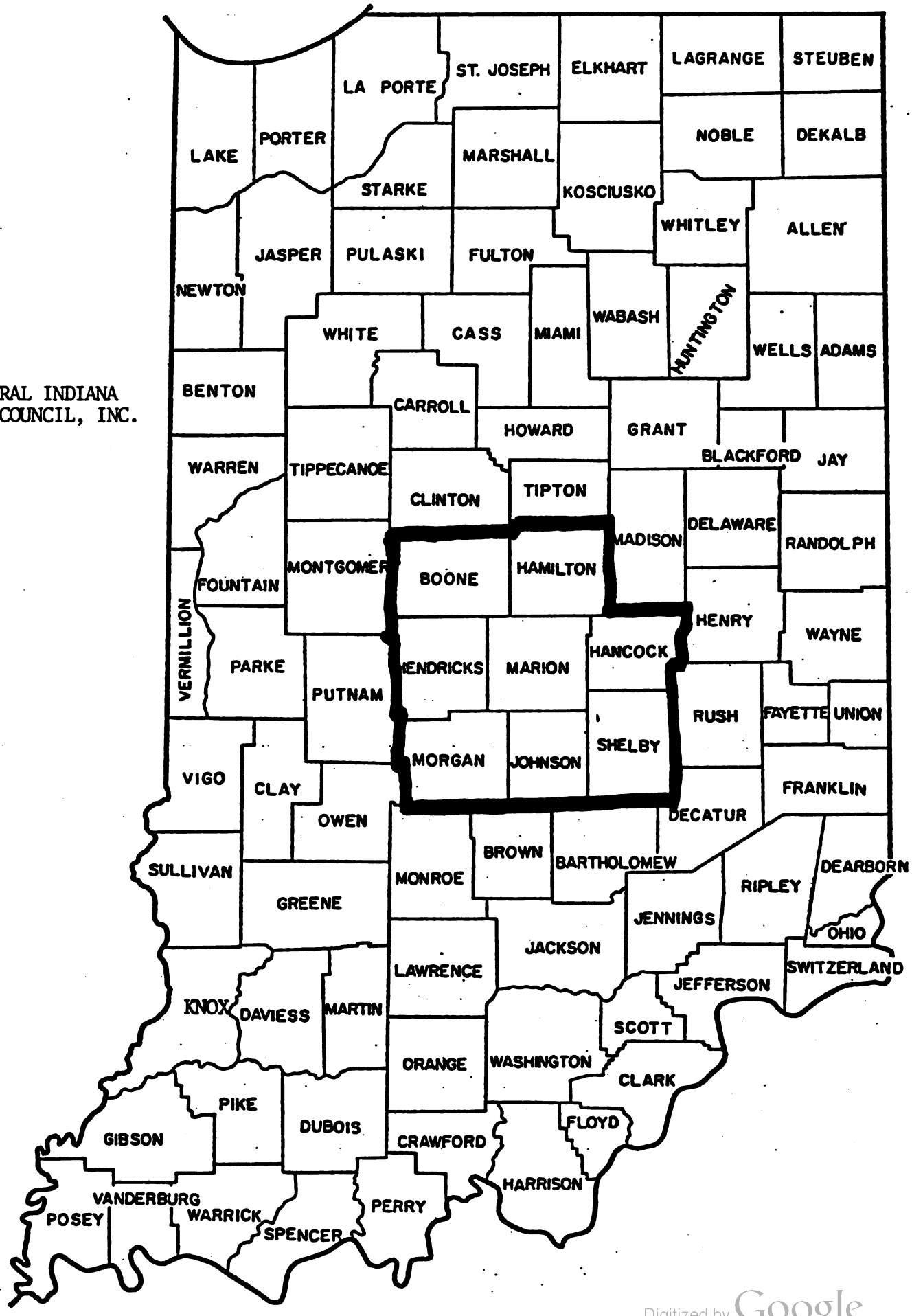
For additional information concerning RCCs, their creation and their purpose, see the RCC Program Manual in the Appendix.

1.4.2. Health Systems Agencies (HSA): The three Health Systems Agencies in Indiana are active in planning for all health care delivery services including emergency medical services within their respective areas. The HSA's activities include ongoing recommendations for EMS system improvements as identified by the Regional Coordinators. The Coordinators are presently employed by the HSA's and are responsible for specific field activities outlined in contracts between the EMS Commission and the HSA's. The contractual obligations of the HSA's for emergency medical services facilitate many one-on-one contacts between the ambulance service providers and the Regional Coordinators. The Regional Coordinators receive much insight on local and regional EMS problems and issues through their field work with the providers. These perspectives are relayed to the EMS Commission for consideration as needs for possible legislative changes as well as Commission policy changes. Such considerations may ultimately benefit local and regional groups in the development and maintenance of comprehensive EMS systems throughout Indiana.

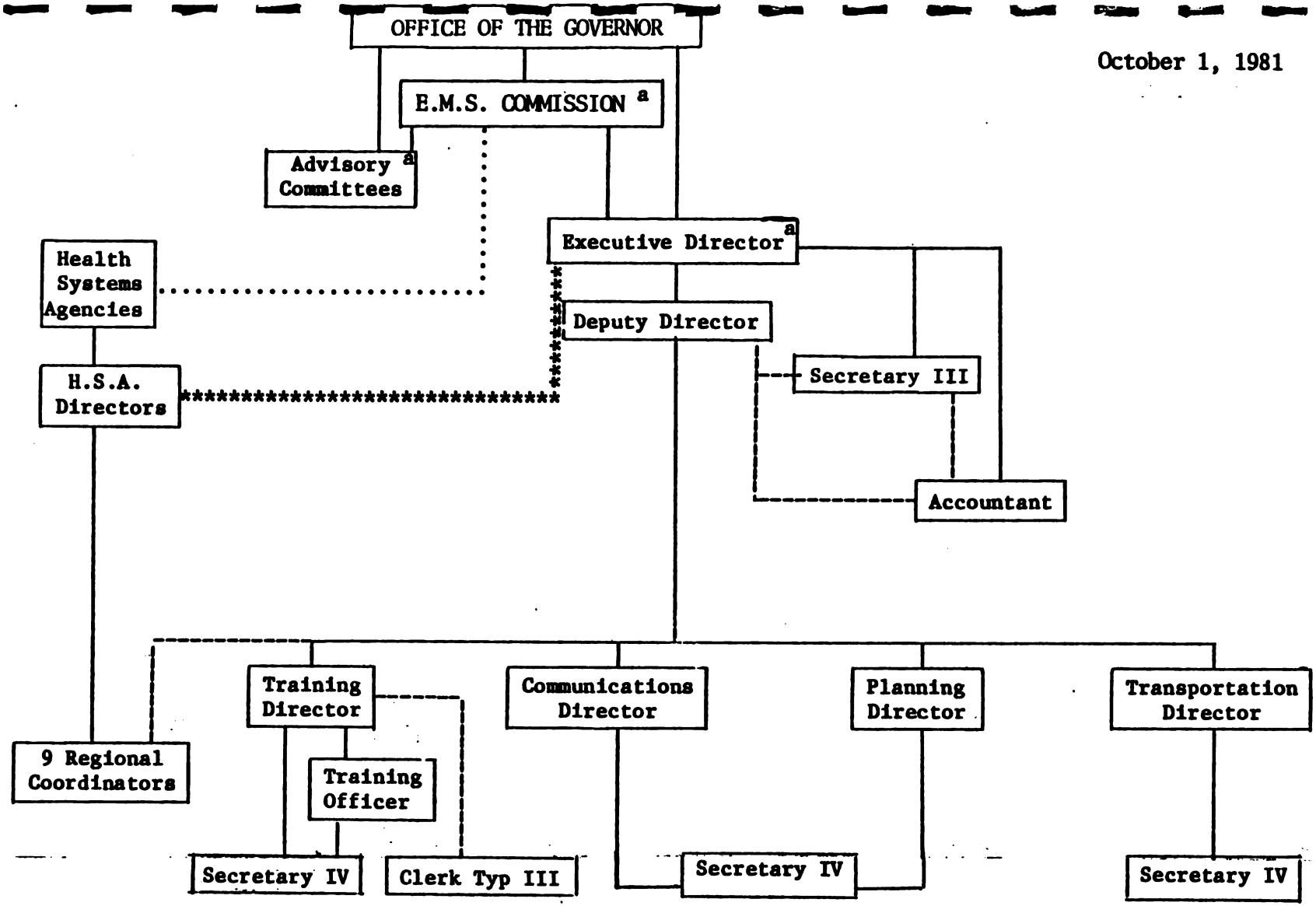
1.4.3. DHHS Regions: There is one active EMS regional council in Indiana which receives Department of Health and Human Services funding to plan and implement a regional EMS system under the Emergency Medical Services Act of 1973. The Central Indiana Emergency Medical Services Council was founded in 1976 to plan and implement a regional EMS system for eight counties in central Indiana. (Figure I-1) The counties are consistent with the central Indiana region as adopted by the Commission in September 1980.

2. Staff Structure of the Agency: The following organizational chart illustrates the relationships between the Governor, the Indiana Emergency Medical Services Commission, the administrative staff, and the HSA's. (Figure I-2)

CENTRAL INDIANA
EMS COUNCIL, INC.



October 1, 1981



____ Primary Relationship

---- Secondary Relationship

.... Contractual Agreement

**** Contractual Relationship

a: Gubernatorial Appointment

3.0. Function Identification

3.1. The Governor: The Chief Executive of the state performs two direct functions relative to EMS. IC 16-1-39-4 states in part: "The Commission shall be composed of thirteen (13) members, who shall be appointed by the governor for a term of four (4) years...not more than seven (7) members appointed by the governor shall be from any one political party". The statute further stipulates that, "The governor shall appoint a full time director of the Commission who shall serve as its chief administrative officer and its executive secretary". Note that the preceeding organizational chart displays the relationship of the Governor of Indiana to both the Commission and the Executive Director.

3.2. Indiana Emergency Medical Services Commission (EMS Commission): See 1.2. Authority - State Legislation.

3.3. Administrative Staff Structure: Staff support for the Indiana EMS Commission is the responsibility of the Executive Director. Present staff positions in addition to the Executive Director are: Deputy Director, Training Director, Training Officer, Transportation Director, Communications Director, Planning Director, Accountant, and clerical staff.

3.3.1. Executive Director: By statute, the Executive Director is the chief administrative officer and executive secretary of the Emergency Medical Services Commission and is charged with administratering all policies of the EMSC and directing all staff activities. This individual is responsible for meeting the desires of the Commission and providing guidance as it carries out the legislative mandates set forth by the General Assembly. As this position is a gubernatorial appointment, the individual is responsible to the governor for all activities of the Commission and staff.

3.3.2. Deputy Director: Responsible to the Executive Director for all activities, this individual's specific duties include direction of all planning activities, coordination of grant applications and liaison with federal, state and local agencies and organizations in the health care field. In addition, the individual is responsible for direction of the regional coordinators and providing assistance to the Executive Director in all areas as may be prescribed.

3.3.3. Training Director: This individual has specific responsibility for the development, coordination and implementation of EMS training state-wide. Included are curriculum, examination, certification and data development with respect to EMT, advanced EMT, emergency paramedic, first responder and emergency extrication training. This individual provides direct staff support to the Commission's Advanced Life Support Operations Committee. This was the first technical assistance position created and staffed in response to the emphasis the Commission placed upon training at its initial meetings.

3.3.4. Training Officer: Assisting the Training Director, this individual works specifically in the area of Emergency Medical Technician (EMT) training. The Commission's program for training which is instituted through the Commission-approved training institutions requires the full-time attention of this individual to insure that program objectives are met.

3.3.5. Transportation Director: This individual is charged with the development of a state-wide plan for EMS trnsportation to include adequate quantities and distribution of ground, sea and air vehicles to meet the needs of all areas within the State. Included is the responsibility for certification of ambulance service providers and ambulances throughout the State and development of a program of extrication training. The preparation of the transportation component of the Comprehensive EMS Plan is also a responsibility of the Transportation Director.

3.3.6. Communications Director: As both state and federal emergency medical services legislation place an emphasis upon the development of an effective emergency medical communications system, a full time staff position has been created for an individual proficient in the area of emergency medical communications. This individual is responsible for all state-wide planning for communications as well as providing technical assistance to EMS providers in the development of local or regional communications systems.

3.3.7. Planning Director: This staff position was created to provide professional staff assistance to the EMS Commission for the development and maintenance of local, regional and State comprehensive emergency medical services planning. The effort to coordinate the development and implementation of the components within the State EMS Plan will insure the orderly progression of existing EMS services toward comprehensive emergency medical services systems throughout Indiana.

3.3.8. Accountant: Due to the complexities of state and federal fiscal management, particularly concerning federal grant awards, a full-time accountant position has been created. This individual is responsible as liaison with the Auditor of the State, the State Budget Agency and others with reference to fiscal matters.

3.3.9. Regional Coordinators: Realizing that Emergency Medical Services is a direct public program, the Commission has insisted that all activities not be based entirely in Indianapolis. Therefore, nine positions, all of which are housed with the three Health Systems Agencies (HSA) in Indiana, have been created in contractual agreements between the Commission and the HSA's. Specific services to assist the EMS Commission in the implementation of the systems programs have been identified as each pertains to the designated regions of the Regional Coordinators. Specific responsibilities agreed upon within the contract between the EMS Commission and the HSA's Include:

- -assistance in the development of regional and/or local emergency medical services councils. Such organizations are a necessity for effective EMS system development on a county-wide or regional basis.

- -public speaking upon request to local and regional groups in an effort to familiarize communities with the EMS system concept.

- -assistance in updating the State EMS Plan by maintaining a current inventory of EMS resources including services, vehicles, equipment, facilities and manpower. Additionally, the Coordinator can provide current information on any changes in provider or facility management of emergency medical services within the region(s).

-assistance to local political subdivisions in the development of grants for Emergency Medical Services funding, and the provision of supplemental information necessary for the Indiana Department of Traffic Safety to consider the grant application.

-completion of site inspections necessary to fulfill Commission requirements for: approval of training institutions providing various EMS training programs, ambulance provider and vehicular certification.

-assistnce to approved training institutions in the coordination and implementation of Emergency Medical Technician training programs including: 1) assistance to the Commission in determining the appropriate location of training programs for emergency medical personnel within the regions, 2) administration of the Indiana Emergency Medical Technician Certification Examination, 3) assistance in the preparation of final reports and evaluations of all training programs.

-participation in training sessions, staff meetings, and other duties requested by the Indiana EMS Commission to develop and coordinate local and regional EMS systems throughout the state.

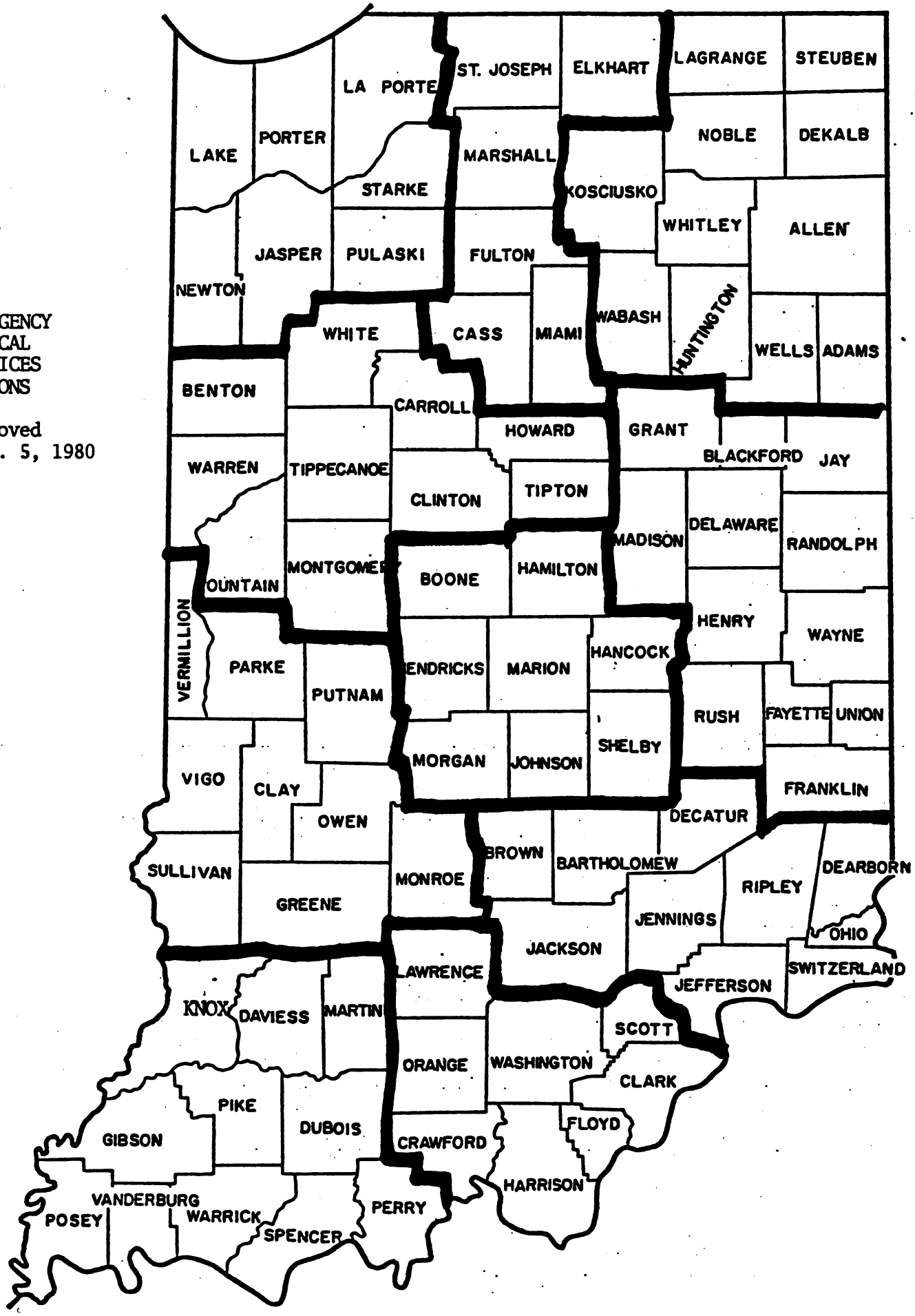
4.0. EMS PLANNING AREA INDENTIFICATION

4.1. In 1968, the state was divided into fourteen economic and development regions. These fourteen regions were subsequently adopted in 1974 for the sake of expediency as EMS planning and development regions for the State. In 1979, as the State EMS Plan was being developed, the appropriateness of the 14 regions as EMS regions was questioned.

To be effective and to benefit EMS providers, a region must be comprised of an area that shares some common features. Paramount among these is a "catchment area" of emergency patient flow, although population centers and geographic features also play a role. Therefore, through a contract with the Indiana Hospital Association and Indiana University, the Commission authorized a retrospective study of patient flow in the state. Based upon this study the Commission identified ten EMS regions in Indiana and adopted them in September 1980.

EMERGENCY
MEDICAL
SERVICES
REGIONS

Approved
Sept. 5, 1980



5.0. ADVISORY COMMITTEES

Immediately following its organization, the Commission directed itself to establishing priorities for fulfilling stated responsibilities. First among these was the establishment of minimum quality standards for emergency ambulance services as provided for under the certification provisions of the EMS act. The action to initiate development of these standards came on May 29, 1974, with the Commission's recommendation to the Governor that technical advisory committees be formed. The request for committee guidance in the development of a minimum program for the ambulance service providers resulted in the formation of committees to develop transportation, training, communications, data and public relations standards for EMS in Indiana.

In January 1975, the Training Committee and the Public Relations Committee were disbanded due to the incorporation of their respective duties and responsibilities within the expanding staff structure. The creation of additional professional staff positions for the EMS Commission allows many of the duties previously requiring an advisory committee to be absorbed into staff responsibilities or accomplished through contractual agreements with outside agencies.

More recently, in ■ 1980, the Commission reorganized both the number and structure of its standing advisory committees, in order to streamline and make more consistent their roles. Pursuant to this action there are four standing committees. They are:

Basic Life Support Test Operations Committee
Advanced Life Support Operations Committee: These two committees, each in their respective area of expertise, advise and assist the Commission in the development of policies, procedures, and revisions to the rules and regulations.

Basic Life Support Test Construction and Evaluation Committee
Advanced Life Support Test Construction and Evaluation Committee: These committees address themselves to all matters pertaining to the Commission's testing and certification responsibilities.

As needed, the EMS Commission and/or its chairman can seat ad hoc committees. Presently there are two such:

Regional Coordination Evaluation Committee: The purpose of this committee is to prepare procedures for the review of RCC applications, conduct preliminary reviews of applications, and prepare recommendations for Commission action.

Regional Coordination Center Committee: This committee is comprised of one representative from each designated RCC. Its purpose is to advise the chairman of any special needs of the RCC's, and to provide a state-wide forum for the RCC's.

6.1. I.C. 16-1-39-1 through 16-1-39-19

I.C. 16-1-39-1 through 16-1-39-19
As of September 1, 1981

Chapter 39. Emergency Medical Services

Chapter 39. Emergency Medical Services.

Indiana Code Sec. 16-1-39-1

Sec. 1. Intent. The Indiana General Assembly hereby delcared that:

(a) The provision of emergency medical services is a matter of vital concern affecting the public health, safety and welfare of the people of the state of Indiana.

(b) It is the purpose of this chapter to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to insure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered.

(c) It is the purpose and intent that the commission to be established under this chapter shall cooperate with other agencies empowered to license persons engaged in the delivery of health care so as to coordinate the efforts of the commission and such agencies, and to establish standards and requirements for the furnishing of emergency medical services by persons not licensed or regulated by other appropriate agencies.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-2

16-1-39-2 Definitions

Sec. 2. Definitions. As used in this chapter:

"Commission" means the Indiana Emergency Medical Services Commission created under this chapter.

"Emergency patient" means an individual who is acutely ill, injured, or otherwise incapacitated or helpless and who requires emergency care.

"Ambulance" means any conveyance on land, sea, or air that is used or is intended to be used, for the purpose of responding to emergency life-threatening situations and providing emergency transportation service.

"Invalid coach" means those vehicles that are routinely used to transport patients who are not acutely ill or injured in a life-threatening manner on an appointment basis and are not included under terms of this chapter.

"Emergency ambulance services" means the transportation of emergency patients by ambulance, and the administration of emergency care procedures to emergency patients before, or during such transportation.

"Emergency medical technician" means an individual who is responsible for the administration of emergency care procedures to emergency patients and for the handling and transportation of such patients.

"Emergency medical service facility" means those facilities that are licensed and operated under IC 16-10-1 and are equipped, prepared, and staffed to provide medical care for emergency patients.

"Person" means any natural person or persons, firm, partnership, corporation, company, association, or joint stock association, and the legal successors thereof including any governmental agency or instrumentality other than an agency or instrumentality of the United States.

"Certificate" or "certification" means authorization in written form issued by the commission to a person to furnish, operate, conduct, maintain, advertise, or otherwise engage in providng emergency medical services as a part of a regular course of doing business, either paid or voluntary.

"Emergency medical services" means the provision of emergency ambulance services or other services utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

(Formerly: Acts 1974, P.L.55, SEC.1). As amended by Acts 1980, P.L.114, SEC.1.

Indiana Code Sec. 16-1-39-3

Sec. 3. Indiana Emergency Medical Commission. There is hereby created an Indiana Emergency Medical Services Commission.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-4 Composition of commission

Sec. 4. Composition of Commission. The commission shall be composed of thirteen (13) members, who shall be appointed by the governor for a term of four (4) years. Not more than seven (7) members appointed by the governor shall be from any one (1) political party. Of the thirteen (13) members appointed by the governor, one (1) must be appointed from a duly organized volunteer fire department which provides ambulance service and one (1) must be appointed from a full time municipal fire or police department which provides ambulance service; one (1) must be from those who provide private ambulance services; one (1) must be a state certified paramedic; one (1) must be a physician with an unlimited license to practice medicine who has a primary interest, training, and experience in emergency medical service, and who is currently practicing in an emergency medical services facility; one (1) must be a chief executive officer of a hospital that provides emergency ambulance services; one (1) must be a licensed registered nurse who has supervisory or administrative responsibility in a hospital emergency department; one (1) must possess an unlimited license to practice medicine, surgery, and obstetrics in the state of Indiana; one (1) must be a state certified emergency medical service technician; one (1) must be from Indiana law enforcement agencies; and three (3) must be persons who are representatives of the public at large and who are not in any way related to providing emergency medical services. Any appointment to fill a vacancy occurring on the commission shall be for the unexpired term.

(Formerly: Acts 1974, P.L.55, SEC.1). As amended by Acts 1980, P.L.114, SEC.2.

Indiana Code Sec. 16-1-39-5

Sec. 5. Director. The governor shall appoint a fulltime director of the commission who shall serve both as its chief administrative officer and its executive secretary.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-6

Sec. 6. Duties and Responsibilities of the Commission. The commission shall have the following duties and responsibilities:

(a) to develop, and promote, in cooperation with state, regional, and local public and private organizations, agencies, and persons, a statewide program for the provision of emergency medical services which shall include, but not be limited to, the following:

(1) preparation of state, regional and local emergency ambulance service plans;

(2) provisions of consultative services to state, regional and local organizations and agencies in developing and implementing emergency ambulance service programs;

(3) promotion of a statewide system of emergency medical care and treatment centers by developing minimum standards, procedures and guidelines in regard to personnel, equipment, supplies, communications, facilities, and location of such centers;

(4) promote programs for the training of personnel engaged in the provision of emergency medical care and treatment, and programs for the eudcation of the general public in first aid techniques and procedures, such training shall be held in various local communities of the state and shall be conducted by agreement with existing publicly supported educational institutions or governmental or nonprofit hospitals wherever appropriate; and

(5) promotion of coordination of emergency communications, resources, and procedures throughout the state and the development of, in cooperation with interested state, regional, and local public and private agencies, organizations, and persons, an effective state, regional, and local emergency communications system;

(b) to regulate, inspect, and certify services, facilities and personnel engaged in providing emergency medical services as provided in this chapter;

(c) to adopt and promulgate such necessary rules and regulations as may be required to implement an approved system of emergency medical services; provided, however, that such rules and regulations are to be submitted to the governor no later than January 1, 1975, and provided, further, that such rules and regulations shall not take effect and shall not be implemented before June 1, 1975.

(d) to apply for, receive and accept gifts, bequests, grants-in-aid, state, federal and local aid; and other forms of financial assistance for the support of emergency medical services;

(e) to employ necessary administrative staff.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-7

Sec. 7. Advisory Committees. In the promulgation of rules and regulations relative to the duties and responsibilities of the commission, the commission shall appoint a technical advisory committee. Members of such advisory committee shall be selected by the commission subject to the approval of the Governor on the basis of their technical expertise and competency in that specific area of emergency medical service concerned.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code 16-1-39-8

Sec. 8. Organization of Commission. The governor or his representative shall serve as temporary chairman and shall convene the first meeting of the commission. At its first meeting, the commission may select such officers from its membership as deems necessary. The commission may meet as often as is necessary upon call of the chairman but meetings shall be held at least four (4) times each year. Each eligible member of the commission and/or advising committees shall receive per diem and mileage allowances. The commission may adopt and use a seal, the description of which shall be filed at the office of the secretary of state, which may be used for the authentification of the acts of the commission.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code 16-1-39-9

Sec. 9. Certification. (a) A person, other than:
(1) a physician with an unlimited license to practice medicine;

(2) a registered nurse, or an individual acting under the supervision of a physician with an unlimited license to practice medicine; or

(3) a person providing health care in a hospital or ambulatory outpatient surgical center licensed under IC 16-10-1;

may not furnish, operate, conduct, maintain, advertise, or otherwise be engaged in providing emergency medical servcies as a part of the regular course of doing business, either paid or voluntary, unless such person holds a currently valid certificate issued by the commission.

(b) The commission shall establish standards for persons required to be certified by it to provide emergency medical services. In order to be so certified, such person shall meet the following minimum requirements:

(1) The personnel certified under this section shall meet the standards for education and training established by the commission by its rules and regulations.

(2) Ambulances to be used shall conform with the requirements of the commission, and must either be covered by insurance issued by a company licensed to do business in this state in such amounts and under such terms as may be required in regulations adopted by the commission, taking into consideration recommendations of the advisory committee, or be owned by a governmental entity covered under IC 34-4-16.5.

(3) Emergency ambulance service shall be provided in accordance with regulations adopted by the commission, taking into consideration recommendations of the advisory committee concerning the staffing, equipping, and operating procedures thereof. However, nothing in the regulations adopted under this chapter shall prohibit the dispatch of an ambulance to aid an emergency patient because an emergency medical technician is not immediately available to staff the ambulance.

(4) Ambulances shall be equipped with a system of emergency medical communications approved by the commission. The emergency medical communication system shall properly integrate and coordinate appropriate local and state emergency communications systems and reasonably available area emergency medical facilities with the general public's need for emergency medical services.

(5) Emergency medical communications shall be provided in accordance with the regulations adopted by the commission, taking into consideration recommendations of the advisory committee concerning such matters.

(c) Notwithstanding subsection (a):

(1) a physician with an unlimited license to practice medicine;

(2) a registered nurse, or an individual acting under the supervision of a physician with an unlimited license to practice medicine; or

(3) a person providing health care in a hospital or ambulatory outpatient surgical center licensed under IC 16-10-1;

who operates a business of transporting emergency patients by ambulance must hold a valid certificate issued by the commission under this chapter.

(Formerly: Acts 1974, P.L.55, SEC.1). As amended by Acts 1976, P.L.61, SEC.1; Acts 1980, P.L.114, SEC.3.

Indiana Code Sec. 16-1-39-10

Sec. 10. Emergency Medical Personnel. On or before January 1, 1976, the commission shall establish standards for persons engaged in providing emergency medical services who are not otherwise licensed or regulated by state law or lawful regulations promulgated thereunder.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-11

Sec. 11. Certification Procedure.

(a) An application for a certificate shall be made upon such forms, provide such information, and be in accordance with such procedures as prescribed by the commission.

(b) Except as provided heretofore, all certificates shall be valid for a period specified by the commission unless earlier suspended, revoked or terminated.

(c) Renewal of any certificate issued hereunder upon expiration for any reason, or after suspension, revocation, or termination shall require conformance with all the requirements of this chapter as upon original certification.

(d) Notwithstanding subsection (c), a renewal of an emergency medical technician certificate shall be issued to an individual who:

(1) enters, while holding a valid emergency medical technician certificate, the armed forces of the United States, including:
(A) the army;
(B) the navy;
(C) the air force;
(D) the marines; or
(E) the coast guard;
but excluding the guard and reserve components of those forces;
(2) is discharged from the armed forces of the United States within forth-eight (48) months of the date he entered the armed forces;
(3) successfully completes, within nine (9) months of the date of his discharge from the armed forces of the United States, a refresher course approved by the commission;
(4) applies for the certificate renewal within one (1) year of the date of his discharge from the armed forces of the United States; and
(5) passes the written and practical skills examinations as upon his original certification.

(e) A certificate issued hereunder shall not be assignable or transferable.

(f) No official entry made upon a certificate may be refaced, removed or obliterated.

(g) Certificates issued hereunder shall be issued without cost to applicants.

(Formerly: Acts 1974. P.L. 55, SEC. 1). As amended by Acts of 1981, P.L. 33, SEC. 23.

Indiana Code Sec. 16-1-39-12

16-1-39-12 Exemptions from this chapter

Sec. 12. Exemptions from this chapter.

(a) A certificate shall not be required for a person who provides emergency ambulance service, an emergency medical technician, or an ambulance when:

(1) rendering assistance to persons certified to provide emergency ambulance service or to emergency medical technicians;

(2) operating from a location or headquarters outside of this state in order to provide emergency ambulance services to patients who are picked up outside the state for transportation to locations within the state; or

(3) providing emergency medical services during a major catastrophe or disaster with which persons or ambulances certified to provide emergency ambulance services are insufficient or unable to cope.

(b) An agency or instrumentatlity of the United States and any emergency medical technicians or ambulances of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed under this chapter.

(Formerly: Acts 1974, P.L. 55, SEC.1). As amended by Acts 1980, P.L.114, SEC.4.

Indiana Code Sec. 16-1-39-13

Sec. 13. Suspension and Revocation Procedure.

(a) After notice and hearing, the commission may and is authorized to suspend or revoke a certificate issued under this chapter, for failure to comply and maintain compliance with, or for violation of, any applicable provisions, standards, or other requirements of this chapter or regulations promulgated under this chapter.

(b) The commission may initiate proceedings to suspend or revoke a certificate upon its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held and conducted in accordance with the provisions of IC 1971, 4-22-1.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section, the commission, upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(d) Upon suspension, revocation, or termination of a certificate the provision of such service shall cease.

(Formerly: Acts 1974, P.L.55, SEC.1).

Indiana Code Sec. 16-1-39-13.5

16-1-39-13.5 Display of green lights on privately-owned vehicles traveling in line of duty; violations

Sec. 13.5. (a) Privately-owned vehicles belonging to any certified emergency medical technician, while traveling in the line of duty in connection with emergency medical services activities, may display green lights, subject to the following restrictions and conditions:

(1) Such lights may not have a light source less than fifty (50) candlepower.

(2) All lights shall be placed on the top of the vehicle.

(3) No more than two (2) green lights may be displayed on any vehicle and each light must be of the flashing or revolving type and visible at three hundred sixty (360) degrees.

(4) The lights must consist of a lamp with a green lens and not of an uncolored lens with a green bulb; however, the revolving lights may contain multiple bulbs.

(5) The green lights may not be a part of the regular head lamps displayed on the vehicles.

(6) In order for an emergency medical technician to display the green light on his vehicle, he must first secure a written permit from the director of the Indiana emergency medical services commission to use the light, and this permit must be carried by him at all times when the light is displayed.

(b) It is a Class C infraction for a person who is not an emergency medical technician to display on any public or private motor vehicle at any time green lights of any size or shape.

(c) Nothing in this section prohibits the operation of a vehicle lawfully equipped with a green light from being operated as any other vehicle when the green light is not illuminated.

(d) a person who is convicted of violating this section and who holds an emergency medical technician certificate may, following the procedures provided in section 13 of this chapter, have the certificate suspended or revoked.

As added by Acts 1976, P.L. 62, SEC.1. Amended by Acts 1978, P.L.2, SEC.1612.

Indiana Code Sec. 16-1-39-14

Sec. 14. Local Governmental Provisions. The provision of emergency medical service is declared to be an essential purpose of the political subdivisions of the state.

(Formerly: Acts 1974, P.L. 55, SEC.1).

Indiana Code Sec. 16-1-39-15

16-1-39-15 Local Procedures

Sec. 15. Local Procedures. The governing body of any city, town, township or county is, by their own action or in any combination thereof empowered to:

(1) establish, operate, and maintain emergency medical services;

(2) levy taxes pursuant to and limited by IC 6-3.5, and expend appropriated funds of the political subdivision to pay the costs and expenses of establishing, operating, maintaining, or contracting for emergency medical services;

(3) authorize, franchise, or contract for emergency medical services; however, no county may provide, authorize, or contract for emergency medical services within the limits of any first, second, or third class city, without the consent of such city; nor may any city or town provide, authorize, franchise, or contract for emergency medical services outside the limits of such city or town without the approval of the governing body of the area to be served.

(4) apply for, receive and accept gifts, bequests, grants-in-aid, state, federal and local aid, and other forms of financial assistance for the support of emergency medical services;

(5) establish and provide for the collection of reasonable fees for emergency ambulance services it provides pursuant to this chapter; and

(6) pay the fees for dues for individual or group membership in any regularly organized volunteer emergency medical services association on their own behalf or on behalf of the emergency medical services personnel serving that unit of government.

(Formerly: Acts 1974, P.L. 55, SEC.1). As amended by Acts 1980, P.L.114.SEC.5.

Indiana Code Sec. 16-1-39-16

Sec. 16. Prosecution of Illegal Acts. The attorney general, the prosecuting attorney, or the commission, where any person shall be in violation of the provisions of this chapter, or any regulations adopted pursuant to this chapter, may, in accordance with the laws of this state governing injunctions, maintain an action in the name of the state of Indiana to enjoin such person from continuing in violation of the provisions of this chapter. However, such injunction shall not relieve any such person from criminal prosecution thereof as provided for in this chapter, but such remedy shall be in addition to any remedy provided for the criminal prosecution of such offense.

(Formerly: Acts 1974, P.L. 55, SEC.1).

Indiana Code Sec. 16-1-39-17

16-1-13-17 Repealed.

Sec. 17.

(History: Repealed by Acts 1978, P.L. 2. SEC.1650).

Indiana Code Sec. 16-1-39-18

Sec. 18. Any monies appropriated by the General Assembly shall be distributed in the manner determined by the General Assembly at the time of the appropriation.

(Formerly: Acts 1974, P.L. 55, SEC.1).

Indiana Code Sec. 16-1-39-19

16-1-39-19 Liability

Sec. 19. (a) An ambulance attendant or a certified emergency medical technician who renders emergency ambulance services to an emergency patient is not liable for his act or omission in rendering those services unless the act or omission constitutes negligence or willful misconduct. If the attendant or technician is not so liable for his act or omission, no other person incurs liability by reason of an agency relationship with the attendant or technician.

(b) This section does not affect the liability of a driver of an ambulance for negligent operation of that ambulance.

As added by Acts 1977. P.L. 183, SEC.8.

Chapter 35. Penalty Clause

Indiana Code Sec. 16-1-35-1 Violations

Sec. 1. A person who recklessly violates or fails to comply with this article commits a Class B misdemeanor, except as otherwise provided. Each day a violation continues constitutes a separate offense.

(NOTE: The penalty provision originally contained in the Emergency Medical Services enabling legislation, I.C. 1971, 16-1-39-17, was repealed in 1978. In its place, the general penalty provision of Title 16, Article 1, I.C. 1971, 16-1-35-1, applies unless a particular section provides otherwise. A Class B misdemeanor carries a maximum inprisonment of 180 days, and a maximum fine of $1,000.00.)

6.2. I.C. 16-1-40-1 through 16-1-40-10

IC. 16-1-40-1 through 16-1-40-10
As of March 1, 1981

Chapter 40. Advanced Life Support

Chpater 40. Advanced Life Support.

Indiana Code Sec. 16-1-40-1

Sec. 1. Definitions. As used in this chapter: (a) "Advanced life support" means care given at the scene of an accident or illness, during transport, or at a hospital by a paramedic or advanced emergency medical technician which is more advanced than that usually rendered by an emergency medical technician, and which may include, but is not limited to, the following:

(1) defibrillation;

(2) endotracheal intubation;

(3) parenteral injections of appropriate medications;

(4) electrocardiogram interpretation; and

(5) emergency management of trauma and illness.

(b) "Commission" means the Indiana emergency medical services commission.

(c) "Paramedic" means a person who:

(1) is affiliated with a certified paramedic organization, is employed by a sponsoring hospital approved by the commission, or is employed by a supervising hospital with a contract for in-service education with a sponsoring hospital approved by the commission;

(2) has completed a prescribed course in advanced life support; and

(3) has been certified by the Indiana emergency medical services commission.

(d) "Provider organization" means an ambulance service provider or other emergency care organization certified by the Indiana emergency medical services commission to provide advanced life support in connection with a supervising hospital.

(e) "Supervising hospital" means a licensed Indiana hospital which has been certified by the Indiana emergency medical services commission to supervise paramedics, advanced emergency medical technicians, and provider organizations in providing advanced life support.

(f) "Advanced emergency medical technician" means a person who can perform one (1) or more but not all of the procedures of a paramedic and who:

(1) has completed a prescribed course in advanced life support;

(2) has been certified by the Indiana emergency medical services commission;

(3) is associated with a single supervising hospital; and

(4) is affiliated with a provider organization.

(g) "Emergency medical services" has the meaning set out in IC 16-1-39-2.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acts 1977, P.L.183, SEC.1; Acts 1980, P.L. 114, SEC.6.

Indiana Code Sec. 16-1-40-2

16-1-40-2 Advanced life support operations committee

Sec. 2. Advanced Life Support Operations Committee. The commission shall appoint an advanced life support operations subcommittee to advise the commission on the development of standards for the certification of provider organizations, paramedics, advanced emergency medical technicians and supervising hospitals, and the development of regulations governing the operation of advanced life support services.

(Formerly: Acts 1975, P.L. 142, SEC.1). As amended by Acts 1977, P.L.183, SEC.2.

Indiana Code Sec. 16-1-40-3

16-1-40-3 Advanced life support services regulations

Sec. 3. Advanced Life Support Services Regulations. The commission shall promulgate rules and regulations which will promote the orderly development of advanced life support services in Indiana. These rules and regulations shall include, but not be limited to, the following:

(a) requirements and procedures for the certification of provider organizations, paramedics, advanced emergency medical technicians and supervising hospitals; and

(b) regulations governing the operation of advanced life support services including the medications and procedures which may be administered and performed by paramedics and advanced emergency medical technicians.

(Formerly: Acts 1975. P.L.142, SEC.1). As amended by Acts 1977, P.L.183. SEC.3.

Indiana Code Sec. 16-1-40-4

16-1-40-4 Scope of practice

Sec. 4. Scope of Practice. (a) Notwithstanding any other provision of law, a certified paramedic or advanced emergency medical technician may perform advanced life support in an emergency according to the rules and regulations of the commission.

(b) Notwithstanding any other provision of law, a person may, during a course of instruction in advanced life support, perform advanced life support according to the rules and regulations of the commission.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acts 1977, P.L.183. SEC.4.

Indian Code Sec. 16-1-40-5

16-1-40-5 Repealed.

Sec. 5. (History: Repealed by Acts 1977, P.L. 183, SEC.9).

Indiana Code Sec. 16-1-40-6

16-1-40-6 Liability

Sec. 6. Liability. An act or omission of a paramedic or advanced emergency medical technician done or omitted in good faith while rendering advanced life support to a patient or trauma victim shall not impose liability upon the paramedic or advanced emergency medical technician, the authorizing physician, the hospital, or the officers, members of the staff, nurses, or other employees of the hospital or the local governmental unit if the advanced life support is rendered in connection with an emergency, and in good faith, and under the written or oral direction of a licensed physician unless the act or omission was a result of negligence or willful misconduct.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acrs 1977, P.L.183, SEC.5.

Indiana code Sec. 16-1-40-7

16-1-40-7 Review of operations

Sec. 7. Review of Operations. The commission shall develop procedures for ongoing review of all emergency ambulance services.

The commission may review any prehospital ambulance rescue or report record, regarding an emergency patient, which is utilized or compiled by an emergency ambulance service employing paramedics, emergency medical technicians, or advanced emergency medical technicians; however, those records shall remain confidential and may be used solely for the purpose of compiling data and statistics. The use of such data or statistics is subject to the provisions of IC 4-1-6.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acts 1977, P.L.183, SEC.6; Acts 1980, P.L.114, SEC.7.

Indiana Code Sec. 16-1-40-8

16-1-40-8 Exemptions

Sec. 8. Exemptions. (a) A certificate shall not be required for a person who provides advanced life support while assisting in the case of a major catastrophe or disaster whereby persons who are certified to provide emergency medical services or advanced life support are insufficient in number or are unable to cope with the situation.

(b) An agency or instrumentality of the United States and any paramedics or advanced emergency medical technicians of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed under this chapter.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acts 1977, P.L.183, SEC.7; Acts 1980, P.L.114, SEC.8.

Indiana Code Sec. 16-1-40-9

Sec. 9. Suspension and Revocation Procedure.

(a) After notice and hearing, the commission may suspend or revoke a certificate issued under this chpater, for failure to comply and maintain compliance with, or for violation of, any applicable provisions, standards, or other requirements of this chapter or regulations promulgated under this chapter.

(b) The commission may initiate proceedings to suspend or revoke a certificate upon its own motion, or on the verified written complaint of any interested person, and all proceedings shall be held according to IC 1971, 4-22-1.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section, the commission, upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(d) Upon suspension, revocation, or termination of a certificate the provision of service shall cease.

(Formerly: Acts 1975, P.L.142, SEC.1).

Indiana Code Sec. 16-1-40-10

16-1-40-10 Necessity of certificate; violation, offense; injunction

Sec. 10. (a) No person, except:

(1) a physician with an unlimited license to practice medicine;

(2) a registered nurse, or an individual acting under the supervision of a physician with an unlimited license to practice medicine; or

(3) a person providing health care in a hospital or ambulatory outpatient surgical center licensed under IC 16-10-1;

may furnish, operate, conduct, maintain, advertise, or otherwise be engaged in providing advanced life support as a part of the regular course of doing business, either paid or voluntary, unless the person holds a valid certificate or provisional certificate issued by the commission to provide advanced life support.

(b) Notwithstanding subsection (a):

(1) a physician with an unlimited license to practice medicine;

(2) a registered nurse, or an individual acting under the supervision of a physician with an unlimited license to practice medicine; or

(3) a person providing health care in a hospital or ambulatory outpatient surgical center licensed under IC 16-10-1;

who operates a business of operating an emergency ambulance service which provides advanced life support must hold a valid certificate issued by the commission under this chapter.

(c) A person who violates this section commits a Class C misdemeanor. Each day of continued violation of this section is a separate offense.

(d) The attorney general, the prosecuting attorney, or the commission, where any person is in violation of this section, or any regulations adopted according to this chapter, may, according to the laws governing injunctions, maintain an action in the name of the state to enjoin the person from continuing the violation. However, the injunction does not relieve any person from criminal prosecution but is in addition to any remedy provided for the criminal prosecution of the offense.

(Formerly: Acts 1975, P.L.142, SEC.1). As amended by Acts 1978, P.L.2, SEC.1613; Acts 1980, P.L.114, SEC.9.

(Note: A Class C misdemeanor is punishable by a fixed term of up to 60 days imprisonment and/or a fine of up to $500.)

6.3. Proposed Legislation

Following two years of efforts by the EMS Commission and other concerned agencies, the Indiana General Assembly in March 1980 passed House Enrolled Act 1163. The bill as signed by Governor Otis R. Bowen, M.D., expanded the Commission to thirteen, defined Emergency Medical Services, and clarified some sections of the original legislation.

At the present time, the EMS Commission has no specific plans for seeking additional legislative authority.

6.4. Compilation of EMS-related Statutes

The staff of the EMS Commission is currently compiling into one document, all existing Indiana Legislation pertaining to EMS.

The study is being done with the help and cooperation of the Legislative Council, by searching their computer record of all laws for key words/phrases.

It is anticipated the study will be complete by the September 1982 EMS Commission meeting.

The following is the format the report will be in:

I. Enabling Legislation
   - A. Emergency Medical Services; Basic Life Support
   - B. Advanced Life Support
   - C. Relationship of Rules and Regulations to Enabling Legislation

II. Local Government Provisions
   - A. Authority in Enabling Legislation
   - B. Statutory requirements for local government interaction vis-a-vis EMS
   - C. Additional statutory provisions
     1. Contracting procedure
     2. Public purchasing procedure
     3. Taxing authority

III. Ambulance Driving Requirements
   - A. Driver Qualification (age, license required)
   - B. Status as "Authorized Emergency Vehicle"
   - C. Exemptions from Traffic Rules
     1. Privileges allowed
     2. Vehicles eligible
     3. Conditions required
        - a. Status of emergency run
        - b. Warning signals utilized
   - D. Warning Signals Required; State Law
     1. Audible
     2. Visual
   - E. Obligations Imposed upon the Public; Right-of-way
     1. Motorists
     2. Pedestrians

F. Ambulance Driver Responsibilities
    1. Duty
    2. Liability

IV. Suspension and Revocation of Certificates
    A. Grounds
    B. Procedure
        1. Initiation
        2. Indiana Administrative Adjudication Act

V. Enforcement of Standards (Statutory and Regulatory)
    A. Injunction
    B. Prosecution

VI. Authority at the Accident Scene: Narrative Statement
    A. EMS Personnel vis-a-vis Law Enforcement Personnel
    B. Coronor's Law

VII. Limitations upon Liability
    A. Emergency Medical Technicians, Advanced Emergency Medical Technicians; Paramedics
    B. Ambulance Drivers and Other Non-Certified Personnel
    C. Employers
        1. Publicly-operated services
        2. Privately-owned services
    D. "Good Samaritan" law; Other provisions protecting non-EMS volunteers
    E. The standard of care required; discussion of negligence

6.5. Official Rules and Regulations for Operation and Administration of Emergency Medical Services

for one (1) of the two (2) next succeeding examinations. After two (2) examinations have been held following any failure, the candidate may be required to retake both the theoretical and practical examinations. *(Indiana State Board of Dental Examiners; PT 2, Rule 12; filed Aug 10, 1973, 11:00 am: Rules and Regs. 1974, p. 53; filed Nov 7, 1980, 12:45 pm)*

LSA Document #0-101(F)
Proposed Rules Published: August 1, 1980; 3 IR 1377
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Approved by Governor: November 3, 1980
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TITLE 836 INDIANA EMERGENCY MEDICAL SERVICES COMMISSION

LSA Document #9-161(F)

DIGEST

Amends rules concerning basic and advanced life support. Adds rules concerning air ambulance service.

836 IAC 1-1	836 IAC 1-6-1
836 IAC 1-2	836 IAC 1-6-2
836 IAC 1-3	836 IAC 1-6-6
836 IAC 1-4	836 IAC 1-7
836 IAC 1-5	836 IAC 2

SECTION 1. 836 IAC 1-1-1 is amended to read as follows:

836 IAC 1-1-1 Definitions
Authority: IC 16-1-39-6
Affected: IC 16-1-39-2; IC 16-1-39-12

Sec. 1. DEFINITIONS USED IN THESE RULES AND REGULATIONS SHALL HAVE THE FOLLOWING MEANING UNLESS THE CONTEXT CLEARLY DENOTES OTHERWISE: (a) "Commission" shall mean the Emergency Medical Services Commission of the State of Indiana.

(b) "Director" shall mean the Director of the Emergency Medical Services Commission of the State of Indiana.

(c) "Person" shall mean any natural person or persons, firm, partnership, corporation, company, association or joint stock association and the legal successors there of including any governmental agency or instrumentality, other than an agency or instrumentality of the United States, except that:

(1) "An agency or instrumentality of the United States" as that phrase is used in IC 16-1-39-12(b), is defined to exclude all non-governmental entities which have a contract with the Government of the United States or any bureau, board, commission, or any statutorily created entity thereof.

(d) "Emergency patient" shall mean an individual who is acutely ill, injured, or otherwise incapacitated or helpless and who requires emergency care.

(e) "Ambulance" shall mean any conveyance on land, sea, or air that is used or is intended to be used, for the purpose of responding to emergency, life-threatening situations and providing emergency transportation service.

(f) "Ambulance service provider" shall mean any person who engages in or seeks to furnish, operate, conduct, maintain, advertise or otherwise engage in services for the transportation and care of emergency patients as a part of a regular course of doing business, either paid or voluntary.

(g) "Emergency medical technician" shall mean any individual certified by the Emergency Medical Services Commission as ~~eligible for engaging in~~ responsible for the administration of emergency care procedures to emergency patients and for the handling and transportation of such patients.

(h) "Certificate" or "Certification" ~~shall mean authorization in written form issued by the commission to a person to operate and maintain an emergency ambulance, to act as an ambulance service provider or to exercise the privileges of an emergency medical technician as defined in these rules and regulations.~~ means authorization in written form issued by the commission to a person to furnish, operate, conduct, maintain, advertise, otherwise engage in providing emergency medical services as a part of a regular course of doing business, either paid or voluntary.

(i) "Emergency ambulance services" means the transportation of emergency patients by ambulance, and the administration of emergency care procedures to emergency patients before, or during such transportation.

(j) "Emergency medical services" means the provision of emergency ambulance services or other services utilized in serving an individual's need for immediate medical care in order to prevent loss of life aggravation of physiological or psychological illness injury.

(k) "ATCO" means Air Taxi and Commercial Operators, with reference to Air Taxi and Commercial Operators, operations certificate outlined in Federal Aviation Regulations, Part 35.

(l) "F.A.A." shall mean the Federal Aviation Administration.

(m) "F.A.R." shall mean the Federal Aviation Regulations including but not limited to the following parts:

(1) Federal Aviation Regulations relative to the certification of pilots and instructors;

(2) Federal Aviation Regulations relative to medical standards and certification of pilots and other F.A.A. related personnel;

(3) Federal Aviation Regulations relative to general operating and flight rules; and

(4) Federal Aviation Regulations relative to air taxi and commercial operators of small aircraft.

(n) A.G.L.—Above Ground Level. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Preliminary; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 84; filed Nov 3, 1980, 3:55 pm)*

SECTION 1. 836 IAC 1-2-1, as amended at 3 IR 2192, SECTION 2, is amended to read as follows:

836 IAC 1-2-1 General certification provisions

Authority: IC 16-1-39-6

Affected: IC 4-22-1; IC 16-1-39-9; IC 16-1-39-13

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (a) Unless otherwise specified, the provisions of 836 IAC 1-2 shall be in full force and effect as of January 1, 1978, however, the Commission may, upon receipt of proper application, certify ambulance service providers on or after January 1, 1976.

(b) A person shall not engage in the business or service of providing emergency ambulance services upon any public way of the state unless he holds a valid certificate issued by the commission for engaging in such a business or service as an ambulance service provider.

(c) A certificate shall not be required for a person who provides emergency ambulance service, an emergency medical technician, or an ambulance when:

(1) rendering assistance to persons certified to provide emergency ambulance service or to emergency medical technicians.

(2) operating from a location or headquarters outside of this state in order to provide emergency ambulance services to patients who are picked up outside the state for transportation to locations within the state; or

(3) providing emergency medical services during a major catastrophe or disaster with which persons or ambulance services are insufficient or unable to cope.

(4) an agency or instrumentality of the United States and any emergency medical technicians or ambulances of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed under 836 IAC 1-1-1(c)(1).

(d) Each ambulance, while transporting an emergency patient, shall be manned by not less than two (2) persons, one of whom must be a certified emergency medical technician and who must be in the patient compartment, unless an exemption is approved by the Commission through 836 IAC 1-2-1(h) or 836 IAC 1-7-3(h).

(e) After notice and hearing, the commission may and is authorized to suspend or revoke a certificate issued under IC 16-1-39 for failure to comply and maintain compliance with, or for violation of, any applicable provisions, standards, or other requirements of IC 16-1-39 or regulations promulgated under Title 836 of the Indiana Administrative Code. The commission may initiate proceedings to suspend or revoke a certificate upon its own notion, or on the verified written complaint of any interested person, and all such proceedings shall be held and conducted in accordance with the provisions of IC ~~1971,~~ 4-22-1.

(f) Notwithstanding the ~~provisions~~ provision of

~~subsections (d) and~~ subsection (e) of this section, the commission, upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(g) Upon suspension, revocation, or termination of a certificate the provision of such service shall cease.

(h) An ambulance owner or lessee seeking certification of a land ambulance which is specially staffed, equipped ~~and~~ or uniquely designed to provide inter-hospital emergency transportation of critical care patients, ~~i.e.,~~ for example; coronary care, high risk infant, poisoning, psychiatric, and alcohol and drug overdose, may petition the Commission for exemption from one or more of the specifications or requirements listed in ~~836 IAC 1-2-3(e),~~ 836 IAC 1-2-1(d), ~~836 IAC 1-3-3(1), (2), (3), (5), (6), (7), and (9)~~ 836 IAC 1-3-3(a), (b), (c), (e), (f), (g), and (i), and 836 IAC 1-3-~~4(2)~~(a)(2). If an exemption is requested from ~~836 IAC 1-2-3(e)~~ 836 IAC 1-2-1(d), the application shall include a description of the medical capability of each person who usually staffs the patient compartment when transporting an emergency patient. The Commission may approve one or more of the requested exemptions and grant certification. However, the Commission may restrict any exemption(s) approved under this rule [*836 IAC 2*]. Exemption(s) requested shall not be approved, if in the opinion of the Commission, the exemption(s) would impair the capabilities of the ambulance service provider to provide proper emergency patient care.

(i) An ambulance owner or lessee seeking certification of other than a land or air ambulance may petition the Commission for an exemption from one or more of these rules and regulations [*836 IAC 1 and 836 IAC 2*]. The air ambulance provision of this subsection expires January 1, 1982. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I, A; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 84; filed Dec 15, 1977: Rules and Regs. 1978, p. 244; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 pm: 3 IR 2192; Errata 4 IR 531; filed Oct 13, 1981, 10:05 am)*

SECTION 2. 836 IAC 1-2-2, as amended at 3 IR 2193, SECTION 3, is amended to read as follows:

836 IAC 1-2-2 Application for certification

Authority: IC 16-1-39-6

Affected: IC 16-1-39-11

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Application for ambulance service provider certification shall be made on such forms as may be prescribed by the commission, and the applicant shall comply with the following requirements:

(1) Applicants shall complete the required forms, and submit same to the director not less than sixty (60) days prior to the requested effective date of the certificate.

(2) Each ambulance, with its equipment as required by these rules and regulations [*836 IAC 1*], shall be made available for inspection by the director, or his duly authorized representative.

(3) The premises on which ambulances are parked or garaged and on which ambulance supplies are stored shall be open during business hours to the director, or his duly authorized representative, for inspection.

(4) A complete listing of personnel to be utilized as emergency medical technicians and ambulance drivers shall be submitted to the director. The director shall be notified in writing within thirty (30) days of any change in personnel.

(5) Each applicant shall provide the director with the following:

(A) A description of the proposed service area.

(B) Evidence of capability to service the proposed service area, including hours of operation, number of ambulances available during business hours, and type and number of personnel on duty and/or on-call during business hours, and shall notify the director in writing within thirty (30) days of any changes.

(C) Proof of insurance coverage in adequate amounts as specified in 836 IAC 1-2-~~3(6)~~(f) shall be submitted with the application and shall be renewed thirty (30) days prior to the expiration of the current insurance.

(D) Other information as required by the commission.

(b) Upon approval by the commission, a certificate shall be issued by the director. The certificate shall be valid for a period of one (1) year from the date of issue unless earlier revoked or suspended by the commission, and shall be prominently displayed at the place of business.

(c) Application for ambulance service provider certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certificate to assure continuity of certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall indicate compliance with the requirements as set forth for original certification, including ambulance inspection.

(d) Upon application the director may grant temporary approval for certification or certification

renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application for initial certification or certification renewal if the applicant is in full compliance with these rules and regulations [*836 IAC 1*], as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I,B; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 86; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 218; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 pm: 3 IR 2193; filed Oct 13, 1981, 10:05 am)*

SECTION 4. 836 IAC 1-2-3 is amended to read as follows:

836 IAC 1-2-3 Ambulance service provider operating procedures

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9; IC 34-4-16.5-1

Sec. 3. AMBULANCE SERVICE PROVIDER OPERATING PROCEDURES. (a) Each ambulance service provider shall maintain accurate records concerning the transportation of each emergency patient within the state including an ambulance and rescue record on a form prescribed by the commission.

(b) An ambulance service provider shall not operate a land ambulance on any public way in this state if the ambulance is not in full compliance with the ambulance certification requirements established by the commission and set forth in these rules and regulations [*836 IAC 1*], and which does not have a certificate issued pursuant to IC 16-1-39, except as follows:

(1) An ambulance service provider may operate, for a period not to exceed thirty (30) consecutive days, a non-certified ambulance if the non-certified ambulance is used to replace a certified ambulance that has been temporarily taken out of service for repair or maintenance, providing that:

(A) The replacement ambulance must meet all certification requirements except 836 IAC 1-3-3(4)(B) and (C), and 836 IAC 1-3-3(10)(A).

(B) The ambulance service provider notifies the commission by letter delivered to the commission office, or postmarked, within seven (7) days of the date the replacement ambulance is placed in service. The letter shall identify the replacement date, the certification number of the replaced ambulance and the vehicle identification number of the replacement ambulance. Upon receipt of the letter the director shall issue a temporary certificate effective the date the certified ambulance was replaced. Temporary certifi-

cation shall not exceed thirty (30) days, and the replaced ambulance shall be returned to service upon completion of the required repair or maintenance if less than thirty (30) days, and upon return to service the use of the replacement vehicle shall cease and the temporary certificate shall be returned to the director. If the replaced ambulance is not returned to service within the thirty (30) day period, use of the replacement ambulance shall cease unless certification is approved through 836 IAC 1-8.

~~(2)~~(C) Premises shall be maintained, suitable to the conduct of the ambulance service, with provision for adequate storage~~, garaging, and/or~~ and maintenance of ambulances and equipment.

~~(3)~~(D) Each ambulance service provider shall provide for a periodic maintenance program to assure that all ambulances, including equipment, are maintained in good working condition and that rigid sanitation procedures are in effect at all times.

~~(4)~~(E) All ambulance service provider premises, records, garaging facilities, and ambulances shall be made available for inspection by the director, or his duly authorized representative, at any time during regular business hours.

~~(5)~~(F) The insurance requirement of IC 16-1-39-9(b) is satisfied if the ambulance service provider; (a) has in force and effect public liability insurance in the sum of not less than ~~$100,000 for injuries to one person, and $300,000 for injuries to more than one person in one accident, and property damage insurance in a sum of not less than $100,000~~ $300,000 combined single limit, issued by an insurance company licensed to do business in the State of Indiana, or, (b) is a governmental entity within the meaning of IC 34-4-16.5-1, et. seq. Coverage must be for each and every ambulance owned and/or operated by or for the ambulance service provider.

~~(6)~~(G) Each ambulance service provider shall provide and maintain a communication system which meets or exceeds the requirements set forth in ~~Rule III~~ 836 IAC 1-4 of these rules and regulations.

~~(7)~~(H) Each ambulance service provider shall designate one (1) person to assume responsibility for in-service training. This person shall be certified as an emergency medical technician, a registered nurse, or a licensed physician.

~~(8)~~(I) Each ambulance service shall submit an annual report in the manner prescribed by the commission.

~~(9)~~(J) An ambulance service provider shall not ~~engage in conduct or practices detrimental~~ to act in a reckless or negligent manner so as to endanger the health ~~and~~ or safety of emergency patients or to members of the general public while in the course of business as an ambulance service provider.

(K) After December 31, 1980, each ambulance service provider shall notify the director within thirty (30) days of the present and past specific location of any ambulance if the location of the ambulance is changed from that specified in the provider's application for ambulance service provider certification or certification renewal.

(L) After December 31, 1980, each fully certified ambulance shall display the last four (4) numbers of the commission assigned ambulance certification number. The four numbers, in sequence, shall be placed on each side of the ambulance on the right and left front fenders and above license plate on left rear door. Each number shall be in block, blue letters not less than three (3) inches in height. Reflective material is recommended. The numbers shall be placed on the vehicle within seven (7) days of the receipt of the ambulance certificate. The numbers shall be removed or permanently covered by the ambulance service provider when the ambulance is permanently removed from service by the ambulance service provider.

(M) After December 31, 1980, each ambulance service provider shall apply the certified vehicle sticker, supplied by the commission, to the inside and lower rear corner of the window of the curb-side patient compartment door.

(N) After December 31, 1980, each ambulance service provider shall, within seven (7) consecutive days of the date a certified ambulance is permanently withdrawn from service, return to the director the certificate and window sticker issued by the commission for the ambulance.

(O) After December 31, 1980, no certified ambulance service provider may operate any non-certified vehicle that displays to the public any word, phrase or markings which implies in any manner that the vehicle is an ambulance as defined in IC 16-1-39.

(P) Each provider shall insure that rigid sanitation procedures are in effect at all times. The following sanitation standards shall apply to all ambulances:

(i) The interior and the equipment within

the vehicle shall be clean and maintained in good working order at all times.
(ii) Freshly laundered linen or disposable linens shall be used on cots and pillows, and linen shall be changed after each patient is transported.
(iii) Clean linen storage shall be provided.
(iv) Closed compartments shall be provided within the vehicle for medical supplies.
(v) Closed containers shall be provided for soiled supplies.
(vi) Blankets shall be kept clean and stored in closed compartments.
(vii) Implements inserted into the patient's nose or mouth shall be single-service, wrapped and properly stored and handled. Multi-use items are to be kept clean and sterile when indicated and properly stored.
(viii) When a vehicle has been utilized to transport a patient known to have a communicable disease, the vehicle shall be cleansed and all contact surfaces shall be washed with soap and water and disinfected.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I,C; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 86; filed May 10, 1977, 10:52: Rules and Regs. 1978, p. 218; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 pm)

SECTION 3. 836 IAC 1-3-1, as amended at 3 IR 2196, SECTION 5, is amended to read as follows:

836 IAC 1-3-1 General certification provisions
Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (a) Unless otherwise specified, the provisions of 836 IAC 1-3 of these rules and regulations shall be in full force and effect as of January 1, 1978, however, the commission may, upon receipt of proper application, certify ambulances on or after January 1, 1976.

(b) All ambulances ordered for purchase, or leased, on or after June 1, 1975, should meet the minimum specifications as set forth in 836 IAC 1-3. Ambulances ordered or leased on or after June 1, 1975 which do not meet minimum specifications will not be eligible for certification, except as defined under 836 IAC 1-2-1(h).

~~(c) Ambulance owner or lessee may petition the commission for certification on or after January 1, 1976.~~

~~(d) Ambulance owner or lessee may apply for provisional certification for ambulances which do not meet specifications under the following conditions:~~
~~(1) Ambulance owner or lessee shall petition the commission for provisional certification on or after January 1, 1976, but prior to January 1, 1978.~~
~~(2) The petition for provisional certification shall be made on such forms as may be prescribed by the commission and shall specify the degree of variance from one or more specifications.~~
~~(3) Ambulances ordered or leased on or after June 1, 1975 which do not meet minimum specifications will not be eligible for provisional certification.~~
~~(4) Ambulances with an inside patient compartment height of less than forty (40) inches will not be eligible for provisional certification.~~
~~(5) Approval for provisional certification shall not be made if variances will, in the opinion of the commission, substantially impair the capabilities of the ambulance service provider to provide proper emergency patient care.~~
~~(6) Provisional certification will be issued only once for any one ambulance.~~
~~(7) Misrepresentation of facts on application for provisional certification shall be cause for denial and/or revocation of same.~~
~~(8) All provisional certificates issued under the provisions of 836 IAC 1-3-1(d), shall expire December 31, 1980, and shall not be renewable.~~

~~(c)~~(c) Procedures for suspension, revocation, or termination of a certificate included under 836 IAC 1-2-1~~(d)~~, (e), (f), and (g) shall apply to certification for ambulances. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II,A; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 87; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 pm: 3 IR 2196; Errata 4 IR 531; filed Oct 13, 1981, 10:05 am)*

SECTION 6. 836 IAC 1-3-2 is amended to read as follows:

836 IAC 1-3-2 Application for certification
Authority: IC 16-1-39-6
Affected: IC 16-1-39-11

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Application for ambulance certification shall be made by the owner or lessee on such forms as may be prescribed by the commission, and shall comply with the following requirements:

(1) Applicants shall complete the required forms, and submit same to the director within ten (10) days after the effective date of ~~sale~~ purchase or lease. Temporary certification for ~~vehicle~~ ambulance use may be issued by the director for a period not to exceed ninety (90) days to allow the commission to act upon the application.

(2) Each ambulance for which certification is requested shall be made available for inspection by the director, or his duly authorized representative, with its equipment as required by these rules and regulations [*836 IAC 1*] prior to approval for certification.

(b) Upon approval by the commission, a certificate shall be issued by the director to the ambulance owner or lessee. The certificate shall be prominently displayed within the ~~vehicle as prescribed by the commission when operating as an emergency vehicle in the transport of emergency patients on a public way of the state~~ ambulance patient compartment.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II.B; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 88; filed Nov 3, 1980, 3:55 pm)

SECTION 4. 836 IAC 1-3-3, as amended at 3 IR 2197, SECTION 7, is amended to read as follows:

836 IAC 1-3-3 Ambulance specifications; land

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 3. AMBULANCE SPECIFICATIONS—LAND. The following specifications shall apply to all land ambulances (excludes air and water conveyances). (a) Performance Characteristics—All ambulances shall meet or exceed the following minimum performance characteristics:

(1) Vehicle Braking System—Vehicle brakes shall be of the power assist type. Front disc brakes are preferred.

(2) Engine—The vehicle engine shall be a six (6) or eight (8) cylinder, internal combustion, liquid cooled engine which meets ambulance chassis manufacturer's standard horse power/displacement requirements.

(3) Speed—The fully loaded vehicle shall be capable of a sustained speed of at least 55 MPH over dry, level, hard-surfaced roads.

(4) Transmission—The vehicle transmission shall have a minimum of three (3) forward gears. Automatic transmission is recommended.

(5) Steering system—The steering system shall be the manufacturer's recommended design and shall be power assisted.

(6) Suspension system—Shock absorbers shall be of the heavy duty, double action type.

(7) Tires—Tires shall meet the manufacturer's standards for the gross vehicle weight of the vehicle.

(b) Physical Characteristics—All ambulances shall meet or exceed the following minimum physical characteristics:

(1) Width—The overall width of the vehicle shall be a minimum of 75 inches and shall not exceed 96 inches. Vehicle width shall be measured at the rear of the vehicle from a point even with the outer edge of the bumper on the driver's side to the outer edge of the bumper on the passenger's side.

(2) Height—The overall vehicle exterior height shall be a maximum of 110 inches which shall be measured at curb weight from the ground to a point which is level with the top of the vehicle, including emergency warning devices, but excluding two-way radio antenna.

(3) Wheelbase—A wheelbase of 123 inches, minimum, is recommended. See 836 IAC 1-3-3~~(5)(A)~~ (e)(1) for minimum inside length of patient compartment.

(c) Electrical System—All ambulances shall meet or exceed the following minimum specifications for electrical systems:

(1) Wiring—Wiring is to be made up into harnesses, properly sized and coded. These are to be reasonably accessible for checking and maintenance. In any area where wiring would be exposed to the elements, it must be protected by weatherproof harness or loom. This loom is to be installed so as to eliminate the possible entrance of water which could cause damage through freeze-bursting. Wiring, in loom or otherwise, will not be accepted if in the area of "wheel wash" abrasion. Wiring is to be protected by rubber grommet or plastic bezel at any point where it may pass through, or over the edge of any metal panel, unless the hole or edge of the metal is hemmed or flanged. Wiring connectors and terminals shall be the manufacturer's recommended standard. Horizontal wiring shall be supported by insulated clips located and spaced to minimize "sag." It is recommended that complete wiring diagrams for standard and for optional equipment be supplied for each vehicle. Ambulance body and accessory electrical equipment should be served by circuit(s) separate and distinct from vehicle chassis circuits.

(2) Electrical Generating System—The generating system shall consist of a 105 ampere alternator minimum.

(3) Batteries—Two (2) batteries shall be provided, each with a 70 amp. hour rating, with switching system to operate each separately or both simultaneously, with capability to completely disconnect both batteries.

(4) Driver compartment lighting—Lighting shall

be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or his line of vision, from instrument panel, switch panel or other areas that may require illumination while the vehicle is in motion.

(5) Patient Compartment Lighting—Illumination must be adequate throughout the compartment, and provide an intensity of 35 foot candles at the level of the patient for adequate observation of vital signs, (such as skin color and pupillary reflex, and for care in transit), and such illumination shall be automatically activated when opening the patient compartment doors in addition to being controlled by a switch panel in the patient compartment located at the head of the patient. Reduced light level may be provided by rheostat control of the compartment lighting, or by a second system of low intensity lights.

(6) Suppression, ignition, and radio—The ignition system shall be suppressed to prevent interference with radio transmission and receiving.

(7) Illumination devices—Exterior—Portable or body mounted flood light(s) shall be provided so as to illuminate a half-circle as wide as the vehicle as to a point six (6) feet behind the vehicle on its center line. After December 31, 1981, the light(s) must be body mounted and activated when rear door(s) are opened.

(8) Circuit breakers—All circuits must be protected by automatic circuit breakers of proper capacity.

(9) Effective January 1, 1982, each ambulance for which certification is requested shall have an audible back-up warning device that is activated when the ambulance is shifted into reverse.

(d) External Identification—All ambulances shall meet the following requirements for external identification:

(1) Warning lights—Warning lights shall be red or red and white, at the discretion of the owner, and must be in conformance with Indiana state law.

(2) Exterior Vehicle Color—The color of the exterior surface of the vehicle shall be basically white in combination with Omaha orange (formulated without black) and blue lettering. A band (stripe) of orange not less than six inches wide, nor more than 14 inches wide shall appear as a stripe near parallel to the road. It is recommended that the word "AMBULANCE", in block, blue letters, not less than four (4) inches high be mirror image centered above the front grill.

(3) Emblems and Markings—~~The "Star of Life Symbol" shall be on each side of the body, on the rear and on the front if the body design allows. Placement of identification markings on the roof of the vehicle is also preferred. Specification for use of the "Star of Life Symbol" shall conform to U.S. Department of Transportation Standards. Reflective markings are recommended.~~ If the vehicle meets U.S. Department of Transportation specifications at time of manufacture the "Star of Life" symbol should be displayed.

(e) Ambulance Body—All ambulance bodies must meet or exceed the following minimum specifications:

(1) Inside length of patient compartment—The length of the patient compartment shall be a minimum of 111 inches and shall provide a minimum of 25 inches clear space at the head and 10 inches at the foot of a 76" litter.

(2) Inside width of the patient compartment—A minimum of 12 inches aisle width the full length of the stretcher must be provided. ~~In vehicles with less than 48 inches headroom, the compartment shall provide space for the technician to perform external cardiac compression when the technician is at a right angle kneeling position to the side of the patient, with 25 inches free of unobstructed space for lower legs and feet measured at the floor from the forward edge of the squad bench or attendant's seat, back to a point which is half the length of the stretcher. After December 31, 1980, only the aisle width requirement of this rule (e)(2) is in effect.~~

(3) Inside height of patient compartment—The inside height of the patient compartment shall be a minimum of 48 inches, measured floor to ceiling in the center of the patient compartment. A height of 60 inches is strongly recommended.

(4) Technician seating—patient compartment—One seat shall be provided within the patient compartment for the technician, the dimensions of which shall be at the discretion of the owner.

(5) Bulkhead between driver and patient compartments—If a bulkhead or partition is provided between the driver and patient compartments, there shall be a means of voice or signal communication between the driver compartment and the patient compartment.

(f) Construction—All ambulances must meet or exceed the following minimum standards of construction:

(1) Body structure—The body structure shall be of prime commercial quality metal or other material with strength at least equivalent to all-steel. Wood shall not be used for structural framing. The exterior of the body shall be finished smooth with symmetrically rounded corners and edges except for rub rails, presenting a modern and aerodynamic

appearance, and shall embody provisions for ~~doors~~ door and windows specified herein. Ambulance body as a unit shall be of sufficient strength to support the entire weight of the fully loaded vehicle on its top or side if overturned, without crushing, separation of joints or permanently deforming roof bow or reinforcements, body posts, doors, strainers, stringers, floor, inner linings, outer panels, rub rails and other reinforcements.

(2) Doors—The vehicle shall provide for large loading door or doors on the right side and at the rear of the vehicle. Rear patient compartment doors shall incorporate a tension, spring or plunger type holding device to prevent the door(s) from closing unintentionally from wind or vibration. Holding devices on the side door(s) are recommended.

(3) Floor—Floor shall be at the lowest level permitted by clearances. It shall be flat and unencumbered in the access and work area. Floor may be metal properly reinforced to eliminate "oil canning", and insulated against outside heat and cold. The floor may also be marine plywood provided the plywood is sufficient in thickness to rigidly take the loads imposed upon it. A combination of plywood over metal will be acceptable provided the surfaces between are coated with waterproof adhesive. There shall be no voids or pockets in the floor to side wall areas where water or moisture can become trapped to cause rusting and/or unsanitary conditions.

(4) Floor covering—The floor covering shall be one piece and skid resistant, and shall extend the full length and width of the compartment. Linoleum vinyl or urethane quartz poured not less than 1/16 inch in thickness permanently applied is recommended. Covering joints at the side walls, where side panels and covering meet shall be sealed and bordered with ~~rustproof~~ rust proof corrosion-resistant metal cove moulding.

(g) Windows—All windows in the patient compartment shall be optional. No windows on the left side of the patient compartment is preferred.

(h) Mirrors—There shall be two large exterior, rear-view mirrors, one mounted on the left side of the vehicle and one mounted on the right side. Exterior mirrors shall be mounted below eye level.

(i) Patient Compartment—Refer to Ambulance Body, 836 IAC 1-3-3 (e)(1), (2) and (3), for compartment capacity. In addition, the patient compartment shall meet the following minimum requirements:

(1) Litter fasteners—Crash-stable fasteners must be provided to secure litters to the floor or side walls. Where a single patient may be centered in the area on the wheeled litter, additional attachments should

Final Rules

be provided.

(2) Litter restraint—If the litter is floor supported on its own support wheels, a means shall be provided to secure it in position under all conditions. These restraints shall permit quick attachment and detachment for quick transfer of patient.

(3) Patient restraint—A restraining device consisting of at least three (3) straps (chest, hip and knee), shall be provided to prevent longitudinal or transverse dislodgement of the patient during transit, or to restrain an unruly patient or prevent injury or aggravation of his existing injury.

(j) Communications—All ambulances shall meet or exceed the following minimum communication standards:

(1) Two-way radio—Two-way radio communication equipment shall conform to the requirements set forth in these rules and regulations [*836 IAC 1*].

(2) Sirens—Type and number of sirens are at the discretion of the purchaser, but shall conform to Indiana State Law.

(k) Environmental Equipment—All ambulances shall meet or exceed the following minimum requirements for environmental equipment:

(1) Heating—Separate heating units shall be provided for the driver and patient compartments. The driver compartment shall provide for window defrosting.

(2) Air conditioning—An adequate air conditioning system shall be provided for cooling both driver and patient ~~compartments~~ compartment.

(3) Insulation—The patient compartment shall be heavily insulated to minimize conduction of heat, cold, or external noise entering the vehicle interior.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II,C; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 88; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 218; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 219; filed Nov 3, 1980, 3:55 pm: 3 IR 2197; Errata 4 IR 531; filed Oct 13, 1981, 10:05 am)

836 IAC 1-3-4 Ambulance rescue equipment; land

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 4. AMBULANCE RESCUE EQUIPMENT—LAND. The mission of extrication ~~is~~ should not ~~to~~ be primarily designated to the ambulance service provider, but ~~is to~~ should be left to the fire service or other locally designated emergency agency.

The following minimum equipment shall apply to land ambulances only (excludes air and water conveyances).

(1) Equipment for Safeguarding Personnel—Equipment for safeguarding personnel shall include one (1) 10 # ABC dry chemical fire extinguisher.

(2) Equipment for release from entrapment or confinement—Minimum equipment shall include the following:

one hammer 5#, 15" handle
one wrecking bar, 24" combination tool
two ropes, 50 foot, ½" nylon or equivalent
24" bolt cutters with ⅜" opening with insulated handles.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II, D; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 93; filed Nov 3, 1980, 3:55 pm)

SECTION 9. 836 IAC 1-3-5 is amended to read as follows:

836 IAC 1-3-5 Emergency care equipment

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 5. EMERGENCY CARE EQUIPMENT. (a) Each and every ambulance shall be provided with the following minimum emergency care equipment:

(1) Portable Suction Apparatus, capable of a minimum vacuum of 300mm mercury, with wide-bore tubing and rigid pharyngeal suction tip.

(2) Bag-Mask Ventilation Unit, hand-operated, with adult and child-size masks. Clear masks are preferable. Valves must operate in cold weather, and unit must be capable of use with oxygen supply.

(3) Oropharyngeal Airways, adult, child and infant sizes.

(4) Until July 1, 1981, Mouth-to-Mouth Artificial Ventilation Airways for adults and children.

(5) Portable Oxygen Equipment of at least 300 liters capacity (D size cylinder) with yoke, medical regulator, pressure gauge and non-dependent flowmeter with adequate tubing and semi open valveless, transparent masks in adult, child and infant sizes.

(6) ~~Mouth Gags~~ Bite Sticks, Two, either commercial or made of three tongue blades taped together and padded.

(7) Universal Dressings, Two, approximately 10 inches by 36 inches, compactly folded and packaged in convenient size.

(8) Until July 1, 1981, Sterile Gauze Pads, 4" x 4".

(9) Until July 1, 1981, Bandages, Four, Soft Roller, self-adhering type, 4" x 5 yards.

(10) Airtight Dressings, Four, for open chest wounds. Minimum size 4" x 4".

(11) Adhesive Tape, Two rolls.

(12) Burn Sheets, Two, Sterile.

(13) Traction Splint, Lower Extremity, hinged half-ring (ring 9" dia., overall length of splint 43"), with commercial limb-support slings, padded ankle hitch, and traction strap, or equivalent.

(14) Padded Boards. Two or more, 4½ feet long x 3 inches wide; two or more, 36 inches long for coaptation splinting of the leg or thigh; two or more, 15" x 3", for fractures of the forearm. Similar splints of cardboard, plastic, wire-ladder, or canvas slotted lace-on may be carried in place of the 36" and 15" boards.

(15) Inflatable Splints, uncomplicated, in addition to item "(14)" above, or as a substitute for the 15" x 3" boards.

(16) Back Boards, Short and Long, with accessories.

(17) Triangular Bandages, Four.

(18) Safety Pins, large size.

(19) Shears, for bandages.

(20) Obstetrical Kit, sterile.

(21) Until July 1, 1981, Blood Pressure Manometer, Cuff and Stethoscope.

(22) After June 30, 1981, the following additional emergency care equipment in the minimum quantity and type indicated must be on board each certified ambulance and on board each ambulance for which certification is requested:

(A) cervical collars, small, medium, and large, one (1) each

(B) one hundred (100) sterile gauze pads, 4 inch x 4 inch

(C) bandages, four (4) soft roller self-adhering type, 2 inch x 5 yards, and four (4) soft roller self-adhering type, 4 inch x 5 yards

(D) blood pressure manometer, adult and pediatric size cuffs, and stethoscope

(E) one (1) medical anti-shock trousers, adult size

(F) one (1) pocket mask with oxygen inlet, for adults and children

(b) Variances or substitutions may be made in emergency care equipment if justification for

variations or substitutions are submitted to and approved by the commission. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II.E; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 93; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 219; filed Nov 3, 1980, 3:55 pm)*

SECTION 5. 836 IAC 1-4-1, as amended at 3 IR 2201, SECTION 10, is amended to read as follows:

836 IAC 1-4-1 General system requirements

Authority: IC 16-1-39-6

Affected: IC 16-1-39-9

Sec. 1. GENERAL SYSTEM REQUIREMENTS. (a) Unless otherwise specified, the provisions of 836 IAC 1-4 of these rules and regulations shall be in full force and effect as of January 1, 1978.

~~(b) Variances in communications equipment may be allowed under provisional certification as provided for in 836 IAC 1-3-1(d). However, no variance shall be allowed for any radio that does not have at least one (1) frequency, and the proper tone equipment, to operate on the Indiana Hospital Emergency Radio Network (I.H.E.R.N.).~~

~~(c)~~(b) Each ambulance service provider shall cooperate with the commission in the development of a statewide emergency communication system which shall, as a minimum, provide for:

(1) Central dispatch of emergency services within a given area to coordinate the dispatching and traffic routing of ambulance and rescue vehicles.

(2) Establishing minimum standards for selection and training of communication dispatchers.

(3) Communication capabilities between

(A) Dispatchers and ambulances

(B) Dispatchers and hospital emergency departments (May be radio and/or land line)

(C) Dispatchers and support services (May be radio and/or land line)

(D) Ambulances and hospital emergency departments.

~~(d)~~(c) After ~~Deecembember~~ December 31, 1981, all ambulance service provider dispatch centers shall be equipped with base stations capable of two-way communications with associated mobile radios on an appropriate frequency-modulated (FM) wavelength. This channel shall be used exclusively for dispatch and tactical communications, and must be apart from any involved in the Indiana Hospital Emergency Radio Network. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule III.A; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 94; filed Nov 3, 1980, 3:55 pm: 3 IR 2201; filed Oct 13, 1981, 10:05 am)*

SECTION 11. 836 IAC 1-4-2 is amended to read as follows:

836 IAC 1-4-2 Ambulance radio equipment

Authority: IC 16-1-39-6

Affected: IC 16-1-39-9

Sec. 2. AMBULANCE RADIO EQUIPMENT. (a) All ambulances~~, with the exception of those exempt under Rule I, A.5,~~ shall be equipped with multi-channel, two-way radio equipment, which shall have a minimum of two frequencies, capable of functioning with an associated base station. The radio shall have at least one (1) frequency, and the proper tone equipment, to operate on the Indiana Hospital Emergency Radio Network (I.H.E.R.N.). The commission strongly recommends four (4) channel capability. Expires January 1, 1982.

~~(2) Radio equipment used in ambulances shall meet or exceed the minimum design specifications established by the Electrical Industries Association standards.~~

~~(3)~~(b) Radio equipment used in ambulances shall have a power output which meets the requirements specified in the applicable Federal Communications Commission Rules and Regulations~~, Standards 89.111~~. The maximum power of the transmitter shall be no more than the minimum required for satisfactory technical operation, commensurate with the size of the area to be served and local conditions which affect radio transmission and reception.

~~(4)~~(c) All radio equipment, used in ambulances, which is ordered or leased, on or after June 1, 1975, ~~should~~ shall meet the minimum specifications as set forth in ~~Rule III~~ 836 IAC 1-4. Radio equipment, used in ambulances, ordered or leased on or after June 1, 1975, which does not meet minimum specifications, will not be eligible for certification.

(d) On and after January 1, 1982, all ambulances shall be equipped with multi-channel, two-way radios which shall be wired, crystalled, and licensed for operation on a minimum of two (2) frequencies. One frequency, shall be used primarily for dispatch and tactical communications. The other frequency shall be 155.340 MHz and shall have the proper tone equipment to operate on the Indiana Hospital Emergency Radio Network (I.H.E.R.N.). *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule III.B; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 94; filed Nov 3, 1980, 3:55 pm)*

SECTION 6. 836 IAC 1-5-1, as amended at 3 IR 2201, SECTION 12, is amended to read as follows:

836 IAC 1-5-1 General certification provisions

Authority: IC 16-1-39-6

Affected: IC 16-1-39-9; IC 16-1-39-13

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (a) Unless otherwise specified the provisions for 836 IAC 1-5 of these rules and regulations shall be in full force and effect as of January 1, 1978, however, the commission may, upon receipt of a proper application, certify Emergency Medical Technicians on or after June 1, 1975.

(b) Applicants for original certification as an emergency medical technician must be eighteen (18) years of age and meet one (1) of the following requirements:

(1) Have successfully completed a commission

approved basic training course as prescribed in these rules and regulations [*836 IAC 1*], and have applied on the form prescribed by the commission postmarked within one (1) year of the date that the course ~~conducted~~ was concluded as shown on the course report. Applications received after this period will be returned and the applicant must enter and successfully complete a commission approved emergency medical technician refresher training course, which shall include the emergency medical technician practical skills examination and successful completion of the written examination for emergency medical technician recertification as defined in 836 IAC 1-5-2(i), during the following year. Reapplication must be postmarked during the year the refresher course is completed. If the application is not postmarked within the required time, the applicant will have to successfully complete another commission approved basic training course as prescribed in these rules and regulations [*836 IAC 1*].

(2) Be a person who, while a resident of Indiana, graduates from an out-of-state basic emergency medical technician training course and who successfully completes the emergency medical technician written and practical examinations composed by the test construction and evaluation committee under the supervision of the commission, and who prior to taking the examinations applies for and receives credit for the course of instruction from the director. If the director determines that the course was equivalent to that required by these rules and regulations [*836 IAC 1*], he may approve the request for credit. The director may request any information to assist in his determination.

(3) A person who ~~possess~~ possesses a valid certificate or license as an emergency medical technician and who resides in a state bordering Indiana, who has completed a basic emergency medical technician training course equivalent to the minimum requirements established by the commission as determined by the director and who has passed the commission practical and written certification examinations as prescribed in these rules [*836 IAC 1*] may apply for certification if evidence of affiliation with a commission certified ambulance service provider is provided by the chief executive ~~office~~ officer of the ambulance service.

(4) A person who, at the time Indiana residency is established, possesses a valid certificate or license as an emergency medical technician from another state, who has completed a basic emergency medical technician training course equivalent to the minimum requirements established by the commission as determined by the director and who has passed the commission practical and written certification examinations as prescribed in these rules [*836 IAC 1*] may apply for certification. Application for certification must be postmarked or delivered to the commission office within six (6) months after establishing residency in this state.

(5) Hold a valid unlimited license to practice medicine in the State of Indiana, and lead an active role in the delivery of emergency care in an emergency medical services facility approved by the state to provide such care.

(c) Notwithstanding the provisions of 836 IAC 1-5-1(b), any non-resident of Indiana who possesses a certificate or license as an emergency medical technician that is valid in another state may, upon establishing residency in this state, apply to the director for temporary certification as an emergency medical technician. Upon receipt of a valid application and verification of valid status by the director, the director may issue temporary certification which shall be valid for the duration of the applicant's current certificate or license, or for a period not to exceed six (6) months from the date residency was established, which ever period of time is shorter. Persons receiving temporary certification under this rule [*836 IAC 1-5*] may apply for full certification using the procedures required in 836 IAC 1-5-1(b)(2). Application must be made within six (6) months after establishing residency in this state.

(d) Pursuant to IC 16-1-39, Section 13, the certificate of an emergency medical technician may be suspended or revoked by the commission for any of the following:

(1) fraud or misrepresentation in procuring certification;

(2) failure to perform or failure to perform competently an indicated procedure for which training has been received in the basic emergency medical technician training course as approved by the commission.

(3) performing a procedure for which training has not been received in the basic emergency medical technician training course as approved by the commission or which is not within the scope and responsibility of an emergency medical technician as determined by the commission.

(4) negligent, reckless or dangerous conduct which endangers the health or safety of emergency patients or the members of the general public while functioning as an ~~emergency~~ eemrgency medical technician.

(5) has been convicted of an offense if the acts that resulted in the conviction have a direct bearing on whether or not the person should be

entrusted to serve the public as an emergency medical technician.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule IV,A; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 95; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 221; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 pm: 3 IR 2202; filed Oct 13, 1981, 10:05 am)

SECTION 7. 836 IAC 1-5-2, as amended at 3 IR 2203, SECTION 13, is amended to read as follows:

836 IAC 1-5-2 Application for original certification or certification renewal

Authority: IC 16-1-39-6

Affected: IC 16-1-39-11; IC 16-1-40

Sec. 2. APPLICATION FOR ORIGINAL CERTIFICATION OR CERTIFICATION RENEWAL. (a) Application for emergency medical technician certification shall be made on such forms as may be prescribed by the commission. Applicants shall complete the required forms, and submit same to the director not less than ninety (90) days prior to the requested effective date of the certificate. Temporary certification may be issued by the director for a period not to exceed ninety (90) days to allow the commission to act upon the application.

(b) Applicant shall present evidence of fitness by a written report of physical examination prescribed by the commission, given by a physician. Applicants shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render them unfit for ambulance service.

(c) All ~~applicatnts~~ applicants for original certification shall provide evidence of compliance with the requirements for certification.

(d) Certification as an emergency medical technician shall be valid for a period of three (3) years from the date of issue, unless earlier suspended, revoked or terminated.

(e) Application for emergency medical technician certification renewal should be made not less than ninety (90) days prior to the expiration date of the current ~~certificate~~ certification to assure continuity of certification. Application for renewal shall be made on such forms as may be prescribed by the commission, and must provide evidence of compliance with the certification renewal requirements.

(f) Emergency Medical Technicians, except those certified under 836 IAC 1-5-1(b)(5), requesting certification renewal must meet the following requirements; (or those of subsection (g) ~~or~~, (h) or (k) below)

(1) Take and report as required by these rules and regulations [*836 IAC 1*] as a minimum of twenty (20) hours of in-service during the first year of the three (3) year certification period, which may include any temporary certification period.

(2) Take and report as required by these rules and regulations [*836 IAC 1*] a minimum of twenty (20) hours of in-service during the second year of the three (3) year certification period.

(3) In-service training sessions shall be designed to review the principles and concepts as presented in the basic training course except as permitted under subsection (g) of this section and shall be combined with practice sessions. Practical experience in a cooperating hospital emergency department may be included as a part of in-service training not to exceed five (5) hours per year, for each of the first two (2) years.

(4) During the third year of the three (3) year certification period, emergency medical technicians shall enter and successfully complete the U.S. Department of Transportation Emergency Medical Technician Refresher Training Course, or other course approved by the commission. The Practical Skills Examination, under the supervision of a physician, is part of the refresher training course. Each refresher training course shall be approved by the commission and shall be administered by either an institution approved to conduct the Basic Training Course or by a certified ambulance service provider. Application for course approval and course report shall be made in the manner prescribed by the commission.

(g) Emergency Medical Technicians requesting certification renewal who are unable to meet the qualifications of subsection (f)(1) and (f)(2), or subsection (k) of this section, must satisfy the recertification requirements in the following manner:

(1) present written evidence to the commission from the Course Instructor of completion of a commission approved emergency medical technician refresher training course, which shall include successful completion of the Emergency Medical Technician Practical Skills Examination administered under the supervision of a licensed physician, during the third year of the three (3) year certification period; and

(2) demonstrate a satisfactory level of knowledge in the area of emergency care by successfully passing the Written Examination for Emergency Medical Technician Recertification. The examination does not have to be taken during the third year,

but must be successfully completed ~~before an application for certification renewal can be made~~ within six (6) months following the expiration date of certification and before an application for certification renewal can be made. (see subsection (h) of this section) Notwithstanding the provisions of 836 IAC 1-5, a certified emergency medical technician may apply for certification renewal upon becoming eligible for certification under IC 16-1-40 as ~~an emergency~~ a paramedic.

(h) Application for certification renewal shall be postmarked or delivered to commission office no later than six (6) months following expiration of the prior certification period. Applicants who do not present evidence of compliance with the certification renewal requirements within six (6) months following expiration of the prior certification period, may satisfy the certification renewal requirements by again sucessfully completing the requirements for original certification as set forth in these rules and regulations [*836 IAC 1*].

(i) The Written Examination for Emergency Medical Technician Recertification shall consist of ninety-five (95) multiple-choice questions divided on the basis of the following categories:

PART I	Respiration and Resuscitation	15 questions
PART II	Bleeding, Shock, and Wound Care	15 questions
PART III	Environmental Emergencies	35 questions
PART IV	Fractures and Splinting	15 questions
PART V	Extrication, Communication, and Patient Handling	15 questions

To successfully complete the Written Examination for Emergency Medical Technician Recertification, the person must achieve a minimum total score of not less than seventy percent (70%) in each of four categories, and not less than sixty percent (60%) in any one category. Individuals who fail may retake the examination, not more than one (1) time, and shall be required to retake each category in which a score of less than seventy percent (70%) was obtained. Individuals who fail the re-examination are subject to subsection (h) of this section regarding certification renewal. The provisions of this subsection shall expire on July 1, 1982.

(j) The written examination for Emergency Medical Technician Recertification shall be composed by the basic life support test construction and evaluation committee under the supervision of the commission. Students shall be notified in writing, at the time of examination, of the criteria for passing the examination. Students who fail the examination may retake the examination not more than one (1) time. A student who fails the re-examination is subject to subsection (h) of this section regarding certification renewal. This subsection shall be effective on and after July 1, 1982.

(k) Notwithstanding the provisions of any subsection of this section (836 IAC 1-5-2) a person whose emergency medical technician certificate expires during service in the armed forces is subject to the provisions of IC 16-1-39-11 regarding certification renewal. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule IV,B; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 96; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 221; filed Dec 15, 1977: Rules and Regs. 1978, p. 246; filed Nov 3, 1980, 3:55 pm: 3 IR 2203; filed Oct 13, 1981, 10:05 am)*

SECTION 8. 836 IAC 1-6-1, as amended at 3 IR 2205, SECTION 14, is amended to read as follows:

836 IAC 1-6-1 General requirements for training institutions

Authority: IC 16-1-39-6
Affected: IC 4-22-1; IC 16-1-39-6

Sec. 1. GENERAL REQUIREMENTS FOR TRAINING INSTITUTIONS. (a) All institutions administering or seeking to administer emergency medical technician training programs shall be approved by the commission. Any multiple campus institution must have individual campus approval.

(b) Institutions seeking commission approval for administering emergency medical technician training shall meet the following minimum requirements:

(1) Submit to an evaluation of training facilities and capabilities by the director, or his duly authorized representative.

(2) Have the necessary clinical facilities, or affiliations with clinical facilities, to conduct the required clinical phases of emergency medical technician training programs.

(3) Provide evidence that an effective ratio of supervisory personnel to students shall be maintained during the clinical phases of the program.

(4) Under conditions where didactic and clinical training are to be conducted by separate institutions, program responsibility shall rest with the institution responsible for the conduct of the didactic training.

(5) Provide evidence of financial responsibility with respect to the conduct of the training program.
(6) Be a public supported educational institution or governmental or non-profit hospital.
(7) Each training institution shall provide adequate classroom space for the optimum didactic ratio of one (1) instructor for each twenty (20) students and optimum practice session ratio of one (1) instructor for each ten (10) students.
(8) The curriculum requirements for training institutions shall include a basic emergency medical technician training course approved by the commission. Approval requests shall be made in the manner prescribed by the commission.
(9) Each training institution shall make available adequate training aids including ~~the~~ emergency care equipment listed in 836 IAC 1-3-5, and such other audio and visual training aids as may be required by the commission.

(c) Staffing for the emergency medical technician training program shall include a medical director and a primary instructor. The staff shall meet the following minimum requirements:
(1) Medical Director—The medical director must be a physician who holds a valid license to practice medicine in the state, preferably one who has an active role in the delivery of emergency care.
(2) Primary Instructor—The primary instructor shall be approved by the commission and shall:
(A) be certified as an emergency medical technician by the commission;
(B) have satisfactorily completed a workshop for new primary instructors approved by the commission;
(C) have at least one (1) year of experience in the delivery of emergency care, 25 hours of which must have been performed in an ambulance.

(d) Effective on and after January 1, 1981, in order to maintain commission approval, each primary instructor shall successfully complete a commission approved primary instructor refresher workshop within each period of three (3) calendar years from date of approval as a primary instructor and demonstrate instructional activity by completing forty (40) teaching contact hours in one or more of the following categories during each calendar year of approval:
(1) Serve as a primary instructor for a commission approved emergency medical technician basic training course during the calendar year.
(2) Conduct one (1) or more commission approved emergency medical technician refresher training courses during the calendar year.
(3) Conduct one (1) or more Emergency ~~Care First~~ Medical Services First Responder courses meeting the U.S. Department of Transportation standards during the calendar year. The primary instructor who elects this option must present evidence of course instruction in writing to the director during the calendar year in order to receive credit.
(4) Conduct a minimum of forty (40) hours of in-service training in basic life support procedures for a ~~class(s)~~ class(es) of emergency medical technicians during the calendar year. The primary instructor who elects this option must present evidence in writing to the director during the calendar year in order to receive credit.
(5) It is the responsibility of the primary instructor to present evidence of compliance with this rule [*836 IAC 1-6*] during the calendar year in which credit is requested.

(e) Institutions shall apply for approval in such a manner as may ~~be~~ prescribed by the commission no less than ninety (90) days prior to the date the approval is requested. Upon certification from the director that the requirements listed in subsections (b), (c), (e), and (f) of this section have been met, the commission will act upon the application during the next regularly ~~scheduled~~ scheduled meeting. However, the director may provide temporary approval if all requirements have been met.

The director will submit a copy of his findings to the institution for verification prior to the commission meeting. Any discrepancies in the findings noted by the institution may be appealed in writing and/or by personal appearance at the commission meeting by the institution's representatives.

(f) Effective on and after January 1, 1981, each commission approved training institution shall provide the primary instructor listed on the course approval request a description of the in-course standards and criteria by which the primary instructor is to determine successful completion of the didactic and clinical portions of the course. The standards and criteria shall include but not be limited to the following:
(1) attendance requirements
(2) in-course testing procedures
(3) number and scope of in-course tests
(4) didactic pass/fail grade average and criteria
(5) provision for make-up classes and tests
(6) minimum age for enrollment

A current copy of the standards and criteria must be maintained on file with the commission.

(g) Commission approval as a training institution shall be valid as long as the institution maintains

compliance with the requirements of these rules and regulations [*836 IAC 1*], unless revoked or suspended pursuant to IC 4-22-1.

(h) Within fifteen (15) days following the completion of each basic emergency medical technician training course, the training institution shall provide the director with a course report in the manner prescribed by the commission.

The course report shall serve as evidence that the students have met the graduation requirements established by the training institution. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule V,A; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 97; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 221; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 222; filed Nov 3, 1980, 3:55 pm: 3 IR 2205; filed Oct 13, 1981, 10:05 am)*

SECTION 15. 836 IAC 1-6-2 is amended to read as follows:

836 IAC 1-6-2 Responsibilities of training institution staff

Authority: IC 16-1-39-6
Affected: IC 16-1-39-6

Sec. 2. RESPONSIBILITIES OF TRAINING INSTITUTION STAFF. (a) Primary Instructor—A primary instructor shall be physically present during each class session and shall be responsible for:

(1) Developing appropriate teaching plans.
(2) Assuring that the course of instruction meets established standards of the commission.
(3) Providing liaison with physicians and other ~~specialties~~ specialists to obtain adequate instructor services.
(4) Monitoring and evaluating classroom activities, including clinical and practice sessions.
(5) Maintaining student records.
(6) Determining student grades.

(b) Medical Director—The medical director shall be responsible for:

(1) Providing competent medical direction to the conduct of the training program.
(2) Providing necessary liaison with physicians to obtain adequate instructor services.

(c) Instructional ~~staff~~ Staff—The instructional staff shall be responsible for the ~~instruction~~ teaching assignments as determined by the ~~instructor-coordinator~~ primary instructor. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule V,B; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 98; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 222; filed Nov 3, 1980, 3:55 pm)*

SECTION 9. 836 IAC 1-6-6, as amended at 3 IR 2207, SECTION 16, is amended to read as follows:

836 IAC 1-6-6 Standards for basic emergency medical technician training and in-service training

Authority: IC 16-1-39-6

Affected: IC 16-1-39-6; IC 16-1-40

Sec. 6. STANDARDS FOR BASIC EMERGENCY MEDICAL TECHNICIAN TRAINING AND IN-SERVICE TRAINING FOR COMMISSION COURSE APPROVAL. (a) Take and report as required by these rules and regulations [*836 IAC 1*] a minimum of twenty (20) hours of in-service during the first year of the three (3) year certification period, which may include any temporary certification period.

(b) Take and report as required by these rules and regulations [*836 IAC 1*] a minimum of twenty (20) hours during the second year of the three (3) year certification period.

(c) In-service training sessions shall be designed to review the principles and concepts as presented in the basic training course except as permitted under subsection (g) of this section, and shall be combined with practice sessions. Practical experience in a cooperating hospital emergency department may be included as a part of in-service training not to exceed five (5) hours per year, for each of the first two (2) years.

(d) During the third year of the three-year certification period, emergency medical technicians shall enter and successfully complete the U.S. Department of Transportation Emergency Medical Technician Refresher Training Course, or other course approved by the commission. The Practical Skills Examination under the supervision of a physician is part of the Refresher Training Course including the commission approved modules for ~~medical~~ anti-shock trousers and cardiopulmonary resuscitation. Each Refresher Training Course shall be approved by the commission and shall be administered by either an institution approved to conduct the basic training course or by a certified ambulance service provider. Application for course approval and course report shall be made in the manner prescribed by the commission.

(e) It is the responsibility of each emergency medical technician to insure that compliance with the in-service requirements for each of the first two (2) years of the three (3) year certification period are reported to the commission within ninety (90) days following the anniversary date of each of the first two (2) years. Credit will not be given for first and second year in-service requirement reports not postmarked or delivered to the commission office prior to the ~~start of the Refresher Training Course for the emergency medical technician in question~~ date of completion of the refresher training course as verified on the refresher course report for the emergency medical technician in question.

(f) After January 1, 1981, to be approved, a Refresher Training Course shall be under the direction of a commission approved primary instructor, and a primary instructor shall be physically present during each class session. The primary instructor listed on the course approval request shall be responsible for:

(1) developing appropriate teaching plans.
(2) assuring that the course of instruction meets established standards of the commission.
(3) providing liaison with physicians and other specialists to obtain adequate instructor services.
(4) monitoring and evaluation of classroom activities and practice sessions.
(5) maintaining student records.
(6) determining course attendance requirements.
(7) establishing in conjunction with the course medical director the Practical Skills Examination team.
(8) determining the course pass/fail grade average. (It is recommended that the average be not less than 70%)
(9) completing the commission prescribed course report and submitting the report and all Practical Skills Examination front sheets to the commission within fifteen (15) days of course completion. The course report shall serve as evidence that the students have met the graduation requirements.

(g) Notwithstanding any other provision of these

rules and regulations [*836 IAC 1*] and effective July 1, 1980, a person also certified under IC 16-1-40 may substitute the required annual continuing education ~~unite~~ credits for subsections (a), ~~and~~ (b) and (d) of this section.

(h) A person may petition the director in writing for prior approval of any other course for credit in lieu of subsection (d) of this section. The director is hereby authorized to approve such requests, but only prior to the course, if in the opinion of the director the course or training is equivalent to the content of the refresher course identified in subsection (d) of this section.

Notwithstanding any other provision of these rules and regulations [*836 IAC 1*], any emergency medical technician meeting one or more of the following criteria may petition the director in writing for credit in lieu of subsection (d) of this section;

(1) A primary instructor who is physically present at all sessions of a commission approved emergency medical technician basic training course during their third year of certification.

(2) An assistant instructor, for ~~a basic emergency medical technician course~~ an emergency medical technician basic training course, who is present for the entire course during their third year of certification and who participates in the course of instruction. The written request must be counter-signed by the course primary instructor and must identify the course number.

~~(3) A person who instructs, totally, a commission approved refresher training course during their third year of certification. This option expires January 1, 1981.~~

~~(4)~~(3) The primary instructor of record who is present for each class session, during their third year of certification, of a commission approved refresher training course.

~~(5)~~(4) A person who successfully completes ~~an emergency~~ a paramedic course, approved under IC 16-1-40, during their third year of certification, or successfully completes equivalent refresher course modules of ~~an emergency~~ a paramedic ~~course~~.

(i) The minimum requirements for basic emergency medical technician training are as follows:

(1) The ~~basic emergency medical training course~~ emergency medical technician basic training course shall be the basic training course outlined by the U.S. Department of Transportation for emergency medical technician-ambulance training, DOT HS 802 534 through DOT HS 802 536 or other course approved by the commission, except that any course conducted after January 1, 1981, must include:

(A) The commission approved module for ~~medical~~ anti-shock trousers, and

(B) The commission approved module for cardiopulmonary resuscitation.

(2) Each course must be under the direction of a commission approved primary instructor.

(j) No course shall be approved as equivalent to subsection (i) of this section unless the course meets the training standards currently in effect ~~at that time~~.

(k) To successfully complete the ~~basic emergency medical technician training course~~ emergency medical technician basic training course for original certification or certification renewal, a student must graduate from a commission approved ~~Basic Emergency Medical Technician Training Course~~ emergency medical technician basic training course and must pass the commission Practical and Written Certification Examinations, composed by the test construction and evaluation committee, under the supervision of the commission. Students shall be notified in writing of the criteria for passing these examinations. Students who fail either the written or practical examinations may retake the examination not more than one (1) time. A student who fails re-examination must retake the ~~Emergency Medical Technician Basic Training Course~~ emergency medical technician basic training course prior to re-examination. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule V, F; filed Jun 5, 1975, 11:57 am: Rules and Regs. 1976, p. 99; filed May 10, 1977, 10:52 am: Rules and Regs. 1978, p. 223; filed Nov 3, 1980, 3:55 pm: 3 IR 2207; filed Oct 13, 1981, 10:05 am)*

SECTION 17. 836 IAC 1 is amended by adding a NEW Rule 7, effective January 1, 1982, to read as follows:

Rule 7. Standards and Certification Requirements for Air Ambulance Service Providers and Air Ambulances

836 IAC 1-7-1 Application for air ambulance service provider certification

Authority: IC 16-1-39-6
Affected: IC 16-1-39-11

Sec. 1. APPLICATION FOR AIR AMBULANCE SERVICE PROVIDER CERTIFICATION. (a) Application for air ambulance service provider certification shall be made on such forms as may be prescribed by the commission, and the applicant shall comply with the following requirements:

(1) Applicants shall complete the required forms and should submit same to the commission not less than sixty (60) days prior to the requested effective date of the certificate.

(2) Each air ambulance, with its equipment as required by these rules and regulations [*836 IAC 1*], shall be made available to the director or his authorized representative for inspection.

(3) The premises on which air ambulances shall be hangared or padded or tied down, and ambulance supplies stored shall be open to the commission or its designate for inspection.

(4) The provider shall include the level of training, certification type, and number for those employees that will be utilized on a routine basis and shall be submitted to the commission upon application. The commission shall be notified in writing within thirty (30) days of any change in staffing. The air ambulance service provider may rely on one or more medical facilities to provide his required patient compartment attendant(s).

(5) Each applicant shall provide the commission with the following:

(A) A description of the proposed service area.

(B) Evidence of capability to service the proposed service area, including hours of operation, number of air ambulances available during business hours.

(C) Proof of insurance coverage in adequate amounts as specified in 836 IAC 1-7-2(e) shall be submitted with the application and annually thereafter.

(D) Name of medical director as referenced in 836 IAC 1-7-3(a).

(E) Other information as required by the commission.

(b) Upon approval by the commission, a certificate shall be issued and shall be valid for a period of one (1) year from the date of issue. The certificate shall be prominently displayed at the place of business.

(c) Application for air ambulance service provider certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certification to assure continuity of certification. Application for renewal shall be made on such forms as prescribed by the commission and shall include proof of compliance with the requirements as set forth for the original certification.

(d) Upon application the director may grant temporary approval for certification or certification renewal for a period not to exceed ninety (90) days to

allow the commission time to act upon the application for initial certification or certification renewal if the applicant is in full compliance with these rules and regulations [*836 IAC 1*], as determined by the director. Such temporary certification may only be approved for one (1) time per certification period. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-1; filed Nov 3, 1980, 3:55 pm)*

836 IAC 1-7-2 Air ambulance service provider operating procedures

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9; IC 34-4-16.5-1

Sec. 2. AIR AMBULANCE SERVICE PROVIDER OPERATING PROCEDURES. (a) Each air ambulance service provider shall maintain accurate records concerning the transporation of each emergency patient in intrastate flights or interstate flights originating in Indiana on a form prescribed by the commission.

(b) Premises shall be maintained, suitable to the conduct of an air ambulance service, with provision for adequate storage, hangars, padding, tie-down, and/or maintenance of air ambulances and the on-board equipment.

(c) Each air ambulance service provider shall provide for a periodic maintenance program as outlined for each specific aircraft certified by the commission in compliance with F.A.A. guidelines as a minimum to assure that each air ambulance, including equipment, is maintained in good, safe working condition and that rigid sanitation conditions and procedures are in effect at all times.

(d) All air ambulance service provider premises, records, hangars, padding and tie-down facilities, and air ambulances shall be made available for inspection by the director or his authorized representative at any time during regularly scheduled business hours.

(e) The insurance requirement of IC 16-1-39-9(b) is satisfied if the ambulance service provider:

(1) has in force and effect public liability insurance in the sum of not less than $300,000 combined single limit, issued by an insurance company licensed to do business in the State of Indiana; or

(2) is a governmental entity within the meaning of IC 34-4-16.5-1, et. seq.

Coverage must be for each and every ambulance owned and/or operated by or for the ambulance service provider.

(f) Each air ambulance service provider shall provide and maintain a communications system which meets or exceeds the requirements set forth in 836 IAC 1-7-7 of these rules and regulations and those set forth in applicable F.A.R. parts.

(g) Each air ambulance service provider shall designate one person to assume responsibility for in-service training. This person shall be certified as an emergency medical technician, a registered nurse or a licensed physician, and who provides patient care on at least a periodic basis during air ambulance transport.

(h) An air ambulance service provider shall not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as an air ambulance service provider.

(i) Each air ambulance service provider shall establish daily equipment checklist procedures to insure that:

(1) Electronic and mechanical equipment are in proper operating condition.

(2) Air ambulances are continuously maintained in safe operating conditions at all times.

(3) Basic life support equipment required for air ambulance certification is maintained in minimum quantities either directly on board the air ambulance or in suitable containers to be placed on board the air ambulance at the time of patient transport.

(j) Each air ambulance service provider shall insure that rigid sanitation conditions and procedures are in effect at all times. The following sanitation standards shall apply to all air ambulances:

(1) The interior and the equipment within the aircraft shall be clean and maintained in good working order at all times.

(2) Freshly laundered or disposable linens shall be used on all litters and pillows and linen shall be changed after each patient is transported.

(3) Blankets to be used by patients shall be kept clean and stored properly.

(4) Plastic bags shall be provided as a minimum for the disposal of soiled items and the storage of soiled supplies until such time that they may be removed from the aircraft and/or cleaned.

(5) A minimum of one urinal, one bedpan and one emesis basin must be available and a means for storing these items must be available after use by the patient while in flight until such time that they may be properly cleaned and returned to service.

(6) When a vehicle has been utilized to transport a patient known to have a communicable disease, the aircraft shall be cleansed and all contact surfaces shall be washed with soap and water and disinfected.

SECTION 10. 836 IAC 1-7-3, as added at 8 IR 2209, SECTION 17, is amended to read as follows:

836 IAC 1-7-3 General certification requirements for air ambulance service providers

Authority: IC 16-1-39-6

Affected: IC 4-22-1; IC 16-1-39-8; IC 16-1-39-13

Sec. 3. GENERAL CERTIFICATION REQUIREMENTS FOR AIR AMBULANCE SERVICE PROVIDERS. (a) The air ambulance provider organization shall have a medical director who must be a physician who holds a valid unlimited license to practice medicine in the State of Indiana and has an active role in the delivery of emergency care. The commission recommends this physician be an aviation medical examiner if service is provided above 2,000 feet AGL. The medical director shall be responsible for providing competent medical aspects of the air ambulance provider organization. The duties of the medical director shall include, but not be limited to:

(1) Developing staffing requirements for all air ambulance transports based on the patient's condition.
(2) Providing liaison with physicians.
(3) Assuring that supplies and equipment are available to the air ambulance provider organization.
(4) Monitor and evaluate day-to-day operations.
(5) Assist in the coordination of in-service training programs.
(6) Provide information concerning the operation of the air ambulance provider organization.
(7) Provide individual consultation to air ambulance personnel.

(b) Each certified air ambulance while transporting an emergency patient shall be manned by not less than two (2) persons. (See 836 IAC 1-2-1(d))
(1) . The second person must be a properly certified pilot. The pilot of the air ambulance must possess a minimum of a Class II F.A.A. Medical Certificate, certification appropriate to the class of aircraft to be piloted, and a valid Commercial Operator's Certificate.
~~(A) It is highly recommended if the ambulance service routinely provides transport above 2,000 feet AGL that the medical personnel aboard the aircraft be trained in "air transport problems and principles of pressure phenomena".~~
(2) Additional personnel to properly care for the medical needs of the patient may be required on board in the patient compartment, at the discretion of the physician initiating the transport. The choice and qualifications of such personnel covered in this section will be at the discretion of the aforementioned physician.
(A) It is highly recommended if the ambulance service routinely provides transport above 2,000 feet AGL that the medical personnel aboard the aircraft be trained in "air transport problems and principles of pressure phenomena".

(c) Before any flight involving transportation of an emergency patient in a fixed-wing air ambulance, the air ambulance service provider shall contact the air ambulance provider organization medical director for pre-flight medical consultation relative to the given patient.

(d) Each air ambulance service provider must meet all applicable parts of F.A.A. regulations, and the following:
(1) Each air ambulance service provider must comply with all F.A.R. required.
(2) A determination of non-compliance with F.A.R. may result in immediate suspension of commission certification as an air ambulance provider, pursuant to IC 4-22-1.
(3) Each aircraft operated affiliated with an air ambulance provider must hold a valid ATCO operations certificate.
(4) Air ambulance service providers must provide for inspection by the director or his authorized representative, proof of compliance with all required F.A.A. inspection programs, at place of operation during regular business hours.
(5) Each air ambulance service provider must make available to the commission for inspection at place of operation during regular business hours any manual of operations required under F.A.R.
(6) Advertising by air ambulance service providers must comply with current F.A.R.
(7) Non-compliance with F.A.R. Part 135 requires the filing of a report with the F.A.A. District Office within ten (10) days of deviation. A copy of such report should be sent to the commission within ten (10) days of such deviation. Copies of any further correspondence with or from the F.A.A. offices relative to this deviation should be available to the commission for review. The pilot is responsible to the air ambulance service provider in providing for commission review, the above outlined documentation.
(8) Within thirty (30) days of the termination of air ambulance operations, the provider shall notify the commission of such termination in addition to notifying the F.A.A. District Office in compliance with F.A.R. Part 135. (A copy of the F.A.A. notification of termination will comply with this requirement.) Commission certification as an air ambulance service provider may be terminated upon the date specified in said notice, pursuant to IC 4-22-1.

(e) After proper notice and hearing, the commission may suspend or revoke an air ambulance certificate issued under these rules and regulations [*836 IAC 1*] for failure to comply and maintain compliance with, or for violation of any applicable provisions, standards, or other requirements of these rules and regulations [*836 IAC 1*], pursuant to IC 4-22-1.

(f) The commission may initiate proceedings to suspend or revoke an air ambulance certificate upon its own motion, or on the verified written complaint of any interested person. All such ~~proceedins~~ proceedings shall be held and conducted in accordance with the provisions of IC 4-22-1.

(g) Notwithstanding, the provisions of subsections (d)(1), (e), and (f) of this section, the commission, upon finding that the public health or safety is in imminent

danger, may temporarily suspend an air ambulance certificate without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder. Upon suspension, revocation or termination of a certificate, the provision of such service shall cease.

(h) An ambulance owner or lessee seeking certification of an air ambulance which is specially staffed ~~and~~, equipped or uniquely designed to provide inter-hospital emergency transportation of critical care patients, ~~i.e.,~~ for example coronary care, high risk infant, poisoning, psychiatric, and alcohol and drug overdose, may petition the commission for exemption from one or more of the specifications or requirements listed in 836 IAC 1-7-6(n). If an exemption is requested from 836 IAC 1-2-1(d), the application shall include a description of the medical capability of each person who usually staffs the patient compartment when transporting an emergency patient.

The commission may approve one or more of the requested exemptions and grant certification. However, the commission may restrict any exemption(s) approved under this rule [*836 IAC 1-7*]. Exemption(s) requested shall not be approved if, in the opinion of the commission, the exemption(s) would impair the capabilities of the ambulance service provider to provide proper emergency patient care.

(i) Unless otherwise specified, the certificate issued pursuant to subsection (h) of this section and 836 IAC 1-7-5(b) shall identify said air ambulance to be used exclusively for the inter-hospital transportation of critical care patients. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-3; filed Nov 3, 1980, 3:55 pm: 3 IR 2211; filed Oct 13, 1981, 10:05 am) NOTE: Effective date Jan 1, 1982.*

836 IAC 1-7-4 General certification requirements for air ambulances

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 4. GENERAL CERTIFICATION REQUIREMENTS FOR AIR AMBULANCES. (a) All air ambulances to be certified must meet the following minimum requirements and comply with all applicable F.A.R. as outlined in 14 CFR §91.10 through 14 CFR §91.311 and 14 CFR §135.10 through 14 CFR §135.443.

(b) An air ambulance service provider shall not operate an air ambulance in this state if the air ambulance does not meet the certification requirements of 836 IAC 1-7 and which does not have a certificate issued pursuant to these rules and regulations [*836 IAC 1*].

(c) Any aircraft which allows for the air transport of emergency patients and provides adequate storage space in the patient compartment for the basic emergency care equipment, advanced life support equipment and communications equipment may be considered for certification.

(d) Procedures for suspension, revocation, or termination of a certificate included under 836 IAC 1-7-3(d), 836 IAC 1-7-3(e) and 836 IAC 1-7-3(f) shall apply to certification for air ambulances. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-4; filed Nov 3, 1980, 3:55 pm)*

836 IAC 1-7-5 Application for air ambulance certification

Authority: IC 16-1-39-6
Affected: IC 16-1-39-11

Sec. 5. APPLICATION FOR AIR AMBULANCE CERTIFICATION. (a) Application for air ambulance certification shall be made by the owner or lessee on such forms as may be prescribed by the commission and shall comply with the following requirements:

(1) Applicants shall complete the required forms and submit same to the commission.

(2) Temporary certification for air ambulance use may be issued by the director for a period not to exceed ninety (90) days for one (1) time to allow the commission to act upon the application.

(3) Each air ambulance for which certification is requested shall be made available for inspection by the director or his duly authorized representative, with its equipment as required by these rules and regulations [*836 IAC 1*] prior to approval for certification.

(4) A copy of the ATCO operations certificate on the specific aircraft for which commission certification is requested must be included with the application for air ambulance aircraft certification.

(5) Proof of compliance with F.A.A. inspection and maintenance programs on an on-going basis for the aircraft for which certification is requested must be available for review by the director or his

authorized representative during an ambulance inspection and thereafter.

(6) A copy of the manual of operations required under F.A.R. which the air ambulance to be certified will operate must be available at the time of air ambulance inspection and thereafter for the review by the director or his authorized representative.

(b) Upon approval by the commission, a certificate shall be issued by the director to the ambulance owner or lessee. The certificate shall be prominently displayed within the aircraft as prescribed by the commission when operating as an air ambulance in the State of Indiana. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-5; filed Nov 3, 1980, 3:55 pm)*

SECTION 11. 836 IAC 1-7-6, as added at 3 IR 2209, SECTION 17, is amended to read as follows:

836 IAC 1-7-6 Air ambulance certification specifications; minimum

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 6. AIR AMBULANCE CERTIFICATION SPECIFICATIONS — MINIMUM. (a) The performance characteristics are inherent in the type of aircraft selected by the provider.

(b) The aircraft and its equipment must be in compliance with prevailing F.A.R. for the type of aircraft in question and flying conditions under which the aircraft will be operated as specified in the ATCO operating certificate of the air ambulance provider.

(c) The aircraft must be capable of carrying a minimum of one patient on a litter in a horizontal position located so as not to obstruct the pilot's ~~vision~~ visions or interfere with the performance of any member of the flight crew or required medical attendant.

(d) There must exist a means of securing the litter and attached patient securely to either the floor (deck), walls (bulkhead), seats or specific litter rack or any combination thereof.

(e) If the aircraft provides for the carrying of more than one litter patient at a time, there must be a minimum vertical spacing of thirty (30) inches between litters.

(f) The upper surface of the single litter must not be closer than thirty (30) inches from the ceiling of the aircraft.

(g) The head and thorax of a patient secured to a litter in an air ambulance must be accessible by a minimum of two (2) attendants at one time from at least one side of the litter without obstruction.

(h) The patient compartment must have lighting available for patient observation (a minimum of forty (40) foot candles at the level of the patient is recommended).

(i) The patient compartment must have fresh air ventilation for patient and attendant comfort.

(j) The patient compartment must have temperature regulation to assure patient and attendant comfort.

(k) The aircraft shall provide one door large enough for ease of litter patient loading and unloading in the supine position.

(l) The electrical system of the aircraft must be capable of supporting all of the ancillary equipment described in these rules and regulations [*836 IAC 1*] without the threat of overload or system's failure.

(m) The "Star of Life" symbol may be displayed on the exterior of the air ambulance.

(n) Each air ambulance shall be provided with the following minimum emergency care equipment to be stored on-board the aircraft such that it is available for attendant use during each and every air ambulance transport:

(1) Portable suction apparatus capable of a minimum vacuum of 300mm mercury with wide bore tubing and a rigid, disposable or resterilizable pharyngeal suction tip. If this item relies on either engine vacuum or aircraft electrical access, such access must be available and compatible with the

normal function of the engine or aircraft's electrical system to include radio equipment.

(2) Bag-mask ventilation unit, hand-operated, with adult and child-size masks. Clear masks are preferable. The valve system in this unit must be capable of working in cold weather and at an altitude in an unpressurized cabin. The unit must be capable of use with an oxygen supply.

(3) Oropharyngeal airways, at least one each of adult, child and infant sizes.

(4) Portable oxygen supply of at least 300 liters capacity (D size cylinder) with yoke, medical regulator, pressure ~~guage~~ gauge, non-dependent flow meter, adequate tubing to reach patient litter area, and transparent masks in adult, child and infant sizes. For flights requiring patient oxygen in excess of 300 liters because of their anticipated duration, additional supplies of supplemental oxygen should be made available on-board on an individual flight basis.

(5) Two (2) mouth gags

(6) Ten (10) sterile ~~guaze~~ gauze pads (4" x 4")

(7) Four (4) airtight dressings of 4" x 4" minimum

(8) Mouth-to-mouth artificial ventilation airways for adults and children

(9) Two (2) rolls 1" or 2" adhesive tape

(10) Two (2) burn sheets (sterile) to be carried when burn patients are anticipated

(11) One (1) short backboard or CPR board sized appropriately for the size of litter utilized for patient transport if a hard based litter is not provided

(12) Triangular bandages, two (2)

(13) Safety pins, large

(14) Bandage shears, one pair

(15) Obstetrical kit, sterile, to be carried when obstetrical patients are anticipated

(16) Blood pressure manometer and cuff which is effective at altitude in an unpressurized cabin or appropriate for the type of aircraft utilized and which will not interfere with the aircraft's electrical system

(17) Stethoscope

(18) Cervical collars, small, medium, large, one (1) each

(19) One (1) ~~medical~~ anti-shock trousers, adult size

(o) Variances or substitutions may be made in emergency care equipment if justification for variations or substitutions is submitted to and approved by the commission. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-6; filed Nov 3, 1980, 3:55 pm: 3 IR 2213; filed Oct 13, 1981, 10:05 am)*

NOTE: Effective date Jan 1, 1982.

836 IAC 1-7-7 Communications systems requirements

Authority: IC 16-1-39-6
Affected: IC 16-1-39-9

Sec. 7. COMMUNICATIONS SYSTEMS REQUIREMENTS. (a) Each air ambulance must contain those items of communication equipment required under F.A.R. Part 135 for the type of aircraft and service provided.

(b) The air ambulance must contain equipment to allow patient attendants to talk via radio with hospitals utilizing the Indiana Hospital Emergency Radio Network (IHERN) and its VHF channel at 155.340 MHz if the aircraft is routinely flown while transporting a patient under one mile altitude above ground level.

(c) Transmitters are to operate with an output power not to exceed ten (10) watts as applicable to F.C.C. Rules and Regulations. *(Indiana Emergency Medical Services Commission; 836 IAC 1-7-7; filed Nov 3, 1980, 3:55 pm)*

SECTION 18. 836 IAC 2-1-1 is amended to read as follows:

2214, SECTION 18, is amended to read as follows:

836 IAC 2-1-1 Definitions

Authority: IC 16-1-39-6; IC 16-1-40-8
Affected: IC 16-1-39-2; IC 16-1-40-8

Sec. 1. DEFINITIONS USED IN THESE RULES AND REGULATIONS SHALL HAVE THE FOLLOWING MEANING UNLESS THE CONTEXT CLEARLY DENOTES OTHERWISE; and shall pertain to all advanced life support requirements and standards ~~and~~ as promulgated by the commission. (a) "Commission" shall mean the Emergency Medical Services Commission of the State of Indiana.

(b) "Director" shall mean the Executive Director of the Emergency Medical Services Commission of the State of Indiana.

(c) "Person" shall mean any natural person or persons, firm, partnership, corporation, company, association or joint stock association and the legal successors thereof including any governmental agency or instrumentality, other than an agency or instrumentality of the United States.

(d) "An agency or instrumentality of the United States" as that phrase is used in IC 16-1-40-8(b), is defined to exclude all non-governmental entities which have a contract with the Government of the United States or any bureau, board, commission, or any statutorily created entity thereof.

(e) "Certificate", "Certification" shall mean authorization in written form issued by the commission to a person to operate and maintain advanced life support services; to act as an advanced emergency medical technician; to act as ~~an emergency~~ a paramedic; or to exercise the privileges as defined in these rules and regulations [*836 IAC 2*].

(f) "Anniversary Date" shall mean date on which certification as ~~an emergency~~ a paramedic or an advanced EMT has been issued by the Indiana Emergency Medical Services Commission.

(g) "Provider Organization Operating Area" shall mean the geographic area in which an advanced emergency medical technician, affiliated with a specific advanced EMT organization, ~~is~~ able to maintain two-way voice communication with the provider organization's supervising hospital(s).

(h) "Provider Organization" shall mean an ambulance service or other emergency care organization certified by the Indiana Emergency Medical Services Commission to provide advanced life support in connection with a supervising hospital.

(i) "Advanced Life Support" shall mean care given

at the scene of an accident or illness, during transport, or at a hospital by a paramedic or advanced emergency medical technician which is more advanced than that usually rendered by an emergency medical technician, and which may include, but is not limited to, the following:

(1) defibrillation;
(2) endotracheal intubation;
(3) parenteral injection of appropriate medications;
(4) electrocardiogram interpretation; and
(5) emergency management of trauma and illness.

(j) "Emergency Management of Trauma and Illness" shall mean:

(1) Those procedures for which the ~~emergency~~ paramedic has been specifically trained which are a part of the curriculum prescribed by the commission.

(2) Those procedures for which the ~~emergency~~ paramedic has been specifically trained as a part of the ~~in-service~~ ~~training~~ continuing education program and approved by the sponsoring hospital and the paramedic organization medical director.

(3) Those procedures for which the advanced emergency medical technician has been specifically trained and which have been approved by the administrative and medical staff of the supervising hospital, the advanced EMT organization medical director, and the commission as being within the scope and responsibility of the advanced emergency medical technician.

(k) "Physician" shall mean an individual who currently holds a valid unlimited license to practice medicine issued by the State of Indiana.

(l) "Supervising Hospital" means a licensed Indiana hospital which has been certified by the Indiana Emergency Medical Services Commission to supervise paramedics, advanced emergency medical technicians and provider organizations in providing advanced life support.

(m) "Advanced Emergency Medical Technician" shall mean a person who can perform one or more, but not all of the procedures of ~~an emergency~~ a paramedic and who:

(1) has completed a prescribed course in advanced life support;
(2) has been certified by the Indiana Emergency Medical Services Commission;
(3) is associated with a single supervising hospital; and
(4) is affiliated with a provider organization.

(n) "Advanced EMT Organization" shall mean an ambulance service provider or other emergency care organization certified by the Indiana Emergency Medical Services Commission to provide advanced life support services administered by advanced EMTs in conjunction with a supervising hospital(s).

(o) "Sponsoring Hospital" shall mean a licensed Indiana hospital which has been certified as a supervising hospital by the Indiana Emergency Medical Services Commission, and whose administrative and medical staff have agreed by contract with a paramedic organization for the following services:

(1) Continuing education
(2) Audit and review
(3) Medical control and direction
(4) Provide liaison and direction for supply of medications, fluids and other items utilized by ~~emergency~~ paramedics.

(p) "Paramedic" means a person who:

(1) is affiliated with a certified paramedic organization, is employed by a sponsoring hospital approved by the commission, or is employed by a supervising hospital with a contract for ~~in-service~~ continuing education with a sponsoring hospital approved by the commission;
(2) has completed a prescribed course in advanced life support; and
(3) has been certified by the Indiana Emergency Medical Services Commission.

(q) "Paramedic Organization" shall mean an ambulance service provider or other emergency care organization certified by the Indiana Emergency Medical Services Commission to provide advanced life support services administered by ~~emergency~~ paramedics or physicians with an unlimited license to practice medicine in Indiana in conjunction with supervising hospitals. *(Indiana Emergency Medical Services Commission; Advanced Life Support Preliminary; filed Dec 15, 1977: Rules and Regs. 1978, p. 248; filed Nov 3, 1980, 3:55 pm: 3 IR 2214; filed Oct 13, 1981, 10:05 am)*

SECTION 13. 836 IAC 2-2-1, as amended at 3 IR 2216, SECTION 19, is amended to read as follows:

836 IAC 2-2-1 General requirements for paramedic organizations

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 4-22-1; IC 16-1-39; IC 16-1-40-3

Sec. 1. GENERAL REQUIREMENTS FOR PARAMEDIC ORGANIZATIONS. (a) Unless otherwise specified, the provisions of 836 IAC 2-2 of these rules and regulations shall be in full force and effect as of the date of promulgation of these rules and regulations [*836 IAC 2*].

(b) Certification by the commission is required for any ambulance service provider who seeks to provide advanced life support services as a paramedic organization.

(c) If the paramedic organization also provides transportation of emergency patients, the paramedic organization shall be certified as an ambulance service provider in accordance with the requirements specified in the Rules and Regulations for the Operation and Administration of Emergency Medical Services pursuant to IC 16-1-39.

(d) The provider of advanced life support services must insure that the patient transport vehicle(s) used in conjunction with the continuation of the advanced life support services provided by ~~emergency~~ paramedics meet the guidelines as specified in 836 IAC 1-3-3 pursuant to IC 16-1-39, and is certified by the Indiana Emergency Medical Services Commission.

~~Paramedic~~ Parmaedic organizations shall have agreed by contract with one or more sponsoring hospitals for the following services:

(1) Continuing education
(2) Audit and review
(3) Medical control and direction
(4) Provide liaison and direction for supply of medications, fluids and other items utilized by ~~emergency~~ paramedics.

(e) Said contract shall include a detailed description of how such services shall be provided to the paramedic organization. In those cases where more than one (1) hospital contracts, or seeks to contract with a paramedic organization as a sponsoring hospital, an inter-hospital agreement shall be provided to the commission which shall clearly define the specific duties and responsibilities of each hospital, to insure medical and administrative accountability of system operation.

(f) The paramedic organization shall have a medical director provided by the paramedic organization, or jointly with the sponsoring hospital, who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana, and has an active role in the delivery of emergency care. The medical director shall be responsible for providing competent medical direction as established by the medical control committee. Upon establishment of a medical control policy, the paramedic organization medical director and the chief executive officer shall have the duty to enact said policy within the paramedic organization and accordingly enforce said policy. The duties and responsibilities of the medical director shall include, but not be limited to:

(1) Providing liaison with physicians and the medical community.
(2) Assuring that the drugs, medications, supplies and equipment are available to the paramedic organization.
(3) Monitor and evaluate day-to-day operations of paramedic organizations.
(4) Assist in the provision and coordination of continuing education.
(5) Provide information concerning the operation of the paramedic organization.
(6) Provide individual consultation to ~~emergency~~ paramedics.
(7) Participate on the assessment committee in the monthly audit and review of cases treated by ~~emergency~~ paramedics of the sponsoring hospital(s).
(8) Attest to the competency of ~~emergency~~ paramedics affiliated with the paramedic organization to perform skills required of ~~an emergency~~ a paramedic under 836 IAC 2-6 of these rules and regulations.

(g) The paramedic organization shall maintain a ~~communication~~ communications system which must be available twenty-four (24) hours a day between the paramedic organization and the emergency department, or coronary care unit, or equivalent, of the sponsoring hospital using UHF (Ultra High Frequency) ECG telemetry and voice ~~communication~~ communications. Communications system must be licensed per FCC rules and regulations. NOTE: Subject to review and approval by the commission, the administrative and medical staff of the sponsoring hospital, with concurrence of the administrative and medical staff of the supervising hospital(s) in the provider ~~organizations~~ organization's normal operating area, and the paramedic organization medical director; the paramedic organization may petition the commission to omit ECG telemetry. However, provision shall be made for an ECG tape read-out on the paramedic organization's advanced life support vehicle(s).

(h) It is recommended that the paramedic organization be part of an area-wide plan to coordinate emergency medical services with rescue, law enforcement, mutual aid back-up systems and central dispatch, when available.

(i) Each paramedic organization shall:
(1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous 24-hour advanced life support services.
(2) Notify the commission in writing prior to assigning any individual to perform the duties and

responsibilities required of ~~an emergency~~ a paramedic pursuant to these rules and regulations [*836 IAC 2*].

(3) Notify the commission in writing within thirty (30) days of ~~an emergency~~ a paramedic's termination of employment, or for any reason which has prohibited a certified individual from performing the procedures required of ~~an emergency~~ a paramedic.

(j) Each ambulance used for the purpose of providing advanced life support services, when dispatched on an emergency run, shall be manned by not less than two (2) persons, one of whom shall be certified as ~~an emergency~~ a paramedic, and the other shall be certified as an emergency medical technician pursuant to IC 16-1-39. However, each non-transport vehicle used for the purpose of providing advanced life support services, when dispatched on an emergency run need only to be manned, as a minimum, by a certified ~~emergency~~ paramedic.

(k) When advanced life support services administered by ~~emergency~~ paramedics at the scene of an accident or illness are continued enroute to an emergency facility, as a minimum, the patient compartment of the transporting vehicle shall be manned by not less than one (1) person who shall be certified as ~~an emergency~~ a paramedic or a physician with an unlimited license to practice medicine in Indiana. Two (2) ~~emergency~~ paramedics in the patient compartment are strongly recommended.

(l) The paramedic organization shall notify the commission in writing within thirty (30) days of any change in the advanced life support services provided, and for which certification has been granted.

(m) No certification shall be required:

(1) For a person who provides advanced life support while assisting in the case of a major catastrophe~~,~~ or disaster, ~~or emergency,~~ whereby persons who are certified to provide emergency medical services or advanced life support are insufficient or are unable to cope with the situation.

(2) For an agency or instrumentality of the United States and any paramedics of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed in these rules and regulations (836 IAC 2-1-1(d)).

(n) After proper notice and hearing, the commission may suspend or revoke a certificate ~~and/or an endorsement~~ issued under these rules and regulations [*836 IAC 2*] for failure to comply and maintain compliance with, or for violation of, any applicable provisions, standards, or other requirements of these rules and regulations [*836 IAC 2*].

(o) The commission may initiate proceedings to suspend or revoke a certificate ~~and/or an endorsement~~ upon its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held in and conducted in accordance with the provisions of IC 4-22-1.

(p) Notwithstanding the provisions of these rules and regulations [*836 IAC 2*], the commission upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate ~~and/or an endorsement~~ without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(q) Upon suspension, revocation, or termination of a certificate ~~and/or an endorsement,~~ the provision of advanced life support services shall cease. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule I,A; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 200; filed Dec 15, 1977: Rules and Regs. 1978, p. 250; filed Nov 3, 1980, 3:55 pm: 3 IR 2216; filed Oct 13, 1981, 10:05 am)*

SECTION 14. 836 IAC 2-2-2, as amended at 3 IR 2218, SECTION 20, is amended to read as follows:

836 IAC 2-2-2 Application for certification

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39; IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Application for certification as a paramedic organization shall be made on such forms ~~as may be~~ prescribed by the commission and shall include, but not be limited to the following:

(1) A narrative summary of plans for providing advanced life support services including:

(A) Defined primary area of response including location of advanced life support response vehicle(s).

(B) Defined time of response.

(C) A listing of ~~emergency~~ paramedics to be affiliated by the paramedic organization.

(D) The staffing pattern of personnel.

(E) Base of operations.

(2) Plans and methodologies to insure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education shall be under the direct supervision of the paramedic organization medical director with the cooperation of the sponsoring hospital(s).

(3) ~~A listing of special on-board life support and~~

~~communications equipment available, or to be acquired, including a list of drug and medications to be carried on board each vehicle, manufacturers name, and equipment description, radio frequencies and date of acquisition.~~ A listing of drugs and medications to be carried on board each vehicle, special on-board life support equipment, and communications equipment including the manufacturer's name, the radio frequencies and date of acquisition.

(4) ~~A letter of approval from the sponsoring hospital(s) stating acceptability of emergency paramedics and compatibility of communications equipment and the written agreement to fulfill the responsibilities of the sponsoring hospital(s).~~ Letter of approval from the sponsoring hospital(s) stating acceptance of the paramedics, compatability of the UHF telemetry communications with the paramedic vehicles, and agreement to fulfill the responsibilities of the sponsoring hospital(s).

(5) It is recommended that a letter of endorsement from various elected officials in the community, township, or county (if a county-wide system) be included as part of the application for certification.

(b) Paramedic organizations which do not also provide transportation of emergency patients shall meet the following additional minimum requirements:

(1) Provide for a periodic maintenance program to assure that emergency response vehicles, including equipment, are maintained in good working condition and that applicable sanitation procedures are in effect at all times.

(2) Paramedic organization premises, records, parking or garaging facilities, ~~(if any)~~ and response vehicles shall be made available for inspection by the director, or his duly authorized representative, at any time during regular business hours.

(3) Each paramedic organization shall have in force and effect public liability insurance in the sum as described in 836 IAC 1-2-3(f) pursuant to IC 16-1-39. Such proof of insurance shall be made on a form prescribed by the commission.

(4) Each non-ambulance vehicle(s) utilized for the provision of advanced life support with its prescribed equipment listed in 836 IAC 1-3-5 (unless a specific deletion(s) is approved by the commission), and 836 IAC 1-4-2, pursuant to IC 16-1-39, shall be made available for inspection by the director or his duly authorized representative.

(5) The paramedic organization shall submit an annual report in the manner prescribed by the commission.

(6) Submit a copy of a legal contract between the non-transporting paramedic provider organization and an ambulance service provider certified pursuant to IC 16-1-39. Said contract shall be for the purpose of insuring that the non-transporting paramedic provider can ~~prove~~ assure that patients treated will be transported in a timely and safe manner. The contract shall not preclude another ambulance service provider, if available, from transporting the patient(s).

~~(d)~~(c) Upon approval of the commission, a paramedic organization shall be issued full certification for the provision of advanced life support services as required in these rules and regulations *[836 IAC 2]*.

~~(e)~~(d) The certificate issued shall be valid for a period of one (1) year from the date of issue and shall be prominently displayed at the place of business.

~~(f)~~(e) Application for paramedic organization certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall be made on such forms ~~as may be~~ prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

~~(g)~~(f) The director may issue temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations *[836 IAC 2]* as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule I,B; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 202; filed Nov 3, 1980, 3:55 pm: 3 IR 2218; Errata 4 IR 531; filed Oct 13, 1981, 10:05 am)*

SECTION 15. 836 IAC 2-2-3, as amended at 3 IR 2219, SECTION 21, is amended to read as follows:

836 IAC 2-2-3 Paramedic organization operating procedures

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-7

Sec. 8. PARAMEDIC ORGANIZATION OPERATING PROCEDURES. (a) Each paramedic organization shall maintain accurate records concerning the emergency care provided to each patient within the State which may include a Rescue Record and Report Form prescribed by the commission. It is recommended that the following data be maintained in order to evaluate the program.

(1) Number of runs

(A) cardiac

(B) trauma
(i) automobile accidents
(ii) other
(C) overdose
(D) medical emergencies—i.e., diabetic, respiratory, etc.
(E) miscellaneous—i.e., obstetrical cases
(2) Number of telemetered runs
(3) Call load/day
(4) Number of cases requiring resuscitation measures
(A) number defibrillated
(B) number requiring CPR only
(C) number resuscitated from ~~full~~ cardiopulmonary arrest improved to having a palpable pulse and hospital admission
(D) operational difficulties; i.e., equipment problems, communication problems, other persons on the scene, etc.

(b) Each paramedic organization shall establish daily equipment checklist procedures to insure that:
(1) electronic and mechanical equipment are in proper operating condition.
(2) emergency response vehicles are continuously maintained in a safe operating condition at all times.
(3) ~~the following medications and I.V. fluids in the minimum quantities indicated, are on-board the emergency response vehicle and available to the emergency paramedic.~~ all medications and intravenous fluids listed in the following chart are required to be on-board the emergency response vehicle and available to the paramedic(s). The minimum quantity specified shall also be maintained if identified in the chart:

~~DRUG (Generic Name)~~	~~WT./VOL.~~	~~BRAND NAME~~	~~QUANTITY~~
~~Atropine Sulfate 10cc Jet~~	~~1mg/10cc~~	~~Atropine~~	~~2~~
~~Dextrose 50cc Jet~~	~~25mgs/50cc~~		~~2~~
~~Epinephrine 1:1000~~	~~1:10,000/10cc~~	~~Adrenalin~~	~~4~~
~~Isoproterenol HCL 1:5000~~	~~1mg/5cc~~	~~Isuprel~~	~~2~~
~~Furosemide 2cc~~	~~20mg/2cc~~	~~Lasix~~	~~4~~
~~Lidocaine HCL 5cc Jet~~	~~100mg/5cc~~	~~Xylocaine I.V.~~	~~4~~
~~Lidocaine HCL 25cc~~	~~1gm/25cc~~	~~Xylocaine I.V.~~	~~2~~
~~Morphine Sulfate 1cc~~	~~10mg/1cc~~		~~4~~
~~Nalaxone HCL 1cc~~	~~0.1mg/1cc~~	~~Narcan~~	~~4~~
~~Sodium Bicarbonate 50cc~~	~~50.0mEq/50cc~~		~~6~~
~~Diazepam 2cc~~	~~10mg/2cc~~	~~Valium~~	~~4~~
~~Calcium Chloride 10cc~~	~~1000mg/10cc~~		~~2~~
~~Meperidine~~	~~100mg/1cc~~	~~Demerol~~	~~5~~
~~Dopamine 5cc~~	~~200mg/5cc~~	~~Intropin~~	~~4~~
~~Metaraminol 10cc~~	~~100mg/10cc~~	~~Aramine~~	~~4~~
~~Levarterenol 4cc~~	~~4mg/4cc~~	~~Levophed~~	~~4~~
~~Hydrocortisone Na Succinate Mix-O-Vial 4cc~~	~~500mg/4cc~~	~~Solu-Cortef~~	~~4~~
~~I.V. FLUIDS~~			
~~500 cc D.W~~	~~_____~~	~~_____~~	~~4~~
~~1000cc Lactated Ringers~~	~~_____~~	~~_____~~	~~6~~
~~1000cc Saline~~	~~_____~~	~~_____~~	~~2~~
~~SYRINGES~~			
~~1cc T.B.~~	~~_____~~	~~_____~~	~~5~~
~~3cc 21ga.~~	~~_____~~	~~_____~~	~~5~~
~~5cc 21ga.~~	~~_____~~	~~_____~~	~~5~~
~~50 cc~~	~~_____~~	~~_____~~	~~2~~

MEDICATION	MINIMUM QUANTITY
atropine sulfate (to be packaged in pre-loaded syringes)	2mg
dextrose 50% (to be packaged in pre-loaded syringes)	100cc
epinephrine 1:10,000 (to be packaged in pre-loaded syringes)	4 mg
epinephrine 1:1,000	2 mg
furosemide	80 mg
lidocaine (to be packaged in pre-loaded syringes)	400 mg
lidocaine	2 gm
narcotic agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—
naloxone HCL	1.6 mg
sodium bicarbonate (to be packaged in pre-loaded syringes)	200 mEq
diazepam	20 mg
calcium chloride (to be packaged in pre-loaded syringes)	2 gm
vasopressor agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—
steroidal agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—
Dextrose 5% in water	2000cc
crystalloid intravenous solution (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	8000cc

(c) ~~The paramedic organization upon written approval of the sponsoring hospitals and paramedic organization medical director, may make additional drugs and/or medications available as deemed appropriate. However, no drugs or medications may be carried on-board the emergency response vehicle which have not been approved.~~ The medications and intravenous fluids referenced in 836 IAC 2-2-3(b)(3) are a minimum requirement. The paramedic organization, upon written approval of the sponsoring hospital(s) and the paramedic organization medical director may make additional medications and/or intravenous fluids available as deemed appropriate. However, no drugs or medications may be carried on-board the emergency response vehicle which have not been approved by the commission. The specific narcotics, vasopressors, steroids and crystalloid solutions shall be identified as required in 836 IAC 2-2-3(b)(3), and a current list shall be kept on file with the commission. Said list shall include the names and quantities of the medications and solutions identified by the paramedic organization medical director. A copy of said report is to be maintained on file at the sponsoring and, where applicable, the supervising hospital(s) of the provider. The report shall include the names and quantities of the medications and intravenous fluids.

(d) All drugs and supplies are to be supplied by the sponsoring hospital, or by written arrangement with a supervising hospital, on an even exchange basis. Lost, stolen or misused drugs will only be replaced on order of the paramedic organization medical director. NOTE: Accountability for distribution, storage, ownership and security of drugs and medications is subject to applicable requirements as determined by the State of Indiana Board of Pharmacy.

(e) The paramedic organization shall insure that the basic life support equipment as described in 836 IAC 1-3-5 pursuant to IC 16-1-39 is carried on-board each ambulance in addition to the equipment identified herein.

(1) Portable defibrillator with self-contained cardiac monitor and ECG strip writer. (Pediatric paddles are recommended)
(2) Portable ventilation kit to include:
(A) Bag-mask device, hand operated with:
(i) O_2 reservoir tubing
(ii) Universal adapters (15mm female and 22mm male)
(iii) Transparent cushion masks (adult and pediatric sizes)

(B) Airway devices to include:
(i) Nasopharyngeal airways (adult sizes)
(C) Oxygen inhalation devices to include:
(i) Portable, of at least 300 liters capacity ('D' size cylinder) with yoke, medical regulator, pressure gauge and non-dependent flowmeter.
(ii) Venturi masks (adult, child and infant sizes)
(iii) Nasal cannula (adult and child sizes)
(iv) Simple mask (adult and child sizes)
(v) Partial rebreather mask (adult and child sizes)
(D) Suction devices to include:
(i) Portable, capable of a minimum vacuum of 300mm of mercury with wide-bore tubing.
(ii) Tracheal suction catheters (adult #14 and #18, child #10)
(iii) Rigid pharyngeal suction tip
(E) Endotracheal intubation devices to include:
(i) Laryngoscope with extra batteries and bulbs
(ii) Laryngoscope blades (adult and pediatric, curved and straight)
(iii) Disposable endotracheal tubes ~~(2.0, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, and 9.0)~~, a minimum of two (2) each, sterile packaged, in the following sizes: 3, 4, 5, 6, 7, 8, 9mm ID (inside diameter).
(iv) Esophageal obturator airway or esophageal gastric obturator airway
(3) Cardiac press board
(4) Intravenous and medication administration supplies to include:
(A) Intravenous administration sets appropriate to the intravenous fluid containers selected and required under 836 IAC 2-2-3(b)(3) in a minimum quantity of one (1) set per each required intravenous fluid bag or bottle.
(B) Syringes and needles in appropriate sizes and quantities identified by the medical director of the paramedic organization to facilitate the administration of medications listed under 836 IAC 2-2-3(b)(3) and the collection of blood samples.

(f) ~~Each paramedic organization, upon written approval of the sponsoring hospital(s) and paramedic organization medical director, may make additional equipment available as deemed appropriate.~~ The equipment and supplies referenced in 836 IAC 2-2-3(e) is the minimum requirement. The paramedic organization, upon written approval of the sponsoring hospital(s) and the paramedic organization medical director may make additional equipment and supplies available as deemed appropriate. Specific items listed in 836 IAC 2-2-3(e)(4)(B) must be identified by the paramedic organization medical director and reported in writing to the commission for initial certification and recertification. This reporting may be a part of the required report referenced 836 IAC 2-2-3(c).

(g) Each paramedic organization shall insure that rigid sanitation procedures are in effect at all times. The following sanitation standards shall apply to all vehicles used for the purpose of providing advanced life support services:
(1) The interior and the equipment within the vehicle shall be clean and maintained in good working order at all times.
(2) Freshly laundered linen or disposable linens shall be used on cots and pillows, and linen shall be changed after each patient is transported.
(3) Clean linen storage shall be provided.
(4) Closed compartments shall be provided within the vehicle for medical supplies.
(5) Closed containers shall be provided for soiled supplies.
(6) Blankets shall be kept clean and stored in closed compartments.
(7) ~~Implements inserted into the patient's nose or mouth shall be single-service, wrapped and properly stored and handled. Multi-use items are to be kept clean and sterile when indicated and properly stored.~~ Single service implements inserted into the patient's nose or mouth shall be wrapped and properly stored and handled. Multi-use items are to be kept clean and sterile when indicated and and properly stored.
(8) When a vehicle has been utilized to transport a patient known to have a communicable disease, the vehicle shall be cleansed and all contact surfaces shall be washed with soap and water and disinfected.
(9) A closed compartment, which shall be substantially constructed and equipped with a secure locking device, shall be provided within the vehicle for storage of drugs and medications when the vehicle is not in use or unattended. Portable drug kits shall not be left in unattended vehicles unless adequate security precautions have been approved by the commission.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule I,C; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 204; filed Nov 3, 1980, 3:55 pm: 3 IR 2219; filed Oct 13, 1981, 10:05 am)

SECTION 16. 836 IAC 2-3-1, as amended at 3 IR 2222, SECTION 22, is amended to read as follows:

836 IAC 2-3-1 General requirements for training institutions

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9; IC 16-1-40-9

Sec. 1. GENERAL REQUIREMENTS FOR TRAINING INSTITUTIONS. (a) All institutions administering or seeking to administer training for ~~emergency~~ paramedics engaged in providing ~~advance~~ advanced life support services are required to be certified by the commission.

(b) An institution certified by the commission to conduct training programs for ~~emergency~~ paramedics may enter into an agreement with other institutions of higher education to conduct the didactic portions of the training program, provided the institution can present to the commission evidence of capability to provide such training. Under conditions where training is conducted by separate institutions, the clinical portion and overall program responsibility shall remain with the institution approved by the commission.

(c) Institutions seeking commission certification shall be certified by the commission as a sponsoring hospital and meet the following minimum requirements:

(1) Submit to an evaluation of training facilities and capabilities by the director, or his duly authorized representative.

(2) Have the necessary clinical facilities and guarantee access to emergency patients to conduct the required clinical phases of the training program.

(3) Provide the necessary supervision of trainees during the clinical experience phase(s) of the training program.

(4) Have approval in writing of the administrative and medical staff.

(5) Provide orientation to hospital personnel and physicians who may be directly or indirectly involved in the training program or the operational aspects of providing advanced life support services.

(d) Staffing for the training program shall include a medical director, a curriculum coordinator, and other technical instructor personnel as deemed necessary by the medical director. The staff shall meet the following minimum requirements:

(1) Medical Director—The medical director must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana, and has an active role in the delivery of emergency care.

(2) Curriculum Coordinator—The curriculum coordinator shall be appointed by the medical director and must be a physician, registered nurse or member of the program instructional staff.

(3) Instructional Staff—The instructional staff shall be selected from various specialties and shall have appropriate education and experience as deemed necessary to teach in assigned areas at the discretion of the medical director.

(e) Each training institution shall insure adequate classroom space for the optimum didactic ratio of one (1) instructor for each ten (10) students and optimum clinical practice session ratio of one (1) instructor for each two (2) students. NOTE: It is recommended that no more than two (2) trainees be assigned at one time to any hospital clinical unit or to any emergency vehicle for clinical experience and training.

(f) The minimum curriculum requirements for training institutions shall be the Training Program for the Emergency Medical Technician—Paramedic training course, outlined by the U.S. Department of Transportation as DOT HS 802 437 through ~~DOT HS 402~~ 452 DOT HS 802 452. Each course must be approved by the commission. A course must be conducted within a maximum period of twenty-four (24) consecutive months unless the training institution petitions the commission for special approval. For the duration of the course, following the appropriate didactic and clinical evaluation of each skill, a student may perform those advanced life support skills evaluated and found to be performed successfully, under the direct supervision of qualified health professionals designated as preceptors by the medical director of the training institution. A list of the preceptors and their qualifications shall be forwarded to the director as a part of the course application.

(1) As a requirement for completion of the course, a person(s) must successfully complete a skills exam. The procedure for testing and skills to be tested will be found in 836 IAC 2-6-1(c)(2).

(2) Medical Director of the training program shall attest to the competency of graduates in a manner as is prescribed in these rules and regulations [*836 IAC 2*].

Individuals certified as Advanced EMTs may waive study of modules 1-3 upon approval of the training institution. However, no examination or certification requirements shall be waived.

(g) Institutions should apply for approval in such manner as may be prescribed by the commission not less than ninety (90) days prior to the date the approval is requested.

(h) Institutional approval shall be valid for a period of three (3) years from the date of issue.

(i) Application for certification renewal should be made not less than sixty (60) days prior to the

expiration date of the current approval. Application for renewal shall be made on such forms as ~~may be~~ prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

(j) Procedures for suspension, revocation, or termination of certification pursuant to IC 16-1-40-9 shall apply to training institutions.

(k) The director may issue a temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule II, A; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 207; filed Nov 3, 1980, 3:55 pm: 3 IR 2222; filed Oct 13, 1981, 10:05 am)*

SECTION 17. 836 IAC 2-3-2, as amended at 3 IR 2223, SECTION 23, is amended to read as follows:

836 IAC 2-3-2 Responsibilities of the training institution staff

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 2. RESPONSIBILITIES OF THE TRAINING INSTITUTION STAFF. (a) Training Program Medical Director—The medical director shall be responsible for providing competent medical direction and overall supervision of the training program which shall include, but not be limited to:

(1) Providing necessary liaison with physicians to obtain adequate instructor services.
(2) Assuring that the course of instruction meets established standards of the commission.
(3) Assuring accurate and thorough presentation of medical content of the course.
(4) Attests to the competency of graduates to perform selected skills as outlined under 836 IAC 2-6-1(c)(2) on forms as may be prescribed by the commission. A copy of said forms shall be returned to the commission by the medical director.

(b) Curriculum Coordinator—The curriculum coordinator shall be responsible for assignments as determined by the medical director which shall include, but not be limited to:

(1) Individual consultation with trainees.
(2) Assure that the required equipment and materials are available at each class.
(3) Monitor and evaluate classroom activities, including clinical and practice sessions.
(4) Schedule students for required clinical experience.
(5) Assist in the coordination of examinations.
(6) Provide information concerning training programs.
(7) Act as liaison between the students, program staff and the training institution.

The curriculum coordinator shall be available each day classes are conducted.

(c) Instructional Staff—The instructional staff shall be held accountable for assignments as determined by the medical director.

It is recommended that instructors selected meet the following requirements:

(1) Have extensive critical and/or emergency care experience compatible with the subject being presented.
(2) Have a level of medical knowledge above that required of the ~~emergency~~ paramedic compatible with the subject being presented.
(3) Be thoroughly knowledgeable about, and able to demonstrate all skills as presented in the course. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule II, B; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 209; filed Nov 3, 1980, 3:55 pm: 3 IR 2223; filed Oct 13, 1981, 10:05 am)*

SECTION 18. 836 IAC 2-3-3, as amended at 3 IR 2224, SECTION 24, is amended to read as follows:

836 IAC 2-3-3 Training institution report requirements

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 3. TRAINING INSTITUTION REPORT REQUIREMENTS. (a) The training institution shall provide a course report in the manner prescribed by the commission within fifteen (15) days of the completion of the course.

(b) The training institution shall complete other such forms as may be required by the commission for the purpose of course and student evaluation, and shall cooperate and assist the commission in collecting statistics and evaluating performance and costs relating to the training of ~~emergency~~ paramedics. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule II, C; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 210; filed Nov 3, 1980, 3:55 pm: 3 IR 2224; filed Oct 13, 1981, 10:05 am)*

SECTION 19. 836 IAC 2-3-4, as amended at 3 IR 2224, SECTION 25, is amended to read as follows:

836 IAC 2-3-4 Student qualifications for paramedic training

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 4. STUDENT QUALIFICATIONS FOR ~~EMERGENCY~~ PARAMEDIC TRAINING. (a) Applicants shall meet the following minimum requirements:

(1) Applicant must hold a valid certificate as an emergency medical technician issued by the commission pursuant to IC 16-1-39.

(2) Applicant must be accepted by the training institution.

(3) Applicant shall show evidence of a physical examination as prescribed by the commission and given by a physician licensed by the State of Indiana.

(4) Applicant shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render them unfit to perform as ~~an emergency~~ a paramedic.

(5) Applicant must pass screening and evaluation as determined necessary by the training program medical director.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule II,D; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 210; filed Nov 3, 1980, 3:55 pm: 3 IR 2224; filed Oct 13, 1981, 10:05 am)

SECTION 20. 836 IAC 2-4-1, as amended at 3 IR 2224, SECTION 26, is amended to read as follows:

836 IAC 2-4-1 General requirements for supervising hospitals

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3; IC 16-1-40-9

Sec. 1. GENERAL REQUIREMENTS FOR SUPERVISING HOSPITALS. (a) Unless otherwise specified, the provisions of 836 IAC 2-4 of these rules and regulations shall be in full force upon promulgation of these rules and regulations [*836 IAC 2*].

(b) All hospitals providing, or seeking to provide, medical supervision of advanced life support services performed by ~~emergency~~ paramedics are required to be certified as a supervising hospital by the commission.

(c) Hospitals seeking commission certification shall meet the following minimum requirements:

(1) Application shall be made on such forms as may be prescribed by the commission.

(2) Submit to an evaluation of facilities and capabilities to supervise advanced life support services by the director, or his duly authorized representative.

(3) Have an open and staffed cardiac care unit and/or intensive care unit.

(4) Have approval in writing of the administrative and medical staff.

(5) Provide and maintain a communication system which must be available twenty-four hours a day between the paramedic organization and the emergency department, or coronary care unit, or equivalent, using UHF (Ultra High Frequency) ECG telemetry and voice communication. Communication system must be licensed per FCC rules and regulations. NOTE: Subject to review and approval by the commission, the administrative and medical staff of the sponsoring hospital, with concurrence of the administrative and medical staff of the supervising hospital(s) in the ~~paramedic~~ organization's normal operating area, and the paramedic organization medical director, the paramedic organization may petition the commission to omit UHF (Ultra High Frequency) ECG telemetry. However, provision shall be made for an ECG tape read-out on the paramedic organization's advanced life support vehicle(s).

(6) Have a physician or physician designate ~~approval~~ approved in writing by the medical staff and who must be immediately available at all times to supervise via communication the advanced life support procedures administered by ~~emergency~~ paramedics.

(7) Provide orientation to hospital personnel and physicians who may be directly or indirectly involved in the operational aspects of providing advanced life support services.

(8) Provide for audit and review of cases on a monthly basis with ~~emergency~~ paramedics, emergency department personnel, and physicians to improve field operations and forward any recommendations for continuing education to the paramedic organization medical director and sponsoring hospital medical director of the emergency department.

(d) Procedures for suspension, revocation, or termination of certification pursuant to IC 16-1-40-9 shall apply to supervising hospitals. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule III,A; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 210; Nov 3, 1980, 3:55 pm: 3 IR 2224; filed Oct 13, 1981, 10:05 am)*

SECTION 27. 836 IAC 2-4-2 is amended to read as follows:

836 IAC 2-4-2 Application for certification

Authority: IC 16-1-39-6; IC 16-1-40-3

Affected: IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Hospitals ~~shall~~ should apply for ~~approval~~ certification not less than ninety (90) days prior to the date ~~the~~ approval is requested.

(b) ~~Upon approval of the commission, a certificate shall be issued by the director. The certificate shall~~ Commission certification shall be valid for a period of three (3) years from the date of issue~~, and shall be prominently displayed~~.

(c) Application for ~~certification~~ renewal ~~shall~~ should be made not less than sixty (60) days prior to the expiration date of the current ~~approval~~ certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

(d) The director may issue a temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule III,B; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 211; filed Nov 3, 1980, 3:55 pm)*

836 IAC 2-5-1 General requirements for sponsoring hospitals

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3; IC 16-1-40-9

Sec. 1. GENERAL REQUIREMENTS FOR SPONSORING HOSPITALS. (a) All hospitals sponsoring, or seeking to sponsor a paramedic organization, are required to be certified by the commission.

(b) Hospitals seeking commission approval shall meet the following minimum requirements:

(1) Application for approval shall be submitted in the manner prescribed by the commission.

(2) The hospital shall be certified by the commission as a supervising hospital pursuant to these rules and regulations [*836 IAC 2*].

(3) The hospital administrative and medical staff of the sponsoring hospital shall have agreed by contract with one or more paramedic organizations ~~for~~ to provide the following services:

(A) Continuing education
(B) Audit and review
(C) Medical control and direction
(D) Provide liaison and direction for supply of medications, fluids and other items utilized by ~~emergency~~ paramedics.

Said contract shall include a detailed description of how such services will be provided to the paramedic organization.

(4) The hospital shall establish an assessment committee for audit and review of medical procedures performed by ~~emergency~~ paramedics of the paramedic organization.

(5) The paramedic organization medical director shall be a member of the assessment committee.

(6) The recommended membership of the assessment committee is:

(A) ~~emergency~~ paramedics.
(B) emergency department supervisory personnel.
(C) paramedic organization supervisory personnel.
(D) emergency department physicians.

(c) The sponsoring hospital(s) shall establish a committee which will develop standardized policies and procedures for medical control and the development of system protocol and/or standing orders to insure the proper response to all emergency situations by ~~emergency~~ paramedics. However, these rules and regulations [*836 IAC 2*] shall not require the sponsoring hospital(s) to issue standing order(s).

(1) The committee, as a minimum, shall be comprised of the following persons:

(A) Medical director(s) of the paramedic organization(s) under sponsorship of the hospital(s);
(B) Medical director or designate of the sponsoring hospital(s) emergency department;
(C) A representative of the administrative staff of the sponsoring hospital(s);
(D) A physician representative of all supervising hospital(s) in the area who shall act in an advisory non-voting role.

In circumstances where one or more hospital(s) sponsor a paramedic organization(s), the medical control of each sponsoring hospital shall be combined into a single function body.

(d) Standing orders must be applicable to specific emergency situations and a current copy of such orders must be maintained on-board the emergency response vehicle at all times, be immediately available at the communications desk of the sponsoring hospital, be available at the paramedic organization dispatch control center, and a current copy maintained by the commission. It is recommended that the supervising hospitals within the operating area of the paramedic organization concur with the standing orders issued.

(e) Hospitals certified under this section may, upon approval by the commission, perform and assume the duties and responsibilities of a supervising hospital as referenced in 836 IAC 2-8. All Advanced EMT training courses shall be conducted as described in ~~836 IAC 2-8-4~~ 836 IAC 2-8-3. Procedures for suspension, revocation, or termination of certification pursuant to IC 16-1-40-9 shall apply to sponsoring hospitals. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule IV,A; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 211; filed Dec 15, 1977: Rules and Regs. 1978, p. 250; filed Nov 3, 1980, 3:55 pm: 3 IR 2226; filed Oct 13, 1981, 10:05 am)*

1978, p. 211; filed Dec 15, 1977: Rules and Regs. 1978, p. 250; filed Nov 3, 1980, 3:55 pm)

SECTION 29. 836 IAC 2-5-2 is amended to read as follows:

836 IAC 2-5-2 Application for certification

Authority: IC 16-1-39-6; IC 16-1-40-3

Affected: IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Hospitals ~~shall~~ should apply for ~~approval~~ certification not less than ninety (90) days prior to the date approval is requested. ~~Upon verification from the director that all requirements have been met, the commission will consider the application at the next regularly scheduled meeting.~~

(b) Commission ~~approval will~~ certification shall be valid for a period of three (3) years from the date of issue.

(c) Application for renewal ~~shall~~ should be made not less than sixty (60) days prior to the expiration date of the current ~~approval~~ certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

(d) The director may issue a temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule IV,B; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 212; filed Nov 3, 1980, 3:55 pm)*

SECTION 22. 836 IAC 2-6-1, as amended at 3 IR 2227, SECTION 30, is amended to read as follows:

836 IAC 2-6-1 General certification provisions

Authority: IC 16-1-39-6; IC 16-1-40-3

Affected: IC 4-22-1; IC 16-1-39; IC 16-1-40-3

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (a) Unless otherwise specified, the provisions of 836 IAC 2-6 of these rules and regulations shall be in full force and effect upon promulgation of these rules and regulations [*836 IAC 2*].

(b) Any person who is currently certified as an emergency medical technician pursuant to IC 16-1-39, and has received advanced instruction and training enabling him to perform under the supervision of a

physician in person, by standing order, or via voice communication may be certified as ~~an emergency~~ a paramedic by the commission.

(c) Applicants for certification as ~~an emergency~~ a paramedic are required to be certified as an emergency medical technician pursuant to IC 16-1-39 and meet the following requirements:

(1) Be affiliated with a certified paramedic organization or be employed by a sponsoring hospital approved by the commission, or be employed by a supervising hospital with a contract for ~~in-service~~ continuing education with a sponsoring hospital approved by the commission and;

(2) Have satisfactorily completed the prescribed training as set forth in these rules and regulations [*836 IAC 2*] and be competent to perform selected Department of Transportation training ~~programs~~ program for emergency medical technician-paramedic curriculum skills as attested to in writing on commission prescribed forms by the medical director of the training program. The required skills are:

(A) Cardiopulmonary resuscitation (one-person, two-person, and infant)

(B) Airway management

(C) Intubation:

(i) Endotracheal

(ii) Esophageal (if included in training program)

(D) Interpretation of ECG monitor strips (static)

(E) Interpretation of ECG monitor strips (dynamic)

(F) Defibrillation

(G) Intravenous line placement

(H) Patient assessment

(I) Traction Splinting (Hare or Thomas splints) or equivalent

(J) Backboard utilization

(K) ~~Military anti-shock trousers~~ Anti-shock trousers

Forms will be provided to the medical director of the training program delineating the skills and the necessary steps to perform these skills competently. Upon satisfactory completion of the required skills and attestment by the medical director, on the required forms, a copy of said form will be forwarded to the commission, and;

(3) Satisfactorily demonstrate knowledge in the area of emergency care by successfully completing the ~~emergency~~ paramedic written examination composed by the Advanced Life Support Test Construction and Evaluation Committee under the supervision of the commission. Students shall be notified in writing, at the time of examination, of the criteria for successful completion of the examination which shall include the maximum number of opportunities for re-examination before re-training is required as follows:

(A) During a twelve (12) month period (the twelve (12) months beginning the first day that a paramedic certification examination is offered by the commission after the candidate has completed his paramedic training program), the candidate will be allowed to take the paramedic certification examination a total of three (3) times. However, the director may approve an extension of the twelve (12) month period for a period of six (6) months upon receipt of a written request during the twelve (12) month period from the candidate. A candidate who fails the written examination a second time should be encouraged to take a program of remedial training designed by the candidate and the training program medical director.

(B) A candidate who fails the written examination the third time or who fails to successfully complete the written examination during the approved time period must retake the entire course of training for paramedics as outlined in these rules and regulations [*836 IAC 2*]. Upon successful completion of said course, the candidate will be eligible to satisfy the requirements for certification as prescribed by these rules and regulations [*836 IAC 2*], and;

(4) Present evidence of fitness by a written report of physical examination prescribed by the commission, given by a physician licensed to practice medicine in the State of Indiana. Applicant shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render him unfit to provide advanced life support services. Determination of fitness may be made by the paramedic organization medical director.

(d) Applicants for certification as ~~an emergency~~ a paramedic residing in states bordering Indiana and who have completed ~~an emergency~~ a paramedic training course equivalent to the minimum requirements established by the commission as determined by the director are required to:

(1) be certified as an emergency medical technician pursuant to IC 16-1-39

(2) be affiliated in the manner described in 836 IAC 2-6-1(c)(1)

(3) successfully pass the ~~emergency~~ paramedic written and practical examinations as outlined in

these rules and regulations [*836 IAC 2*]
(4) present evidence of fitness as described in 836 IAC 2-6-1(c)(4)

(e) Applicants for certification as ~~an emergency~~ a paramedic who, at the time Indiana residence is established, possesses a valid certificate or license as ~~an emergency~~ a paramedic from another state, who has completed ~~an emergency~~ a paramedic training course equivalent to the minimum requirements established by the commission as determined by the director are required to:
(1) be certified as an emergency medical technician pursuant to IC 16-1-39
(2) be affiliated in the manner described in 836 IAC 2-6-1(c)(1)
(3) successfully pass the ~~emergency~~ paramedic written and practical examinations as outlined in these rules and regulations [*836 IAC 2*]
(4) present evidence of fitness as described in 836 IAC 2-6-1(c)(4)

(f) Certification exemptions identified under ~~836 IAC 2-2-1(d)~~ 836 IAC 2-2-1(m) shall apply to the certification of ~~emergency~~ paramedics.

(g) The commission may initiate proceedings to suspend or revoke certification on its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held in and conducted in accordance with the provisions of IC 4-22-1 upon proof that any ~~emergency~~ paramedic:
(1) is guilty of fraud or deceit in procuring ~~or attempting to procure~~ certification as ~~an emergency~~ a paramedic;
(2) is unfit or incompetent by reason of negligence, habit, or other causes;
(3) is habitually intemperate or is addicted to the use of habit-forming drugs;
(4) is mentally incompetent;
(5) is guilty of unprofessional conduct;
(6) is guilty of delegating to a person less qualified any service which requires the professional competence of ~~an emergency~~ a paramedic;
(7) is guilty of a direct violation of a physician's reasonable and and prudent order from the supervising hospital;
(8) has willfully or repeatedly violated any of the provisions of these rules and regulations [*836 IAC 2*];
(9) has been convicted of an offense if the acts that resulted in the conviction have a direct bearing on whether or not the person should be entrusted to serve the public as a paramedic.

(h) Emergency Paramedics should comply with the standards of ethical conduct which ~~include~~ follow:
(1) strive to improve medical knowledge and skill on a continuing basis.
(2) offer optimal support to the patient, doctor, supervising and sponsoring hospital.
(3) respect the patient's right to privacy, dignity and safety.
(4) understand the legal responsibility and the limitations imposed upon them.
(5) understand the principles of the practice of medicine, and the practice of the ~~emergency~~ paramedic.
(6) understand all types of emergencies, both medical and mechanical, and the measures that must be applied to solve the problem at hand, and/or the prevention of such emergencies.
(7) be skilled to act instead of react in times of emergency and/or stress.
(8) always seek to increase knowledge and skill to perform to the best of their ability with full recognition of their limitations and to accept ~~and~~ the benefit from constructive criticism and advice.
(9) encourage participation in activities whose goal is to improve the health and well-being of the individual as well as the community as a whole.
(10) strive to publicly uphold the image, goals and ideals of the program and the profession.
(11) take pride in his personal appearance and at all times realize that he is being observed by members of the community.
(12) have a calm and reassuring manner when dealing with patients, relatives and bystanders in order to gain confidence and cooperation of all concerned.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule V,A; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 213; filed Dec 15, 1977: Rules and Regs. 1978, p. 250; filed Dec 15, 1977: Rules and Regs. 1978, p. 251; filed Nov 3, 1980, 3:55 pm: 3 IR 2227; filed Oct 13, 1981, 10:05 am)

SECTION 23. 836 IAC 2-6-2, as added at 3 IR 2229, SECTION 31, is amended to read as follows:

836 IAC 2-6-2 Application for certification
Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Application for certification as ~~an emergency~~ a paramedic shall be made on such forms as may be prescribed by the commission. Applicants shall complete the required forms, and should submit same to the director not less than ninety (90) days prior to the requested effective date of certification.

(b) Valid application for certification as ~~an emergency~~ a paramedic shall be made within one (1)

year of the date of successful completion of the ~~emergency~~ paramedic written certification examination. Failure to do so shall result in the following:

(1) Applicant shall retake and successfully complete the ~~emergency~~ paramedic certification examination as described in 836 IAC 2-6-1 (c)(3) and;

(2) Submit an eligible application as ~~an emergency~~ a paramedic within said twelve (12) month period, identified in 836 IAC 2-6-2(b). Failure to meet the requirements outlined herein shall result in the applicant's retraining as ~~an emergency~~ a paramedic according to these rules and regulations [*836 IAC 2*].

(c) The director may issue a temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time.

(d) Upon approval of the commission, ~~an emergency~~ a paramedic shall be issued certification for the provision of advanced life support services as described in these rules and regulations [*836 IAC 1 and 836 IAC 2*].

(e) A certificate issued in accordance with these provisions shall be valid as long as compliance is maintained with the continuing education requirements as set forth in these rules and regulations [*836 IAC 1 and 836 IAC 2*].

(f) Individuals who have failed to comply with the continuing education requirements as determined by the director shall not exercise any of the rights and privileges nor shall individual(s) administer advanced life support services to emergency patients until the following requirements are met:

(1) Show competency to perform selected Department of Transportation Training Program for Emergency Medical Technician-Paramedic curriculum skills as attested to in writing on commission prescribed forms by the medical director of an approved training program, an approved paramedic provider or an approved sponsoring hospital. The required skills are outlined in 836 IAC 2-6-1(c)(2) of the rules and regulations for advanced life support.

(2) Satisfactorily demonstrate knowledge in the area of emergency care by successfully completing the ~~emergency~~ paramedic written examination composed by the Advanced Life Support Test Construction and Evaluation Committee under the supervision of the commission. The criteria for examination and re-examination are outlined in 836 ~~IAC 2-6-1(c)(2)(A) and (B)~~ 836 IAC 2-6-1(c)(3)(A) and (B) of the rules and regulations for advanced life support.

(3) Present evidence of fitness as outlined in 836 IAC 2-6-1(c)(4).

(4) Be currently affiliated as described in 836 IAC 2-6-1(c)(1).

(g) ~~Application for certification renewal shall be made on forms prescribed by the commission within one (1) year from date of non-compliance.~~ **Application for certification renewal shall be made on forms prescribed by the commission within one (1) year from date of non-compliance with 836 IAC 2-6-4.**

(h) ~~A person who fails to apply for certification renewal within one (1) year from the date of determination of non-compliance will be required to successfully complete the prescribed training for initial certification as set forth in these rules and regulations.~~ **A person who fails to apply for certification renewal within one (1) year from the date of non-compliance with 836 IAC 2-6-4 will be required to successfully complete the prescribed training for initial certification as set forth in these rules and regulations** [*836 IAC 2*]. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule V, B; filed Jan 21, 1977, 11:30 am: Rules and Regs. 1978, p. 215; filed Nov 3, 1980, 3:55 pm: 3 IR 2229; filed Oct 13, 1981, 10:05 am)*

SECTION 24. 836 IAC 2-6-3, as amended at 3 IR 2231, SECTION 32, is amended to read as follows:

836 IAC 2-6-3 Requirements for continuing education

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 3. REQUIREMENTS FOR CONTINUING EDUCATION. (a) Any applicant making application for certification or certification renewal on or after January 1, 1981, must meet the following qualifications to maintain their certification. Concurrent emergency medical technician certification will be maintained if these requirements are fulfilled.

(1) Have successfully completed the requirements for ~~in-service training~~ continuing education which shall provide for a minimum of sixty (60) continuing education credits (CEC) per year as outlined below. The CEC may be accumulated in any combination from up to ~~six (6)~~ five (5) categories as described below provided there is adherence to the annual minimum and maximum CEC limits per category.

CATEGORY I Lectures and Critiques

Attendance at D.O.T. paramedic course related lectures or critiques (audits) of paramedic-related activities conducted by the paramedic organization's sponsoring hospital(s).

Each candidate shall individually report his attendance on the required CEC form annually and each ~~lecture~~ lecturer or critique director will submit a signed attendance roster attesting to the completion of the lecture or critique session to the commission.

Value: 1 CEC/1 hour lecture or critique time
Minimum Category I CEC Required Per Year 15
Maximum Category I CEC Allowed Per Year No Limit

CATEGORY II Skills

Attendance at or conduction of D.O.T. paramedic course related "hands on" skill refresher or skill testing programs conducted by the paramedic organization's sponsoring hospital(s). Each candidate shall individually report his attendance on the required form annually and each course director will submit a signed attendance roster at the completion of the course denoting both the names of those attending as well as their performance level (satisfactory vs. unsatisfactory). Credit will only be allowed for satisfactory performance.

Value: 1 CEC/1 hour skill laboratory or testing time
Minimum Category II CEC required Per year 10*
Maximum Category II CEC allowed Per year No limit

*Note: The ten (10) credit minimum Category II CEC per year ~~must~~ must include time spent in each of the curriculum skills enumerated in 836 IAC 2-6-1(c)(2) of rules and regulations for advanced life support of the commission.

CATEGORY III Other Learning Experiences

Lecture or skills ~~sessions~~ session in emergency medical technician or paramedic related activities not conducted by the paramedic organization's sponsoring hospital(s). Each candidate should individually report his attendance on the required form annually and each course director should maintain an attendance roster for verification (may be requested by the commission) or may voluntarily submit an attendance roster to the commission.

Value: 1 CEC/3 hours learning or skills experience
Minimum Category III CEC Required Per Year None
Maximum Category III CEC Allowed Per Year No Limit

CATEGORY IV Teaching Experiences

Participation as an instructor (lecture or laboratory) in an educational program utilizing emergency medical technician paramedic-level knowledge or skills. The CEC's will be allotted as outlined in the commission publication entitled: "Advanced Life Support Continuing Education Requirements" which allows 1 CEC for every hour of teaching experience. Each candidate shall individually report his participation on the required form annually and each course director should maintain an instructor roster for verification (may be requested by the commission) or may voluntarily submit an instructor roster to the commission.

Value: 1 CEC/1 hour
Minimum Category IV CEC Required Per Year None
Maximum Category IV CEC Allowed Per Year No Limit

CATEGORY V Advanced Life Support Ambulance Experience

Documented active participation in advanced life support activities during the paramedic organization's ambulance run. A letter of verification must be submitted to the medical director of the paramedic organization along with the annual paramedic CEC summary form for credit to be allowed. It is the responsibility of the paramedic to tabulate the appropriate runs, report the run activity on the required form annually and solicit the required letter from the paramedic organization's medical director to substantiate his claim for Category V CEC credit.

Value: 1 CEC/10 Advanced Life Support Ambulance Runs

Minimum Category V CEC Required Per year None
Maximum Category V CEC Allowed Per Year 10

Refer to the commission publication entitled "Advanced Life Support Continuing Education Requirements" for examples of continuing education activities in each category, CEC allotment for recognized and established advanced life support activities.

(b) Currently certified ~~emergency~~ paramedics whose annual anniversary date does not fall on January 1, 1981 shall be notified by the commission of their continuing education requirements based upon a formula established by the commission. Said formula shall be a ratio of the number of months remaining in the ~~emergency~~ paramedics annual anniversary period to the number of continuing education credits as required by these rules and regulations [*836 IAC 2*]. *(Indiana Emergency Medical Services Commission; 836 IAC 2-6-3; filed Nov 3, 1980, 3:55 pm: 3 IR 2231; filed Oct 13, 1981, 10:05 am)*

SECTION 25. 836 IAC 2-6-4, as added at 3 IR 2232, SECTION 33, is amended to read as follows:

836 IAC 2-6-4 Continuing education reporting requirements

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 4. CONTINUING EDUCATION REPORTING REQUIREMENTS. (a) Each ~~Emergency~~ paramedic shall report to the commission evidence of having completed the required continuing education within thirty (30) days of the anniversary date of the ~~emergency~~ paramedic's original certification.

(b) The sponsoring hospital(s) shall maintain accurate records which shall serve as partial evidence of the ~~emergency~~ paramedics compliance with the continuing education requirements. However, each ~~emergency~~ paramedic must report such compliance with the continuing education requirements as described herein.

(c) Reports of continuing education shall be made on such forms as may be prescribed by the commission. *(Indiana Emergency Medical Services Commission; 836 IAC 2-6-4; filed Nov 3, 1980, 3:55 pm: 3 IR 2232; filed Oct 13, 1981, 10:05 am)*

NOTE: THE FOLLOWING SECTIONS (836 IAC 2-7, 2-8, and 2-9) (Pages A-M) ARE EFFECTIVE UNTIL JANUARY 1, 1983. ADVANCED RULES AND REGULATIONS EFFECTIVE JANUARY 1, 1983 ARE FOUND ON PAGES 46-59.

836 IAC 2-7-1 General requirements for organizations providing advanced life support by advanced emergency medical technicians

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 1. GENERAL REQUIREMENTS FOR PROVIDER ORGANIZATIONS. (1) Unless otherwise specified, the provisions of Rule VI *[836 IAC 2-7]* of these rules and regulations shall be in full force and effect as of January 1, 1978.

(2) Any organization providing, or seeking to provide advanced life support services administered by advanced emergency medical technicians shall be certified by the commission.

(3) If the provider organization also provides transportation of emergency patients, the provider organization shall be certified as an ambulance service provider in accordance with the requirements specified in the Rules and Regulations for the Operation and Administration of Emergency Medical Services *[836 IAC 2]* pursuant to I.C. 1971, 16-1-39.

(4) The provider of advanced life support services must insure that the patient transport vehicle(s) used in conjunction with advanced life support services meets the requirements specified in Rule II.C *[836 IAC 1-3-3]* pursuant to I.C. 1971, 16-1-39, and is certified by the Indiana Emergency Medical Services Commission.

(5) The provider organization shall have agreed by contract with a supervising hospital to insure the provision of continuing education and in-service training, liaison and direction for emergency care equipment and supplies and overall supervision of the medical and non-medical aspects of service provided by advanced emergency medical technicians.

In those cases where more than one hospital seeks to supervise the medical and non-medical aspects of service provided by advanced emergency medical technicians and provider organization, an inter-hospital agreement shall be provided to the Commission to insure uniform and consistent policies and procedures as adopted by the administrative and medical staff of each hospital. The agreement shall clearly define the duties and responsibilities of each hospital and its medical and administrative staff to insure medical accountability of system operation. Such agreement shall constitute compliance with an advanced emergency medical technicians association with a single supervising hospital.

(6) Under those conditions where an advanced emergency medical technician may be directed by a physician, or an individual authorized in writing to act on behalf of a physician, via voice communication to defibrillate an emergency patient, the provider organization shall be required to have a functioning U.H.F. telemetry system between the emergency response vehicle(s) owned and/or operated by the provider organization and the emergency department, or coronary care unit, or equivalent of the supervising hospital(s). Voice communication capability is also required.

(7) The provider organization shall have a medical director provided by the provider organization, or jointly with the supervising hospital(s), who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana and who has an active role in the delivery of emergency care. The medical director shall be responsible for providing competent medical direction and overall supervision of the medical aspects of the provider organization. The duties and responsibilities of the medical director shall include, but not be limited to:

(a) Providing liaison with physicians.

(b) Assuring that appropriate drugs, medications, supplies and equipment are available to the provider organization.

(c) Monitor and evaluate day-to-day operations.

(d) Assist in the coordination of in-service training programs.

(e) Provide information concerning the operation of the provider organization.

(f) Provide individual consultation to advanced emergency medical technicians.

(g) Assure continued competence of advanced emergency medical technicians affiliated with, or by the provider organization.

(8) Each provider organization shall:

(a) Provide continuous 24-hour advanced life support services.

(b) Notify the commission in writing prior to assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician.

(c) Notify the commission in writing within thirty (30) days if an advanced emergency medical technician terminates employment, or affiliation, or for any reason in which an advanced emergency medical technician is prohibited from performing the procedures for which certification has been granted.

(9) When advanced life support services are administered by an advanced emergency medical technician and the patient is being transported to a medical facility, as a minimum, the patient compartment of the transporting vehicle shall be manned by not less than one (1) person who shall be certified as an advanced emergency medical technician or be certified as an emergency paramedic as set forth in Rule V *[836 IAC 2-6]* of these rules and regulations.

(10) The provider organization shall notify the commission in writing within thirty (30) days of any expected change in the advanced life support services provided and for which certification has been granted.

(11) No certification shall be required:

(a) For a person who provides advanced life support while assisting in the case of a major catastrophe, disaster, or emergency whereby persons who are certified to provide emergency medical services or advanced life support are insufficient or are unable to cope with the situation.

(b) For an agency or instrumentality of the United States and any advanced emergency medical technicians of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed in these rules and regulations *[836 IAC 2]*.

(12) After proper notice and hearing, the commission may suspend or revoke a certificate and/or an endorsement issued under these rules and regulations *[836 IAC 2]* for failure to comply and maintain compliance with, or for violation of, any applicable provisions, standards, or other requirements of these rules and regulations *[836 IAC 2]*.

(13) The commission may initiate proceedings to suspend or revoke a certificate and/or an endorsement upon its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held in and conducted in accordance with the provisions of I.C. 1971, 4-22-1.

(14) Notwithstanding the provisions of these rules and regulations *[836 IAC 2]*, the commission upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate and/or an endorsement without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(15) Upon suspension, revocation, or termination of a certificate and/or an endorsement, the provision of advanced life support services shall cease. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI,A; filed Dec 15, 1977: Rules and Regs. 1978, p. 251)*

Cited in: 836 IAC 2-1-1; 836 IAC 2-8-2; 836 IAC 2-9-1.

836 IAC 2-7-2 Application for certification

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION. (1) Application for certification as a provider organization shall be made on such forms

as may be prescribed by the commission and shall include, but not be limited to the following:

(a) A narrative summary of plans for providing advanced life support services including:

(1) Defined primary area of response including location of advanced life support response vehicle(s).

(2) Defined time of response within the normal operating area.

(3) The number of advanced emergency medical technicians to be involved.

(4) The staffing pattern of personnel to assure 24 hour availability.

(5) Base of operations.

(b) Plans to insure that trained personnel are provided with supervised in-service training to maintain proficiency. In-service training shall be under the direct supervision of the supervising hospital(s).

(c) A listing of special on-board life support and communications equipment available, or to be acquired, including manufacturers name, equipment description, radio frequencies (or status of F.C.C. license) and date of acquisition.

(d) A letter of approval from the supervising hospital(s) stating the acceptability of advanced emergency medical technicians and compatibility of communications equipment and the written agreement to fulfill the responsibilities of the supervising hospital(s).

(e) It is recommended that a letter of endorsement from various elected officials in the community, township, or county (if a county-wide system) be included as part of the application for certification.

(2) Organizations which do not also provide transportation of emergency patients shall meet the following requirements:

(a) Provide for a periodic maintenance program to assure that emergency response vehicle(s), including equipment, are maintained in good working condition and that applicable sanitation procedures are in effect at all times.

(b) Provider premises, records, garaging facilities and response vehicle(s) shall be made available for inspection by the director, or his duly authorized representative, at any time during regular business hours.

(c) Each provider shall have in force and effect public liability insurance in the sum of not less than $100,000 for injuries to one person, and $300,000 to more than one person in one accident, and property damage insurance in a sum of not less than $100,000, issued by an insurance company licensed to do business in the State of Indiana; or, be a governmental entity within the meaning of I.C. 34-4-16.5-1, et. seq. This coverage must be for each and every vehicle owned and/or operated by or for the provider for the purpose of providing advanced life support services.

(d) Each provider shall maintain a communication system which must be available twenty-four hours a day between the emergency response vehicles owned and/or operated by the provider organization and the emergency department, or coronary care unit or equivalent of the supervising hospital.

(e) The provider shall insure that the basic life support equipment required by Rule II.E *[836 IAC 1-3-5]*, pursuant to I.C. 16-1-39, is carried on-board each non-ambulance vehicle which is used for the purpose of providing advanced life support services. Variances or substitutions may be made in emergency care equipment if justification for variations or substitutions is submitted to and approved by the Commission.

(f) The provider shall submit an annual report in the manner prescribed by the commission.

(3) Upon approval of the commission, an endorsement to the provider certification granted in accordance with the requirements specified in Rule I of the Rules and Regulations for the Operation and Administration of Emergency

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Medical Services pursuant to I.C. 1971, 16-1-39 shall be issued.

(4) Organizations approved by the commission which do not provide transportation of emergency patients shall be issued a certificate for the provision of advanced life support as specified in these rules and regulations *[836 IAC 2]*.

(5) The certificate issued in accordance with these provisions shall be valid for a period of one (1) year from the date of issue and shall be prominently displayed at the place of business.

(6) Application for provider certification renewal shall be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

(7) Upon application the Director may issue temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the Commission to act upon the application, if the applicant is in full compliance with these Rules and Regulations *[836 IAC 2]* as determined by the Director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI,B; filed Dec 15, 1977: Rules and Regs. 1978, p. 253)*

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836 IAC 2-7-3 Provider organization operating procedures

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-7

Sec. 3. PROVIDER ORGANIZATION OPERATING PROCEDURES. (1) Each provider shall maintain accurate records concerning the emergency care provided to each patient within the State which may include an Ambulance Report Form prescribed by the commission. Such records shall contain information regarding the advanced life support procedures performed and under whose direction, control and supervision.

(2) Each provider organization shall establish daily equipment checklist procedures to insure that:

(a) Mechanical and/or electronic equipment is in proper operating condition.

(b) Emergency response vehicle(s) are continuously maintained in a safe operating condition at all times.

(c) Only those drugs and/or medications, in the approved quantities, are available to the advanced emergency medical technician.

(3) The following requirements shall apply to the use of drugs and medications by advanced emergency medical technicians:

(a) Advanced emergency medical technicians shall be prohibited from having in their possession, or maintaining on-board emergency response vehicle(s), any drugs or medication which has not been approved by the administrative and medical staff of the supervising hospital, the provider organization medical director and the commission. The maximum quantity of any Class II drug shall be the minimum quantity necessary to treat two (2) emergency patients simultaneously.

(b) All drugs, medications and related supplies are to be supplied by the supervising hospital(s) on an even exchange basis.

(c) Lost, stolen or misused drugs will only be replaced on order of the provider organization medical director.

(d) Advanced emergency medical technicians shall be prohibited from administering any drug or medication, or performing any emergency care procedure which is considered more advanced than usually rendered by a basic emergency medical technician without first establishing two-way voice communication with a physician, or an individual authorized in writing to act on behalf of a physician.

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(e) Accountability for distribution, storage, ownership and security of drugs and medications shall be subject to applicable requirements as determined by the State of Indiana Board of Pharmacy.

(f) A closed compartment, which shall be substantially constructed and equipped with a secure locking device, shall be provided within the vehicle for storage of drugs and medications when the vehicle is not in use or unattended. Portable drug kits shall not be left in an unattended vehicle unless adequate security precautions have been taken.

(4) Each provider organization shall insure that rigid sanitation procedures are in effect at all times. The following minimum sanitation standards shall apply to all vehicles used for the purpose of providing advanced life support services:

(a) The interior and the equipment within the vehicle shall be clean and maintained in good working order at all times.

(b) Freshly laundered linen or disposable linens shall be used on cots and pillows, and linen shall be changed after each patient is transported.

(c) Clean linen storage shall be provided.

(d) Closed compartments shall be provided within the vehicle for medical supplies.

(e) Closed compartments shall be provided for soiled supplies.

(f) Blankets shall be kept clean and stored in closed compartments.

(g) Implements inserted into the patient's nose or mouth shall be single-service, wrapped and properly stored and handled. Multi-use items are to be kept clean and sterile when indicated and properly stored.

(h) When a vehicle has been utilized to transport a patient known to have a communicable disease, the vehicle shall be cleansed and all contact surfaces shall be washed with soap and water and disinfected.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI,C; filed Dec 15, 1977: Rules and Regs. 1978, p. 255)

Rule 8. Requirements and Standards for Supervising Hospitals

Cited in: 836 IAC 2-8-1.

836 IAC 2-8-1 General requirements for hospitals supervising advanced emergency medical technicians
836 IAC 2-8-2 Application for supervising hospital certification
836 IAC 2-8-3 Advanced emergency medical technician training

836 IAC 2-8-1 General requirements for hospitals supervising advanced emergency medical technicians

Authority: IC 16-1-39-4; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 1. GENERAL REQUIREMENTS FOR SUPERVISING HOSPITALS. (1) Unless otherwise specified, the provisions of Rule VII *[836 IAC 2-7]* of these rules and regulations shall be in full force and effect as of January 1, 1978. However, the commission may, upon receipt of proper application, certify supervising hospitals on or before December 31, 1977.

(2) All hospitals providing, or seeking to provide medical supervision of advanced life support services administered by advanced emergency medical technicians and to provide training programs for emergency medical technicians to perform one or more, but not all of the procedures performed by an emergency paramedic, shall be certified by the commission as a supervising hospital.

(3) A hospital certified by the commission as a supervising hospital may enter into an agreement with other institutions of higher education to conduct the didactic portion of the training program for advanced emergency medical technicians; provided the institution can present to the commission evidence of capability to provide

such training. Under conditions where training is conducted by separate institutions, the clinical portion and overall program responsibility shall remain with the hospital(s) approved by the commission.

(4) The supervising hospital shall have in full force and effect at all times, a written agreement with the provider organization in which the administrative and a majority of the medical staff have agreed to provide continuing education and in-service training, liaison and direction for emergency care equipment and supplies, and overall supervision of the medical and non-medical aspects of service provided by advanced emergency medical technicians employed by, or affiliated with the provider organization.

In those cases where more than one hospital seeks to supervise the medical and non-medical aspects of service provided by advanced emergency medical technicians and provider organizations, an inter-hospital agreement shall be provided to the commission to insure uniform and consistent policies and procedures as adopted by the administrative and medical staff of each hospital. The agreement shall clearly define the duties and responsibilities of each hospital and its medical and administrative staff to insure medical accountability of system operation. Such agreement shall constitute compliance with an advanced emergency medical technicians association with a single supervising hospital.

(5) The supervising hospital(s) shall assume responsibility for development of system protocol and/or the provider organization operating procedures to insure the proper response to emergency situations by advanced emergency medical technicians. However, the supervising hospital shall be prohibited from establishing any procedure or protocol which would:

(a) permit an advanced emergency medical technician to perform any procedure which is more advanced than usually rendered by emergency medical technicians without first establishing two-way voice communication with a physician, or an individual authorized in writing to act on behalf of a physician.

(b) permit an advanced emergency medical technician to perform any advanced life support procedure for which certification by the commission has not been granted.

(c) permit a physician, or other representative of the supervising hospital(s), to authorize any advanced emergency medical technician not employed by, or affiliated with, a provider organization with whom the supervising hospital has an agreement, to perform any advanced life support procedure.

(6) Under those conditions where an advanced emergency medical technician may be directed by a physician, or an individual authorized in writing to act on behalf of a physician, via voice communication to defibrillate an emergency patient, the supervising hospital(s) shall be required to have a functioning U.H.F. telemetry system between the emergency response vehicle(s) owned and/or operated by the provider organization and the emergency department, or coronary care unit, or equivalent of the supervising hospital(s). Voice communication capability is also required.

(7) All drugs and supplies are to be supplied by the supervising hospital(s) on an even exchange basis. Lost, stolen or misused drugs will only be replaced on order of the provider organization medical director. NOTE: Accountability for distribution, storage, ownership and security of drugs and medications is subject to applicable requirements as determined by the State of Indiana Board of Pharmacy. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII,A; filed Dec 15, 1977: Rules and Regs. 1978, p. 256)*

Cited in: 836 IAC 2-1-1.

836 IAC 2-8-2 Application for supervising hospital certification

Authority: IC 16-1-39-4; IC 16-1-40-3
Affected: IC 16-1-39-11

Sec. 2. APPLICATION FOR SUPERVISING HOSPITAL CERTIFICATION. (1) Hospi-

tals seeking certification by the commission as a supervising hospital shall meet the following minimum requirements:

(a) Application shall be made on such forms as may be prescribed by the commission.

(b) Submit to an evaluation of facilities and capabilities by the director or his duly authorized representative.

(c) Have approval in writing of the administrative and a majority of the medical staff which may be evidenced by a written agreement with the provider organization as required by these rules and regulations *[836 IAC 2]*.

(d) Provide orientation to hospital personnel and physicians who may be directly or indirectly involved in the operational aspects of providing advanced life support services.

(e) Provide for audit and review of cases on a monthly basis with advanced emergency medical technicians, emergency department personnel and physicians to evaluate operations.

(f) Have a physician, or an individual authorized in writing to act on behalf of a physician, immediately available at all times to supervise via voice communication advanced life support procedures administered by advanced emergency medical technicians.

(g) Have the necessary clinical facilities and guarantee access to emergency patients to conduct the required clinical phase(s) of the training program.

(h) Provide the necessary supervision of trainees during the clinical phase(s) of the training program.

(2) Hospitals shall apply for approval in such manner as may be prescribed by the commission not less than ninety (90) days prior to the date approval is requested.

(3) Commission certification as a supervising hospital shall be valid for a period of three (3) years from the date of issue.

(4) Application for certification renewal shall be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall evidence compliance with the requirements as set forth for original certification.

(5) Certification exemptions identified under Rule VI, A.11 *[836 IAC 2-7-1(11)]* shall apply to supervising hospitals.

(6) Procedures for suspension, revocation, or termination of certification included under Rule VI.A.12, A.13 and A.14 *[836 IAC 2-7-1(12)-(14)]* shall apply to supervising hospitals.

(7) Upon application the Director may issue temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these Rules and Regulations *[836 IAC 2-8-2]* as determined by the Director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII,B; filed Dec 15, 1977: Rules and Regs. 1978, p. 258)*

836 IAC 2-8-3 Advanced emergency medical technician training

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 3. ADVANCED EMERGENCY MEDICAL TECHNICIAN TRAINING. (1) The curriculum for advanced emergency medical technician training programs shall be established and adopted by the administrative and a majority of the medical staff of the supervising hospital(s) and shall be approved by the commission. The curriculum shall be directed toward the attainment of specific skills and knowledge considered within the scope and responsibility of the advanced emergency medical technician (see Rule VIII.B.5 *[836 IAC 2-9-2(5)]*) and shall:

(a) identify the skills and knowledge required for successful course completion;

(b) identify methods to be used in accomplishing stated objectives;

(c) outline the procedures for evaluation of student competency, using a commission developed practical skills examination.

(2) The minimum curriculum requirements for advanced emergency medical technician training programs shall be determined on the basis of those procedures which the advanced emergency medical technician will be expected to perform upon receiving certification by the commission. When applicable, the training program shall include, but not be limited, to the following objectives:

(a) Performing Patient Assessment, including

(1) History taking (chief complaint, pertinent history of the present illness/injury and past medical history).

(2) Assessment of patient's general appearance and state of consciousness.

(3) Evaluation of vital signs, including pulse, blood pressure, and respirations.

(4) Trauma-oriented and medically oriented head-to-toe survey.

(b) Shock and Fluid Therapy Techniques, including:

(1) The cause, signs, symptoms and treatment of shock.

(2) The indications, contra-indications, and dosage of those medications available to the advanced emergency medical technician.

(3) The procedure for verifying medication orders received over the radio from a physician.

(4) The procedure for calculating the volume of fluid to be administered.

(5) Demonstrating the technique of peripheral venipuncture using an over-the-needle catheter device or straight needle.

(6) Demonstrating the technique for drawing-up the designated volume of fluid in a syringe from an ampule and a vial.

(7) Demonstrating the technique for administering drugs using a prepackaged disposable syringe.

(8) Demonstrating the technique for subcutaneous and intramuscular injection.

(9) Demonstrating the technique for the administration of drugs into an IV bottle or through an IV insertion site.

(c) Cardiovascular Emergencies, including

(1) The cause, signs, symptoms, and treatment of each of the following:

(a) Acute myocardial infarction

(b) Congestive heart failure

(c) Cardiac arrest

(d) Cardiogenic shock

(e) Myocardial trauma

(f) Hypertensive states

(2) Identifying the structures of the heart and the function of each.

(3) Demonstrating the application of electrodes and the monitoring of a patient's electrocardiogram activity.

(4) Demonstrating on an adult manikin and an infant manikin the technique for one-person and two-person cardiopulmonary resuscitation.

(5) Demonstrating the technique for cardioversion on a manikin.

(d) Respiratory Emergencies, including

(1) Identifying the structures of the respiratory system.

(2) Demonstrating the procedure for the evaluation of a patient with suspected respiratory distress, including the evaluation of hypoxia, pulse, blood pressure, and neck vein distention.

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(3) The cause, signs, symptoms and treatment of the following:

(a) Respiratory depression and respiratory distress

(b) Upper airway obstruction

(c) Toxic inhalations

(d) Pulmonary edema

(e) Hyperventilation

(f) Trauma, including rib fractures, flail chest, traumatic pneumothorax and hemothorax.

(g) Pulmonary embolism

(4) Demonstrating the use of oropharyngeal airways, bag-valve-mask and demand valve resuscitators on a non-breathing patient or manikin.

(5) Demonstrating proper assembly, cleaning, functioning and testing of all respiratory and airway equipment.

(e) Performance objectives, including

(1) Demonstrating the technique for spinal immobilization using:

(a) Short spine board

(b) Long spine board

(c) Orthopedic stretcher

(2) Demonstrating the techniques for controlling hemorrhage.

(3) Demonstrating the procedure for dressing and bandaging an avulsion or an impaled object.

(4) Demonstrating the procedure for treating specific injuries to the eye, face and neck.

(5) Identify the types and degrees of burns, and demonstrating the treatment of each.

(6) Demonstrating the technique of immobilization using the traction splint, air splint, and board splint.

(7) Demonstrating the technique for managing a dislocation of the elbow, knee, ankle, hip, shoulder, or wrist.

(8) Demonstrating on an obstetrical manikin the procedure for the preparation of a mother and the delivery of an infant in a cephalic birth.

(9) Identify the procedures to be followed in an abnormal delivery.

(10) Demonstrating the technique for assessing and managing pediatric patients.

(11) Demonstrating the procedure for gaining access and disentangling a patient in a vehicle or structure.

(12) Demonstrating the procedure for the transportation of a patient having the following conditions:

(a) Flail chest

(b) Fracture of an extremity

(c) Spinal trauma

(d) Multiple trauma

(e) Myocardial infarction

(f) Foreign body impaled in the abdomen, back or thorax

(13) Demonstrating techniques for lifting and moving patients in emergency and non-emergency conditions.

(14) Demonstrating the procedure for dispatching and using radio communications equipment.

(15) Demonstrating the procedure for relaying information to the physician in the correct sequence.

(f) Clinical training to provide an opportunity to relate the principles and concepts as presented in the training program to emergency care in practice. Clinical training must be performed under direct supervision and should provide the student with an opportunity to demonstrate proficiency in all skills.

(3) Staffing for the training program shall include:

(a) A medical director who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana and who has an active role in the delivery of emergency care and who shall have the following responsibilities:

(1) Providing necessary liaison with physicians to obtain adequate instructor services.

(2) Assuring that the course of instruction meets established standards of the commission.

(3) Assuring accurate and thorough presentation of the medical content of the course.

(4) Attesting to the competence of graduates to perform skills required of an advanced emergency medical technician.

(b) A training coordinator who shall be appointed by the medical director and who must be a physician, registered nurse or member of the program instructional staff with appropriate education and experience as determined by the medical director. The training coordinator shall be responsible for:

(1) Individual consultation with trainees.

(2) Assuring that the required equipment and materials are available at the class session.

(3) Evaluating classroom activities, including clinical and practice sessions.

(4) Assisting in the coordination of examinations.

(5) Providing information concerning training programs.

(6) Acting as liaison between the students and the program staff.

(c) The instructional staff which shall be selected from various specialties and shall have appropriate education and experience to teach in assigned areas at the discretion of the medical director. It is recommended that instructors meet the following requirements:

(1) Have extensive critical and/or emergency care experience compatible with the subject being presented.

(2) Have a level of medical knowledge above that required of the advanced emergency medical technician, compatible with the subject being presented.

(3) Be thoroughly knowledgeable about, and able to demonstrate all skills as presented in the course.

(4) Each supervising hospital shall insure adequate classroom space for the optimum didactic ratio of one (1) instructor for each twenty (20) students and optimum clinical practice session ratio of one (1) instructor for each six (6) students. It is recommended that not more than two (2) trainees be assigned at one time to any hospital clinical unit or to any emergency vehicle for clinical experience and evaluation.

(5) The supervising hospital shall provide a course report in the manner prescribed by the commission.

(6) The supervising hospital shall complete other forms as may be required by the commission for the purpose of course and student evaluation, and shall cooperate and assist the commission in collecting statistics and evaluating performance and costs relating to training advanced emergency medical technicians.

(7) The supervising hospital(s) shall establish criteria for selection of students for advanced emergency medical technician training programs. However, applicants shall meet the following minimum requirements:

(a) Applicant must hold a valid certification as an emergency medical technician issued by the commission pursuant to I.C. 1971, 16-1-39.

(b) Applicant must be accepted by the administrative staff of the supervising hospital.

(c) Applicant shall show evidence of physical examination as prescribed by the commission and given by the training program medical director.

(d) Applicant shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render them unfit to perform as an advanced emergency medical technician.

(e) Applicant must pass screening and evaluation as determined necessary by the supervising hospital and/or provider organization medical director.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII,C; filed Dec 15, 1977: Rules and Regs. 1978, p. 259)

Rule 9. Certification of Advanced Emergency Medical Technicians

Cited in: 836 IAC 2-9-1.

836 IAC 2-9-1 General certification provisions

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-11

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (1) Unless otherwise specified, the provisions of Rule VIII *[836 IAC 2-9]* of these rules and regulations shall be in full force and effect as of January 1, 1978. However, the commission may, upon receipt of proper application, certify advanced emergency medical technicians on or before December 31, 1977.

(2) Any person who is currently certified as an emergency medical technician pursuant to I.C. 16-1-39, and has received advanced instruction and training enabling him to perform one or more, but not all of the procedures performed by an emergency paramedic, under the direct supervision of a physician in person, or via voice communication, must be certified as an advanced emergency medical technician by the commission.

(3) Applicants for certification as an advanced emergency medical technician shall be eighteen (18) years of age and meet the following requirements:

(a) Be currently affiliated with a certified provider organization.

(b) Have satisfactorily demonstrated knowledge and skill in the area of emergency care acceptable to the administrative and medical staff of the supervising hospital, the provider organization medical director, and approved by the commission.

(c) Present evidence of fitness by a written report of physical examination prescribed by the commission, given by a physician licensed to practice medicine in the State of Indiana. Applicants shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any informity of body or mind which might render them unfit to provide advanced life support services. Determination of fitness shall be made by the provider organization medical director.

(4) Certification exemptions identified under Rule VI.A.11 *[836 IAC 2-7-1(11)]* shall apply to the certification of advanced emergency medical technicians.

(5) The commission may initiate proceedings to suspend or revoke an endorsement as an advanced emergency medical technician on its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held and conducted in accordance with the provisions of I.C. 1971, 4-22-1 upon proof that any advanced emergency medical technician:

(a) is guilty of fraud or deceit in procuring or attempting to procure certification as an advanced emergency medical technician.

(b) is unfit or incompetent by reason of negligence, habit, or other causes;

(c) is habitually intemperate or is addicted to the use of habit-forming drugs;

(d) is mentally incompetent;

(e) is guilty of unprofessional conduct;

(f) is guilty of delegating to a person less qualified any service which requires the professional competence of an advanced emergency medical technician.

(g) is guilty of a direct violation of a physician's order from the supervising hospital;

(h) has willfully or repeatedly violated any of the provisions of these rules and regulations *[836 IAC 2]*.

(6) Procedures for suspension, revocation, or termination of certification included under Rule VI, 14 and 15 *[836 IAC 2-7-1(14), (15)]* shall apply to advanced emergency medical technician certification. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VIII,A; filed Dec 15, 1977: Rules and Regs. 1978, p. 263)*

836 IAC 2-9-2 Application for certification

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-11

Sec. 2. APPLICATION FOR CERTIFICATION. (1) Application for certification as an advanced emergency medical technician shall be made on such forms as may be prescribed by the commission. The application for certification shall include, but not be limited to, a statement of competence which shall be signed by an appropriate representative of the supervising hospital administrative staff and the provider organization medical director and which shall indicate that the individual requesting certification is capable of performing the advanced life support procedures for which certification is requested.

(2) Any person who has served as an advanced emergency medical technician in another state within six (6) months preceding the date of application, who has satisfactorily completed a course in advanced life support, and has satisfactorily demonstrated knowledge and skill in the area of emergency care acceptable to the administrative and medical staff of the supervising hospital and the provider organization medical director, may petition the commission for certification as an advanced emergency medical technician. Application must be made within six (6) months after establishing residency in Indiana, and shall indicate compliance with the certification requirements as set forth in these rules and regulations *[836 IAC 2]*.

(3) Temporary authorization to act in the capacity of an advanced emergency medical technician may be issued by the Director for a specified period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations *[836 IAC 2]* as determined by the Director. Such temporary authorization may only be approved one (1) time.

(4) Upon approval by the commission, an endorsement to the certification granted in accordance with the requirements specified in Rule IV.B.1, 2., 3., and 4. *[836 IAC 1-5-2(1)-(4)]* pursuant I.C. 1971, 16-1-39 shall be issued. Such endorsement shall indicate compliance with the requirements as set forth in these rules and regulations and shall specify those advanced life support procedures which may be administered under the supervision of a physician in person, or via voice communication, by the certificate holder.

(5) Advanced emergency medical technicians shall be limited to perform only those procedures as specified on the endorsement as approved by the commission. Those approved procedures, limited to defibrillation, parenteral injections of appropriate medications or emergency management of trauma and illness, singularly or in any combination thereof, may only be performed when affiliated with a certified provider organization and while under the direct supervision of a physician staff member of the specified supervising hospital(s), or an individual authorized in writing to act in the behalf of a physician staff member of the approved su-

pervising hospital(s). Advanced emergency medical technicians are prohibited from performing any advanced life support procedure, with or without physician direction, for which certification by the commission has not been approved.

(6) An advanced emergency medical technician may, at any time, petition the commission for changes in the current endorsement. Administrative changes (such as provider affiliation) may be made by the Director without commission approval. Changes in advanced life support procedures must be submitted to and approved by the commission.

(7) Application for advanced emergency medical technician certification renewal shall be made not less than ninety (90) days prior to the expiration date of the current certificate to assure continuity of certification. Application for renewal shall be made on such forms as may be prescribed by the commission.

(8) Advanced emergency medical technicians seeking certification renewal shall meet the following qualifications:

(a) Have successfully completed the requirements for in-service training during each year of the three (3) year certification period in accordance with the requirements set forth for emergency medical technician certification renewal.

(b) Have satisfactorily demonstrated, in a manner acceptable to the administrative and medical staff of the supervising hospital(s), and approved by the commission, knowledge and skill in those advanced life support procedures for which certification has been granted during each year of the three (3) year certification period.

The supervising hospital(s) shall maintain accurate records which shall serve as evidence of compliance with the in-service training requirements. However, each advanced emergency medical technician shall be held individually accountable to insure that compliance is reported to the commission within thirty (30) days following the anniversary date of each year of the three (3) year certification period.

(9) Advanced emergency medical technicians who are unable to meet the requirements for recertification within six (6) months following expiration of the current certification, may satisfy the recertification requirements by presenting evidence of compliance with the requirements as set forth for original certification. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VIII,B; filed Dec 15, 1977: Rules and Regs. 1978, p. 264)*

NOTE: THE FOLLOWING SECTIONS (836 IAC 2-7, 2-8, and 2-9) (Pages 46-59) ARE EFFECTIVE JANUARY 1, 1983. ADVANCED EMT RULES AND REGULATIONS EFFECTIVE UNTIL JANUARY 1, 1983 ARE FOUND ON PAGES A-M, IMMEDIATELY PRECEEDING THIS SECTION.

SECTION 26. 836 IAC 2-7-1, as amended at 3 IR 2232, SECTION 34, is amended to read as follows:

836 IAC 2-7-1 General requirements for advanced EMT organizations

Authority: IC 16-1-39-6; IC 16-1-40-3

Affected: IC 4-22-1; IC 16-1-39; IC 16-1-40-3

Sec. 1. GENERAL REQUIREMENTS FOR ADVANCED EMT ORGANIZATIONS. (a) Unless otherwise specified, the provisions of 836 IAC 2-7 of these rules and regulations shall be in full force and effect as of January 1, 1983.

(b) Certification by the commission is required for any ambulance service provider who seeks to provide advanced life support services as an advanced EMT organization.

(c) If the advanced EMT organization also provides transportation of emergency patients, the advanced EMT organization shall be certified as an ambulance service provider in accordance with the requirements specified in the Rules and Regulations for the Operation and Administration of Emergency Medical Services [*836 IAC 1*]pursuant to IC 16-1-39.

(d) The advanced EMT organization must insure that the ~~patient transport vehicle(s)~~ ambulances used in conjunction with advanced life support services meets the requirements specified in 836 IAC 1-3 pursuant to IC 16-1-39, and is certified by the Indiana Emergency Medical Services Commission.

(e) Advanced EMT organizations shall have agreed by contract with one (1) or more supervising hospital(s) for the following services:

(1) Continuing education;
(2) Audit and review;
(3) Medical control and direction;
(4) Provide liaison and direction for supply of intravenous fluids and other items utilized by advanced EMTs.

Contract shall also include services for the overall supervision of the medical aspects of the service provided by advanced EMTs employed by or affiliated with the advanced EMT organization. Said contract shall include a detailed description of how such services shall be provided to the advanced EMT organization.

In those cases where more than one hospital seeks to supervise the medical aspects of service provided by advanced emergency medical technicians and advanced EMT organizations an inter-hospital agreement shall be provided to the commission to insure uniform and consistent policies and procedures as adopted by the administrative and medical staff of each hospital. The agreement shall clearly define the duties and responsibilities of each hospital and its medical and administrative staff to insure medical accountability of system operation. Such agreement shall constitute compliance with an advanced emergency medical technician's association with a single supervising hospital.

(f) The advanced EMT organization shall have a medical director provided by the advanced EMT organization, or jointly with the supervising hospital(s), who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana and who has an active role in the delivery of emergency care. The medical director shall be responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced EMT organization. The duties and responsibilities of the medical director shall include, but not be limited to:

(1) Providing liaison with physicians.
(2) Assuring that appropriate intravenous solutions, supplies and equipment are available to the advanced EMT organization.
(3) Monitor and evaluate day-to-day operations.
(4) Assist the supervising hospital in the coordination of in-service training programs.
(5) Provide information concerning the operation of the advanced EMT organization.

(6) Provide individual consultation to advanced emergency medical technicians.
(7) Assure continued competence of advanced emergency medical technicians affiliated with, or employed by the advanced EMT organization.
(8) Participate on the assessment committee of the supervising hospital(s) in the monthly audit and review of cases treated by advanced emergency medical technicians.

(g) Each advanced EMT organization shall:
(1) Maintain an adequate number of trained personnel and emergency ~~response~~ vehicles to provide continuous 24-hour advanced life support services.
(2) Notify the commission in writing prior to assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician.
(3) Notify the commission in writing within thirty (30) days if an advanced emergency medical technician terminates employment, or affiliation, or for any reason in which an advanced emergency medical technician is prohibited from performing the procedures for which certification has been granted.

(h) When advanced life support services administered by advanced EMTs at the scene of an accident or illness are continued enroute to an emergency facility, as a minimum, the patient compartment of the ~~transporting vehicle~~ ambulance shall be manned by not less than one (1) person who shall be certified as an advanced EMT. Two (2) advanced EMTs in the patient compartment are strongly recommended.

(i) The advanced EMT organization shall notify the commission in writing within thirty (30) days of any change in the advanced life support services provided and for which certification has been granted.

(j) No certification shall be required:
(1) For a person who provides advanced life support while assisting in the case of a major catastrophe, disaster, ~~or emergency~~ whereby persons who are certified to provide emergency medical services or advanced life support are insufficient or are unable to cope with the situation.
(2) For an agency or instrumentality of the United States and any advanced emergency medical technicians of such agency or instrumentality shall not be required to be certified nor to conform to the standards prescribed in these rules and regulations (See 836 IAC 2-1).

(k) After proper notice and hearing, the commission may suspend or revoke a certificate ~~and/or an endorsement~~ issued under these rules and regulations [*836 IAC 2*] for failure to comply and maintain compliance with, or for violation of any applicable provisions, standards, or other requirements of these rules and regulations [*836 IAC 2*].

(l) The commission may initiate proceedings to suspend or revoke a certificate ~~and/or an endorsement~~ upon its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held in and conducted in accordance with the provisions of IC 4-22-1.

(m) Notwithstanding the provisions of these rules and regulations [*836 IAC 2*], the commission upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate ~~and/or an endorsement~~ without hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(n) Upon suspension, revocation, or termination of a certificate ~~and/or an endorsement~~, the provision of advanced life support services shall cease. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI, A; filed Nov 3, 1980, 3:55 pm: 3 IR 2232; filed Oct 13, 1981, 10:05 am) NOTE: Effective date Jan 1, 1983.*

SECTION 27. 836 IAC 2-7-2, as amended at 3 IR 2234, SECTION 35, is amended to read as follows:

836 IAC 2-7-2 Application for certification
Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 2. APPLICATION FOR CERTIFICATION.
(a) Application for certification as an advanced EMT organization shall be made on such forms ~~as may be~~ prescribed by the commission and shall include, but not be limited to the following:
(1) A narrative summary of plans for providing advanced life support services including:
(A) Defined primary area of response including location of advanced life support response vehicle(s).
(B) Defined time of response within the normal operating area.
(C) A list of advanced emergency medical technicians affiliated with the advanced emergency medical technician organization.
(D) The staffing pattern of personnel to assure 24 hour availability.
(E) Base of operations.
(2) Plans and methodologies to insure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education shall be under the direct

supervision of the advanced emergency medical technician organization medical director with the cooperation of the supervising hospital(s).

(3) ~~A listing of special on-board life support and communications equipment including intravenous solutions available or to be assigned, including manufacturer name, equipment description, radio frequencies and date of acquisition.~~ A listing of intravenous solutions, special on-board life support equipment, and communications equipment including manufacturer's name, the radio frequencies, and date of acquisition.

(4) ~~A letter of approval from the supervising hospital(s) stating the acceptability of advanced emergency medical technicians and compatibility of communications equipment and a copy of the contract with the supervising hospital(s).~~ A letter of approval from the supervising hospital(s) stating acceptance of the advanced emergency medical technicians, compatability of communications with the advanced EMT vehicles, and a copy of the contract.

(5) It is recommended that a letter of endorsement from various elected officials in the community, township, or county (if a county-wide system) be included as part of the application for certification.

(b) Advanced emergency medical technician organizations which do not also provide transportation of emergency patients shall meet the following minimum requirements:

(1) Provide for a periodic maintenance program to assure that emergency response vehicle(s), including equipment, are maintained in good working condition and that applicable sanitation procedures are in effect at all times.

(2) Provider premises, records, parking or garaging facilities ~~(if any)~~ and response vehicle(s) shall be made available for inspection by the director, or his duly authorized representative, at any time during regular business hours.

(3) Each provider shall have in force and effect public liability insurance in the sum as described in 836 IAC 1-2-3(f) pursuant ~~to~~ ot IC 16-1-39. Proof of insurance shall be made on a form prescribed by the commission.

(4) The provider shall insure that the basic life support equipment required by 836 IAC 1-3-5 and 836 IAC 1-4-2 pursuant to IC 16-1-39, is carried on-board each non-ambulance vehicle which is used for the purpose of providing advanced life support services. Variances or substitutions may be made in emergency care equipment if justification for variations or substitutions is submitted to and approved by the commission.

(5) The provider shall submit an annual report in the manner prescribed by the commission.

(c) Upon approval of the commission, an advanced emergency medical technician organization shall be granted certification for the provision of advanced life support services as specified in these rules and regulations [*836 IAC 2*]. The certificate issued shall be valid for a period of one (1) year and shall be prominently displayed at the place of business.

(d) Application for advanced EMT organization certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall show evidence of compliance with the requirements as set forth for original certification.

(e) Upon application the director may issue temporary certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI, B; filed Nov 3, 1980, 3:55 pm: 3 IR 2234; filed Oct 13, 1981, 10:05 am) NOTE: Effective date Jan 1, 1983.*

SECTION 36. 836 IAC 2-7-3 is amended to read as follows:

836 IAC 2-7-3 Advanced EMT organization operation procedures

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-7

Sec. 3. ~~PROVIDER~~ ADVANCED EMT ORGANIZATION OPERATING PROCEDURES. (a) Each ~~provider~~ advanced EMT organization shall maintain accurate records concerning the emergency care provided to each patient within the State which may include an Ambulance Report Form prescribed by the commission. Such records shall contain information regarding the advanced life support procedures performed and under whose direction, control and supervision.

(b) Each ~~provider~~ advanced EMT organization shall establish daily equipment checklist procedures to insure that:

(1) Mechanical and/or electronic equipment is in proper operating condition.

(2) Emergency response vehicle(s) are continuously maintained in a safe operating condition at all times.

(3) Only those ~~drugs and/or medications~~ intravenous solutions, in the approved quanitites, are available to the advanced emergency medical technician.

(c) The following requirements shall apply to the use of ~~drugs and medications~~ intravenous solutions by advanced emergency medical technicians:

(1) Advanced emergency medical technicians shall be prohibited from having in their possession, or maintaining on-board emergency response vehicle(s), any ~~drugs or medication~~ intravenous

solution which has not been approved by the administrative and medical staff of the supervising ~~hospital~~ hospital(s), the ~~provider~~ advanced EMT organization medical director and the commission. ~~The maximum quantity of any Class II drug shall be the minimum quantity necessary to treat two (2) emergency patients simultaneously.~~

(2) All ~~drugs, medications~~ intravenous solutions and related supplies are to be supplied by the supervising hospital(s) on an even exchange basis.

(3) Lost, stolen or misused ~~drugs~~ intravenous solutions will only be replaced on order of the ~~provider~~ advanced EMT organization medical director.

(4) Advanced emergency medical technicians shall be prohibited from ~~administering any drug or medication, or performing any emergency care procedure which is considered more advanced than usually rendered by a basic emergency medical technician~~ initiating an intravenous route and administering an intravenous solution without first establishing two-way voice communication with a physician, or an individual authorized in writing to act on behalf of a physician.

(5) Accountability for distribution, storage, ownership and security of ~~drugs and medications~~ intravenous solutions and supplies shall be subject to applicable requirements as determined by the State of Indiana Board of Pharmacy.

(6) A closed compartment, which shall be substantially constructed and equipped with a secure locking device, shall be provided within the vehicle for storage of ~~drugs and medications~~ intravenous solutions and supplies when the vehicle is not in use or unattended. Portable ~~drug~~ solution administration kits shall not be left in an unattended vehicle unless adequate security precautions have been taken.

(d) Each ~~provider~~ advanced EMT organization shall insure that rigid sanitation procedures are in effect at all times. The following minimum sanitation standards shall apply to all vehicles used for the purpose of providing advanced life support services:

(1) The interior and the equipment within the vehicle shall be clean and maintained in good working order at all times.

(2) Freshly laundered linen or disposable linens shall be used on cots and pillows, and linen shall be changed after each patient is transported.

(3) Clean linen storage shall be provided.

(4) Closed compartments shall be provided within the vehicle for medical supplies.

(5) Closed compartments shall be provided for soiled supplies.

(6) Blankets shall be kept clean and stored in closed compartments.

(7) Implements inserted into the patient's nose or mouth shall be single-service, wrapped and properly stored and handled. Multi-use items are to be kept clean and sterile when indicated and properly stored.

(8) When a vehicle has been utilized to transport a patient known to have a communicable disease, the vehicle shall be cleansed and all contact surfaces shall be washed with soap and water and disinfected.

(e) The following represents a list of equipment to be carried on each vehicle used to provide advanced life support by advanced EMTs for which certification has been granted:

(1) Eight 500cc D_5W
(2) Six 1000cc Ringers Lactate
(3) Two 1000cc Saline
(4) Seven Solution Administration sets
(5) Seven Anesthesia Extension sets
(6) Four 20 gauge overneedle catheters
(7) Four 18 gauge overneedle catheters
(8) Two 16 gauge overneedle catheters
(9) Two 19 gauge throughneedle catheters (recommended)
(10) Two 16 gauge throughneedle catheters (recommended)
(11) Two 14 gauge throughneedle catheters (recommended)

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VI, C; filed Dec 15, 1977: Rules and Regs. 1978, p. 255; filed Nov 3, 1980, 3:55 pm)

SECTION 37. 836 IAC 2-8-1 is amended to read as follows:

836 IAC 2-8-1 General requirements for supervising hospitals

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-40-3

Sec. 1. GENERAL REQUIREMENTS FOR SUPERVISING HOSPITALS. (a) Unless otherwise specified, the provisions of ~~Rule VII~~ 836 IAC 2-8 of these rules and regulations shall be in full force and effect as of ~~January 1, 1978. However, the commission may, upon receipt of proper application, certify supervising hospitals on or before December 31, 1977.~~ January 1, 1983.

(b) All hospitals providing, or seeking to provide medical supervision of advanced life support services administered by advanced emergency medical technicians and to provide training programs for advanced emergency medical technicians to perform

~~one or more, but not all of the procedures performed by an emergency paramedic, shall~~ intravenous line placement and fluid administration are required to be certified by the commission as a supervising hospital.

(c) A hospital certified by the commission as a supervising hospital may enter into an agreement with other institutions of higher education to conduct the didactic portion of the training program for advanced emergency medical technicians; provided the institution can present to the commission evidence of capability to provide such training. Under conditions where training is conducted by separate institutions, the clinical portion and overall program responsibility shall remain with the hospital(s) approved by the commission.

(d) ~~The supervising hospital shall have in full force and effect at all times, a written agreement with the provider organization in which the administrative and a majority of the medical staff have agreed to provide continuing education and in-service training, liaison and direction for emergency care equipment and supplies, and overall supervision of the medical and non-medical aspects of service provided by advanced emergency medical technicians employed by, or affiliated with the provider organization.~~ The supervising hospital shall have agreed by contract with the advanced emergency medical technician organization in which the administration and a majority of the medical staff have agreed to provide the following services:

(1) Continuing education
(2) Audit and review
(3) Medical control and direction
(4) Liaison and direction for supply of intravenous fluids and other items utilized by advanced emergency medical technicians

Said contract shall also include services for the overall supervision of the medical aspects of service provided by advanced emergency medical technicians employed by or affiliated with the advanced emergency medical technician organization. In those cases where more than one hospital seeks to supervise the medical ~~and non-medical~~ aspects of service provided by advanced emergency medical technicians and ~~provider~~ advanced EMT organizations, an inter-hospital agreement shall be provided to the commission to insure uniform and consistent policies and procedures as adopted by the administrative and medical staff of each hospital. The agreement shall clearly define the duties and responsibilities of each hospital and its medical and administrative staff to insure medical accountability of system operation. Such agreement shall constitute compliance with an advanced emergency medical ~~technicians~~ technician's association with a single supervising hospital.

(e) The supervising hospital(s) shall assume responsibility for development of system protocol and/or the ~~provider~~ advanced EMT organization operating procedures to insure the proper response to emergency situations by advanced emergency medical technicians. However, the supervising hospital shall be prohibited from establishing any procedure or protocol which would:

(1) permit an advanced emergency medical technician to perform any procedure which is more advanced than usually rendered by emergency medical technicians without first establishing two-way voice communication with a physician, or an individual authorized in writing by the medical staff to act on behalf of a physician.
(2) permit an advanced emergency medical technician to perform any advanced life support procedure for which certification by the commission has not been granted.
(3) permit a physician, or other representative of the supervising hospital(s), to authorize any advanced emergency medical technician not employed by, or affiliated with, a ~~provider~~ advanced EMT organization with whom the supervising hospital has an agreement, to perform any advanced life support procedure.

(f) ~~Under those conditions where an advanced emergency medical technician may be directed by a physician, or an individual authorized in writing to act on behalf of a physician, via voice communication to defibrillate an emergency patient, the supervising hospital(s) shall be required to have a functioning U.H.F. telemetry system between the emergency response vehicle(s) owned and/or operated by the provider organization and the emergency department, or coronary care unit, or equivalent of the supervising hospital(s). Voice communication capability is also required.~~ The hospital shall establish an assessment committee for audit and review of medical procedures performed by advanced emergency medical technicians of the advanced emergency medical technician organization.

(1) The advanced emergency medical technician organization medical director shall be a member of the committee.
(2) The recommended membership of the assessment committee is:
(A) advanced emergency medical technicians

(B) emergency department supervisory personnel
(C) advanced EMT organization supervisory personnel
(D) emergency department physicians

(g) All ~~drugs~~ intravenous solutions and supplies are to be supplied by the supervising hospital(s) on an even exchange basis. Lost, stolen or misused ~~drugs~~ intravenous solutions will only be replaced on order of the ~~provider~~ advanced EMT organization medical director. NOTE: Accountability for distribution, storage, ownership and security of ~~drugs~~ intravenous solutions and ~~medications~~ supplies is subject to applicable requirements as determined by the State of Indiana Board of Pharmacy. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII,A; filed Dec 15, 1977: Rules and Regs. 1978, p. 256; filed Nov 3, 1980, 3:55 pm)*

SECTION 38. 836 IAC 2-8-2 is amended to read as follows:

836 IAC 2-8-2 Application for supervising hospital certification

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-11; IC 16-1-40-9

Sec. 2. APPLICATION FOR SUPERVISING HOSPITAL CERTIFICATION. (a) Hospitals seeking certification by the commission as a supervising hospital shall meet the following minimum requirements:

(1) Application shall be made on such forms as may be prescribed by the commission.
(2) Submit to an evaluation of facilities and capabilities by the director or his duly authorized representative.
(3) Have approval in writing of the administrative and a majority of the medical staff which may be evidenced by a written agreement with the ~~provider~~ advanced EMT organization as required by these rules and regulations [*836 IAC 2*].
(4) Provide orientation to hospital personnel and physicians who may be directly or indirectly involved in the operational aspects of providing advanced life support services.
(5) Provide for audit and review of cases on a monthly basis with advanced emergency medical technicians, emergency department personnel and physicians to evaluate operations.
(6) Have a physician~~,~~ or ~~an individual~~ physician designate authorized in writing ~~to act on behalf of a physician,~~ by the medical staff immediately available at all times to supervise via voice communication advanced life support procedures administered by advanced emergency medical technicians.
(7) Have the necessary clinical facilities and guarantee access to emergency patients to conduct the required clinical phase(s) of the training program.
(8) Provide the necessary supervision of trainees during the clinical phase(s) of the training program.

(b) Hospitals ~~shall~~ should apply for approval in such manner as may be prescribed by the commission not less than ninety (90) days prior to the date approval is requested.

(c) Commission certification as a supervising hospital shall be valid for a period of three (3) years from the date of issue.

(d) Application for certification renewal ~~shall~~ should be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall be made on such forms as may be prescribed by the commission and shall evidence compliance with the requirements as set forth for original certification.

(e) Certification exemptions identified under ~~Rule VI, A.11~~ 836 IAC 2-7-1(j) shall apply to supervising hospitals.

(f) Procedures for suspension, revocation, or termination of certification ~~included under Rule VI.A.12, A.13 and A.14~~ pursuant to IC 16-1-40-9 shall apply to supervising hospitals.

(g) Upon application the ~~Director~~ director may issue temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these ~~Rules and Regulations~~ rules and regulations [*836 IAC 2-8*] as determined by the ~~Director~~ director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII,B; filed Dec 15, 1977: Rules and Regs. 1978, p. 258; filed Nov 3, 1980, 3:55 pm)*

SECTION 39. 836 IAC 2-8-3 is amended to read as follows:

836 IAC 2-8-3 Requirements for training advanced emergency medical technicians

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 3. REQUIREMENTS FOR TRAINING ADVANCED ~~EMERGENCY MEDICAL TECHNICIAN TRAINING~~ EMERGENCY MEDICAL TECHNICIANS. (a) ~~The curriculum for advanced~~

~~emergency medical technician training programs shall be established and adopted by the administrative and a majority of the medical staff of the supervising hospital(s) and shall be approved by the commission. The curriculum shall be directed toward the attainment of specific skills and knowledge considered within the scope and responsibility of the advanced emergency medical technician (see Rule VIII.B.5) and shall:~~

~~(a) identify the skills and knowledge required for successful course completion;~~

~~(b) identify methods to be used in accomplishing stated objectives;~~

~~(c) outline the procedures for evaluation of student competency, using a commission developed practical skills examination.~~

The minimum curriculum requirements for supervising hospitals providing advanced emergency medical technician training shall be selected modules from the Training Program for the Emergency Medical Technician-Paramedic training course, outlined by the U.S. Department of Transportation as DOT HS 802 437 through DOT HS 802 452, Modules 1-3 inclusive and shall include a practical skills examination on forms provided by the commission. Skills to be tested are described in 836 IAC 2-9-3(a)(1) Category II.

(b) ~~The minimum curriculum requirements for advanced emergency medical technician training programs shall be determined on the basis of those procedures which the advanced emergency medical technician will be expected to perform upon receiving certification by the commission. When applicable, the training program shall include, but not be limited, to the following objectives:~~

~~(a) Performing Patient Assessment, including~~

~~(1) History taking (chief complaint, pertinent history of the present illness/injury and past medical history).~~

~~(2) Assessment of patient's general appearance and state of consciousness.~~

~~(3) Evaluation of vital signs, including pulse, blood pressure, and respirations.~~

~~(4) Trauma-oriented and medically oriented head-to-toe survey.~~

~~(b) Shock and Fluid Therapy Techniques, including:~~

~~(1) The cause, signs, symptoms and treatment of shock.~~

~~(2) The indications, contra-indications, and dosage of those medications available to the advanced emergency medical technician.~~

~~(3) The procedure for verifying medication orders received over the radio from a physician.~~

~~(4) The procedure for calculating the volume of fluid to be administered.~~

~~(5) Demonstrating the technique of peripheral venipuncture using an over-the-needle catheter device or straight needle.~~

~~(6) Demonstrating the technique for drawing-up the designated volume of fluid in a syringe from an ampule and a vial.~~

~~(7) Demonstrating the technique for administering drugs using a prepackaged disposable syringe.~~

~~(8) Demonstrating the technique for subcutaneous and intramuscular injection.~~

~~(9) Demonstrating the technique for the administration of drugs into an IV bottle or through an IV insertion site.~~

~~(c) Cardiovascular Emergencies, including~~

~~(1) The cause, signs, symptoms, and treatment of each of the following:~~

~~(a) Acute myocardial infarction~~

~~(b) Congestive heart failure~~

~~(c) Cardiac arrest~~

~~(d) Cardiogenic shock~~

~~(e) Myocardial trauma~~

~~(f) Hypertensive states~~

~~(2) Identifying the structures of the heart and the function of each.~~

~~(3) Demonstrating the application of electrodes and the monitoring of a patient's electrocardiogram activity.~~

~~(4) Demonstrating on an adult manikin and an infant manikin the technique for one-person and two-person cardiopulmonary resuscitation.~~

~~(5) Demonstrating the technique for cardioversion on a manikin.~~

~~(d) Respiratory Emergencies, including~~

~~(1) Identifying the structures of the respiratory system.~~

~~(2) Demonstrating the procedure for the evaluation of a patient with suspected respiratory distress, including the evaluation of hypoxia, pulse, blood pressure, and neck vein distention.~~

~~(3) The cause, signs, symptoms and treatment of the following:~~

~~(a) Respiratory depression and respiratory distress~~

~~(b) Upper airway obstruction~~

~~(c) Toxic inhalations~~

~~(d) Pulmonary edema~~

~~(e) Hyperventilation~~

~~(f) Trauma, including rib fractures, flail chest, traumatic pneumothorax and hemothorax~~

~~(g) Pulmonary embolism~~

~~(4) Demonstrating the use of oropharyngeal~~

~~airways, bag-valve-mask and demand valve resuscitators on a non-breathing patient or manikin.~~

~~(5) Demonstrating proper assembly, cleaning, functioning and testing of all respiratory and airway equipment.~~

~~(c) Performance objectives, including~~

~~(1) Demonstrating the technique for spinal immobilization using:~~

~~(a) Short spine board~~

~~(b) Long spine board~~

~~(c) Orthopedic stretcher~~

~~(2) Demonstrating the techniques for controlling hemorrhage.~~

~~(3) Demonstrating the procedure for dressing and bandaging an avulsion or an impaled object.~~

~~(4) Demonstrating the procedure for treating specific injuries to the eye, face and neck.~~

~~(5) Identify the types and degrees of burns, and demonstrating the treatment of each.~~

~~(6) Demonstrating the technique of immobilization using the traction splint, air splint, and board splint.~~

~~(7) Demonstrating the technique for managing a dislocation of the elbow, knee, ankle, hip, shoulder, or wrist.~~

~~(8) Demonstrating on an obstetrical manikin the procedure for the preparation of a mother and the delivery of an infant in a cephalic birth.~~

~~(9) Identify the procedures to be followed in an abnormal delivery.~~

~~(10) Demonstrating the technique for assessing and managing pediatric patients.~~

~~(11) Demonstrating the procedure for gaining access and disentangling a patient in a vehicle or structure.~~

~~(12) Demonstrating the procedure for the transportation of a patient having the following conditions:~~

~~(a) Flail chest~~

~~(b) Fracture of an extremity~~

~~(c) Spinal trauma~~

~~(d) Multiple trauma~~

~~(e) Myocardial infarction~~

~~(f) Foreign body impaled in the abdomen, back or thorax~~

~~(13) Demonstrating techniques for lifting and moving patients in emergency and non-emergency conditions.~~

~~(14) Demonstrating the procedure for dispatching and using radio communications equipment.~~

~~(15) Demonstrating the procedure for relaying information to the physician in the correct sequence.~~

~~(f) Clinical training to provide an opportunity to relate the principles and concepts as presented in the training program to emergency care in practice. Clinical training must be performed under direct supervision and should provide the student with an opportunity to demonstrate proficiency in all skills.~~

(b) Each course conducted by the supervising hospital shall be approved in a manner prescribed by the commission.

(c) Each course shall be conducted within a period of six (6) consecutive months for advanced emergency medical technicians.

(d) For the duration of the course, following appropriate didactic and clinical evaluation of each skill, a student may perform those advanced life support skills evaluated and found to be performed successfully, under the direct supervision of qualified health professionals designated as preceptors by the medical director of the training program. The medical director of the training program shall provide a list of said preceptors to the commission.

~~(3)~~**(e) Staffing for the training program shall include:**

(1) A medical director who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana and who has an active role in the delivery of emergency care and who shall have the following responsibilities:

(A) Providing necessary liaison with physicians to obtain adequate instructor services.

(B) Assuring that the course of instruction meets established standards of the commission.

(C) Assurring accurate and thorough presentation of the medical content of the course.

(D) Attesting to the competence of graduates to perform skills required of an advanced emergency medical technician.

(2) A training coordinator who shall be appointed by the medical director and who must be a physician, registered nurse or member of the program instructional staff with appropriate education and experience as determined by the medical director. The training coordinator shall be responsible for:

(A) Individual consultation with trainees.

(B) Assuring that the required equipment and materials are available at the class session.

(C) Evaluating classroom activities, including clinical and practice sessions.

(D) Assisting in the coordination of examinations.

(E) Providing information concerning training programs.

(F) Acting as liaison between the students and the program staff.

(3) The instructional staff which shall be selected from various specialties and shall have appropriate education and experience to teach in assigned areas at the discretion of the medical director. It is recommended that instructors meet the following requirements:

(A) Have extensive critical and/or emergency care experience compatible with the subject being presented.

(B) Have a level of medical knowledge above that required of the advanced emergency medical technician, compatible with the subject being presented.

(C) Be thoroughly knowledgeable about, and able to demonstrate all skills as presented in the course.

~~(4)~~(f) Each supervising ~~hospital~~ hospital(s) shall insure adequate classroom space for the optimum didactic ratio of one (1) instructor for each twenty (20) students and optimum clinical practice session ratio of one (1) instructor for each six (6) students. It is recommended that not more than two (2) trainees be assigned at one time to any hospital clinical unit or to any emergency vehicle for clinical experience and evaluation.

~~(5)~~(g) The supervising ~~hospital~~ hospital(s) shall provide a course report in the manner prescribed by the commission.

~~(6)~~(h) The supervising ~~hospital~~ hospital(s) shall complete other forms as may be required by the commission for the purpose of course and student evaluation, and shall cooperate and assist the commission in collecting statistics and evaluating performance and costs relating to training advanced emergency medical technicians.

~~(7)~~(i) The supervising hospital(s) shall establish criteria for selection of students for advanced emergency medical technician training programs. However, applicants shall meet the following minimum requirements:

(1) Applicant must hold a valid certification as an emergency medical technician issued by the commission pursuant to IC ~~1971,~~ 16-1-39.

(2) Applicant must be accepted by the administrative staff of the supervising hospital.

(3) Applicant shall show evidence of physical examination as prescribed by the commission and given by the training program medical director.

(4) Applicant shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render them unfit to perform as an advanced emergency medical technician.

(5) Applicant must pass screening and evaluation as determined necessary by the ~~supervising hospital~~ training program and/or ~~provider~~ advanced EMT organization medical director.

(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VII, C; filed Dec 15, 1977: Rules and Regs. 1978, p. 259; filed Nov 3, 1980, 3:55 pm)

SECTION 28. 836 IAC 2-9-1, as amended at 3 IR 2241, SECTION 40, is amended to read as follows:

836 IAC 2-9-1 General certification provisions

Authority: IC 16-1-39-6; IC 16-1-40-3

Affected: IC 16-1-39-11

Sec. 1. GENERAL CERTIFICATION PROVISIONS. (a) Unless otherwise specified, the provisions of 836 IAC 2-9 of these rules and regulations shall be in full force and effect as of January 1, 1983.

(b) Any person who is currently certified as an emergency medical technician pursuant to IC 16-1-39, and has received advanced instruction and training enabling him to perform intravenous line placement and fluid administration, under the direct ~~supervision~~ supervision of a physician in person, or via voice communication, may be certified as an advanced emergency medical technician ~~by the commission.~~

(c) Applicants for certification as an advanced emergency medical technician are required to be certified as an emergency medical technician pursuant to IC 16-1-39 and meet the following requirements:

(1) Be affiliated with a certified advanced emergency medical technician organization and;
(2) Have satisfactorily completed the prescribed training as set forth in these rules and regulations [*836 IAC 2*] and satisfactorily demonstrate knowledge in the area of emergency care by successfully ~~completing~~ completed the advanced emergency medical technician written examination composed by the Advanced Life Support Test Construction and Evaluation Committee under the supervision of the commission. Students shall be notified in writing, at the time of the examination, of the criteria for successful completion of the examination which shall include the maximum number of opportunities for re-examination before retraining is required as follows:

(A) During a twelve (12) month period (the twelve (12) months beginning the first day that an advanced EMT certification examination is offered by the commission after the candidate has completed his advanced EMT training program), the candidate will be allowed to take the advanced EMT certification examination a total of three (3) times. However, the director may approve an extension of the twelve (12) month period for a period of six (6) months upon receipt of a written request during the twelve (12) month period from the candidate. A candidate who fails the written examination a second time should be encouraged to take the program of remedial training designed by the candidate and the supervising hospital medical director.

(B) A candidate who fails the written examination the third time or who fails to successfully complete the written examination during the approved time period must retake the entire course of training for advanced EMTs as outlined in these rules and regulations [*836 IAC 2*]. Upon successful completion of said course, the candidate will be eligible to satisfy the requirements for certification as prescribed by these rules and regulations [*836 IAC 2*], and:

(3) Present evidence of fitness by a written report of physical examination prescribed by the commission, given by a physician licensed to practice medicine in the State of Indiana. Applicants shall have no addiction to drugs or alcohol and be of sound physique, and not subject to any infirmity of body or mind which might render him unfit to provide advanced life support services. Determination of fitness may be made by the advanced EMT organization medical director.

(d) Applicants for certification as an advanced EMT residing in states bordering Indiana and who have completed an advanced EMT training course equivalent to the minimum requirements established by the commission as determined by the director are required to:

(1) be certified as an emergency medical technician pursuant to IC 16-1-39.
(2) be affiliated with an advanced EMT organization.
(3) successfully pass the advanced EMT organization written and practical ~~examinations~~ examination as outlined in these rules and regulations [*836 IAC 2*].
(4) present evidence of fitness as described in 836 IAC 2-9-1(c)(3).

(e) Applicants for certification as an advanced EMT who, at the time Indiana residence is established, possesses a valid certificate or license as an advanced EMT from another state, who has completed an advanced EMT training course equivalent to the minimum requirements established by the commission ~~as~~ ads determined by the director are required to:

(1) be certified as an emergency medical technician pursuant to IC 16-1-39.
(2) be affiliated with an advanced EMT organization.
(3) successfully pass the advanced EMT written and practical examinations as outlined in these rules and regulations [*836 IAC 2*].
(4) present evidence of fitness as described in 836 IAC 2-9-1(c)(3).

(f) Certified advanced emergency medical technicians must meet all continuing education requirements including reporting procedures as outlined in these rules and regulations [*836 IAC 2*].

(g) Certification exemptions identified under 836 IAC 2-7-1(j) shall apply to the ~~certification~~ certifications of advanced emergency medical technicians.

(h) Advanced emergency medical technicians should comply with standards of ethical conduct which ~~include~~ follow:

(1) Strive to improve medical knowledge and skill on a continuing basis.
(2) Offer optimal support to the patient, doctor and supervising hospital.
(3) Respect the patient's right to privacy, dignity and safety.
(4) Understand the legal responsibility and the limitations imposed upon them.
(5) Understand the principles of the practice of medicine, and the practice of the advanced emergency medical technician.
(6) Understand all types of emergencies, both medical and mechanical, and the measures that

must be applied to solve the problem at hand, and/or the prevention of such emergencies.
(7) Be skilled to act instead of react in times of emergency and/or stress.
(8) Always seek to increase knowledge and skill to perform to the best of their ability with full recognition of their limitations and to accept and benefit from constructive criticism and advice.
(9) Encourage participation in activities whose goal is to improve the health and well-being of the individual as well as the community as a whole.
(10) Strive to publicly uphold the image, goals and ideals of the program and the profession.
(11) Take pride in his personal appearance and at all times realize that he is being observed by members of the community.
(12) Have a calm and reassuring manner when dealing with patients, relatives and bystanders in order to gain confidence and cooperation of all concerned.

(i) The commission may initiate proceedings to suspend or revoke ~~an endorsement~~ a certificate as an advanced emergency medical technician on its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held and conducted in accordance with the provisions of IC 4-22-1 upon proof that any advanced emergency medical technician:
(1) is guilty of fraud or deceit in procuring ~~or attempting to procure~~ certification as an advanced emergency medical technician;
(2) is unfit or incompetent by reason of negligence, habit, or other causes;
(3) is habitually intemperate or is addicted to the use of habit-forming drugs;
(4) is mentally incompetent;
(5) is guilty of unprofessional conduct;
(6) is guilty of delegating to a person less qualified any service which requires the professional competence of an advanced emergency medical technician;
(7) is guilty of a direct violation of a physician's ~~proper~~ reasonable and prudent order from the supervising hospital;
(8) has willfully or repeatedly violated any of the provisions of these rules and regulations [*836 IAC 2*];
(9) has been convicted of an offense if the acts that resulted in the conviction have a direct bearing on whether or not the person should be entrusted to serve the public as an advanced emergency medical technician.

(j) Procedures for suspension, revocation, or termination of certification pursuant to IC 16-1-40-9 shall apply to advanced emergency medical technician certification. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VIII, A; filed Nov 3, 1980, 3:55 pm: 3 IR 2241; filed Oct 13, 1981, 10:05 am) NOTE: Effective date Jan 1, 1983.*

SECTION 29. 836 IAC 2-9-2, as amended at 3 IR 2243, SECTION 41, is amended to read as follows:

836 IAC 2-9-2 Application for certification
Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-11; IC 16-1-40

Sec. 2. APPLICATION FOR CERTIFICATION. (a) Application for certification as an advanced emergency medical technician shall be made on such forms as may be prescribed by the commission. The application for certification shall include, but not be limited to, a statement of competence which shall be signed by an appropriate representative of the supervising hospital(s) administrative staff and the advanced EMT organization medical director and which shall indicate that the individual requesting certification is capable of performing the intravenous procedures for which certification is requested.

(b) Valid application for certification as an advanced EMT shall be made within one (1) year of the date of successful completion of the advanced EMT written certification examination. Failure to do so shall result in the following:
(1) Applicant shall retake and successfully complete the advanced EMT certification examination as described in 836 IAC 2-9-1(c)(2)(A) and (B) and;
(2) Submit an eligible application as an advanced EMT within said twelve (12) month period (See 836 IAC 2-9-1(c)(2)(A) and (B)). Failure to meet the requirements outlined herein shall result in the applicant's retraining as an advanced EMT according to these rules and regulations [*836 IAC 2*].

(c) Temporary authorization to act in the capacity of an advanced emergency medical technician may be issued by the director for a specified period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary authorization may only be approved one (1) time.

(d) Upon approval by the commission, an advanced emergency medical technician shall be issued certification for the provision of advanced life support services as described in these rules and regulations [*836 IAC 2*].

(e) A certificate issued in accordance with these

provisions shall be valid ~~as long~~ as compliance is maintained with the continuing education requirements as set forth in these rules and regulations [*836 IAC 1 and 836 IAC 2*].

(f) Advanced emergency medical technicians shall be limited to perform only intravenous line placement. Said procedure may only be performed when affiliated with a certified advanced emergency medical technician organization and while under the direct supervision of a physician of the supervising hospital(s), or an individual authorized in writing by the medical staff to act in the behalf of a physician of the approved supervising hospital(s). Advanced emergency medical technicians are prohibited from performing any advanced life support procedure, with or without physician direction, for which certification by the commission has not been granted.

(g) Advanced emergency medical technicians who have failed to comply with the continuing education requirements as determined by the director shall not, upon written notice, exercise any of the rights and privileges granted by certification under IC 16-1-40 nor shall they administer advanced life support to any emergency patient until the following requirements are met:

(1) Satisfactorily demonstrate knowledge in the area of emergency care by successfully completing the advanced emergency medical technician written examination, as composed by the Advanced Life Support Test Construction and Evaluation Committee under the supervision of the commission. The criteria for examination and re-examination are outlined in 836 IAC 2-9-1(c)(2)(A) and (B).

(2) Present evidence of fitness as outlined in 836 IAC 2-9-1(c)(3).

(3) Be currently affiliated with a certified advanced emergency medical technician organization.

(h) Application for certification renewal shall be made on forms prescribed by the commission within one (1) year from date of non-compliance.

(i) Advanced emergency medical technicians failing to satisfy the requirements of subsection ~~(i)~~(g) of this section shall satisfy the requirements for certification renewal by fulfilling the requirements for original certification as outlined in these rules and regulations [*836 IAC 2*]. *(Indiana Emergency Medical Services Commission; Advanced Life Support Rule VIII, B; filed Nov 3, 1980, 3:55 pm: 3 IR 2243; filed Oct 13, 1981, 10:05 am) NOTE: Effective date Jan 1, 1983.*

~~emergency medical technician training programs shall be established and adopted by the administrative and a majority of the medical staff of the supervising hospital(s) and shall be approved by the commission. The curriculum shall be directed toward the attainment of specific skills and knowledge considered within the scope and responsibility of the advanced emergency medical technician (see Rule VIII.B.5) and shall:~~

~~(a) identify the skills and knowledge required for successful course completion;~~

~~(b) identify methods to be used in accomplishing stated objectives;~~

~~(c) outline the procedures for evaluation of student competency, using a commission developed practical skills examination.~~

The minimum curriculum requirements for supervising hospitals providing advanced emergency medical technician training shall be selected modules from the Training Program for the Emergency Medical Technician-Paramedic training course, outlined by the U.S. Department of Transportation as DOT HS 802 437 through DOT HS 802 452, Modules 1-3 inclusive and shall include a practical skills examination on forms provided by the commission. Skills to be tested are described in 836 IAC 2-9-3(a)(1) Category II.

(b) ~~The minimum curriculum requirements for advanced emergency medical technician training programs shall be determined on the basis of those procedures which the advanced emergency medical technician will be expected to perform upon receiving certification by the commission. When applicable, the training program shall include, but not be limited, to the following objectives:~~

~~(a) Performing Patient Assessment, including~~

~~(1) History taking (chief complaint, pertinent history of the present illness/injury and past medical history).~~

~~(2) Assessment of patient's general appearance and state of consciousness.~~

~~(3) Evaluation of vital signs, including pulse, blood pressure, and respirations.~~

~~(4) Trauma oriented and medically oriented head to toe survey.~~

~~(b) Shock and Fluid Therapy Techniques, including:~~

~~(1) The cause, signs, symptoms and treatment of shock.~~

~~(2) The indications, contra-indications, and dosage of those medications available to the advanced emergency medical technician.~~

~~(3) The procedure for verifying medication orders received over the radio from a physician.~~

~~(4) The procedure for calculating the volume of fluid to be administered.~~

~~(5) Demonstrating the technique of peripheral venipuncture using an over-the-needle catheter device or straight needle.~~

~~(6) Demonstrating the technique for drawing-up the designated volume of fluid in a syringe from an ampule and a vial.~~

~~(7) Demonstrating the technique for administering drugs using a prepackaged disposable syringe.~~

~~(8) Demonstrating the technique for subcutaneous and intramuscular injection.~~

~~(9) Demonstrating the technique for the administration of drugs into an IV bottle or through an IV insertion site.~~

~~(c) Cardiovascular Emergencies, including~~

~~(1) The cause, signs, symptoms, and treatment of each of the following:~~

~~(a) Acute myocardial infarction~~

~~(b) Congestive heart failure~~

~~(c) Cardiac arrest~~

~~(d) Cardiogenic shock~~

~~(e) Myocardial trauma~~

~~(f) Hypertensive states~~

~~(2) Identifying the structures of the heart and the function of each.~~

~~(3) Demonstrating the application of electrodes and the monitoring of a patient's electrocardiogram activity.~~

~~(4) Demonstrating on an adult manikin and an infant manikin the technique for one-person and two-person cardiopulmonary resuscitation.~~

~~(5) Demonstrating the technique for cardioversion on a manikin.~~

~~(d) Respiratory Emergencies, including~~

~~(1) Identifying the structures of the respiratory system.~~

~~(2) Demonstrating the procedure for the evaluation of a patient with suspected respiratory distress, including the evaluation of hypoxia, pulse, blood pressure, and neck vein distention.~~

~~(3) The cause, signs, symptoms and treatment of the following:~~

~~(a) Respiratory depression and respiratory distress~~

~~(b) Upper airway obstruction~~

~~(c) Toxic inhalations~~

~~(d) Pulmonary edema~~

~~(e) Hyperventilation~~

~~(f) Trauma, including rib fractures, flail chest, traumatic pneumothorax and hemothorax~~

~~(g) Pulmonary embolism~~

~~(4) Demonstrating the use of oropharyngeal~~

~~airways, bag-valve-mask and demand valve resuscitators on a non-breathing patient or manikin.~~

~~(5) Demonstrating proper assembly, cleaning, functioning and testing of all respiratory and airway equipment.~~

~~(c) Performance objectives, including~~

~~(1) Demonstrating the technique for spinal immobilization using:~~

~~(a) Short spine board~~

~~(b) Long spine board~~

~~(c) Orthopedic stretcher~~

~~(2) Demonstrating the techniques for controlling hemorrhage.~~

~~(3) Demonstrating the procedure for dressing and bandaging an avulsion or an impaled object.~~

~~(4) Demonstrating the procedure for treating specific injuries to the eye, face and neck.~~

~~(5) Identify the types and degrees of burns, and demonstrating the treatment of each.~~

~~(6) Demonstrating the technique of immobilization using the traction splint, air splint, and board splint.~~

~~(7) Demonstrating the technique for managing a dislocation of the elbow, knee, ankle, hip, shoulder, or wrist.~~

~~(8) Demonstrating on an obstetrical manikin the procedure for the preparation of a mother and the delivery of an infant in a cephalic birth.~~

~~(9) Identify the procedures to be followed in an abnormal delivery.~~

~~(10) Demonstrating the technique for assessing and managing pediatric patients.~~

~~(11) Demonstrating the procedure for gaining access and disentangling a patient in a vehicle or structure.~~

~~(12) Demonstrating the procedure for the transportation of a patient having the following conditions:~~

~~(a) Flail chest~~

~~(b) Fracture of an extremity~~

~~(c) Spinal trauma~~

~~(d) Multiple trauma~~

~~(e) Myocardial infarction~~

~~(f) Foreign body impaled in the abdomen, back or thorax~~

~~(13) Demonstrating techniques for lifting and moving patients in emergency and non-emergency conditions.~~

~~(14) Demonstrating the procedure for dispatching and using radio communications equipment.~~

~~(15) Demonstrating the procedure for relaying information to the physician in the correct sequence.~~

~~(f) Clinical training to provide an opportunity to relate the principles and concepts as presented in the training program to emergency care in practice. Clinical training must be performed under direct supervision and should provide the student with an opportunity to demonstrate proficiency in all skills.~~

(b) Each course conducted by the supervising hospital shall be approved in a manner prescribed by the commission.

(c) Each course shall be conducted within a period of six (6) consecutive months for advanced emergency medical technicians.

(d) For the duration of the course, following appropriate didactic and clinical evaluation of each skill, a student may perform those advanced life support skills evaluated and found to be performed successfully, under the direct supervision of qualified health professionals designated as preceptors by the medical director of the training program. The medical director of the training program shall provide a list of said preceptors to the commission.

~~(3)~~(e) Staffing for the training program shall include:

(1) A medical director who must be a physician who holds a currently valid unlimited license to practice medicine in the State of Indiana and who has an active role in the delivery of emergency care and who shall have the following responsibilities:

(A) Providing necessary liaison with physicians to obtain adequate instructor services.

(B) Assuring that the course of instruction meets established standards of the commission.

(C) Assurring accurate and thorough presentation of the medical content of the course.

(D) Attesting to the competence of graduates to perform skills required of an advanced emergency medical technician.

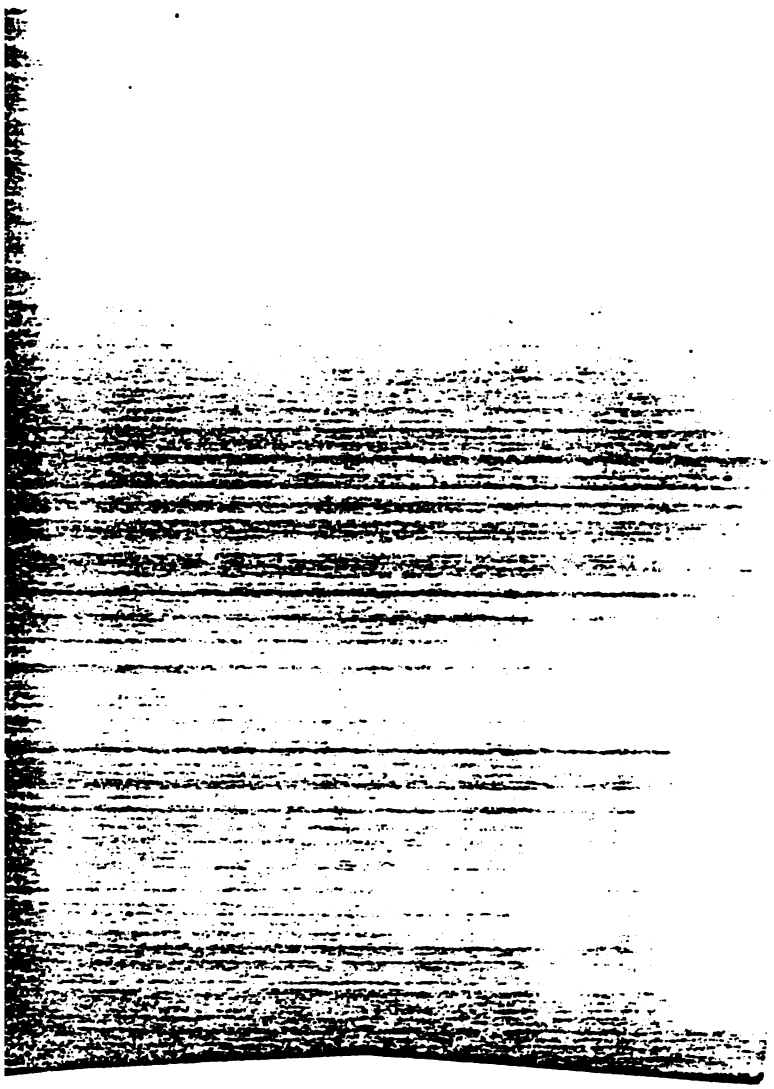
(2) A training coordinator who shall be appointed by the medical director and who must be a physician, registered nurse or member of the program instructional staff with appropriate education and experience as determined by the medical director. The training coordinator shall be responsible for:

(A) Individual consultation with trainees.

(B) Assuring that the required equipment and materials are available at the class session.

(C) Evaluating classroom activities, including clinical and practice sessions.

(D) Assisting in the coordination of examinations.



SECTION 42. 836 IAC 2-9 is amended by adding a NEW section 3 to read as follows:

836 IAC 2-9-3 Continuing education requirements

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 3. CONTINUING MEDICAL EDUCATION REQUIREMENTS. (a) Advanced emergency medical technicians must meet the following continuing education requirements to maintain their certification or certification eligiblity. Concurrent emergency medical technician certification pursuant to IC 16-1-39 will be maintained if these requirements are fulfilled:

(1) has successfully completed requirements for continuing education which shall provide for a minimum of sixty (60) continuing education credits (C.E.C.) per year as outlined below. The C.E.C. may be accumulated in any combination from up to six (6) categories as described below provided there is adherence to the annual minimum and maximum C.E.C. limits per category.

CATEGORY I Lectures and Critiques

Attendance at D.O.T. advanced Emergency Medical Technician course related lectures or critiques (audits) of advanced emergency medical technician related activities conducted by the advanced EMT organization's supervising hospital(s). Each candidate should individually report his attendance on the required CEC form annually and each lecture or critique director will submit a signed attendance roster at the completion of the lecture or critique session to the commission.

Value: 1 CEC/1 hour lecture or critique time
Minimum Category I CEC Required Per Year 15
Maximum Category I CEC Allowed Per Year No Limit

CATEGORY II Skills

Attendance at D.O.T. Advanced Emergency Medical Technician course related "hands on" skill refresher or skill testing programs conducted by the advanced EMT's supervising hospital(s). Each candidate shall individually report his attendance on the required form annually and each course director will submit a signed attendance roster at the completion of the course denoting both the names of those attending as well as their performance level (satisfactory vs. unsatisfactory). Credit will only be allowed for satisfactory performance.

Value: 1 CEC/1 hour skill laboratory or testing time.

Minimum Category II CEC Required Per Year 10*
Maximum Category II CEC Allowed Per Year No Limit

*Note: The ten (10) credit minimum category II CEC per year must include time spent in each of the curriculum skills enumerated in 836 IAC 2-6-1(c)(2) of the rules and regulations for advanced life support appropriate to the advanced EMT. These are: cardiopulmonary resuscitation (one-person, two-person, infant), airway management, intravenous line placement, patient assessment, traction splinting, backboard utilization, and MAST trousers.

CATEGORY III Other Learning Experiences

Lecture or skills sessions in emergency medical technician or advanced emergency medical technician related activities not conducted by the advanced EMT organization's supervising hospital(s). Each candidate should individually report his attendance on the required form annually and each course director should maintain an attendance roster for verification (may be requested by the commission) or may voluntarily submit an attendance roster to the commission.

Value: 1 CEC/3 hours

Minimum Category III CEC Required Per Year None
Maximum Category III CEC Allowed Per Year No Limit

CATEGORY IV Teaching Experiences

Participation as an instructor (lecture or laboratory) in an educational program utilizing emergency medical technician or advanced emergency medical technician-level knowledge or skills. The CEC will be allotted as outlined in the commission publication entitled: "Advanced Life Support Continuing Education Requirements" which allows 1 CEC for every hour of teaching experience. Each candidate should individually report his participation on the required form annually and each course director should maintain an instructor roster for verification (may be requested by the commission) or may voluntarily submit an instructor roster to the commission.

Value: 1 CEC/1 hour

Minimum Category IV CEC Required Per Year None
Maximum Category IV CEC Allowed Per Year No Limit

CATEGORY V Advanced Life Support Ambulance Experience

Documented active participation in advanced life support activities during an advanced EMT organization ambulance run. A letter of verification must be submitted by the medical director of the advanced EMT organization along with the advanced emergency medical technician's annual CEC summary form for credit to be allowed. It is the responsibility of the advanced emergency medical technician to tabulate the appropriate runs, report the run activity on the required form annually and solicit the required letter from the provider organization's medical director to substantiate his claim for Category V CEC credit.

Value: 1 CEC/10 Advanced Life Support Ambulance Runs

Minimum Category V CEC Required Per Year None
Maximum Category V CEC Allowed Per Year 10

CATEGORY VI Department of Transportation (D.O.T.) Refresher Training Course

During the third year of the EMT certification period pursuant to IC 16-1-39, each advanced emergency medical technician shall be required to take and successfully complete a D.O.T. Refresher Training Course outlined in Rule 836 IAC 1-5-2(f)(4) pursuant to IC 16-1-39. Reporting shall be made on forms as may be prescribed by the commission.

Value: 1 CEC/3 hours of lecture and practical skills found in the D.O.T. Refresher Training Course.

Minimum Category VII CEC Required in 3rd Year of EMT Certification 7

Maximum Category VII CEC Required in 3rd Year of EMT Certification No Limit

Refer to the commission publication entitled "Advanced Life Support Continuing Education Requirements" for examples of continuing education activities in each category. CEC allotment for recognized and established advanced life support activities.

(b) Each advanced emergency medical technician shall report to the commission evidence of having completed the required continuing education within thirty (30) days of the anniversary date of the advanced emergency medical technicians' orginal certification.

(c) The supervising hospital(s) shall maintain accurate records which shall serve as partial evidence of the advanced emergency medical technicians' compliance with the continuing education requirements. However, each advanced emergency medical technician must report such compliance with the continuing education requirements as described herein.

(d) Reports of continuing education shall be made on such forms as may be prescribed by the commission

836 IAC 2-10-1 Application for advanced life support air ambulance service provider certification

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 16-1-39-9

Sec. 1. APPLICATION FOR ADVANCED LIFE SUPPORT AIR AMBULANCE SERVICE PROVIDER CERTIFICATION. (a) Application for certification as an advanced life support air ambulance service provider shall be made on forms as may be prescribed by the commission and shall include, but not be limited to the following:

(1) A narrative summary of plans for providing advanced life support services including:

(A) The staffing pattern of personnel

(B) Defined area of response

(C) Base of operations

(D) A listing of all personnel and their qualifications who will regularly serve as medical attendants on the aircraft.

(2) Plans and methodologies to insure that the trained personnel are provided with continuing education relative to their level of training. It is recommended that continuing education on air transport problems and pressure phenomena given by a certified F.A.A. medical examiner be provided on an annual basis. Continuing education shall be under the direct supervision of the advanced life support air ambulance service provider organization medical director with the cooperation of the sponsoring hospital.

(3) A listing of special on-board life support and medical communications equipment available including a list of drugs and medications to be carried on each aircraft.

(4) A letter of approval from the sponsoring hospital stating acceptability of emergency paramedics and a copy of the contract between the advanced life support air ambulance service provider organization and the sponsoring hospital.

(5) A copy of the complete set of all treatment protocols and standing orders (if applicable) under which all non-physician personnel shall operate.

(b) Upon approval of the commission an advanced life support air ambulance service provider organization shall be issued certification for the provision of advanced life support services as required by these rules and regulations [*836 IAC 2*].

(c) The certificate issued pursuant to these rules and regulations [*836 IAC 2*] shall be valid for a period of one (1) year from the date of issue and shall be prominently displayed at the place of business.

(d) Application for certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certificate. Application for renewal shall be made on such forms as may be prescribed by the commission and shall show evidence of compliance with these rules and regulations [*836 IAC 2*] as set forth for original certification.

(e) The director may issue temporary certification or certification renewal for a period not to exceed ninety (90) days to allow the commission to act upon the application, if the applicant is in full compliance with these rules and regulations [*836 IAC 2*] as determined by the director. Such temporary certification may only be approved one (1) time. *(Indiana Emergency Medical Services Commission; 836 IAC 2-10-1; filed Nov 3, 1980, 3:55 pm)*

SECTION 30. 836 IAC 2-10-2, as added at 8 IR 2246, SECTION 43, is amended to read as follows:

836 IAC 2-10-2 Advanced life support air ambulance service provider operating procedures

Authority: IC 16-1-39-6; IC 16-1-40-8
Affected: IC 16-1-39-9

Sec. 2. ADVANCED LIFE SUPPORT AIR AMBULANCE SERVICE PROVIDER OPERATING PROCEDURES. (a) Each organization shall maintain accurate records concerning the emergency care provided to each patient within the State which may include a Rescue Record and Report Form prescribed by the commission. It is recommended that the following data be maintained in order to evaluate the program.

(1) Number of runs
  (A) cardiac
  (B) trauma
  (i) automobile accidents
  (ii) other
  (C) overdose
  (D) medical emergencies, i.e., diabetic, respiratory, etc.
  (E) miscellaneous, i.e., obstetrical cases

(2) Call load/day
  (A) number defibrillated
  (B) number requiring CPR only
  (C) number ~~resuscitated~~ resuscitation from ~~full~~ cardiopulmonary arrest improved to having a palpable pulse and hospital admission
  (D) operational difficulties, i.e., equipment problems, communication problems, other persons on the scene, etc.

(b) Each advanced life support air ambulance service provider organization shall establish daily equipment checklist procedures to insure that:

(1) electronic and mechanical equipment are in proper operating condition at all times.

(2) aircraft are continuously maintained in a safe operating condition at all times.

(3) ~~the following medications and IV fluids in the minimum quantities indicated, are on board the aircraft and available to the emergency personnel:~~ all medications and intravenous fluids listed in the following chart are required to be on-board the aircraft and available to the emergency personnel. The minimum quantity specified shall also be maintained if identified in the chart.

DRUG (Generic Name)	WT/VOL	TRADE BRAND NAME	QUANTITY
Atropine Sulfate 10cc Jet	1mg/10cc	Atropine	2
Dextrose 50cc Jet	25mgs/50cc		2
Epinphrine 1:1000 Jet	1:10,000/10cc	Adrenalin	4
Isoproterenol HCL 1:5000	1mg/5cc	Isuprel	2
Furosemide 2cc	20mg/2cc	Lasix	4
Lidocaine HCL 5cc Jet	100mg/5cc	Xylocaine I.V.	4
Lidocaine HCL 25cc	1gm/25cc	Xylocaine I.V.	2
Morphine Sulfate 1cc	10mg/1cc		4
Naloxone HCL 1cc	0.4mg/1cc	Narcan	4
Sodium Bicarbonate 50cc	50.0mEq/50cc		6
Diazepam 2cc	10mg/2cc	Valium	4
Calcium Chloride 10cc	1000mg/10cc		2
Meperidine	100mg/1cc	Demerol	5
Dopamine 5cc	200mg/5cc	Intropin	4
Metaraminol 10cc	100mg/10cc	Aramine	4
Levarterenol 4cc	4mg/4cc	Levophed	4
Hydrocortisone Na Succinate Mix-O-Vial 4cc	500mg/4cc	Solu Cortef	4
I.V. FLUIDS			
500cc D.W	———	———	4
1000cc Lactated Ringers	———	———	6
1000cc Saline	———	———	2
SYRINGES			
1cc T.B.	———	———	5
3cc 21ga.	———	———	5
5cc 21 ga.	———	———	5
50 cc	———	———	2

MEDICATION	MINIMUM QUANTITY
atropine sulfate (to be packaged in pre-loaded syringes)	2mg
dextrose 50% (to be packaged in pre-loaded syringes)	100cc
epinephrine 1:10,000 (to be packaged in pre-loaded syringes)	4 mg
epinephrine 1:1,000	2 mg
furosemide	80 mg
lidocaine (to be packaged in pre-loaded syringes)	400 mg
lidocaine	2 gm
narcotic agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—
naloxone HCL	1.6 mg
sodium bicarbonate (to be packaged in pre-loaded syringes)	200 mEq
diazepam	20 mg
calcium chloride (to be packaged in pre-loaded syringes)	2 gm
vasopressor agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—
steroidal agent(s) (note: agent(s) and quantity at the discretion of the medical director of the paramedic organization)	—

EDICATION	MINIMUM QUANTITY
xtrose 5% in water	2000cc
ystalloid intravenous solution	8000cc
note: agent(s) and quantity at the discretion of the medical irector of the paramedic organization)	

c) ~~The advanced life support air ambulance rvice provider organization, upon written approval the sponsoring hospital and advanced life support ambulance service provider organization medical rector, may make additional drugs and/or dications available as deemed appropriate. wever, no drugs or medications may be carried on- ard the emergency response vehicle which have been approved.~~ The medications and IV fluids ferenced in 836 IAC 2-10-2(b)(3) are a minimum quirement. The air ambulance service provider ganization, upon written approval of the nsoring hospital(s) and the air ambulance rvice provider organization medical director y make additional medications and/or IV fluids ailable as deemed appropriate. However, no ugs or medications may be carried on-board the craft which have not been approved by the mmission. The specific narcotics, vasopressors, eriods, and crystalloid solutions shall be ntified as required in 836 IAC 2-10-2(b)(3) and current list shall be kept on file with the mmission. Said list shall include the names and antities of the medications and solutions ntified by the air ambulance service provider ganization medical director. A copy of said port is to be maintained on file at the sponsoring d, where applicable, the supervising hospital(s) the provider. The report shall include the names d quantities of the discretionary medications d IV fluids.

(d) All drugs and supplies are to be supplied by the nsoring hospital, or by written arrangement with a pervising hospital, on an even exchange basis. Lost, len or misused drugs will only be replaced on order the advanced life support air ambulance service vider organization medical director. NOTE: countability for distribution, storage, ownership d security of drugs and medications is subject to plicable requirements as determined by the State of diana Board of Pharmacy.

e) The advanced life support air ambulance rvice provider organization shall insure that the sic life support equipment as described in 836 IAC -6(n) pursuant to IC 16-1-39 is carried on-board each aircraft in addition to the equipment identified herein:

(1) Portable defibrillator with self-contained cardiac monitor and E.C.G. strip writer which will interface with the aircraft's electrical and radio system properly (Pediatric paddles are recommended)
(2) Nasopharyngeal airways in adult sizes
(3) Nasal cannulas
(4) Tracheal suction catheters sizes #10, #14, and #18
(5) Endotracheal intubation equipment to include laryngoscopes with spare batteries and bulbs for each, laryngoscope blades and endotracheal tubes in sizes ~~2.0, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, and 9.0~~ 3.0, 4.0, 5.0, 6.0, 7.0, 8.0, and 9.0.
(6) Intravenous and medication administration supplies to include:
(A) Intravenous administration sets appropriate to the intravenous fluid containers selected and required under 836 IAC 2-10-2(b)(3) in a minimum quantity of one (1) set per each required intravenous fluid bag or bottle.
(B) Syringes and needles in appropriate sizes and quantities identified by the medical director of the air ambulance service provider organization to facilitate the administration of medications listed under 836 IAC 2-10-2(b)(3) and the collection of blood samples.

(f) ~~Each advanced life support air ambulance service provider organization, upon written approval of the sponsoring hospital and advanced life support air ambulance provider organization medical director, may make additional equipment available as deemed appropriate.~~ The equipment and supplies referenced in 836 IAC 2-10-2(e) is the minimum requirement. The air ambulance service provider organization, upon written approval of the sponsoring hospital(s) and the air ambulance service provider organization medical director may make additional equipment and supplies available as deemed appropriate. Specific items listed in 836 IAC 2-10-2(e)(6)(B) air ambulances must be identified by the air ambulance service

rganization medical director and reported in vriting to the Commission for initial certification nd recertification. This reporting may be a part f the required report referenced 836 IAC 2-10-(c).

(g) A closed compartment, which shall be ubstantially constructed and equipped with a secure ocking device, shall be provided within the aircraft or storage of drugs and medications when the ~~aircraft~~ ircraft is not in use or unattended. Portable drug kits hall not be left on unattended aircraft unless adequate ecurity precautions have been taken as described in he Application for Advanced Life Support Air mbulance Service Provider Organization and pproved by the commission. *(Indiana Emergency Medical Services Commission; 836 IAC 2-10-2; filed Nov 3, 1980, 3:55 pm: 3 IR 2249; filed Oct 13, 1981, 10:05 m) NOTE: Effective Jan 1, 1982.*

SECTION 31. 836 IAC 2-10-3, as added at 3 IR 246, SECTION 43, is amended to read as follows:

836 IAC 2-10-3 General requirements for advanced life support air ambulance service provider organizations

Authority: IC 16-1-39-6; IC 16-1-40-3
Affected: IC 4-22-1; IC 16-1-39

Sec. 3. GENERAL REQUIREMENTS FOR ADVANCED LIFE SUPPORT AIR AMBULANCE SERVICE PROVIDER ORGANIZATIONS. (a) Any organization providing, or seeking to provide advanced life support services administered by medical personnel from an aircraft is required to be certified as an advanced life support air ambulance service provider organization by the commission.

(b) The advanced life support air ambulance service provider organization shall be certified as an air ambulance service provider in accordance with the requirements specified in the Rules and Regulations for the ~~Operation~~ Opeartion and Administration of Emergency Medical Services pursuant to IC 16-1-39.

(c) The provider of advanced life support services must insure that the aircraft used in conjunction with the provision of advanced life support services meets the guidelines as specified in 836 IAC 1-7 pursuant to IC 16-1-39, and is certified by the Indiana Emergency Medical Services Commission.

(d) Advanced life support air ambulance service provider organizations shall have agreed ~~by~~ to contract with one or more sponsoring hospitals for the following services:

(1) Continuing education
(2) Audit and review
(3) Medical control and direction
(4) Provide liaison and direction for supply of medications, fluids and other items utilized by the organization.

Said contract shall include a detailed description of how such services shall be provided to the advanced life support air ambulance service provider organization. In those cases where more than one (1) hospital contracts, or seeks to contract with an advanced life support air ambulance service provider organization as a sponsoring hospital, an inter-hospital agreement shall be provided to the commission which shall clearly define the specific duties and responsibilities of each hospital, to insure medical and administrative accountability of system operation.

(e) The advanced life support air ambulance service provider organization shall have a medical director provided by the advanced life support air ambulance service provider organization, or jointly with the sponsoring hospital, who must be a ~~physician~~ physical who holds a currently valid unlimited license to practice medicine in the State of Indiana ~~and~~ nad has an active role in the delivery of emergency care. The medical director shall be responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced life support air ambulance service provider organization. The duties and responsibilities of the medical director shall include, but not be limited to:

(1) providing liaison with physicians.
(2) assuring that the drugs, medications, supplies and equipment are available to the advanced life support air ambulance service provider organization.
(3) monitor and evaluate day-to-day operations.
(4) assist in the coordination and provision of continuing education.
(5) provide information concerning the operation ~~of~~ fo the advanced life support air ambulance service provider organization to the commission.
(6) provide individual consultation to the ~~emergency~~ paramedics and other medical personnel.
(7) participate on the assessment committee of the sponsoring hospital in the monthly audit and review of cases treated by ~~emergency~~ paramedics and other medical personnel.
(8) attest to the competency of ~~emergency~~ paramedics affiliated with the advanced life support air ambulance service provider organization to perform skills required of ~~an emergency~~ a paramedic under 836 IAC 2-5 of these rules and regulations.

(f) It is recommended that the advanced life

port air ambulance service provider organization part of an area-wide plan to coordinate emergency dical services with rescue, law enforcement, tual aid back-up systems and central dispatch, hen available.

g) Each advanced life support air ambulance vice provider organization shall:
(1) maintain an adequate number of trained personnel and aircraft to provide continuous 24 hour advanced life support services.
(2) notify the commission in writing prior to assigning any individual to perform the duties and responsibilities required of ~~an emergency~~ a paramedic pursuant to these rules and regulations [*836 IAC 2*].
3) notify the commission in writing within thirty (30) days of ~~an emergency~~ a paramedic's termination of employment, ~~or~~ for any reason which has prohibited a certified individual from performing the procedures required of ~~an emergency~~ a paramedic.

n) When advanced life support services, administered medical personnel affiliated with the advanced life port air ambulance service provider organization ganization are continued enroute to an emergency cility, as a minimum, the patient compartment of the craft shall be manned by not less than one (1) son. Said person shall be either ~~an emergency~~ a ramedic, registered nurse with extensive experience in rdiac care, intensive care and/or emergency partment nursing and who holds a valid advanced rdiac life support certification from the American art Association, or a physician with a valid limited license to practice medicine in Indiana. The lvanced life support air ambulance service provider ganization, when staffed pursuant to this rule [*836 C 2-10*], is exempted from 836 IAC 1-2-1(d).

(i) The advanced life support air ambulance vice provider organization shall notify the mmission in writing within thirty (30) days of any ange in the advanced life support services provided, for which certification has been granted.

j) Certification by the commission as an advanced e support air ambulance service provider is not uired:
(1) for a person who provides advanced life support while assisting in the case of major catastrophe, disaster, ~~or emergency,~~ whereby persons who are certified to provide emergency medical services or advanced life support are insufficient or are unable to cope with the situation.
(2) for an agency or instrumentality of the United States as defined in 836 IAC 2-1-1(d).

(k) After proper notice and hearing, the commission may suspend or revoke a certificate ~~and/or an endorsement~~ issued under these rules and regulations [*836 IAC 1 and 836 IAC 2*] for failure to comply and maintain compliance with, or for violation of any applicable provisions, standards, or other requirements of these rules and regulations [*836 IAC 1 and 836 IAC 2*].

(l) The commission may initiate proceedings to suspend or revoke a certificate ~~and/or an endorsement~~ and upon its own motion, or on the verified written complaint of any interested person, and all such proceedings shall be held in and conducted in accordance with the provisions of IC 4-22-1.

(m) Notwithstanding the provisions of these rules and regulations [*836 IAC 1 and 836 IAC 2*], the commission upon finding that the public health or safety is in imminent danger, may temporarily suspend a certificate ~~and/or an endorsement~~ and without a hearing for a period not to exceed thirty (30) days upon notice to the certificate holder.

(n) Upon suspension, revocation, or termination of a certificate ~~and/or an endorsement,~~ the provision of advanced life support services shall cease. *(Indiana Emergency Medical Services Commission; 836 IAC 2-10-3; filed Nov 3, 1980, 3:55 pm: 3 IR 2249; Errata 4 IR 531; filed Oct 13, 1981, 10:05 am) NOTE: Effective Jan 1, 1982.*

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6.6. OPERATIONAL AUTHORITY AT THE SCENE OF AN EMERGENCY

The Indiana General Assembly has not set forth, by statute, clearly delineated lines of authority and/or responsibility at the scene of emergencies.

Tort law has, over the years, created a de facto policy at the scene of accidents and homicides that charges law enforcement personnel with security of the scene, traffic control, and other legal aspects of the situation. Additionally, dependent upon the nature and scope of the emergency, non-medical responsibilities may be under the "jurisdiction" of fire department(s), Civil Defense, the county coroner, or other public safety agencies. Medical control and responsibility however, is the domain of emergency medical personnel (see definition below).

In 1977, the First Regular Session of the 100th General Assembly of the State of Indiana enacted Public Law 341 which states in part:

a. A person who knowingly or intentionally obstructs or interferes with an emergency medical person performing or attempting to perform his emergency functions or duties as an emergency medical person commits obstructing an emergency medical person, a Class B misdemeanor.

b. "Emergency medical person" means a person who holds a certificate issued by the Indiana Emergency Medical Services Commission to provide emergency medical care. (For entire legislation, see Section I 6.4 Compilation of EMS-related Statutes)

The EMS Commission does not believe that the enactment of legislation is the complete answer to all on-the-scene jurisdictional problems. Rather, education of the role that all responders play, and mutual understanding and cooperation is the key to improved coordination at the emergency scene.

III. EMS SYSTEM COMPONENTS AND AFFECTING EMS COMMISSION REGULATORY STANDARDS

As emergency ambulance service grew into Emergency Medical Service, it became apparent that due to its complexity and far-reaching involvement, it was best to view EMS from a "systems" approach.

Throughout the country, at both the state and federal level, patterns began to emerge in EMS planning and administration. These have evolved and merged into some 16 "components" that aid in conceptualizing and planning EMS as a system. As stated in Section I, Facilities and Critical Care Units have been combined in this plan.

Following is a definition of each of these 15 components and a citation of the EMS Commission Rules and Regulations affecting them. If no rule nor regulation exists for a particular component, this is so noted. (The complete Rules and Regulations for the Operation and Administration of EMS are included in Section I, 6.5).

1. MANPOWER Definition: This component concerns the adequate number of health professionals, allied health professionals, and other personnel, with appropriate training and experience to provide EMS 24 hours/day, 7 days/week.

Regulatory Standard: The Rules and Regulations promulgated by the EMS Commission call for, at the Basic Life Support level, one certified EMT to be in the patient compartment of every ambulance when transporting an emergency patient. At the Advanced Life Support - Paramedic level, one certified Emergency Paramedic and one certified EMT are required to be on board the ambulance at the time of dispatch; during transportation, one certified Emergency Paramedic must be in the patient compartment.

2. TRAINING Definition: In a comprehensive EMS system training should be available which is 1) both initial and continuing in nature, 2) at a cost reasonable to the student, and 3) coordinated throughout the system's service area.

Regulatory Standard: Through its Rules and Regulations, the EMS Commission has set forth guidelines for the training and certification of EMT's, Advanced EMT's, and Emergency Paramedics. The EMT and Emergency Paramedic training requirements meet or exceed those established by the U.S. Department of Transportation.

3. COMMUNICATIONS Definition: A comprehensive EMS system should include linkages between personnel, facilities, and equipment (preferably at a common, central dispatch center) so that requests for emergency medical care will be handled by a facility that 1) utilizes emergency telephonic screening; 2) utilizes or will utilize the universal 9-1-1 emergency telephone number, or an equivalent seven-digit number; and 3) will have direct communications connections and interconnections with personnel, facilities, and equipment of the system and with surrounding EMS services.

Regulatory Standard: The Basic Life Support Rules and Regulations require that every ambulance be equipped with multi-channel 2-way radios, one channel of which must be 155.340 (IHERN). Advanced Life Support ambulances must contain UHF telemetry equipment. For a hospital to be a Supervising or Sponsoring Hospital, it must have a UHF telemetry base station.

Although not a promulgated rule, those hospitals categorized to the Emergency, General, or Comprehensive level must have an IHERN (155.340) base.

4. TRANSPORTATION Definition: An EMS system must include the adequate number and proper distribution of appropriately equipped emergency vehicles to meet the needs of the area.

Regulatory Standard: The Rules and Regulations establish a list of required equipment and design criteria for ambulances. They also require providers to demonstrate the capability to service their proposed area of coverage.

5. FACILITIES / CRITICAL CARE UNITS Definition: The EMS system must include the necessary numbers and types of easily accessible emergency medical service facilities and specialized critical medical care units (trauma, neonatal, cardiac, poison, psychiatric, and burn).

Regulatory Standard: The EMS Commission has set forth guidelines for classifying hospital emergency departments based upon their equipment, staffing patterns, and quantity of services provided.

6. PUBLIC SAFETY AGENCIES Definition: An EMS system must provide for effective utilization of appropriate personnel, facilities, and equipment of each public safety agency in the area, with sharing of resources and personnel as appropriate. "Effective utilization" means the integration of public safety agencies into standard EMS and disaster operating procedures of the system. It also includes the shared use of personnel and equipment, such as helicopters and rescue boats, appropriate for medical emergencies.

Regulatory standard: The EMS Commission does not have the authority, nor believes it appropriate to dictate relationships between EMS providers and other public safety agencies. The Commission does, however, recognize the importance of these relationships and therefore encourages cooperation and understanding between agencies.

7. CONSUMER PARTICIPATION Definition: An EMS system must be structured such that the non-EMS-affiliated lay public may participate in policy making.

Regulatory Standard: There are, by statute, three persons who "shall be representatives of the public at large who are in no way related to emergency medical services" on the Indiana Emergency Medical Services Commission.

8. ACCESS TO CARE Definition: The EMS system must provide necessary emergency medical care to all patients, regardless of their ability to pay.

Regulatory Standard: "An ambulance service provider shall not engage in conduct or practices detrimental to the health and safety of emergency patients...while in the course of doing business..." (836 IAC 1-2-3 (b)(1)(3)

9. TRANSFER OF PATIENTS Definition: A comprehensive EMS System must provide for the efficient transfer of patients between emergency medical care facilities and critical care units, through written pre-transfer and transfer protocalls.

Regulatory Standard: The EMS Commission does not regulate the transfer of patients between health care facilities. However, if the patient being transferred is emergent, the Commission Rules and Regulations do apply.

10. COORDINATED MEDICAL RECORDKEEPING Definition: The EMS System should have a coordinated medical recordkeeping system that may be used in evaluating the system's inpact and appropriateness by facilitating the following of the patient's care from on-the-scene through final disposition. In addition, quality patient care in the emergency department can often be facilitated by their receiving a history, vital signs, and assessment from the scene, at the same time the patient arrives at the emergency department.

Regulatory Standard: The Basic Life Support rules and regulations state that "Each ambulance service provider shall maintain accurate records concerning the transportation of each emergency patient within the state including an ambulance and rescue record on a form prescribed by the Commission."

The Advanced Life Support rules and regulations state that "Each provider organization shall maintain accurate records concerning the emergency care provided to each patient within the State which may include a Rescue Record and Report Form prescribed by the Commission. It is recommended that the following data be maintained in order to evaluate the program.

(1) Number of runs
   A. cardiac
   B. trauma
      i. automobile accidents
      ii. other
   C. overdose
   D. medical emergencies, i.e., diabetic, respiratory, etc.
   E. miscellaneous, i.e., obstetrical cases

(2) Number of telemetered runs

(3) Call load/day

(4) Number of cases requiring resuscitation measures
   A. number defibrillated
   B. number requiring CPR only
   C. number resuscitated from cardiopulmonary arrest to having a palpable pulse and hospital admission
   D. operational difficulties; i.e., equipment problems, communication problems, other persons on the scene, etc.

11. PUBLIC INFORMATION AND EDUCATION Definition: An EMS system should provide programs of public education and information for all people in the area so they know about the system, how to access it, and how to use it properly.

Regulatory Standard: The EMS Commission has no promulgated rule governing PI and E, however, the Commission has endorsed various Regional and local Public Information and Education programs and seminars. It has also published and distributed a state EMS Newsletter (The "Communicator")

12. EVALUATION Definition: An EMS system should provide for periodic, comprehensive, and independent review and evaluation of the extent and quality of the emergency health care services provided in the system.

Regulatory Standard: To facilitate the evaluation process, the EMS Commission requires each ambulance service provider to maintain accurate records of their operations. (See Coordinated Medical Recordkeeping above)

13./14. DISASTER LINKAGE and MUTUAL AID AGREEMENTS Definition: Anytime the demand for Emergency Medical Services exceeds the available resources to meet that need, and in times of gross natural or man-made disasters, there is a need for cooperation between EMS providers and other public safety agencies, in order to coordinate efficient response and allocation of resources.

Regulatory Standard: The EMS Commission does not have the authority, nor believes it appropriate to dictate relationships between EMS providers and other public safety agencies. The Commission does, however, recognize the importance of these relationships and therefore encourages cooperation and understanding between agencies through written community and EMS disaster plans and Mutual Aid Agreements.

15. SYSTEM MANAGEMENT Definition: Due to its complexity and importance, a comprehensive EMS system must have a recognized, formal method of management and administration which servies to maintain and direct the system.

Regulatory Standard: IC 16-1-39 created the Indiana Emergency Medical Services Commission which is the lead agency for EMS in the state.

IV. PROGRAM OBJECTIVES AND IMPLEMENTATION

This section begins with a general description of the Emergency Medical Services System and the linkages between the fifteen identified components.

Following that is the overall goal statement for the development and maintenance of a comprehensive EMS system for the State of Indiana. Also included are the specific Sub-Goals, Objectives, and Activities for each component of the system, necessary for system success.

As one reads this document, it is apparent that only by the active involvement of all the public and private, consumer and provider, agencies and individuals cited in this section can a truly comprehensive system of Emergency Medical Services be established and maintained in Indiana.

It is further noted that the Objectives and Activities called for in this State Plan are designed to stimulate regional and local planning activities that will result in more specific and quantifiable objectives and activities in tune with unique local needs, resources, and constraints.

The format used to present each component of the system is:

Component Sub-Goal
Component Sub-Goal Discussion
Objective (Often more than one)
Objective Discussion (Where necessary)
Activity (Often more than one)

Included in each activity is the identification of what entity(-ies) is (are) involved in the activity. Responsible entities are also referenced and cross-referenced in Section VI, Program Resource and Commitment Summary.

The implementation time-table for each activity is contained in Section V, Implementation Schedule.

NOTE FOR THE 1981 STATUS REPORT:

PRESENTED IN THIS SECTION, AS IN THE ORIGINAL PLAN, ARE THE COMPONENT SUB-GOALS, OBJECTIVES, AND ACTIVITIES NECESSARY TO DEVELOP A COMPREHENSIVE EMS SYSTEM IN INDIANA.

TO DETERMINE THE STATUS OF A PARTICULAR ACTIVITY, READERS ARE REFERRED TO SECTION V, IMPLEMENTATION SCHEDULE.

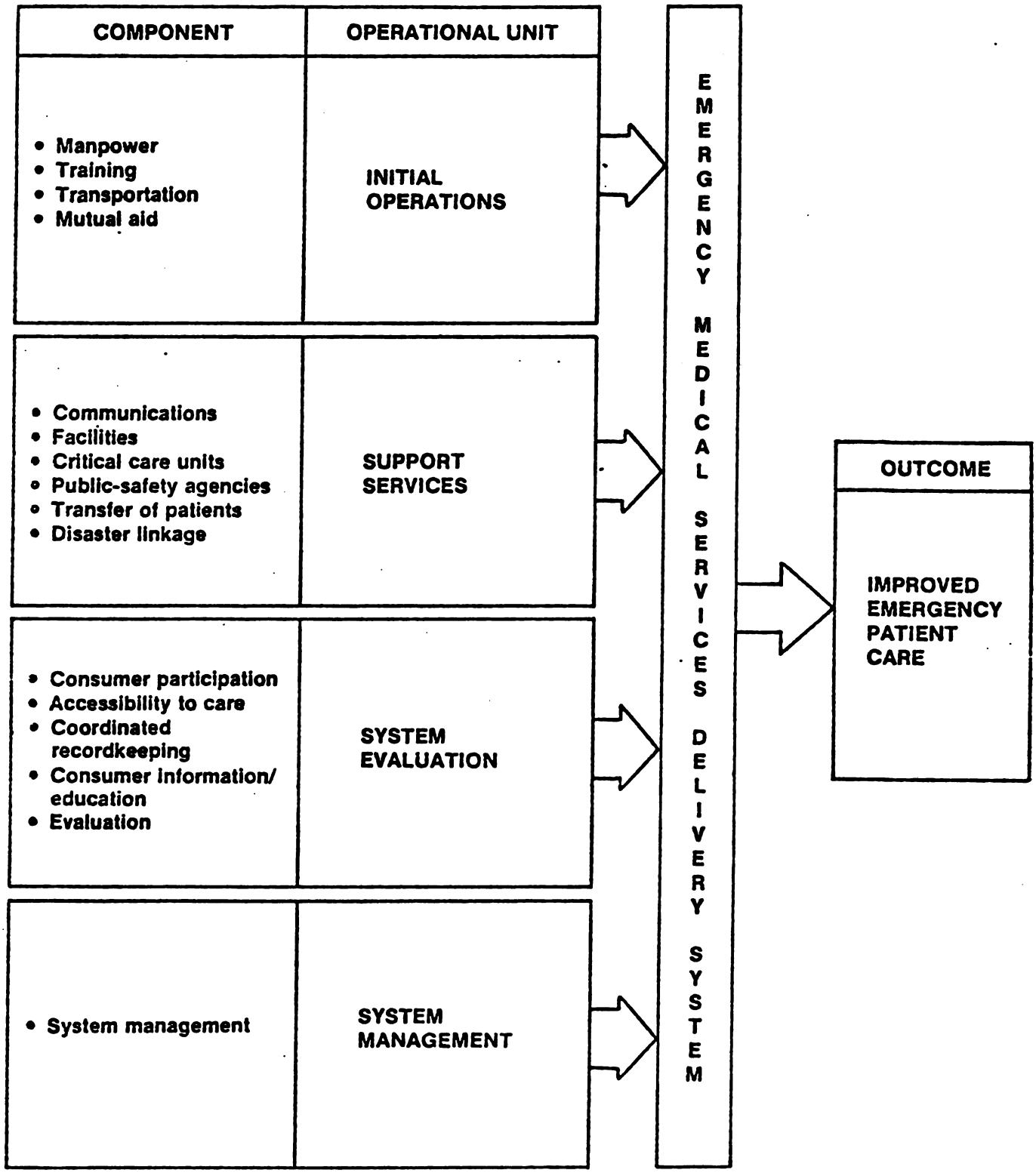
1.0. THE EMERGENCY MEDICAL SERVICES SYSTEM

The "system" of emergency medical services is a continuum of patient care from the onset of injury or illness through maximum patient rehabilitation. In the true "systems approach" to EMS planning, operations and management should be evaluated upon:

1. Ready citizen access to the system,
2. Effectiveness of pre-hospital emergency care administered and transportation services provided,
3. Actual hospital capabilities within the EMS region and surrounding areas,
4. Availability of definitive care services as well as rehabilitation services to enable maximum patient care and rehabilitation.

The following illustration outlines the components of an EMS System, the operational linkage of the components, and the outcome to be expected if the components are identified, linked and managed successfully in initial planning.

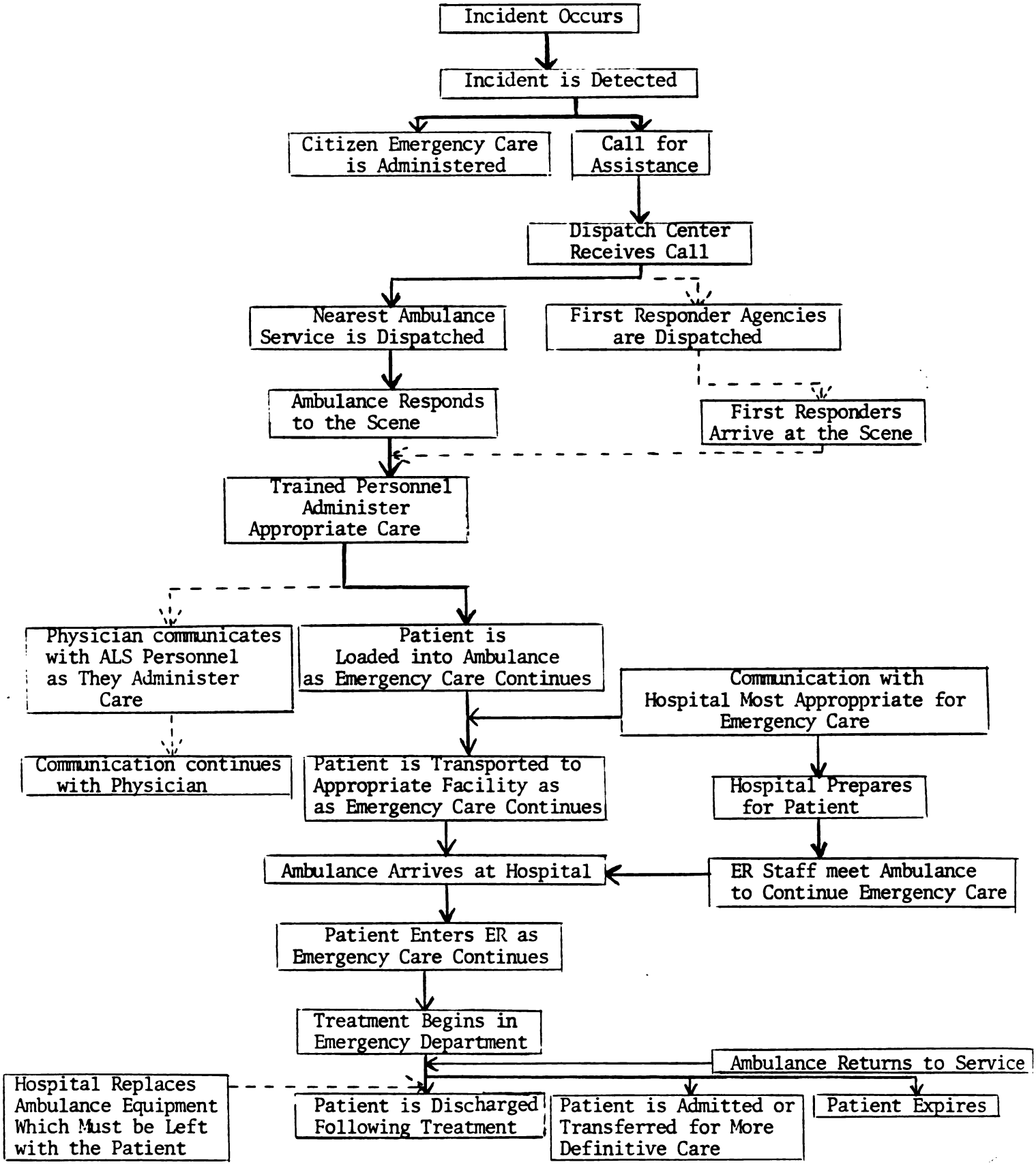
THE EMERGENCY MEDICAL SERVICES SYSTEM



Source: Central Indiana Emergency Medical Services Council

To further illustrate the systems concept of emergency medical services, the flow chart which follows displays the linkages of the components. The operational linkages and inter-relationships of the components are seen throughout the entire system.

THE ACTIVATED EMS SYSTEM



2.0. GOAL STATEMENT

TO PROMOTE THE DEVELOPMENT AND MAINTENANCE OF A COMPREHENSIVE SYSTEM OF EMERGENCY MEDICAL SERVICES WHICH SHALL INSURE THAT ALL EMERGENCY PATIENTS RECEIVE PROMPT AND ADEQUATE MEDICAL CARE THROUGHOUT THE RANGE OF EMERGENCY CONDITIONS ENCOUNTERED.

Rationale: The provision of a comprehensive system of emergency medical services is of vital concern to all. An EMS system is developed on the premise that death and disability may be reduced if designed realizing that systematic planning and operation of emergency medical services requires strong involvement by state government, financial participation by local governments, clear and strong medical leadership at the local level, and medical supervision over the care and management of emergency patients in conjunction with the hospitals in each area.

In 1977, motor vehicle accidents numbering 213,739 (State Board of Health, Indiana Plan for Health, 1979) accounted for 1,256 deaths in Indiana and 66,319 injuries. Accidental deaths other than motor vehicles numbered 1,258 in 1977. Motor vehicle deaths ranking fifth and other accidents ranking sixth as leading causes of death in Indiana places a major focus on the EMS program in Indiana in the reduction of deaths from accidents.

In addition to the accidental death rates in Indiana being diminished by EMS, the Indiana Plan for Health also focuses on EMS for the reduction of deaths due to heart and cardiovascular diseases within the state. In 1977, a total of 17,938 deaths in Indiana were attributed to heart diseases. Deaths from cerebrovascular disease (stroke) totaled 5,928, and these deaths combined with the deaths attributed to heart diseases account for the leading cause of mortality in Indiana.

The Indiana Emergency Medical Services Act, P.L. 55, Acts of 1974, created the Indiana Emergency Medical Services Commission with the purpose and intent that the Commission would,"...promote the establishement and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to insure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encounterd." Although the Commission has developed and enacted rules and regulations for the operation and administration of ambulance services in Indiana, these regulations are merely a base - the minimum requirements for operating a service in Indiana. The Certified ambulances and the certified personnel who operate them are only portions, albeit important, of a comprehensive system of emergency medical services. The rules and regualations have served as a frame-work to better EMS in Indiana. However, to achieve the stated over-all goal, the EMS systems currently established and those yet to be designed throughout the state, must address all aspects and components of an emergency medical services system.

The Commission, therefore, promotes the development of a statewide emergency medical services systems which meets all minimum requirements outlined in the rules and regulations and recommends that all components of an EMS system be addressed as outlined in this plan to meet the statewide goal.

3.1. MANPOWER Sub-Goal: There will be sufficient numbers and adequate distribution of trained EMS personnel, including CPR and first-aid trained citizens, public safety agency First Responders, EMTs, Advanced EMTs, Paramedics, Primary Instructors, Dispatchers, Emergency Department and Critical Care Unit Nurses, Emergency Department Physicians, and EMS Management personnel to provide Emergency Medical Services 24 hour/day, 7 days/week.

Discussion: The range of manpower in a comprehensive EMS system extends from citizens capable of performing CPR at the scene, to the trained emergency physician in the hospital emergency department, to professionals with expertise in management of the system. The following have been identified as essential categories of manpower in the EMS system in Indiana:

1) Citizens trained to administer CPR
2) Citizens trained to administer first aid
3) Public Safety Agency First Responders
4) Dispatchers
5) Emergency Medical Technicians (EMTs)
6) Advanced EMTs
7) Emergency Paramedics
8) Emergency Department Nurses
9) Critical Care Unit Nurses
10) Emergency Department Physicians
11) EMS System Management Personnel
12) Instructors for all categories of manpower
13) Extrication Personnel

In designing a comprehensive EMS system, the appropriate numbers of all emergency health care professionals and trained lay people must be determined from the expected frequency of emergency situations in the area, and special consideration given to any unique variables or contraints in the area.

However, the Commission has established the following recommendations for certain of the identified categories:

CPR Trained Citizens

The EMS Commission on May 25, 1976, adopted a resolution endorsing the training of one of every five adults over the age of sixteen in the use of Cardiopulmonary Resuscitation. Nationwide, research studies have indicated that in areas where a high percentage of the citizenry is proficient in CPR, a significant number of lives can be saved. The prime example is in King County, Washington, where statistics indicate that when CPR is initiated within 5 minutes of cardio-respiratory arrest, 35% of the victims can be saved.

Therefore, the EMS Commission reiterates its 1976 resolution, and further promotes the availability of a person trained in CPR with 3-5 minutes whenever and wherever a cardio-respiratory arrest occurs. Viewed from yet a third perspective, the EMS Commission feels that at least one person per household should possess skills in CPR. When these three recommendations are combined, and training is conducted to meet them, a significant decrease in cardio-respiratory arrest deaths should be realized in Indiana.

First-Aid Trained Citizens

The EMS Commission recognizes that many acute illnesses and injuries could be dealt with more successfully if they were recognized and treated immediately.

In some cases, the initial care given prior to the arrival of an ambulance or public safety agency can literally mean the difference between life and death, or between a quick uneventful recovery and a lengthy, involved hospital stay.

The Commission, therefore, recommends that the adequate number of First Aid trained citizens be the same as for those with CPR training - one in five adults, one per household, and available within 3-5 minutes.

Emergency Medical Technicians (EMTs)

Minimum staffing requirements for ambulance services providing Basic Life Support have been established by the Commission through duly promulgated rules and regulations. (These may be found in Sections II and III of this plan.) However, these requirements pertain only to the staffing of individual ambulances when transporting patients, not to the number of trained persons necessary to provide service to an area 24 hours/day, 7 days/week.

The Commission has, therefore, adopted the following staffing schedule for planning purposes:

1) Volunteer ambulance service only - 20 EMTs for the first 50 calls per month average; plus 5 additional Basic EMTs for every 10 calls per month over 50.
2) Volunteer fire department ambulance service - 20 EMTs for the first 30 ambulance calls per month average; plus 5 additional Basic EMTs for every 10 calls per month over 30.
3) Full-time paid service (including funeral home and hospital-operated services) - 6 EMTs for each vehicle which is routinely operated.

Advanced Emergency Medical Technicians

For planning purposes, 5 Advanced EMTs per vehicle is recommended for paid services, and 10 per vehicle for volunteer services.

Emergency Paramedics

Providers of Advanced Life Support have historically offered Emergency Paramedic training for those individuals in their organization who have proven their capabilities as EMTs.

In view of this "train-from-within" practice, Emergency Paramedic manpower is more appropriately addressed by individual providers of Advanced Life Support, as long as they meet the minimum rule and regulation requirements of the Commission. However, for planning purposes, a ratio of 5 Emergency Paramedics per each vehicle routinely used for Advanced Life Support is recommended.

Emergency Department Nurses

NOTE: It is clearly recognized that the rule and regulatory authority of the EMS Commission is limited to the provision of pre-hospital emergency care and transportation. However, when viewing Emergency Medical Services as a "system", Emergency and Critical Care Nurses and Emergency Physicians must be considered.

The emergency department nurse represents an essential component in the

continuum of care provided in the pre-hospital phase. The number of nurses required to staff emergency departments is a responsibility of the individual emergency-patient receiving hospital.

To provide a uniform standard of measurement, the Commission recommends a staffing schedule for specialty-trained emergency department nurses based upon patient volume per shift. It should be noted that the recommendations pertain only to those Registered Nurses dealing directly with patient care and do not include Registered Nurses with primarily administrative responsibilities, nor Licensed Practical Nurses who in many institutions play an important role. Adjustments in staffing must also be made to accommodate increased or decreased patient load periods. The recommended staffing is:

1) 0-25 patients per shift - 1 ED-RN/shift
2) 26-40 patients per shift - 2 ED-RNs/shift
3) 41-60 patients per shift - 3 ED-RNs/shift
4) 61 or more patients per shift - 4 or more ED-RNs/shift

Critical Care Nurses

Determining the number of registered nurses required to staff coronory care and/or intensive care units is a responsibility of each hospital based upon occupancy and specialty services available.

A ratio of one critical care nurse per shift for every two critical care beds is recommended.

Emergency Department Physicians

The number of physicians proficient in Emergency Medicine per hospital emergency department is appropriately determined by individual hospitals and their medical staffs. The Commission recommends, however, that hospitals offering emergency medical care have at least one Emergency Physician in-house at all times.

In order to meet the manpower sub-goal, the Commission has formulated the following Objectives and Activities.

Objective 1.1: To identify existing EMS manpower resources.

Activity 1.1.A: The EMS Commission will develop an inventory methodology and survey instrument.

Activity 1.1.B: The EMS Commission will conduct an initial manpower survey and collate the data.

Objective 1.2: To determine the adequacy of existing EMS manpower resources and/or the need for additional personnel.

Activity 1.2.A: The Regional Coordination Center (RCC) will compare the manpower inventory with staffing schedules and determine where the need for additional manpower exists.

Activity 1.2.B: After designation each RCC will conduct a regional manpower inventory update every two years. Results of this inventory will be reported to the Commission.

3.2. TRAINING Sub-Goal: There will be available throughout the State, at a reasonable cost to the student, sufficient educational programs (both initial and continuing education) to provide the manpower at all levels necessary to insure EMS 24 hours/day, 7 days/week.

Discussion: Quality emergency medical care is dependent upon the training and abilities of those attending to victims; regardless of whether the care is given at the scene, enroute to the emergency facility, or in the emergency department. For this reason, the Commission considers Training to be a priority component of the EMS system.

The Commission, in most instances, is not a provider of EMS training programs; however, promotion and guidance in developing and maintaining educational programs through training institutions is a primary function of the Commission.

In order to meet the Training Sub-Goal, the Commission has formulated the following Objectives and Activities.

Objective 2.1: To promote the training of one of every five adults over the age of 16 in CPR.

Discussion: The American Heart Association and the American Red Cross have to date, been the main impetus for the development of CPR training courses and the teaching of the courses. Their efforts are laudable and should continue as the EMS system develops

In addition, many local providers have found it to be to their advantage to offer these classes to their citizens. Not only do these provider-offered courses improve emergency medical care in their service area, but they also are one of the best and most cost effective methods of Public Information and Education available to the individual provider.

The certification of high school health teachers as CPR instructors and the inclusion of CPR courses into the curriculum of secondary schools would provide a forum for the establishment of an appreciation of proper EMS uses and basic resuscitative techniques in the state's young adult population and establish a sound base for citizen EMS.

Activity 2.1.A: Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, hospitals, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.

Activity 2.1.B: The EMS Commission will pursue the inclusion of Basic CPR instruction into the core requirements for secondary education in Indiana.

Objective 2.2: To promote the training of one of every five adults over the age of 16 in basic First Aid techniques.

Activity 2.2.A: Local affiliates of the ARC, local EMS providers, high schools, universities, hospitals, and various community and civic organizations will conduct basic First Aid classes, in cooperation with the RCC, to meet the identified needs of the region.

Activity 2.2.B: The EMS Commission will pursue the inclusion of basic

First Aid instruction into the core requirements for secondary education in Indiana.

Objective 2.3: To provide training for EMS system management/administrative personnel on two levels; the ambulance service provider manager/superviser, and the multi-entity EMS system planner/administrator.

Discussion: Structurally the EMS management hierarchy has traditionally been bottom heavy, that is; many individuals to provide the medical care (EMTs, Paramedics, etc.) and very few individuals with the necessary background and education to effectively manage or administer a sophisticated EMS system.

Management and administrative personnel must be provided with opportunities to develop and sharpen their skills with respect to personnel management, budgeting, planning, grantsmanship and other skills necessary to remain viable in today's EMS environment. Management courses of a seminar nature have been conducted in Indiana in the past. Currently, two hospitals are working in conjunction with institutions of higher education to develop an associate's and bachelor's degree program in EMS system management. Any course designed to meet this need must be developed to provide instruction at two levels: 1) the ambulance service provider manager, and 2) the EMS system administrator.

Activity 2.3.A: The EMS Commission, in cooperation with the Indiana Hospital Association, the Health Systems Agencies, Central Indiana EMS Council, Northeastern Indiaan EMS Council, and other entities deemed appropriate will identify the necessary course content, curriculum, instructional strategies and course production requisites.

Activity 2.3.B: The EMS Commission will encourage the RCCs to include these management courses in their training activities and will make these curricula available to other educational institutions including EMT training institutions.

Activity 2.3.C: The EMS Commission will encourage the development of EMS management degree programs at the Associate, Bachelor's and Master's levels.

Objective 2.4: To promote the training of public safety agents (law enforcement, fire, etc.) whose primary function is other than the provision of emergency medical service, to the level of the DOT's Emergency Medical Service First Responder.

Discussion: The importance of the Public Safety Agency First Responder in an EMS system has become increasingly visible in recent years. Areas throughout the State have developed local EMS systems utilizing many different First Responder organizations as integral parts of their system.

The U.S. Department of Transportation has developed a 40-hour Emergency Medical Services First Responder Training Course for indivuduals who routinely respond first to the scene of an emergency, but for other than a primarily medical purpose. This program essentially teaches individuals the basic medical skills for stabilizing an ill or injured person in instances where transportation is provided by another agency

In the past, there has been little effort to insure that the skills mastered in the EMS First Responder training course are maintained. Therefore, the

Commission recognizes a responsibility to create a voluntary certification mechanism for EMS First Responders and to promote the continuing education of these individuals in order to assure proficiency of skills.

Activity 2.4.A: The EMS Commission will develop a program for the voluntary certification of Emergency Medical Service First Responders.

Activity 2.4.B: Emergency Medical Service First Responder Training Courses will be conducted throughout the state through the efforts of the RCCs, the Law Enforcement Training Academy, and local EMS providers and public safety agencies.

Objective 2.5: To promote the training of dispatchers at Public Safety Answering Points (PSAPs) and/or Communications Medical Emergency Dispatch (CMED) centers, utilizing at a minimum, the DOT Dispatcher Training Course.

Discussion: The Emergency Dispatcher plays a key role in an Emergency Medical Services system. A competent dispatcher can (1) extract pertinent information from the calling public (emotionally charged), (2) determine what types of services are required, (3) provide guidance, both medical and otherwise to the caller before responding units arrive, and (4) coordinate the activities of all responders in the area.

The U.S. Department of Transportation has developed a training course for EMS dispatchers which serves to orient the individual not only to the hardware of communications, but to procedures as well.

Activity 2.5.A: The RCC's will determine the need for Dispatcher training in their region.

Activity 2.5.B: The RCC's will coordinate the provision of Dispatcher training based on the identified need.

Objective 2.6: To promote EMT training programs to insure that manpower is available to provide Emergency Medical Service 24 hours/day, 7 days/week.

Discussion: The determination of need for additional EMTs in each region has been addressed in Manpower Objectives 1.2. However, many individual EMS providers feel that optimal patient care results when both the attendant and driver are certified EMTs, and this may create an additional need for EMTs in some regions. Two EMTs in the response vehicle upon dispatch is recommended.

Activity 2.6.A: The RCCs will determine the need for EMT and DOT Refresher Training Courses in their regions.

Activity 2.6.B: The EMS Commission approved training institutions, coordinated through the RCC, will conduct EMT and DOT Refresher Courses to meet the identified need.

Objective 2.7: To provide training for Primary Instructors to insure the availability of insturctors for EMT and Refresher Training courses.

Discussion: Just as quality emergency medical care is dependent upon the qualifications and abilities of those rendering the care, quality educational experiences are dependent upon the instructor. In 1977, the EMS Commission set forth requirements for those persons instructing EMT courses. In 1980, the Commission amended its rules and regulations to require the Refresher

Training Course also be taught by an accredited Primary Instructor, after January 1, 1981.

Activity 2.7.A: The RCCs will determine the need for Primary Instructors in their regions.

Activity 2.7.B; The EMS Commission, in conjunction with the RCCs, and approved training institutions, will conduct Primary Insturctor Workshops, to meet the identified need.

Objective 2.8: To encourage the provision of Advanced Life Support Training programs.

Discussion: When seeking to provide Advanced Life Support training programs, communities and providers must approach training in a rational manner. The community, when designing training programs, must address certain considerations before entering into the actual training of students.

First, the community must identify the constituency who will benefit from the provision of Advanced Life Support, i.e., high incidence of senior citizens; large number of multi-lane highways; or immense clustering of industry.

Secondly, the community must identify the available manpower resources who will be providing services. Many times a service will simply not be able to provide the manpower necessary to insure 24 hour service. In other cases, it may require two or more classes to meet the 24 hour service requirement of the EMS Commission rules and regulations.

Finally, the community must determine the scope (level) of Advanced Life Support services to be provided in the community. Having identified the area, the constituency, and ambulance service proficer resources, the community is in a position wo make a rational decision regarding the level to which the EMT will be trained in Advanced Life Support. Presently, there are two levels of training approved by the EMS Commission. They are: 1) the DOT Paramedic Training Course, a modularized training course; and 2) the Advanced EMT program which is locally designed and locally structured. When the community has determined the scope of their service, the community is then prepared to begin the process of training students in Advanced Life Support.

Activity 2.8.A: The RCCs will determine the need for, and level and scope of Advanced Life Support training regionally.

Activity 2.8.B: The RCCs will coordinate the regional training activity of Advanced Life Support training institutions to meet the identified need.

Objective 2.9: To encourage initial and continuing education programs to insure proficiency in Emergency and Critical Care nursing skills.

Activity 2.9.A: The EMS Commission will cooperate with concerned institutions and appropriate nursing organization, including the Indiana State Nurses Association and the Emergency Department Nurses Association, to assist in the development and administration of Emergency and Critical Care nursing training programs.

Activity 2.9.B: The RCCs will determine Emergency and Critical Care nursing training needs regionally.

Activity 2.9.C: The RCCs will coordinate the provision of Emergency and Critical Care continuing education programs based on the identified need.

Objective 2.10: To encourage initial and continuing education in Emergency Medicine for emergency department physicians.

Activity 2.10.A: The EMS Commission will cooperate with, and encourage the Indiana Chapter of American College of Emergency Physicians, and the Emergency Medicine Section of the Indiana State Medical Association to determine the appropriate skill level of physicians working in emergency departments.

Activity 2.10.B: The EMS Commission will encourage the establishment of training programs to meet the need for maintaining specific skills identified in Activity 2.10.A.

Activity 2.10.C: The RCCs will identify the need for training of Emergency Department Physicians based upon the skill levels developed in Activity 2.10.A.

Activity 2.10.D: The RCCs will coordinate training programs for Emergency Department Physicians to meet the identified need.

Objective 2.11: To promote extrication training programs throughout the State.

Discussion: The Emergency Medical Services Commission recognizes the need to improve extrication services in the state. Not only does the need exist for extrication tools and devices, but there is also the need for qualified, trained individuals to use these tools. No matter how sophisticated the equipment a service has, it can be dangerous in untrained hands.

Activity 2.11.A: The EMS Commission will train at least there (3) persons per extrication service as instructors in state-of-the-art extrication techniques.

Activity 2.11.B: EMS Commission trained extrication instructors within each extrication service provider organization will conduct training and continuing education programs for all extrication personnel in their organization in cooperation with the RCCs.

Activity 2.11.C: The EMS Commission will purchase and distribute extrication training equipment to extrication services to assist the Commission trained extrication instructors.

Objective 2.12: To train drivers of emergency ambulances and other EMS vehicles in defensive and emergency driving, using as a minimum, the DOT's "Training Program for Operation of Emergency Vehicles".

Discussion: The Training Program for Operation of Emergency Vehicles includes basic instruction on the safe operation of an emergency vehicle. This course represents the only exposure to a structured approach to emergency driving recieved by many vehicle operators.

The Indiana Law Enforcement Training Academy is constructing a Defensive Driving range in Plainfield, Indiana that will be available to all emergency vehicle operators upon completion (late 1980).

Activity 2.12.A: The EMS Commission and the RCCs will identify the need for emergency driving training regionally.

Activity 2.12.B: The EMS Commission will cooperate with the Law Enforcement Training Academy, the RCCs, and other concerned agencies in conducting classes to meet identified needs.

Activity 2.12.C: The EMS Commission and the Traffic Accident Investigations System Working Committee will develop a system to identify emergency vehicle accidents.

Objective 2.13: To promote classes in Hazardous Materials for EMS personnel.

Discussion: Indiana has been identified as having one of the highest volumes of transportation of Hazardous Materials on highways and railways in the country. These vehicles often are involved in motor vehicle accidents or derailment, which in turn, causes major damage to the environment and adversely affects the health and welfare of the public. Therefore, it is necessary to promote awareness of Hazardous Materials among EMS personnel. EMS personnel are called upon to provide treatment and transportation to victims of these accidents. In order to protect the EMS response personnel from the deleterious effects of a hazardous materials spill, an acute awareness of the effects of hazardous materials must be instilled in the minds of those persons. EMS personnel must be trained to identify hazardous materials; make appropriate calls to fire departments, law enforcement agencies, State Civil Defense, and State Board of Health. In addition, the EMS personnel must be trained to have an awareness and appreciation of the severity of the incident, and the need to cooperate with the coordinating agencies as outlined above.

Activity 2.13.A: The EMS Commission will work in cooperation with the Indiana State Police; State Civil Defense; and the State Board of Health to promote awareness of the dangers of hazardous materials among public service professionals.

Activity 2.13.B: The EMS Commission will identify Hazardous Materials training programs offered by the State Board of Health, the DOT, and the National Fire Protection Association.

Activity 2.13.C: The EMS Commission will provide technical assistance to the RCCs and coordinate the provision of such courses regionally.

Activity 2.13.D: The EMS Commission will provide one copy of "DOT Emergency Action Guide for Selected Hazardous Materials" to each certified provider and each ambulance.

3.3. COMMUNICATIONS Sub-Goal: There will be coordinated communications capabilities which will be responsive to EMS system needs.

Discussion: A vital component of the EMS system is communications capabilities which include easy public access to the system, a reliable inter-face of communications between pre-hospital and hospital emergency medical personnel, and the coordination of available resources.

Recognizing the importance and far-reaching impact of the communications component, the Commission in 1979 developed and adopted the "State of Indiana Communications Plan for Emergency Medical Services". (See Appendix)

The following Objectives and Activities are, in part, extracted from the Communications Plan.

Objective 3.1: To designate Regional Medical Communications Centers (RMCC's).

Discussion: Through the activities of an RMCC, the use of all medical radio communications channels within the region may ultimately be coordinated. Inter-regional communications will also be the responsibility of the RMCC, and will be conducted primarily on IHERN 155.280 MHz inter-hospital frequency.

Activity 3.1.A: The RCC's will recommend for Commission approval, Regional Medical Communication Centers (RMCC's).

Activity 3.1.B: The EMS Commission will evaluate candidates for designation as RMCC's.

Activity 3.1.C: The EMS Commission will designate an RMCC in each region.

Objective 3.2: To develop and implement Regional EMS Communications Plans consistent with the State EMS Communications Plan.

Activity 3.2.A: The RMCC will coordinate the planning, development and operation of EMS communications systems within the region, in cooperation with the RCC, local hospitals, EMS providers and other appropriate agencies.

Activity 3.2.B: The RMCC will strive to assure the proper utilization of these systems, through monitoring of the activities of system participants and the establishment of a method for review of communications operating procedures regionwide.

Activity 3.2.C: The RMCC will develop, in cooperation with sponsoring and supervising hospitals, EMS providers and the appropriate interested and involved agencies (i.e., local or regional councils), a regional Advanced Life Support communications plan which will define, among other things, the mechanism of channel allocation designed to eliminate the probability of co-channel interference of transmitted telemetry signals.

Activity 3.2.D: The RMCC will notify all system participants of Commission actions relative to the operations of the system, through the RCC.

Objective 3.3: To develop and distribute an implementation manual to compliment the State Communications Plan.

Activity 3.3.A: The EMS Commission will develop a Communications Implementation Manual.

Activity 3.3.B: The EMS Commission will print and distribute the Communications Implementation Manual.

Activity 3.3.C: The EMS Commission will reveiw and revise annually the Communications Implementation Manual.

Objective 3.4: To develop an IHERN (Indiana Hospital Emergency Radio Network) Manual and Directory.

Activity 3.4.A: The EMS Commission will develop an IHERN Manual and Directory.

Activity 3.4.B: The EMS Commission will print and distribute the IHERN Manual and Directory

Activity 3.4.C: The EMS Commission will review and revise the IHERN Manual and Directory every two years.

Objective 3.5: To promote the completion of the Indiana Hospital Emergency Radio Network, including both 155.340 and 155.280.

Activity 3.5.A: The EMS Commission will provide technical assistance to hospitals in upgrading their IHERN capabilities to include both 155.340 and 155.280.

Activity 3.5.B: The EMS Commission will explore funding through the Department of Traffic Safety to complete the IHERN system.

Activity 3.5.C: The EMS Commission will develop and circulate an IHERN participation agreement for EMS ambulance service providers and hospitals.

Objective 3.6: To promote regional coordination of UHF "Medical Frequencies" and the designation and identification of "Med Eight" (463.175/468.175) as a state-wide "hailing frequency" for ALS.

Activity 3.6.A: The EMS Commission will explore funding through the Department of Traffic Safety to improve the UFH medical system in the State.

3.4. TRANSPORTATION Sub-Goal: There will be sufficient number of strategically placed certified ambulances (both primary and secondary) to meet the need of each region and of the state.

Discussion: Emergency transportation of the sick and injured is one of the most critical areas of the emergency medical care system. Transportation provides a connecting link between the EMS system components. However, when evaluating the transportations sub-system, consideration must be given to training levels of personnel who routinely staff the vehicle, communications capability for medical control, on-board emergency care equipment, the ability of personnel to utilize equipment, and the design of the vehicle. It is the primary purpose of an ambulance to transport qualified personnel and equipment to the scene to initiate immediate care to the ill or injured and then to transport the victim to the most appropriate medical facility.

As used in this plan, the terms primary ambulance, primary response ambulance, and primary response refer to the vehicles and services that respond to the scene of an emergency and are then able to transport the patient to an appropriate medical facility. A secondary transportation service or vehicle is that which is used for either inter-hospital transfers or for convalescent/invalid coach type runs.

In order to meet the Transportation Sub-Goal, the Commission has formulated the following Objectives and Activities.

Objective 4.1: To promote a maximum ambulance response time of 20 minutes in 95% of all emergency responses.

Discussion: A review of the existing vehicle location maps indicate that nearly all parts of Indiana are within 20 minutes of a primary response ambulance. This results from the coordinated efforts of many, including city and county officials, volunteer fire departments and volunteer ambulance services, commercial ambulance services, as well as through the planning and financial assistance of the EMS Commission and the Department of Traffic Safety. However, for the EMS system to improve, a measurable standard such as the 20 minute response time is required. This will enable all concerned official agencies to determine where best to locate vehicles.

As the various regions and their RCC's develop regional plans for EMS, they may find it advantageous to differentiate between urban and rural ambulance response. Some planning entities, for example Northern Indiana Health Systems Agency, have proposed a response time of 20 minutes rural and 10 minute urban. It should also be reiterated here that if a particular region or regions determine that the recommended 20 minute maximum response time is too long, they may adjust it downward based upon the needs of their region.

Currently, 50 of 717 certified ambulances in Indiana are provisionally certified, because of deficiencies in design criteria and/or equipment. By January 1, 1981, all ambulances in Indiana must be fully certified to remain in operation. Therefore, the EMS Commission will also assist in the development of a procurement strategy for those areas exhibiting a need for additional and/or certifiable vehicles.

Activity 4.1.A: The EMS Commission, with the RCCs will determine areas currently exceeding the 20 minute response objective.

Activity 4.1.B: The EMS Commission and the RCCs, in cooperation with local providers, will develop a vehicle placement and/or procurement strategy for the areas identified above.

Activity 4.1.C: The EMS Commission and the RCCs will assist local units of government and providers in developing methods to improve response times where needed.

Activity 4.1.D: The Commission will continue to provide funding assistance to local units of government toward the purchase of vehicles and mobile radios based on published funding guidelines.

Objective 4.2: To promote the development of a state-wide system of secondary transportation.

Discussion: Care provided to an emergency patient should not be compromised during secondary transportation efforts. Some facilities have developed specialized transport services and vehicles for the transfer or retrieval of patients. Among these are Riley Hospital's and Parkview Hospital's neonatal units, Welborn Baptist's and Lutheran's mobile intensive care units, and Methodist Hospital of Indiana's Life Line helicopter. Vehicles and services such as these are making a contribution to the developing EMS systems, but it is not known to what extent the need exists for other specialty vehicles and services.

Although precluded by statute from regulating convalescent/invalid coaches, it is a subject that concerns the Commission. Some EMS providers must provide invalid service using a certified primary response vehicle. When this occurs, emergency medical services coverage of the area may be compromised. In addition, the Commission feels that convalescent transfer patients have a right to service utilizing vehicles and personnel, of sufficient quality and quantity, so as to be commensurate with the guidelines established for certification.

Activity 4.2.A: The EMS Commission will assess the secondary transportation system in Indiana.

Activity 4.2.B: The EMS Commission will promote and provide technical assistance in the development of a comprehensive secondary transportation system based on the results of the assessment referred to in 4.2.A.

3.5. FACILITIES/CRITICAL CARE UNITS Sub-Goal: There will be easily accessible emergency medical service facilities and critical care units (Cardiac, Burn, Poison, Psychiatric, Neonatal, and Trauma) which are available and open to provide service 24 hours/day, 7 days/week.

Discussion: Vital to optimal patient outcome is the pre-hospital care received Equally important is the care and treatment received in the hospital Emergency Department and Critical Care Unit.

Categorization of overall hospital emergency capabilities has little meaning or effect by itself; however, when considered with triage and treatment protocols, coordination mechanisms for transfer, and identification of specialty care capabilities, categorization can provide vital guidance to physicians for medical control of patients when transported to appropriately staffed and equipped hospitals for care commensurate with the extent and nature of injury or illness.

Responsibility for the categorization of hospital facilities and for the implementation of the categorization scheme rests with the Commission. Horizontal categorization of Indiana hospitals was initiated in 1975 in accordance with state law (Indiana Code 16-1-39-6), which requires the Commission to promote a "state-wide system of emergency medical care and treatment centers by developing minimum standards, procedures, and guidelines in regard to personnel, equipment, supplies, communications facilities and location of such centers".

There are at least two methods in which hospitals can be categorized: (1) horizontal categorization and (2) vertical categorization. The Commission established horizontal categorization criteria and completed its initial assessment of hospital emergency service capabilities in 1976. In 1977, the Commission revised the categorization guidelines. The state horizontal categorization plan describes the readiness and capability of each emergency facility to recieve, diagnose and treat emergency patients in an expedious manner. Vertical categorization involves the classification of emergency facilities according to the level of specialty care. Particular attention is given to the levels of care provided to patients in six major critical care areas: (1) trauma, (2) burn, (3) cardiac emergency, (4) high-risk infant, (5) poisoning, and (6) behavioral emergencies (including psychiatric and alcohol/drug-related crises).

Vertical categorization to date has not been implemented state-wide. Two Department of Health, Education and Welfare-funded Regional EMS Councils, (Northeast Indiana and Central Indiana) have implemented vertical categorization utilizing physician-developed criteria produced on the basis of existing national standard guidelines (i.e., American College of Surgeons (trauma), American Burn Association (burns), and American Heart Association (cardiac). The Indiana State Board of Health has developed criteria for high-risk infants, and the American Psychiatric Association has recently published criteria for behavioral emergency patients. The American Medical Association and the American Association for Poison Control Centers have independently developed guidelines for categorization of Poison Care Facilities.

It is generally recognized and acknowledged that there are many problems associated with the process of categorizing hospital emergency facilities according to the level of emergency treatment which may be afforded to emergency patients. In the proper perspective, categorization is considered as a means that should enhance the provision of emergency medical services through appropriate utilization of resources.

In order to meet the Facilities/Critical Care Unit Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 5.1: To identify Emergency Medical Service facilities and Critical Care Units throughout the state.

Activity 5.1.A; The EMS Commission will review and revise, as necessary, the guidelines for horizontal categorization of hospitals every two years.

Activity 5.1.B: The EMS Commission will conduct a horizontal categorization every two years.

Activity 5.1.C: The EMS Commission will develop, in cooperation with other appropriate agencies, guidelines for vertical categorization of hospitals' critical care capabilities and review and revise these guidelines every two years.

Activity 5.1.D: The EMS Commission will conduct a vertical categorization every two years.

3.6. PUBLIC SAFETY AGENCIES Sub-Goal: Promote the availability and involvement of public safety agencies within the total Emergency Medical Service system, through adequate training of personnel, integration of communication, transportation capabilities and extrication services throughout the state.

Discussion: The utilization of the manpower and resources of public safety agencies broadens the scope of the EMS systems capability. Often it will be the public safety agent who arrives first on the scene, and thus plays an important role in emergency patient care.

Although the EMS Commission has no regulatory authority over Public Safety Agencies, the Commission recognizes the importance of those agencies and therefore feels that consideration must also be given to the methods employed to integrate transportation and communication systems in order to augment the coordination of response to medical emergency situations and subsequent transportation to primary care facilities. To achieve integration and utilization of public safety agencies, these agencies must become active participants in the planning and ongoing management of the EMS system.

In order to meet the Public Safety Agencies Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 6.1: To promote inter-agency communication interface for proper management of resources in medical emergencies.

Activity 6.1.A: The RCC, with the Regional Medical Communication Center, will endeavor to coordinate frequencies in the region between public safety agencies and Emergency Medical Service providers.

Activity 6.1.B: The EMS Commission will explore funding for upgrading coordinated frequency communications between public safety agencies and EMS providers.

Objective 6.2: To promote understanding and cooperation between EMS providers and public safety agencies.

Activity 6.2.A: The RCC's will encourage periodic meetings between public safety agencies and EMS providers.

Objective 6.3.: To reduce entrapment time and aggravation of injuries by promoting the utilization of state-of-the-art extrication techniques.

Discussion: The Emergency Medical Services Commission has recognized the need to improve extrication and rescue services in Indiana. This important ancillary service of the Emergency Medical Service system has 363 providers rendering various levels of rescue and extrication technique. The scope of services provided vary from the minimum mandatory ambulance rescue equipment [(2) 50 foot ropes; (1) 5 pound hammer; (1) 24-inch wrecking bar; (1) 24-inch bolt cutter and (1) 10 pound ABC fire extinguisher] to a few services equipped with a full compliment of state-of-the-art extrication equipment.

The levels of training also vary considerably from one service to another. Some services have no formalized extrication training, while others have regular monthly, scheduled in-service covering a wide variety of rescue techniques

The Emergency Medical Services Commission, cognizant that rescue needs vary from one defined geographical area of coverage to the next, has developed the following activities concerning extrication and rescue service availability and quality in Indiana.

Activity 6.3.A: The EMS Commission will conduct a survey and collate data to determine scope of extrication services provided.

Activity 6.3.B: The EMS Commission will develop guidelines for categorization of extrication services, based upon available manpower, equipment, and training levels. (Note: This activity has been completed. See Appendix)

Activity 6.3.C: The EMS Commission will encourage the availability, within a twenty minute response time, of at least one county based extrication service at the designated Level Two. (See Appendix)

Activity 6.3.D: The EMS Commission will encourage the availability of an extrication service at the designated Level Three in a defined area if the need is demonstrated by the region(s) and endorsed by the RCC(s).

Activity 6.3.E: The EMS Commission will provide funding assistance to local units of government toward the purchase of heavy duty power extrication spreader tools based on published funding criteria to achieve one (1) such tool per county as a minimum.

Activity 6.3.F: The EMS Commission will provide funding assistance to local units of government toward the purchase of heavy extrication equipment sets.

Activity 6.3.G: The EMS Commission will explore various methodologies for the research and testing of emergency rescue and extrication equipment.

3.7. CONSUMER PARTICIPATION Sub-Goal: There will continue to be provisions for consumer participation in the policy-making decisions of the EMS Commission, and there will be consumer members on local and regional EMS organizations and agencies.

Discussion: Health care providers believe the operating characteristics of an EMS system must be understood by the general public. At the same time, health care planners and program administrators must be cognizant of the problems and misconceptions the public may have regarding the emergency medical services available to them.

Active participation by consumers serves to provide a lay-perspective which is easily and frequently overlooked in health care planning. While consumers may find certain components of the system difficult in which to provide input, the questions asked may often generate discussion leading to alternative solutions to complex problems. Undoubtedly, consumer involvement in public information/education programs is absolutely essential.

Consumers must not only have access to system management, but must become participants in the planning, operation and implementation of the total EMS system. Health care planning and development must also be responsive to the needs of consumers.

Representation and participation by consumers has always been and will continue to be an integral part of the policy-making process of the EMS Commission. Three (3) persons who shall be representatives of the public at large and who are not in any way related to providing emergency medical services, serve on the State Commission. These individuals are appointed by the Governor for a term of four (4) years.

In order to meet the Consumer Participation Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 7.1: To continue to solicit public input into EMS Commission policy-making decisions.

Activity 7.1.A: The EMS Commission will continue to conduct open business and committee meetings and hold public hearings on rule and regulatory changes.

Objective 7.2: To continue to be responsive to complaints from consumers.

Activity 7.2.A: The EMS Commission will continue to investigate thoroughly all alleged violations of Indiana Code 16-1-39, 16-1-40, and all rules and regulations duly promulgated thereunder, in accordance with the Commission's policy regarding complaints.

Objective 7.3: To promote the inclusion of consumers in local and regional EMS organizations and agencies.

Activity 7.3.A: The EMS Commission will encourage EMS organizations and agencies to include the non-EMS affiliated lay public in their organization.

3.8. ACCESS TO CARE Sub-Goal: Emergency medical care will be available to all residents and transients in Indiana regardless of their ability to pay.

Discussion: An EMS system is designed to be responsive to the emergency medical needs of the community, area or region it serves. Since an emergency is an unforeseen event, victims of illness or injury may not be prepared to have the available financial resources to afford the emergency services which may be required. Because of this, the Emergency Medical Services system must provide for non-discriminatory access to the system regardless of ability to pay for needed service.

In order to meet the Access to Care Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 8.1: To promote the adoption by ambulance service providers and emergency care facilities of written policies so that all emergency patients will be cared for regardless of their ability to pay.

Activity 8.1.A: The RCC's will identify those institutions and agencies in their region that do have written policies pertaining to non-discriminatory access to care.

Activity 8.1.B: The RCC's will encourage and work with those entities who do not have such policies to develop them.

Activity 8.1.C: The EMS Commission will develop a position paper on access to care.

3.9. TRANSFER OF PATIENTS Sub-Goal: There will be protocols for the transfer of patients between facilities to assure continuity of care and optimal patient disposition.

Discussion: In the continuum of care, transfer to critical care units for specialized care and rehabilitation is an integral component of the total EMS system.

It is desirable that formal arrangements between hospitals and physicians which identify the procedures for transfer and provide for physician-to-physician consul-tation, transfer of records and equipment, and central control and coordination be established to assure continuity of care for critical care patients after the intitial definitive care phase.

The Commission realizes that patients will sometimes be transferred from one region to another and therefore recommends that provisions be made to assure the continuity of care in such instances.

In order to meet the Transfer of Patients Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 9.1: To develop a model patient transfer protocol for use throughout the state.

Activity 9.1.A: The EMS Commission will, with assistance from the Indiana Chapter of ACEP, the Emergency Medicine Section of the Indiana State Medical Association and the Indiana Hospital Association, formulate and distribute a model patient transfer protocol.

Objective 9.2: To promote the adoption of written transfer protocols.

Activity 9.2.A: The RCC's will identify those hospitals in their region that do have written transfer protocols.

Activity 9.2.B: The RCC's will encourage and work with thos hospitals that do not have written transfer protocols to adopt them.

3.10. COORDINATED MEDICAL RECORDKEEPING Sub-Goal: There will be a standardized methodology for gathering data to provide a base from which EMS system assessment, evaluation and planning can be conducted.

Discussion: The most significant impediment to the planning process is its dependency on the availability of reliable and valid data. The more accurate the available data are, the greater the probability of determining accurate problem solutions. Such information can be used to monitor the consistency of performance in establishing and maintaining determined response times or to determine what adjustments may be required to maintain or improve the quality of services provided. Examples of system adjustment include increased levels of training or personnel, greater emphasis in certain aspects of personnel in-service training, additional vehicles, re-evaluation of vehicle placement strategy and upgrading of emergency equipment.

Of equal importance, hospital emergency rooms and other entities receiving emergency patients are better able to render care to these patients if they know the patient's pre-arrival history and treatment. This record should be structured so that it may be incorporated into the patient's hospital medical record if the hospital so desires.

Collection and retention of data related to dispatch, on-site emergency care and transportation services state-wide are currently unsatisfactory. Most ambulance service providers have limited resources which can be dedicated to data collection. Patient information is generally limited to the patient's name, address, the location of the accident and name of the hospital to where the patient was transported.

The Commission requires each provider of emergency ambulance service "to maintain accurage data concerning the transportation of emergency patients within the state, which may include an ambulance report form prescribed by the Commission".

The types of information necessary for optimal patient care and system evaluation include, but are not necessarily limited to how the system was accessed, response time to the scene, time on the scene, type of injury/illness, time required for transportation, and patient condition at the scene and upon arrival at the emergency facility.

In order to meet the Coordinated Medical Recordkeeping Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 10.1: To develop a standard Rescue Record Report Form.

Activity 10.1.A: The EMS Commission will identify the necessary data elements to be included on the form.

Activity 10.1.B: The EMS Commission, with the assistance of the State Central Data Processing, or a contractual agency, will format data elements, subject to the approval of the State Data Processing Oversight Committee.

Activity 10.1.C: The EMS Commission will conduct a field study of the form to determine it's user acceptability, validity and performance.

Activity 10.1.D: After final refinements are made, the EMS Commission will distribute the form for general provider use.

Objective 10.2: To develop a data processing system utilizing the Rescue Record Report Form to provide a means of collecting data for Commission use and disseminating it for RCC and individual provider use.

Activity 10.2.A: The EMS Commission will identify the system needs and goals with Central Data Processing or a contractual agency, subject to the approval fo the State Data Processing Oversight Committee.

Activity 10.2.B: The EMS Commission will field test the data processing system concurrently with the Rescue Record Report form to determine viability of the system.

Activity 10.2.C: The EMS Commission will implement the data processing system on a statewide basis in cooperation with the RCCs and the local providers.

Objective 10.3: To develop an annual Provider Report Form.

Activity 10.3.A: The EMS Commission will develop an Annual Provider Report from for use by providers.

3.11. PUBLIC INFORMATION AND EDUCATION Sub-Goal: There will be a public information and education program which provides information on the effective and efficient use of the EMS system and generates public support to continue and expand the services provided by the EMS system.

Discussion: An effective public information and education program is essential to maintain interest in the field of emergency medical services and to create new interest in improving the existing emergency medical services system. A viable public information system is the key to providing continued state and community support for this program.

A viable public education program must go beyond the mere distribution of helpful information. The program must influence public opinion in support of a more coherent, better organized, staffed and equipped emergency health care delivery system than is now operative.

The general knowledge a consumer has of the EMS system will have a direct bearing on the effectiveness of the system. The consumer's ability to answer questions regarding the location of ambulances, the method of system access (911, universal number or separate telephone number for each provider), and the existence of special access numbers (poison control/poison information), will depend on the effectiveness of the EMS public information and education program.

In order to meet the Public Information and Education Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 11.1: To establish citizen-targeted first-aid and CPR courses.

Activity 11.1.A: Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, hospitals, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.

Activity 11.1.B: Local affiliates of the American Red Cross, local EMS providers, high schools, universities, hospitals, and various community and civic organizations will conduct basic first-aid classes, in cooperation with the RCC, to meet the identified needs of the region.

Objective 11.2: To develop a detailed plan and implementation strategy for Public Information and Education.

Activity 11.2.A: The EMS Commission will identify Public Information and Education priorities and guidelines.

Activity 11.2.B: The RCCs will develop a methodology to address identified priorities for each region.

Objective 11.3: To advise all providers of Emergency Medical Services and other concerned entities and individuals of commission activities, changes in the state-of-the-art provision of EMS, and social and legislative actions and trends impacting EMS.

Activity 11.3.A: The EMS Commission will publish a state-wide EMS newsletter.

3.12. EVALUATION Sub-Goal: There will be at the state, regional, local and provider level, a formal method of periodically reviewing and evaluating and appropriateness and effectiveness of the emergency medical services system.

Discussion: The EMS system is an integral part of the health care delivery system. EMS is often the entry point for patient care and rehabilitation; any evaluation of the health care system must include EMS.

Only by systematically and objectively evaluating the EMS system to identify weaknesses and problems can efforts be made toward improving the system. Additionally, a periodic review will serve to identify progress that has been made.

The enactment of the federal Emergency Medical Services System Act of 1973 provided the impetus for evaluation of emergency care systems throughout the country. This Act provided a series of program standards and criteria against which an EMS system can measure its programs compliance and effectiveness. The involvement of national and state medical and health organizations has contributed to the promotion of the evaluative process through the adoption of standards or models of performance expected of acceptable EMS programs. Despite the participation of the federal government and interested national, state and local agencies in providing program criteria and standards, evaluation of natural area-wide emergency care "systems" does not occur regularly or extensively.

The evaluation process presently is conducted by Commission staff and has consisted of continuing inventory activities designed to determine the current status of program components. In cooperation with the Indiana Hospital Association, the Commission has undertaken a study of emergency department visits which is designed to identify patient "catchment" and referral patterns. However, a coordinated medical recordkeeping system, which is the foundation for system evaluation, necessarily must be implemented before significant, continuing evaluative efforts can be sustained.

In order to meet the Evaluation Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 12.1: To identify component elements to be evaluated in the EMS system.

Activity 12.1.A: The EMS Commission, with helpfrom its complementary agencies, will identify the appropriate elements to be measured.

Objective 12.2: To develop an evaulation methodology.

Activity 12.2.A: The EMS Commission, with help from its complementary agencies, will develop necessary evaluation instruments.

Activity 12.2.B: The EMS Commission, with help from its complementary agencies, will develop evaluation procedures.

3.13. DISASTER LINKAGE Sub-Goal: The EMS system will be capable of providing emergency care and transportation during mass-casualty situations and natural disasters.

Discussion: The Indiana Disaster Preparedness Plan implements certain requirements and authority of the Indiana Civil Defense and Disaster Law of 1975. The plan is applicable to quasi-governmental and non-governmental agencies to the extent that they must comply with the policies and procedures contained in the State Disaster Preparedness Plan and agree to cooperate during periods of emergency. The plan is deliberately structured on a broad and general basis because of the variety of disasters and situations of varying degrees of magnitude.

Primary responsibility for disaster preparedness rests with the respective heads of the political subdivisions, and response to disaster is made on the basis of individual local and inter-jurisdictional plans. Local governments are expected to develop disaster emergency plans while considering the guidance outlined in the state Disaster Preparedness Plan.

Although the EMS system is not charged with the responsibility of being the ultimate disaster organization, it plays an important role in both disaster planning and response, and must be prepared to work with other agencies in times of disaster.

In order to meet the Disaster Linkage Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 13.1: To promote the development and maintenance of coordinated county and regional medical emergency disaster plans.

Activity 13.1.A: The RCCs will identify existing provider, local, county and regional disaster plans.

Activity 13.1.B: The EMS Commission will develop "model" medical emergency disaster plans.

Activity 13.1.C: The RCCs will assist county authorities in developing and adopting medical emergency disaster plans.

Objective 13.2: To promote public awareness of disaster operations and procedures.

Activity 13.2.A: The EMS Commission will publish a state-wide EMS newsletter.

Activity 13.2.B: The RCC's will issue news releases as necessary, to inform the general public of disaster plans, procedures, and drills in their area.

See also Objective 15.1, RCC responsibility number 14.

3.14. MUTUAL AID AGREEMENTS Sub-Goal: Written Mutual Aid Agreements will exist between all EMS providers in adjacent service areas to assure assistance on a reciprocal basis when the need for service is beyond the capabilities of any one provider.

Discussion: In the event of any major catastrophe, disaster or other local emergency which exceeds the resources of any individual ambulance service provider, a mechanism must be developed which provides for supplemental assistance regardless of jurisdictional boundaries, by neighboring ambulance providers to ensure that emergency patients receive prompt emergency service. The conditions upon which mutual assistance is requested, the method of obtaining assistance, reimbursement and other factors considered essential to ambulance service providers should be contained in a written mutual aid agreement which is accepted by emergency ambulance service providers within a defined area.

To insure the continued appropriateness of these agreements, they should be reviewed and renewed at least once every two years.

In order to meet the Mutual Aid Agreements Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 14.1: To promote the adoption and maintenance of formal Mutual Aid Agreements.

Activity 14.1.A: The RCC's will survey EMS providers in their region to identify existing Mutual Aid Agreements.

Activity 14.1.B: The EMS Commission with help from its supplementary agencies, will develop a "model" Mutual Aid Agreement

Activity 14.1.C: The RCC's will assist EMS providers in adopting Mutual Aid Agreements.

3.15. SYSTEM MANAGEMENT Sub-Goal: There will be established a management and administrative framework on a state and regional basis to insure the efficient delivery of emergency medical services which includes a hierarchy of authority, appropriate lines of communications, and definition of participant roles and responsibilities.

Discussion: The degree of success achieved in the development of an emergency medical services system is based upon the ability and expertise of system administrators and the method in which the program is organized and administered. The organizational structure, the functional duties and responsibilities of key personnel, and a staffing plan which emphasizes functional areas of responsibility provide the framework by which the EMS system can be developed and implemented.

Organization is a grouping of activities necessary to attain objectives and the assignment of each activity group to an individual with authority to manage these activities. The organizational structure fosters communication between people so that they can perform as a group. The structure must, therefore, be designed to function, to permit contributions by members of the group, and to help organizations attain objectives.

In order to meet the System Management Sub-Goal, the EMS Commission has formulated the following Objectives and Activities.

Objective 15.1: To provide regional EMS systems' management.

Discussion: A major requirement in developing an emergency medical services system is to identify those areas described as "patient service areas". The area must be large enough in size and population to provide difinitive care services to the majority of general emergency and critical patients. Variables which must be taken into consideration when determining planning subdivisions include: (1) heterogeneous service populations; (2) scope of EMS currently available; (3) existing organizational relationships; (4) transportation characteristics; (5) geographic characteristics; (6) population configurations; (7) patient origin; and (8) advanced life support potential.

Although programmatic activities have previously been planned and implemented within the designated "regional" structure, there is no data to verify the appropriateness of these regional boundaries based on patient flow or "catchment" or effectiveness of EMS system planning. It is the intent of the Commission to carefully assess the "natural flow" of emergency patients and to amend the structure of regions to reflect patient catchment areas if necessary. In cooperation with the Indiana Hospital Association, the Commission is currently conducting a study of emergency department visits to identify natural emergency patient referral patterns.

It is impractical for the EMS Commission to develop the necessary staff and resources to arbitrate and effectively deal with all EMS operational matters that exist throughout the state. Further, as various regions around Indiana develop EMS systems, it is clear that these systems must be tailored to meet local needs and priorities within the framework of the State EMS Plan.

Therefore, supplemental to the identification of planning regions is the designation of an agency, organization, consortium, or council to serve as the focal point for the regional planning and program implementation.

In July 1974, the Commission designated certain hospitals in the state as Regional Hospitals. These hospitals were to function as the focal point for training, communications and data collection. It was assumed at that time that sufficient program-development funding would be made available and would enable these hospitals to actively promote EMS "system" development in their respectiver region. To date, the most active involvement between the hospitals and the Commission has been in the area of EMT training. Each hospital entered into a contractual agreement with the Commission to coordinate EMT training programs. Funding for this training was provided by teh Division of Allied Health Services, and U.S. Department of Health, Education and Welfare. This grant and the contractual agreements terminated on June 30, 1979.

Although many of the regional hospitals did much to develop the EMS system, successful completion of the system now necessitates the broader based involvement of health care providers, public safety agencies and consumers. The inclusion of various agencies and organizations in the planning and implementation process does not, however, preclude a hospital or other single entity from accepting these responsiblities.

The anticipated responsibilities for the Regional Coordination Centers will be:

1. Include other agencies, organizations, institutions, and committees with EMS responsibilities within the region in the RCC's administrative or operational structure, as required by the Commission.
2. Develop a plan for the management and operation of the Regional Coordination Center. (RCC)
3. Develop a plan for EMS for the region consistent with the comprehensive State Plan, and taking into consideration the recommendations of their EMS Council or board.
4. Develop a mechanism/plan for assuring and evaluating the success of the implementation of all plan components.
5. Provide feedback to the EMS Commission on its data collection activities.
6. Identify a Regional Medical Communications Center for approval by the Commission, to assist in the development and implementation of a Regional Communications Plan.
7. Develop a plan for the placement of primary response transportation (both Basic Life Support and Advanced Life Support) vehicles necessary to provide a maximum 20 minute response time for 95% of all responses; and assist in implementation of the plan.
8. Develop a plan to assure the availability of secondary transportation vehicles.
9. Periodically identify training needs of: dispatchers, citizen and Public Safety Agency first responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians, Emergency Paramedics, Refresher and continuing education primary instructors, systems managers, Emergency and Critical Care Nurses, Emergency Physicians and Extrication Personnel.
10. Define an annual and long range plan to assure the meeting of those needs.
11. Be willing to provide office space and clerical support to the Regional Coordinator in return for his/her assistance giving staff support to the RCC.
12. Store, distribute, and maintain Emergency Medical Services Commission owned films, training equipment, etc.
13. Maintain a file of Primary Instructors and other qualified individuals who are willing to speak to classes.
14. Publish a regional newsletter of upcoming classes, 20-Hour Refresher Courses, and in-services, open positions, changes in provider (hospital and ambulance) policies, major road changes, etc.

15. Assist other agencies, organizations, and individuals within the region with public information and education.
16. Advise the Emergency Medical Services Commission of deficiencies in either quantity and/or quality of courses/classes within the region.
17. Be responsible for providing review and comment on all training course applications from the region.

When reviewing applications for designation, the Commission will make its decision based on how and to what extent the application:

a. describes the proposed management structure of the RCC, including a description of the anticipated scope of membership, authority, and responsibilities of the board of directors or regional EMS advisory council.
b. demonstrates the applicant's plan to identify needs within the region, and then meet those needs.
c. demonstrates the applicant's proposed mechanism for meeting the identified roles and responsibilities and other EMS system component needs, and
d. indicates a proposed budget and financial plan for the management of the RCC.

The Regional Coordination Center should, to offset the cost of systems development, investigate the practicality and availability of (1) local monies, (2) private funding sources, (3) federal Emergency Medical Services funds, and (4) other funding sources.

Activity 15.1.A: The EMS Commission will identify appropriate EMS regions throughout the state based in part upon existing patient flow patterns.

Activity 15.1.B: The EMS Commission will advertise that it is accepting applications for designation as Regional Coordination Centers, explain the roles and responsibilities of an RCC, and describe the application process.

Activity 15.1.C: The EMS Commission will accept applications for the designation as an RCC

Activity 15.1.D: The EMS Commission will designate an RCC in each of the identified regions.

Activity 15.1.E: The EMS Commission will announce its decision to all EMS providers.

Activity 15.1.F: If no application for designation is received from a region, or if no application received is deemed appropriate for designation, the EMS Commission will provide a means for the establishment of an RCC in the region.

Objective 15.2: To provide professional staff support to the designated RCCs.

Activity 15.2.A: Under the present contract between the EMS Commission and the HSA's (effective until September 30, 1980), the present Regional Coordinators will provide assistance to the applying/developing RCCs.

Activity 15.2.B: The EMS Commission will use its available funds to renew the present HSA contract through June 30, 1981.

Activity 15.2.C: The EMS Commission will seek funds from the 1981 General Assembly to maintain, on a continuing basis, a regional field staff.

Activity 15.2.D: The EMS Commission will explore funding alternatives from the Indiana Department of Traffic Safety to offset planning and administrative costs of the RCCs.

Objective 15.3: To provide continuing professional staff support to the EMS Commission.

Activity 15.3.A: The EMS Commission will seek funding from the Indiana Department of Traffic Safety to continue the staff positions of Planning Associate and one clerical position.

Activity 15.3.B: The EMS Commission will seek funding from the Indiana General Assembly in the next biennial budget to assume fiscal responsibility for the Planning Associate and clerical position.

Objective 15.4: To designate regional practical examination teams to administer the practical skills examinations for EMT and Department of Transportation Refresher Courses.

Discussion: In order to successfully complete the EMT course, each student must "pass" the practical skills examination adopted by the EMS Commission. Although the examination is comprehensive and relevant to the basic skills learned in the EMT course, it is difficult to insure standardized practical skills examination techniques.

The development of regional testing teams designated by the RCCs would establish standard skills testing region wide, therefore supporting a quality of skills suitable and acceptable throughout the region.

Activity 15.4.A: The EMS Commission will identify the role and responsibilities of the regional practical examination team.

Activity 15.4.B: The RCCs will designate regional practical examination teams.

Activity 15.4.C: The Regional Coordinators and the RCCs will coordinate the administration of practical examinations.

Objective 15.5: To conduct a state-wide emergency medical services seminar.

Discussion: The purpose of a Commission-sponsored seminar would be to provide a forum for the exchange of ideas that it would not usually be possible for local entities to provide.

By drawing together approximately 600 individuals, at a state-wide emergency medical services seminar, participants would be able to meet and exchange ideas with their peers from around the state.

Active emergency medical care personnel could have the opportunity to gain continuing education from recognized emergency medical service authorities on state-of-the-art emergency care procedures and trends.

In addition, program tracks and lectures could be provided for local and county government officials, members of the press, and emergency medical service provider owners, directors, and administrators.

Activity 15.5.A: The EMS Commission will plan, develop, and conduct an EMS seminar every two years.

Objective 15.6: To develop and distribute model written protocols for Basic Life Support and Advanced Life Support operations.

Activity 15.6.A: The EMS Commission will review existing protocols and solicit input to formulate reasonable and appropriate operational protocols.

Activity 15.6.B: The EMS Commission will distribute these protocols to all concerned agencies and individuals.

Objective 15.7: To insure the smooth and efficient development of Advanced Life Support programs.

Discussion: The advancement of an ambulance service provider from Basic Life Support (EMT) to Advanced Life Support (Advanced EMT or Paramedic) is a significant step which must be taken judiciously. Presently, twenty-six (26) Paramedic providers and nineteen (19) Advanced EMT providers offer coverage to approximately 50% of the state population. These services have advanced to their present level of care for four reasons.

The first, and perhaps most important consideration in evaluating Advanced Life Support needs is the medical community's expressed desire to raise the level of care being offered by an ambulance service. The emergency physician and the surgeon are usually the prime motivators in moving to Advanced Life Support. They routinely see patients expire who could have been resuscitated had Advanced Life Support techniques been administered in the field. The resulting feeling of frustration and helplessness often provides strong impetus toward the establishment of an Advanced Life Support system.

A second consideration is response volumes. When reviewing needs, a community must evaluate numbers of runs generated within the community. Generally, types of runs can be categorized into six major areas: cardiac, trauma, burns, neonate, poisons, and behavioral emergencies. It is logical to view a system such that the higher the incidence of one of six categories or a combination of all six will provide a higher response volume in which the Advanced Life Support technician can perform Advanced Life Support skills. Similarly, a lower run volume will produce fewer Advanced Life Support type runs, which will cause an Advanced Life Support technician's skills to deteriorate at a proportionally faster pace.

The third consideration is the willingness of a hospital to become involved in pre-hospital medicine. The hospital is the focal point of Advanced Life Support. The hospital provides retrospective audit and review; continuing education, medical control of field activities, exchange of drugs, and liaison to the general medical community. In addition, the hospital must bear a major economic investment in training and hardware purchases, most notably, the UHF radio system, to link the physician and the technician. Therefore, the willingness and cooperation of a hospital to participate in an Advanced Life Support program must be given serious consideration.

The final consideration of Advanced Life Support is the financial responsibility. Advanced Life Support is costly. Presently, the cost of mobile telemetry with repeater mode exceeds ten thousand dollars ($10,000.00). The cost of a base station for hospital use is triple this amount. A monitor-defibrillator can cost up to seven thousand dollars ($7,000.00), depending upon the model. Training costs include: education of the student, cost of maintenance of skills, emergency physician reimbursement for services rendered, and preceptors' salaries. The exact dollar figure is then based upon the level of Advanced Life Support care being sought by a community. However, a more comprehensive level of care will increase the cost of the system.

When researching the need for Advanced Life Support service and training, a community, it's hospitsls, medical community, and ambulance services must consider the aforementioned areas as guides to meeting that need.

Activity 15.7.A: The EMS Commission will develop and publish an Advanced Life Support systems' manual.

Activity 15.7.B: The RCC's will determine the regional need for Advanced Life Support utilizing the Advanced Life Support systems' manual.

Activity 15.7.C: The RCC's will coordinate the development of Advanced Life Support systems regionally to meet the identified need in 15.7.B. NOTE: Advanced Life Support needs assessment may determine that the regions cannot, at that time, support an Advanced Life Support effort.

Objective 15.8: To evaluate the Emergency Medical Technician test.

Discussion: A test evaluation study will help insure that the written test prescribed by the Commission is educationally proper and statistically reliable and valid.

Activity 15.8.A: Indiana State University will provide computer services and conduct reliability and validity studies.

Activity 15.8.B: Indiana State University will provide services necessary to prepare test forms, grade written tests, and print test scores and mailing lists.

Objective 15.9: To evaluate the Emergency paramedic Paramedic Examination

Discussion: A test evaluation study will help insure that the written test prescribed by the Commission is educationally proper and statistically reliable and valid.

Activity 15.9.A: Indiana State University will evaluate the examinations of some 163 Paramedic applicants for validity and reliability.

Activity 15.9.B: The Paramedic Test Construction and Evaluation Committee will review and revise current Paramedic Examination.

Activity 15.9.C: The Paramedic Test Construction and Evaluation Committee will field test the revised examination.

Activity 15.9.D: The Emergency Medical Services Commission will implement the revised Paramedic Examination.

Activity 15.9.E: The Paramedic Test Construction and Evaluation Committee will develop a written examination for two levels of Advanced EMTs.

Activity 15.9.F: The Paramedic Test Construction and Evaluation Committee will field test draft examinations for the two Advanced EMT Examinations.

Activity 15.9.G: The Paramedic Test Constructionand Evaluation Committee will revise the draft examinations.

Activity 15.9.H: The Emergency Medical Services Commission will implement two Advanced EMT examinations.

Activity 15.9.I: The Advanced Life Support Operations Committee will develop standards and criteria for Advanced Life Support Skills Examination.

Activity 15.9.J: The Commission will field test the draft of the skills examination.

Activity 15.9.K: The Commission will implement the skills testing.

V. IMPLEMENTATION SCHEDULE

The following implementation time-table, presented by quarters, will serve to provide a standard by which implementation of the plan may be evaluated. Additionally, it will give direction to the various system participants as a comprehensive system of Emergency Medical Services is developed in Indiana.

Arrows on the end of an implementation time-frame indicate either that the activity commenced before the start of the chart (April 1980), or will extend beyond the end of the chart (March 1984).

Broken lines followed by a solid line in activities assigned to both the EMS Commission and the RCC's indicate that the activity will be undertaken by the Commission alone until the RCC's are designated.

Broken lines following solid lines indicate that the activity is to be completed by a certain date (the end of the solid line); from that time on, the level of achievement should be maintained as necessary (the broken line).

An asterik on a particular date represents a single day that something will be announced or designated.

NOTE FOR THE 1981 STATUS REPORT:

SUPERIMPOSED UPON THE IMPLETATION TIME-TABLE IS THE CURRENT (NOVEMBER 1981) STATUS OF EACH ACTIVITY.

1. MANPOWER Sub-Goal: There will be sufficient numbers and adequate distribution of trained EMS personnel, including CPR and first-aid trained citizens, public safety agency First Responders, EMTs, Paramedics, Primary Instructors, Dispatchers, Emergency Department and Critical Care Unit Nurses, Emergency Department Physicians, and EMS Management personnel to provide Emergency Medical Services 24 hour/day, 7 days/week.

Objective 1.1: To identify existing EMS manpower resources.

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
1.1.A. The EMS Commission will develop an inventory methodology and survey instrument.	Done: The EMSC has developed an Annual Report for use by each ambulance service provider in the State which complements its other inventory methods.															
1.1.B. The EMS Commission will conduct a manpower survey and collate the data.	Results of the collation of the 1980 Annual Report will be published in January 1982.															
Objective 1.2: To determine the adequacy of existing EMS manpower resources and/or the need for additional personnel.																
1.2.A. The RCC will compare the manpower inventory with staffing schedules and determine where the need for additional manpower exists.	Extended to 10/82 revised to reflect submission date for Regional EMS Plans.				M											
1.2.B. After designation each RCC will conduct a regional manpower inventory update every two years. Results of this inventory will be reported to the Commission.														—		

2. TRAINING Sub-Goal: There will be available throughout the State, at a reasonable cost to the student, sufficient educational programs (both initial and continuing education) to provide the manpower at all levels necessary to provide EMS 24 hours/day, 7 days/week.

Objective 2.1: To promote the training of one of every five adults over the age of 16 in CPR.

ACTIVITY

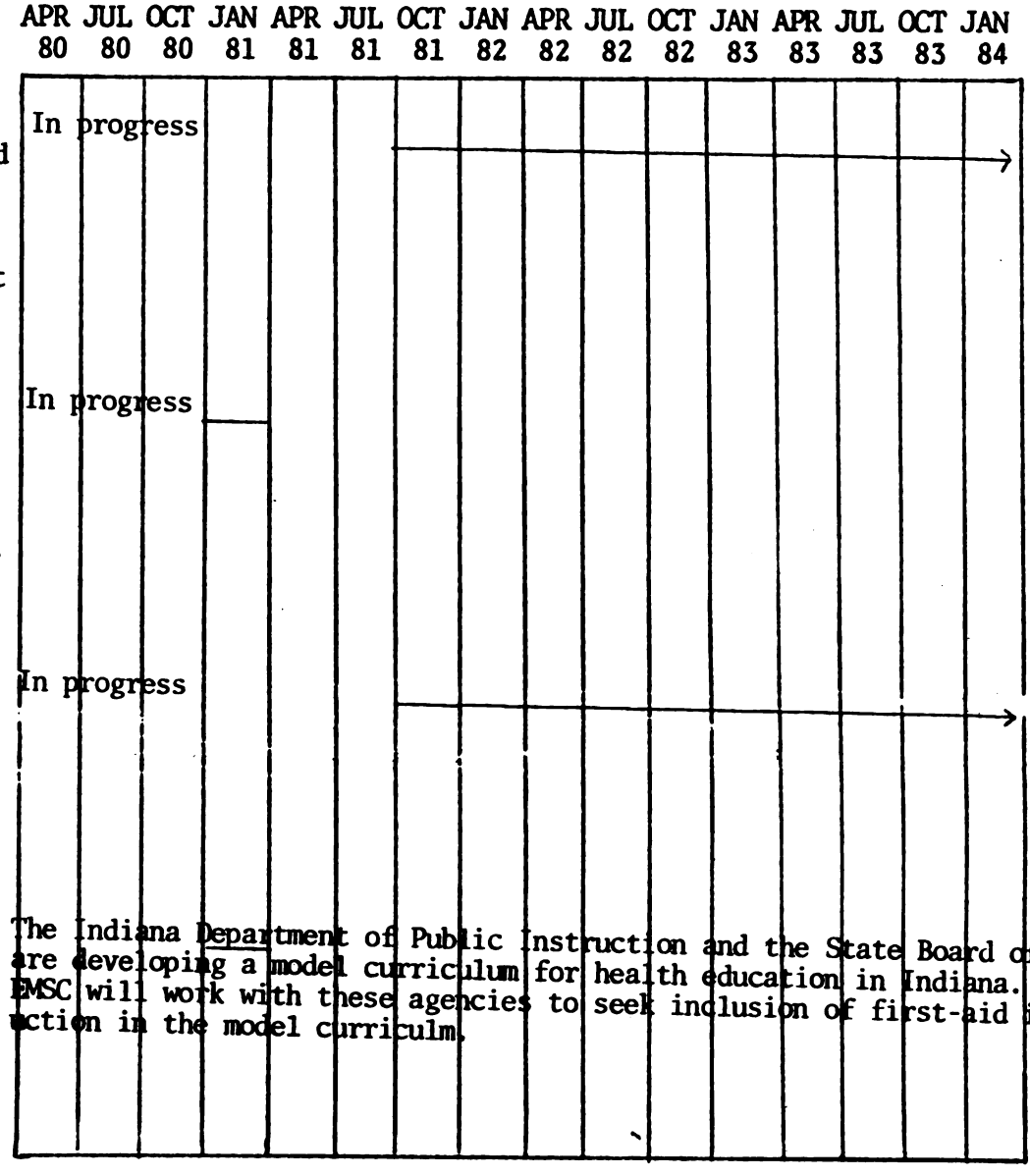
2.1.A. Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.

2.1.B. The EMS Commission will pursue the inclusion of Basic CPR instruction into the core requirements for secondary education in Indiana.

Objective 2.2: To promote the training of one of every five adults over the age of 16 in basic First Aid techniques.

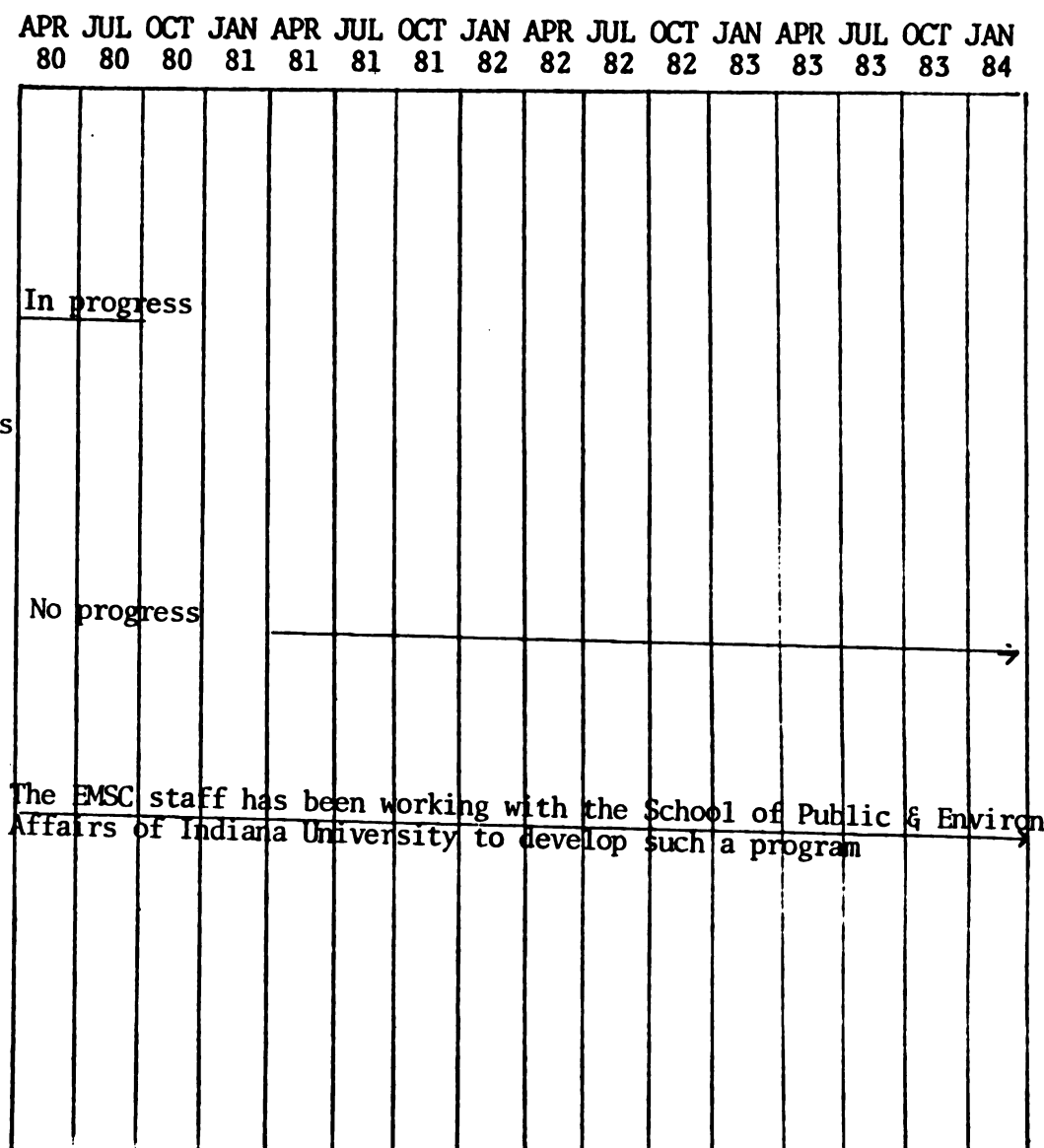
2.2.A. Local affiliates of the ARC, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic First Aid classes, in cooperation with the RCC, to meet the identified needs of the region.

2.2.B. The EMS Commission will pursue the inclusion of basic First Aid instruction into the core requirements for secondary education in Indiana.



The Indiana Department of Public Instruction and the State Board of Health are developing a model curriculum for health education in Indiana. The EMSC will work with these agencies to seek inclusion of first-aid instruction in the model curriculum.

ACTIVITY



Objective 2.3: To provide training for EMS system management/administrative personnel on two levels; the ambulance service provider manager/supervisor, and the multi-entity EMS system planner/administrator.

2.3.A. The EMS Commission, in cooperation with the Indiana Hospital Association, the Health Systems Agencies, Central Indiana EMS Council, Northeastern Indiana EMS Council, and other entities deemed appropriate will identify the necessary course content, curriculum, instructional strategies and course production requisites.

2.3.B. The EMS Commission will encourage the RCCs to make these management courses available to other educational institutions including EMS training institutions.

2.3.C. The EMS Commission will encourage the development of EMS management degree programs at the Associate, Bachelor's and Master's levels.

Objective 2.4: To promote the training of public safety agents (law enforcement, fire, etc.) whose primary function is other than the provision of emergency medicalservice, to the level of the DOT's Emergency Medical Service First Responder training course (formerly Crash Injury Management).

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.4.A. The EMS Commission will develop a mechanism for the voluntary certification of Emergency Medical Service First Responders.	Done: The Voluntary First Responder Training and Certification program was begun and the first individual certified in June 1981.															
2.4.B. Emergency Medical Service First Responder Training Courses will be conducted throughout the state through the efforts of the RCCs, the Law Enforcement Training Academy, and local EMS providers and public safety agencies.	In progress															
Objective 2.5: To promote the training of dispatchers at Public Safety Answering Points (PSAPs) and/or Communications Medical Emergency Dispatch (CMED) centers, utilizing the DOT Dispatcher Training Course.																
2.5.A. The RCCs will determine the need for Dispatcher training in their region.	Extended to 10/82 revised to reflect submission date for Regional EMS Plan.				M											
2.5.B. The RCC will coordinate the provision of Dispatcher training based on the identified need.																
Objective 2.6: To promote EMT training programs to insure that manpower is available to provide Emergency Medical Service 24 hours/day, 7 days/week.																
2.6.A. The RCCs will determine the need for EMT and DOT Refresher Training Courses in their regions.	Extended to 10/82 revised to reflect submission date for Regional EMS Plan.				M											

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.6.B. The EMS Commission approved training institutions, coordinated through the RCC, will conduct EMT and DOT Refresher Courses to meet the identified need.	In progress															
Objective 2.7: To provide training for Primary Instructors to insure the availability of instructors for EMT and Refresher Training Courses.																
2.7.A. The RCCs will determine the need for Primary Instructors in their regions.	Extended to 10/82 revised to reflect submission date for Regional EMS Plans.															
2.7.B. The EMS Commission, in conjunction with the RCCs, and approved training institutions, will conduct Primary Instructor Workshops, to meet the identified need.	In progress															
Objective 2.8: To encourage the provision of Advanced Life Support Training programs.																
2.8.A. The RCCs will determine the need and scope of Advanced Life Support training regionally.	Extended to 10/82 revised to reflect submission date for Regional EMS Plans.															
2.8.B. The RCCs will coordinate the regional training activity of Advanced Life Support training institutions to meet the identified need.																
Objective 2.9: To encourage initial and continuing education programs to ensure proficiency in Emergency and Critical Care nursing skills.																

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.9.A. The EMS Commission will cooperate with concerned institutions and appropriate nursing organizations, to assist in the development and administration of Emergency and Critical Care nursing training programs.	The EMSC has identified, and maintains a file of various programs in emergency and critical care nursing.															
2.9.B. The RCCs will determine Emergency and Critical Care nursing training needs regionally.	Extended to 10/82 revised to reflect submission date for Regional EMS Plans.				M											
2.9.C. The RCCs will coordinate the provision of Emergency and Critical Care continuing education programs based on the identified need.																
Objective 2.10: To encourage initial and continuing education in Emergency Medicine for emergency department physicians.																
2.10.A. The EMS Commission will cooperate with, and encourage the Indiana Chapter of American College of Emergency Physicians, and the Emergency Medicine Section of the Indiana State Medical Association to determine the appropriate skill level of physicians working in emergency departments.	Done: In September 1980, the EMSC endorsed the physician skill list adopted by the American College of Emergency Physicians as appropriate.															
2.10.B. The EMS Commission will encourage the establishment of training programs to meet the need for maintaining specific skills identified in Activity 2.10.A.	Done: In June 1980, the Dean of the Indiana University School of Medicine approved the establishment of an endowed professorship for Emergency Medicine in the name of Otis R. and Elizabeth Bowen.															

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.10.C. The RCCs will identify the need for training of Emergency Department Physicians based upon the skill levels developed in Activity 2.10.A.	Extended to 10/82, revised to reflect submission date for Regional EMS Plans.															
2.10.D. The RCCs will coordinate the provision of training programs for Emergency Department Physicians to meet the identified need.																
Objective 2.11: To promote extrication training programs throughout the state.																
2.11.A. The EMS Commission will train at least three (3) persons per extrication service as instructors in state-of-the-art extrication techniques.	In progress. Since 1979, the EMSC has conducted extrication instructor workshops state-wide. A summary is contained in the appendix.															
2.11.B. EMS Commission trained extrication instructors within each extrication service provider organization will conduct training and continuing education programs for all extrication personnel at their organization in cooperation with the RCCs.	In progress															
2.11.C. The EMS Commission will purchase extrication training equipment.	Done: Ten sets of extrication training materials have been purchased and will be distributed to Regional Coordination Centers.															
Objective 2.12: To train drivers of emergency ambulances and other EMS vehicles in defensive and emergency driving, using as a minimum, the DOT's "Training Program for Operation of Emergency Vehicles".																

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.12.A. The EMS Commission and the RCCs will identify the need for emergency driving training regionally.	Commission Only		M				Extended to 10/82 revised to reflect submission date for Regional EMS Plans									
2.12.B. The EMS Commission will cooperate with the Law Enforcement Training Academy, the RCCs, and other concerned agencies in conducting classes to meet the identified needs.	In progress															
2.12.C. The EMS Commission and the Traffic Accident Investigations System Working Committee will develop a system to identify emergency vehicle accidents.	Done: The system is functioning, and the first six month (Jan.-Jun 1981) report has been received.															
Objective 2.13: To promote classes in identification of Hazardous Materials for EMS personnel.																
2.13.A. The EMS Commission will work in cooperation with the Indiana State Police, State Civil Defense, and the State Board of Health to promote awareness of the dangers of hazardous materials among public service professionals.	In progress															
2.13.B. The EMS Commission will identify training programs offered by DOT and the National Fire Protection Association.	Done: The EMSC has identified, and maintains a file of various programs in the recognition and management of hazardous materials.															

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
2.13.C. The EMS Commission will provide technical assistance to the RCCs and coordinate the provision of such courses regionally.	In progress															
2.13.D. The EMS Commission will provide one copy of "DOT Emergency Action Guide for Selected Hazardous Materials" to each certified provider and each ambulance.	Done: In September 1981, the EMSC mailed 350 copies of the Firefighters Handbook on Hazardous Materials extrication service providers in the State. By January 1982, copies of the 1980 Action Guide will also be distributed.															

to EMS system needs.

Objective 3.1: To designate Regional Medical Communications Centers (RMCC's).

ACTIVITY

3.1.A. The RCC's will recommend, for Commission approval, Regional Medical Communication Centers.

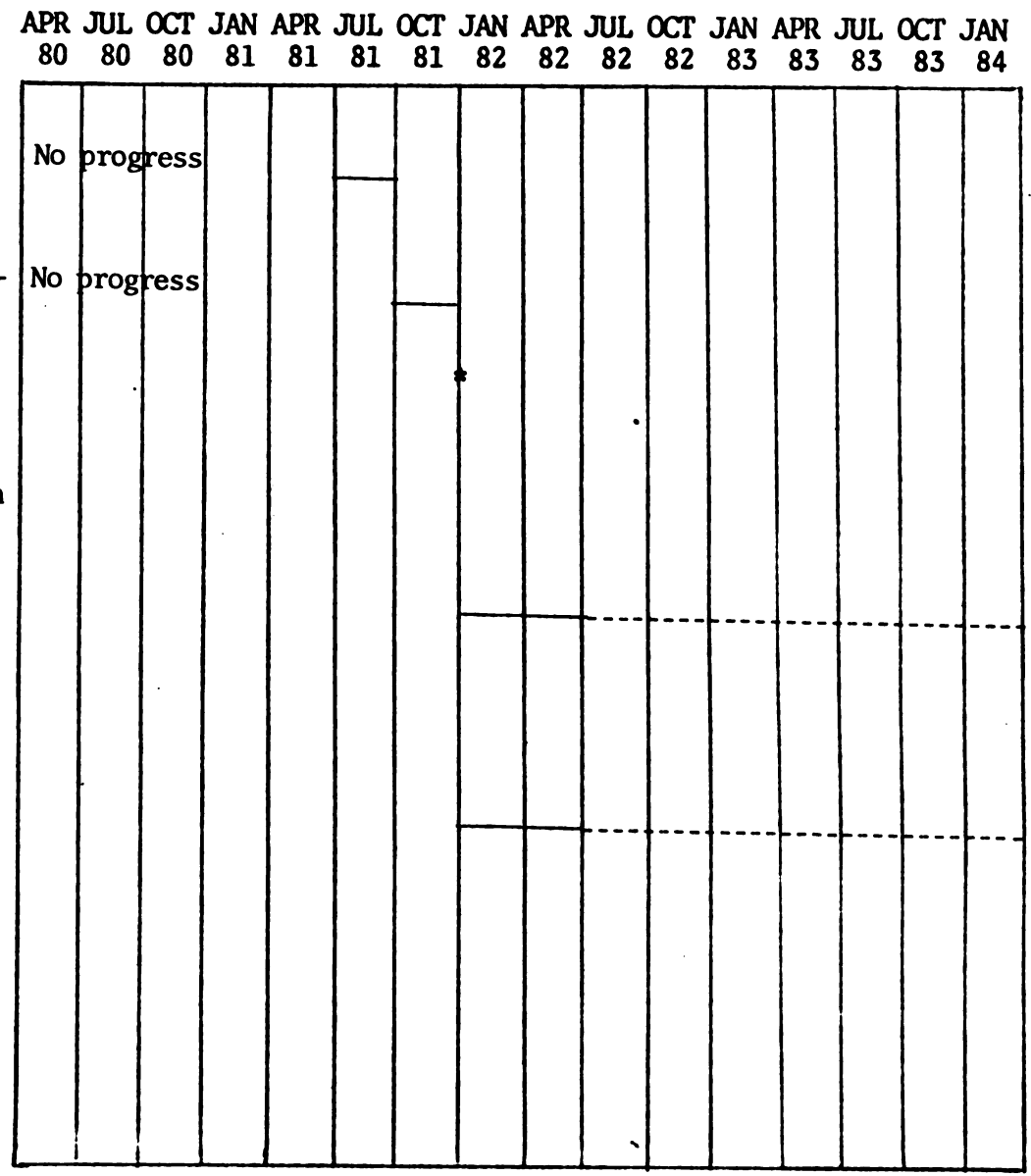
3.1.B. The EMS Commission will evaluate candidates for designation as RMCC'S.

3.1.C. The EMS Commission will designate an RMCC in each region.

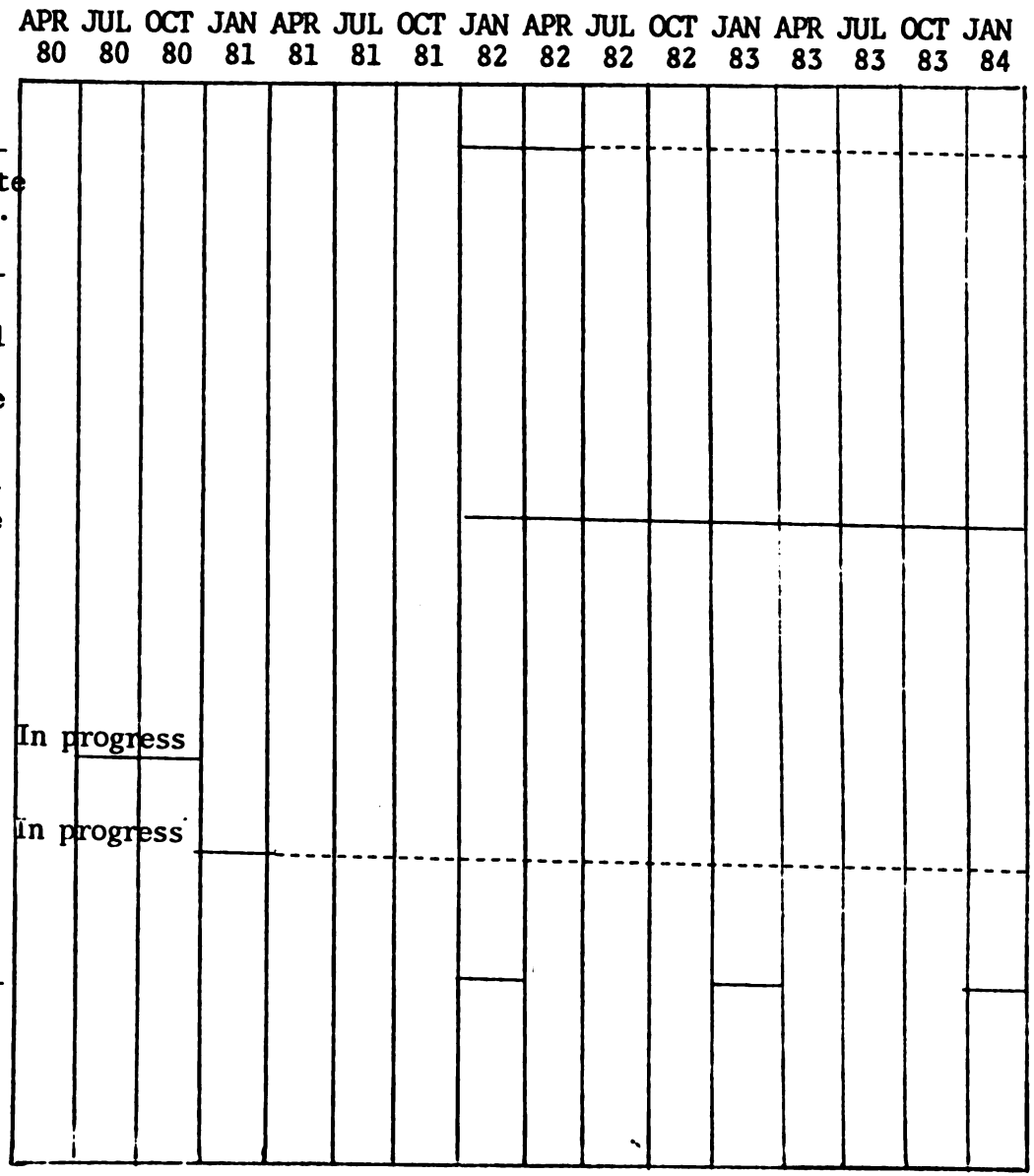
Objective 3.2: To develop and implement Regional EMS Communications Plans consistent with the State EMS Communications Plan.

3.2.A. The RMCC will coordinate the planning, development and operation of EMS communications systems within the region, in cooperation with the RCC, local hospitals, EMS providers and other appropriate agencies.

3.2.B. The RMCC will strive to assure the proper utilization of these systems, through monitoring of the activities of system participants and the establishment of a method for review of communications operating procedures regionwide.



ACTIVITY



3.2.C. The RMCC will develop in cooperation with sponsoring and supervising hospitals, EMS providers and the appropriate interested and involved agencies (e.g. local or regional councils) of a reional Advanced Life Support communications plan which will define, among other things, the mechanism of channel allocation designed to eliminate the probability of co-channel interference of transmitted telemetry signals.

3.2.D. The RMCC will notify all system participants of Commission actions relative to the operations of the system.

Objective 3.3: To develop and distribute an implementation manual to compliment the State Communications Plan.

3.3.A. The EMS Commission will develop a Communications Implementation Manual.

3.3.B. The EMS Commission will print and distribute the Communications Implementation Manual.

3.3.C. The EMS Commission will review and revise annually the Communications Implementation Manual.

Objective 3.4: To develop an IHERN (Indiana Hospital Emergency Radio Network) Manual and Directory.

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
3.4.A. The EMS Commission will develop an IHERN Manual and Directory.	← Done: August 1980.															
3.4.B. The EMS Commission will print and distribute the IHERN Manual and Directory.	← Done: In October 1980, copies of the IHERN Manual and Directory were mailed to all ambulance service providers and hospitals in the State.															
3.4.C. The EMS Commission will review and revise the IHERN Manual and Directory every two years.																
Objective 3.5: To promote the completion of the Indiana Hospital Emergency Radio Network, including both 155.340 and 155.280.																
3.5.A. Provide technical assistance to hospitals in upgrading their IHERN capabilities to include both 155.340 and 155.280.	In progress															
3.5.B. The EMS Commission will explore funding through the Department of Traffic Safety to complete the IHERN system.	M		Done: Due to the completion of the essential IHERN frequency of 155.340, and the current available level of FY 1982 Highway Safety funding for equipment, monies available were transferred into ambulances, mobil radios, and extrication equipment.													
3.5.C. Develop and circulate an IHERN participation agreement for EMS ambulance service providers and hospitals.	M—		Done: Contained in IHERN Manual													
Objective 3.6: To promote regional coordination of UHF "Medical Frequencies", and the designation and identification of "Med Eight" (463.175/468.175) as a statewide "hailing frequency" for ALS.																

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
3.6.A. The EMS Commission will explore funding through the Department of Traffic Safety to improve the UHF medical system in the State.	Done: Due to current available level of Highway Safety funding, and future restriction of funds to use for training, it was unfeasable to seek Highway Safety monies for this purpose. See 3.5.B above.															

4. TRANSPORTATION Sub-Goal: There will be a sufficient number of strategically placed certified ambulances (both primary and secondary) to meet the need of each region and of the state.

Objective 4.1: To promote a maximum ambulance response time of 20 minutes in 95% of all emergency responses.

ACTIVITY

4.1.A. The EMS Commission, with the RCCs will determine areas currently exceeding the 20 minute response objective.

4.1.B. The EMS Commission and the RCCs, in cooperation with local providers, will develop a vehicle placement and/or procurement strategy for the areas identified above.

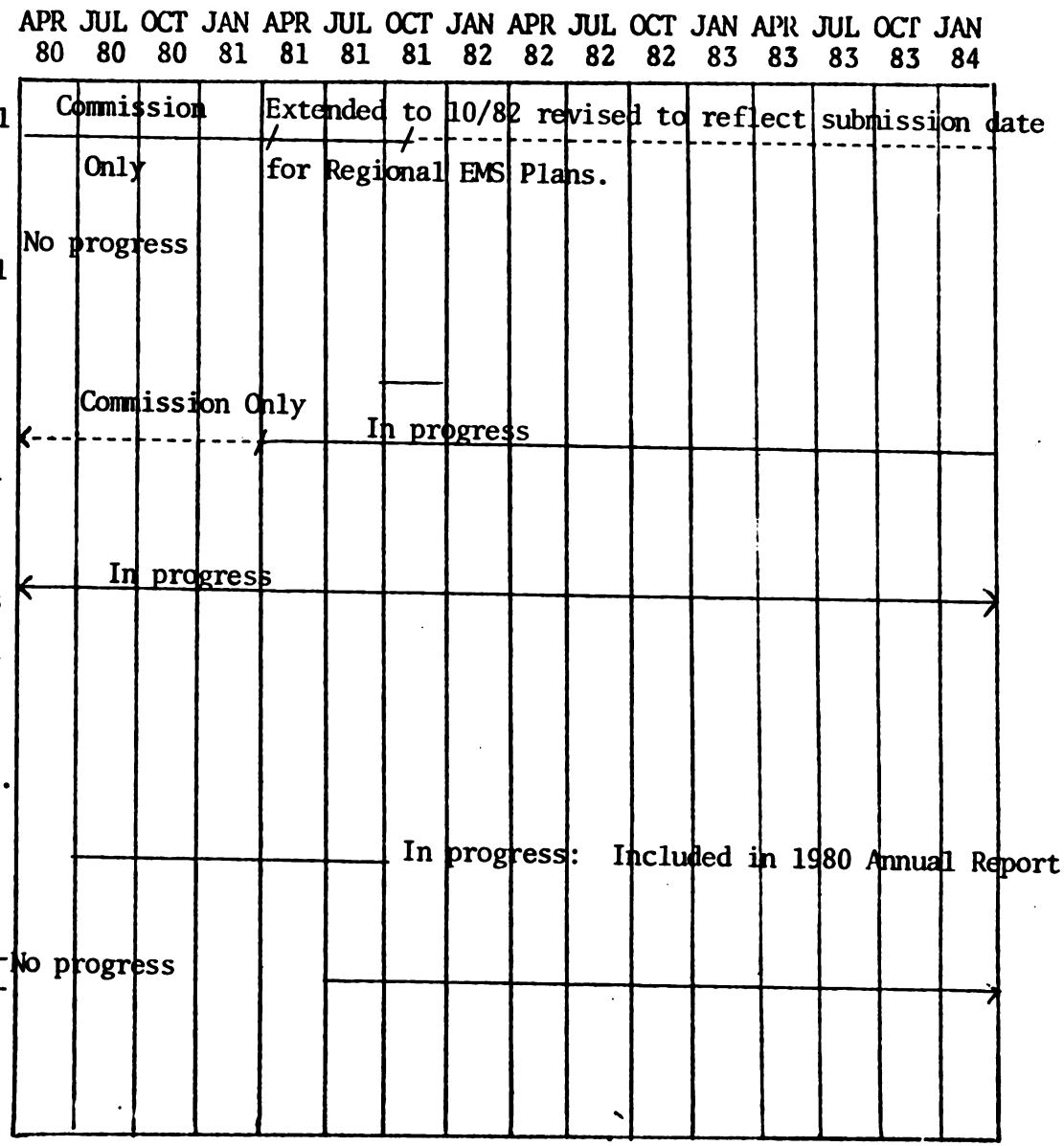
4.1.C. The EMS Commission and the RCCs will assist local units of government and providers in developing methods to improve response times where needed.

4.1.D. The Commission will continue to provide funding assistance to local units of government toward the purchase of vehicles and mobile radios based on published funding guidelines.

Objective 4.2: To promote the development of a statewide system of secondary transportation.

4.2.A. The EMS Commission will assess the secondary transportation system in Indiana.

4.2.B. The EMS Commission will promote and assist in the development of a comprehensive secondary transportation system based on the results of the assessment referred to in 4.2.A.



5. FACILITIES/CRITICAL CARE UNITS Sub-Goal: There will be easily accessible emergency medical service facilities and critical care units (Cardiac, Burn, Poison, Psychiatric, Neonatal, and Trauma) which are available and open to provide service 24 hours/day, 7 days/week.

Objective 5.1: To identify Emergency Medical Service facilities and Critical Care Units throughout the State.

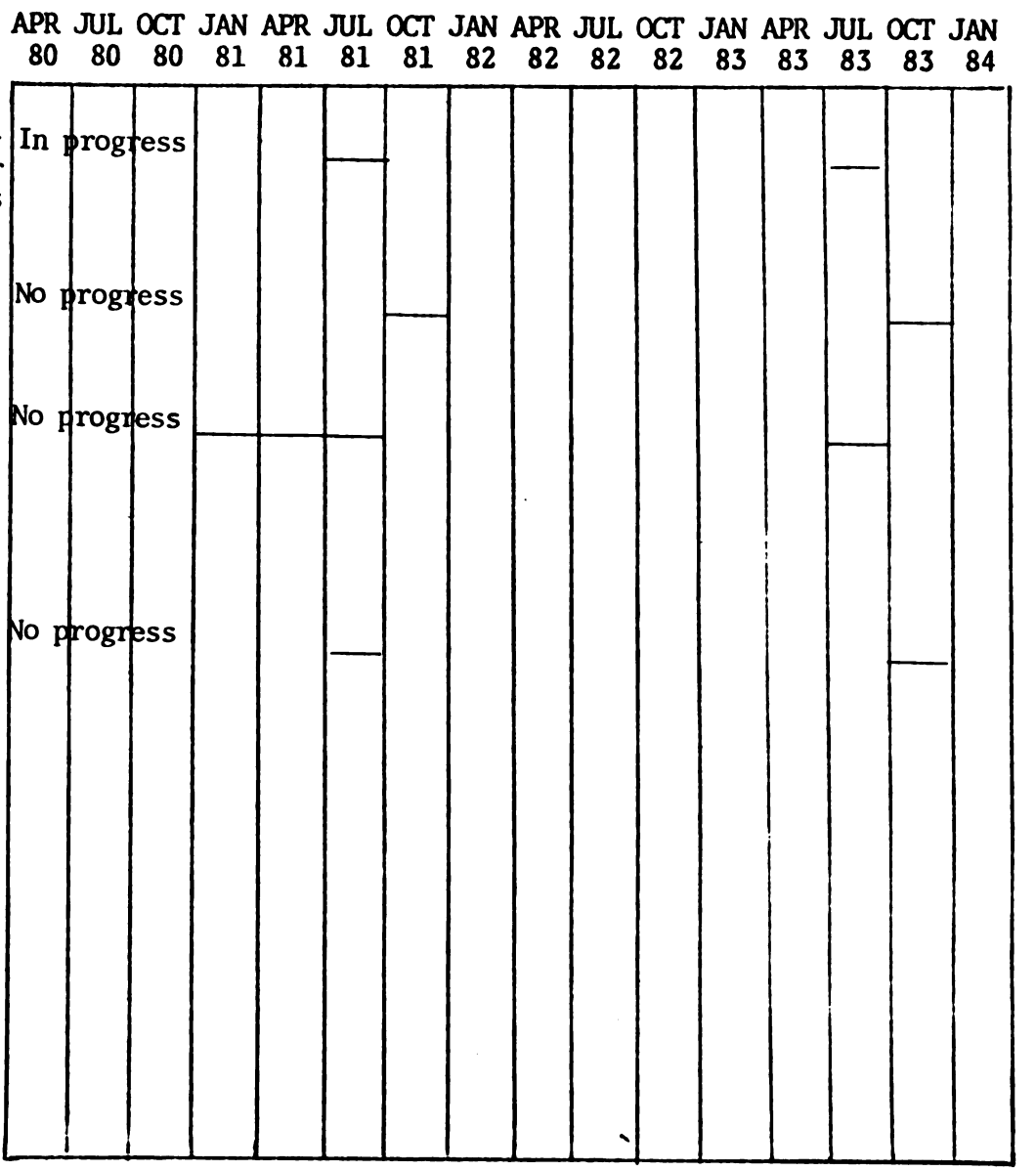
ACTIVITY

5.1.A. The EMS Commission will review and revise, as necessary, the guidelines for horizontal categorization of hospitals every two years.

5.1.B. The EMS Commission will conduct a horizontal categorization survey every two years.

5.1.C. The EMS Commission will develop, in cooperation with other appropriate agencies, guidelines for vertical categorization of hospitals' critical care capabilities and review and revise these guidelines every two years.

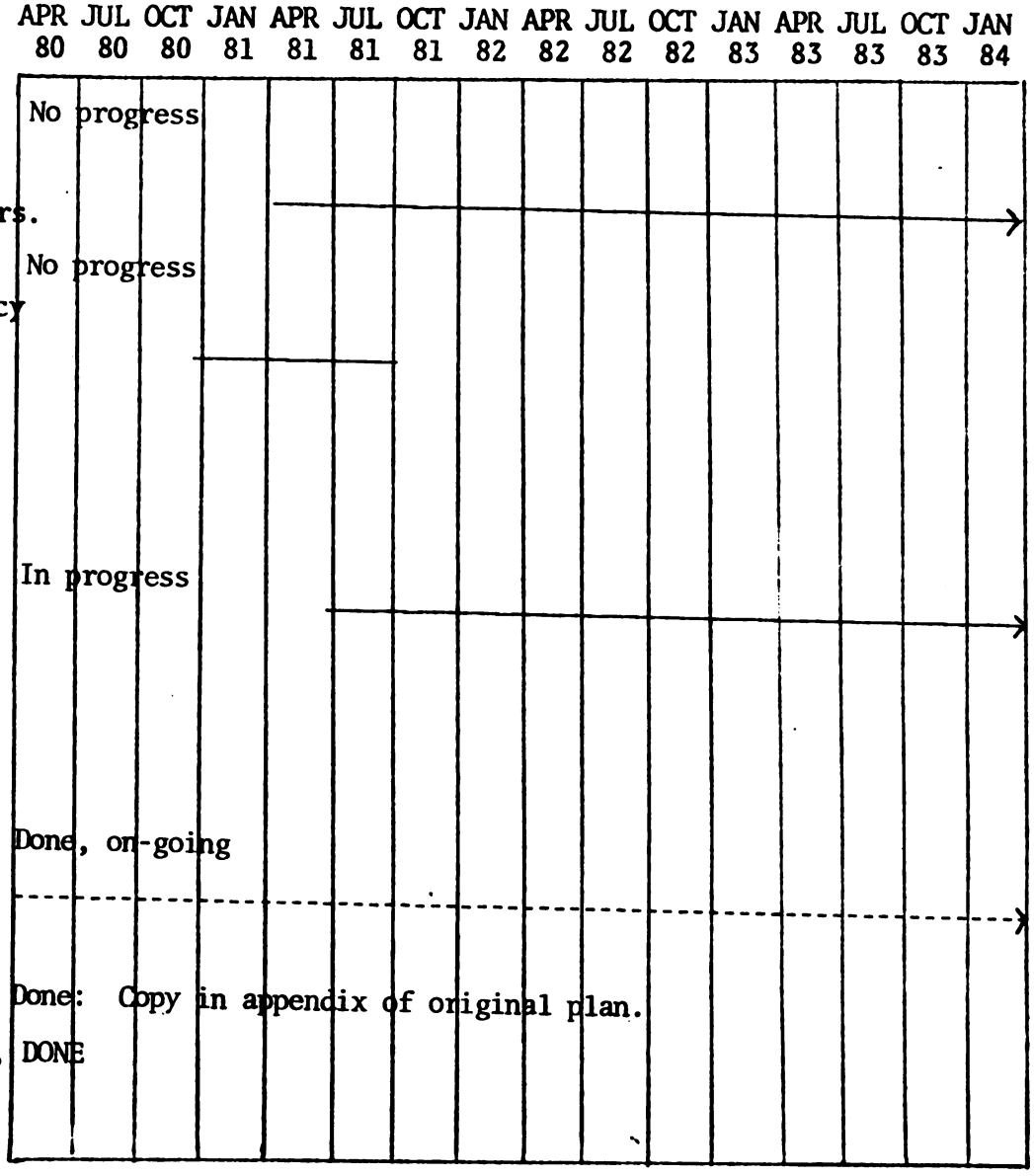
5.1.D. The EMS Commission will conduct a vertical categorization survey every two years.



6. PUBLIC SAFETY AGENCIES Sub-Goal: Promote the availability and involvement of public safety agencies within the total Emergency Medical Service system, through adequate training of personnel, integration of communication, transportation capabilities and extrication services throughout the state.

Objective 6.1: To promote inter-agency communication interface for proper management of resources in medical emergencies.

ACTIVITY



6.1.A. The RCC, with the Regional Medical Communication Center, will endeavor to coordinate frequencies in the region between public safety agencies and Emergency Medical Service providers.

6.1.B. The EMS Commission will explore funding for upgrading coordinated frequency communications between public safety agencies and EMS providers.

Objective 6.2: To promote understanding and cooperation between EMS providers and public safety agencies.

6.2.A. The RCC's will encourage periodic meetings between public safety agencies and EMS providers.

Objective 6.3: To reduce entrapment time and aggravation of injuries by promoting the utilization of state-of-the-art extrication techniques.

6.3.A. The Emergency Medical Services Commission will conduct a survey and collate data to determine scope of extrication services provided.

6.3.B. The Emergency Medical Services Commission will develop guidelines for categorization of extrication services, based upon available manpower, equipment, and training levels. (Note: this activity has been completed. See Appendix)

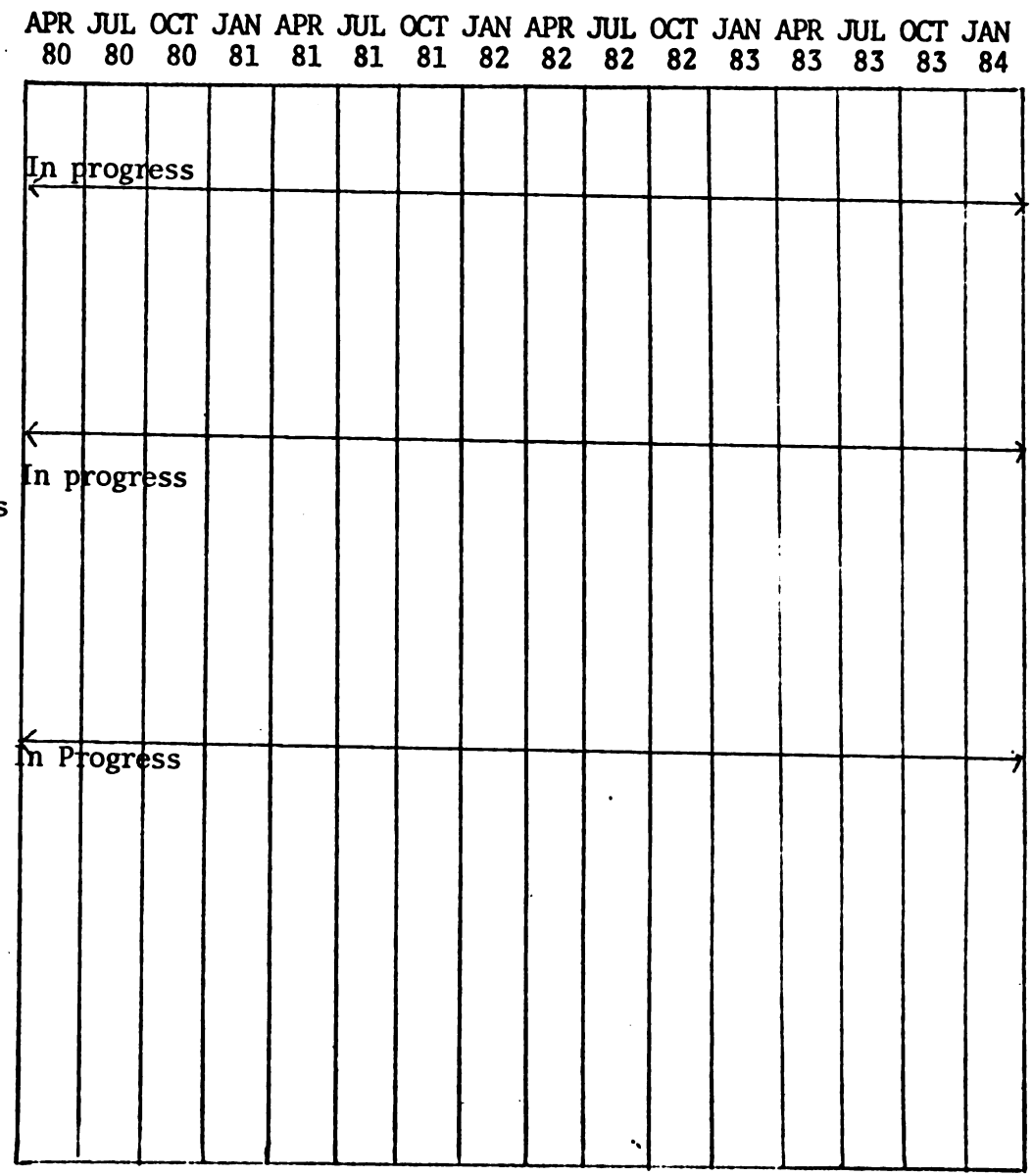
ACTIVITY

	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
6.3.C. The Commission will encourage the availability within a twenty minute response time at least one county based extrication service at the designated Level Two. (See Appendix)	In progress															
6.3.D. The Commission will encourage the availability of an extrication service at the designated Level Three in a defined area if the need is demonstrated by the region(s) and endorsed by the RCC(s).	In progress															
6.3.E. The Commission will provide funding assistance to local units of government toward the purchase of heavy duty power extrication spreader tools based on published funding criteria to achieve one (1) such tool per county as a minimum.	In progress															
6.3.F. The Commission will provide funding assistance to local units of government toward the purchase of heavy extrication equipment sets.	In progress															
6.3.G. The EMS Commission will explore various methodologies for the research and testing of emergency rescue and extrication equipment.	The DHHS 1205 EMS research monies are no linger available. However, the EMSC does subscribe to Technology for EMS, published by the Emergency Care Research Institute (ECRI).															

7. CONSUMER PARTICIPATION Sub-Goal: There will continue to be provisions for consumer participation in the policy-making decisions of the EMS Commission, and there will be consumer members on local and regional EMS organizations and agencies.

Objective 7.1: To continue to solicit public input into EMS Commission policy-making decisions.

ACTIVITY



7.1.A. The EMS Commission will continue to conduct open business and committee meetings and hold public hearings on rule and regulatory changes.

Objective 7.2: To continue to be responsive to complaints from consumers.

7.2.A. The EMS Commission will continue to investigate thoroughly all alleged violations of Indiana Code 16-1-39, 16-1-40, and all rules and regulations duly promulgated thereunder.

Objective 7.3: To promote the inclusion of consumers in local and regional EMS organizations and agencies.

7.3.A. The EMS Commission will encourage existing and forming EMS organizations and agencies to include the non-EMS affiliated lay public in their organization.

8. ACCESS TO CARE Sub-Goal: Emergency medical care will be available to all residents and transients in Indiana regardless of their ability to pay.

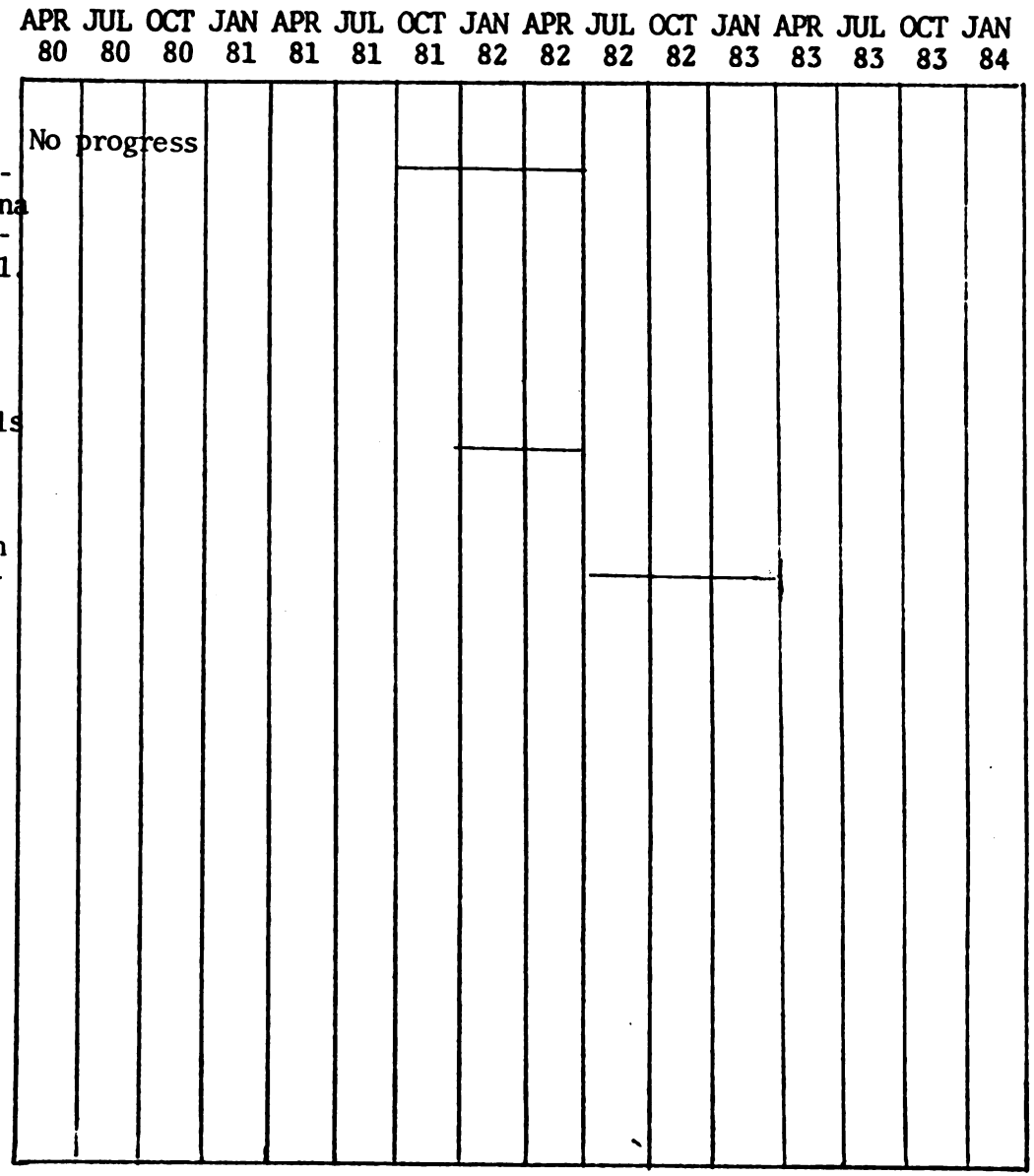
Objective 8.1: To promote the adoption of written policies so that all emergency patients will be cared for regardless of their ability to pay.

ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
8.1.A. The RCC's will identify those institutions and agencies in their region that do have written policies pertaining to non-discriminatory access to care.	Extended to 10/28 revised to reflect submission date for Regional EMS Plans.															
8.1.B. The RCC's will encourage and work with those entities who do not have such policies to develop them.	No progress															
8.1.C. The EMS Commission will develop a position paper on access to care.	Done: In March 1981, the EMSC adopted a position pater on non-discriminatory access to care.															

9. TRANSFER OF PATIENTS Sub-Goal: There will be protocols for the transfer of patients between facilities to assure continuity of care and optimal patient disposition.

Objective 9.1: To develop a model patient transfer protocol for use throughout the state.

ACTIVITY



9.1.A. The EMS Commission will, with assistance from the Indiana Hospital Association's EMSS Committee and the Indiana Chapter of ACEP, formulate and distribute a model patient rransfer protocol.

Objective 9.2: To promote the adoption of written transfer protocols.

9.2.A. The RCC's will identify those hospitals in their region that do have written transfer protocols.

9.2.B. The RCC's will encourage and work with those hospitals that do not have written transfer protocols to adopt them.

NOTE: In September 1981, the BLS and ALS Operations Committees adopted a new policy requiring the distribution of recommended date elements to all ambulance service providers and directed the implementation of a data abstract form in lieu of a detailed Rescue Record Report Form.

10. COORDINATED MEDICAL RECORDKEEPING Sub-Goal: There will be a standardized methodology for gathering data to provide a base from which EMS system assessment, evaluation and planning can be conducted. *

Objective 10.1: To develop a standard Rescue Record Report Form.

ACTIVITY

10.1.A. The EMS Commission will identify the necessary data elements to be included on the form.

10.1.B. The EMS Commission, with the assistance of the State Central Data Processing, or a contractual agency, will format the data elements.

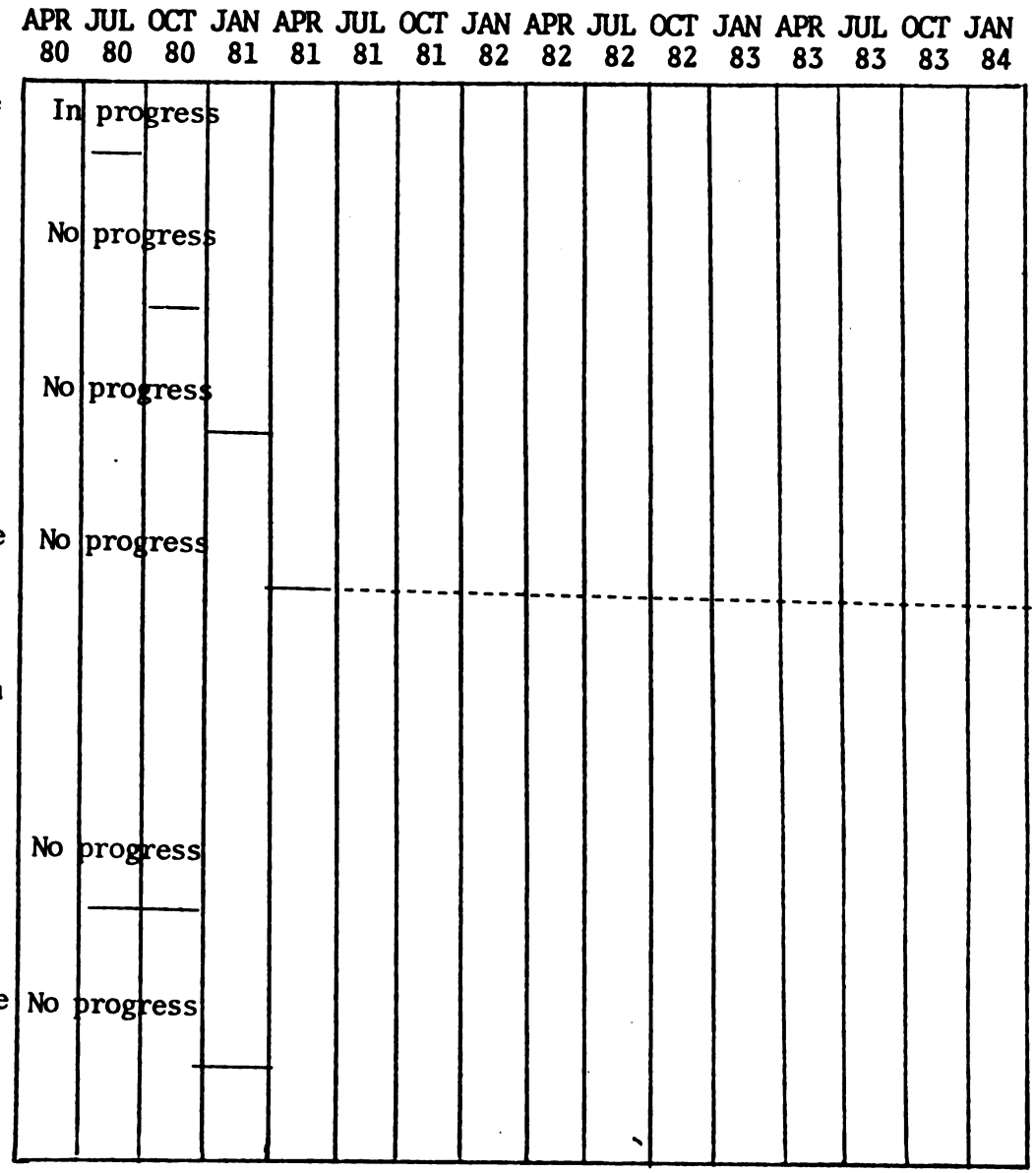
10.1.C. The EMS Commission will conduct a field study of the form to determine it's user acceptability, validity and performance.

10.1.D. After final refinements are made, the EMS Commission will distribute the form for general provider use.

Objective 10.2: To develop a data processing system utilizing the Rescue Record Report Form to provide a means of collecting data for commission use and disseminating it for RCC and individual provider use.

10.2.A. The EMS Commission will identify the system needs and goals with Central Data Processing or a contractual agency.

10.2.B. The EMS Commission will field test the data processing system concurrently with the Rescue Record Report form to determine viability of the system.



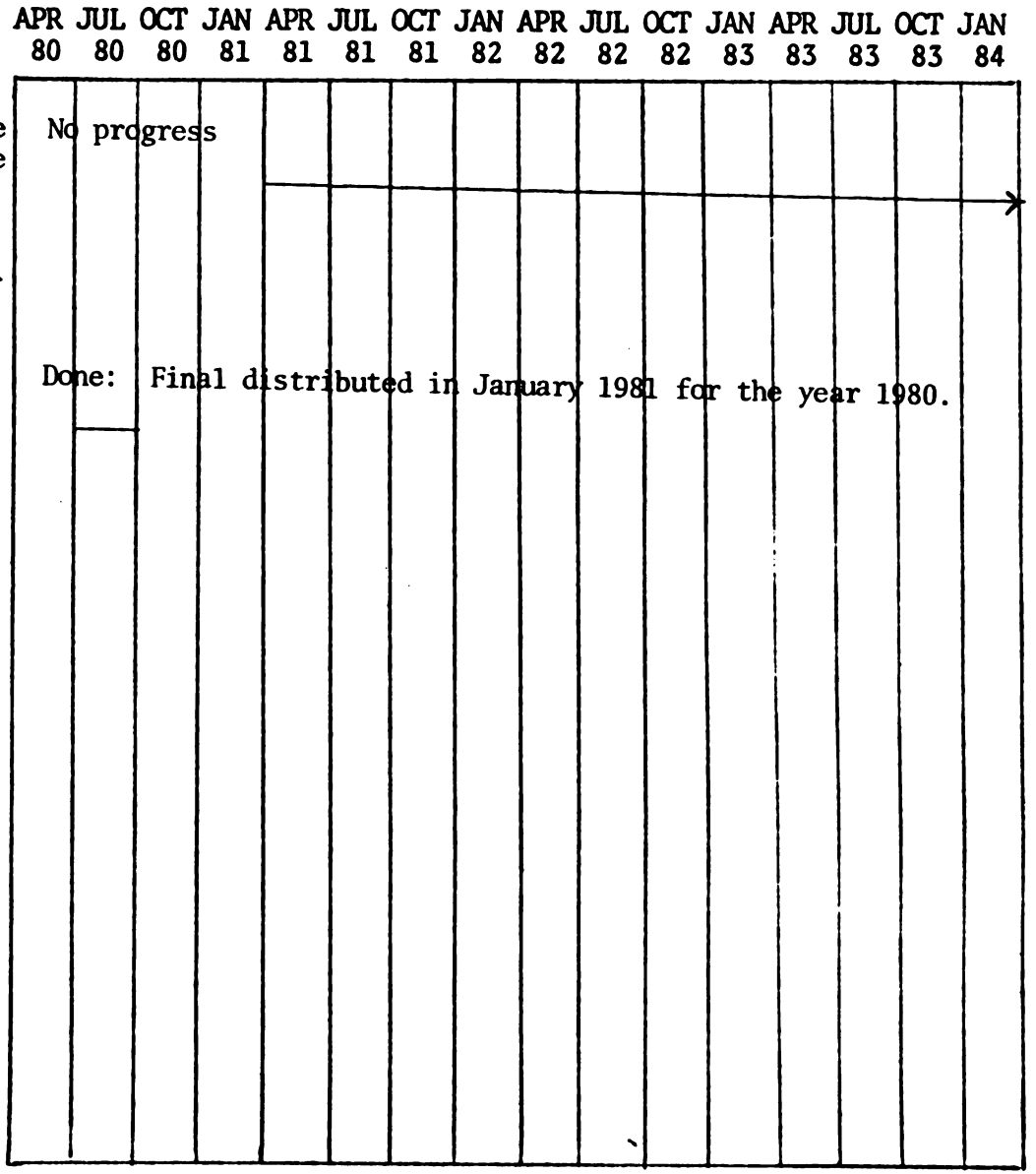
* See note on preceeding page.

ACTIVITY

10.2.C. The EMS Commission will implement the data processing system on a statewide basis in cooperation with the RCCs and the local providers.

Objective 10.3: To develop an Annual Provider Report Form.

10.3.A. The EMS Commission will develop an Annual Provider Report form for use by providers at time of recertification.



11. PUBLIC INFORMATION AND EDUCATION Sub-Goal: There will be a public information and education program which provides information on the effective and efficient use of the EMS system and generates public support to continue and expand the services provided by the EMS system.

Objective 11.1: To establish citizen-targeted first-aid and CPR courses.

ACTIVITY

11.1.A. Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.

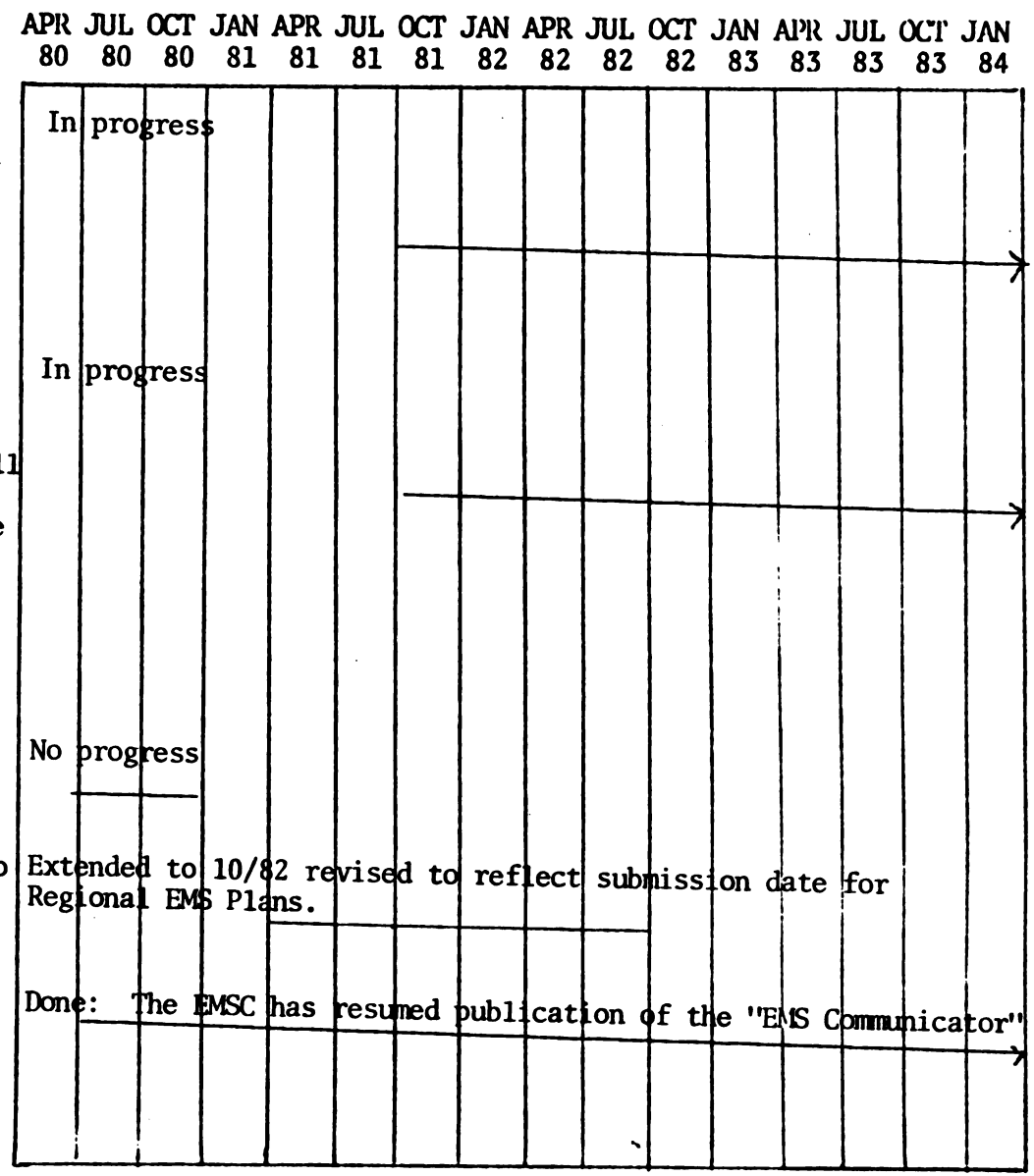
11.1.B. Local affiliates of the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic first aid classes, in cooperation with the RCC, to meet the identified needs of the region.

Objective 11.2: To develop a detailed plan and implementation strategy for Public information and Education.

11.2.A. The EMS Commission will identify Public Information and Education priorities and guidelines.

11.2.B. The RCCs will develop a methodology to address identified priorities for each region.

11.3.A. The EMS Commission will publish a state-wide EMS newsletter.



12. EVALUATION Sub-Goal: There will be at the state, regional, local and provider level, a formal method of periodically reviewing and evaluating the appropriateness and effectiveness of the emergency medical services system.

Objective 12.1: To identify component elements to be evaluated in the EMS system.

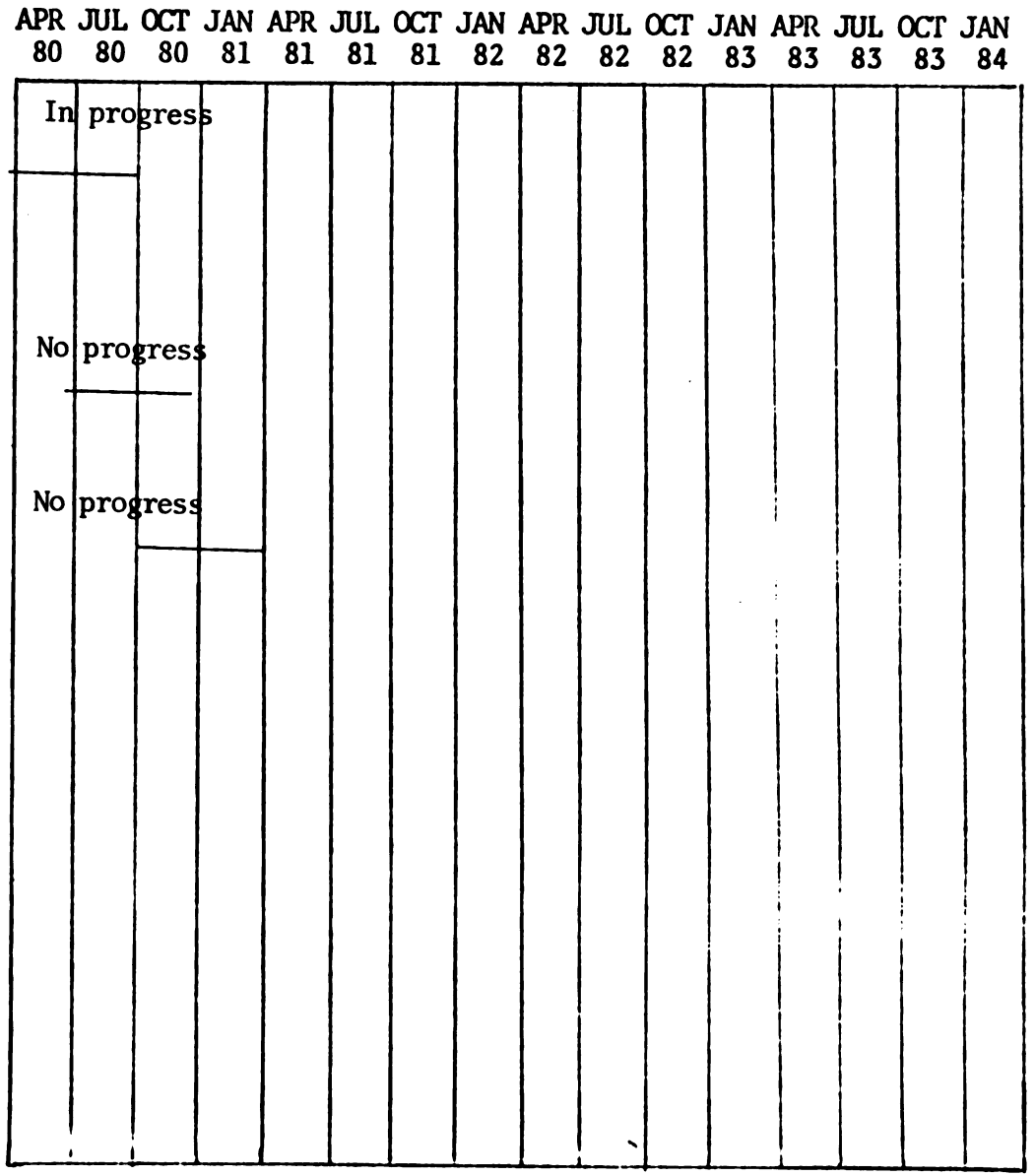
ACTIVITY

12.1.A. The EMS Commission, with the help from its supplementary agencies, will identify the appropriate elements to be measured.

Objective 12.2: To develop an evaluation methodology.

12.2.A. The EMS Commission, with help from its supplementary agencies, will develop necessary evaluation instruments.

12.2.B. The EMS Commission, with help from its supplementary agencies, will develop evaluation procedures.



13. DISASTER LINKAGE Sub-Goal: The EMS system will be capable of providing emergency care and transportation during mass-casualty situations and natural disasters.

Objective 13.1: To promote the development and maintenance of coordinated county and regional medical emergency disaster plans.

ACTIVITY

13.1.A. The RCCs will identify existing provider, local, county and regional disaster plans.

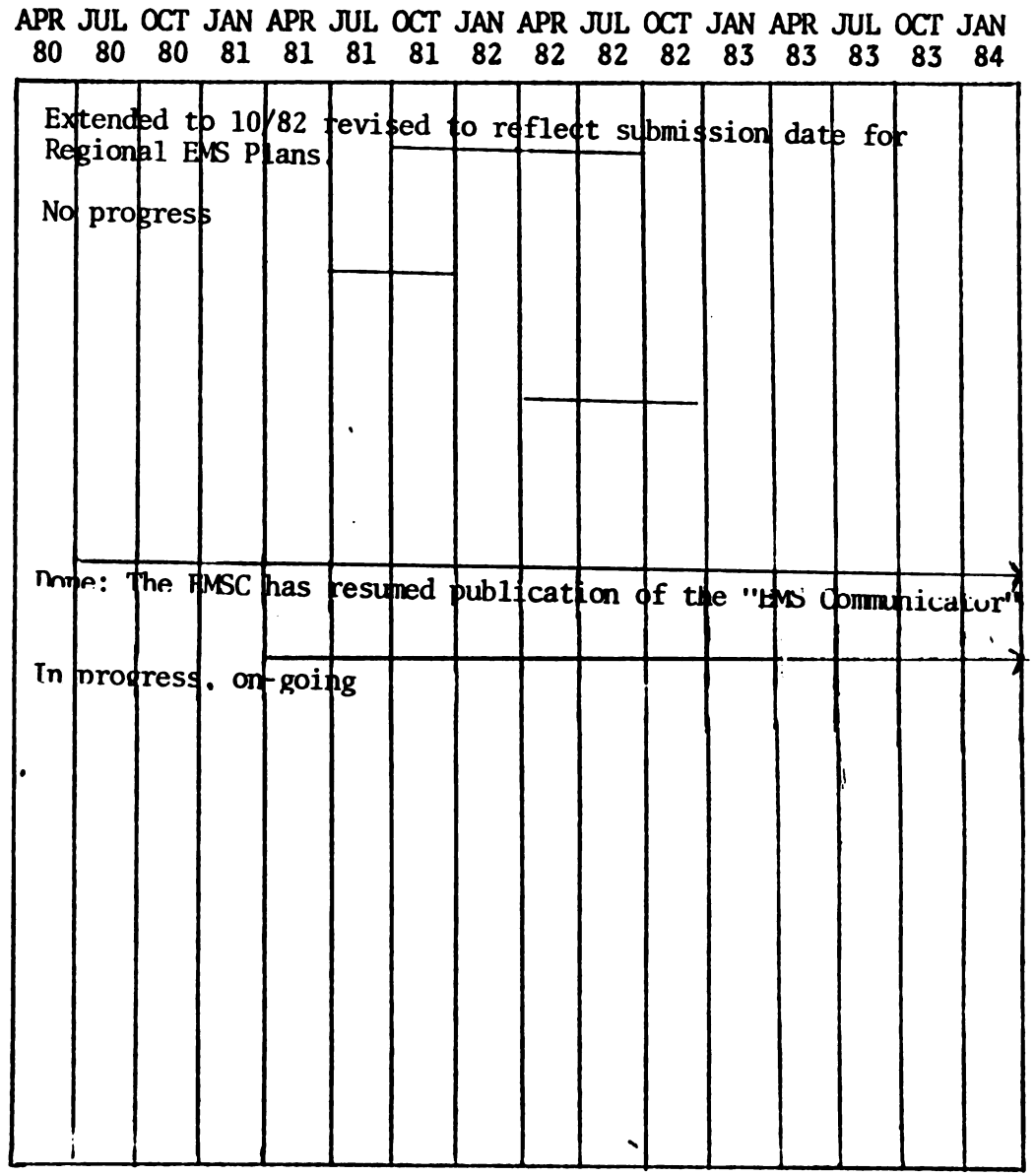
13.1.B. The EMS Commission will develop "model" medical emergency disaster plans.

13.1.C. The RCCs will assist county authorities in developing and adopting medical emergency disaster plans.

Objective 13.2: To promote public awareness of disaster operations and procedures.

13.2.A. The EMS Commission will publish a state-wide EMS newsletter.

13.2.B. The RCC's will issue news releases as necessary, to inform the general public.



14. MUTUAL AID AGREEMENTS Sub-Goal: Written Mutual Aid Agreements will exist between all EMS providers in adjacent service areas to assure assistance on a reciprocal basis when the need for service is beyond the capabilities of any one provider.

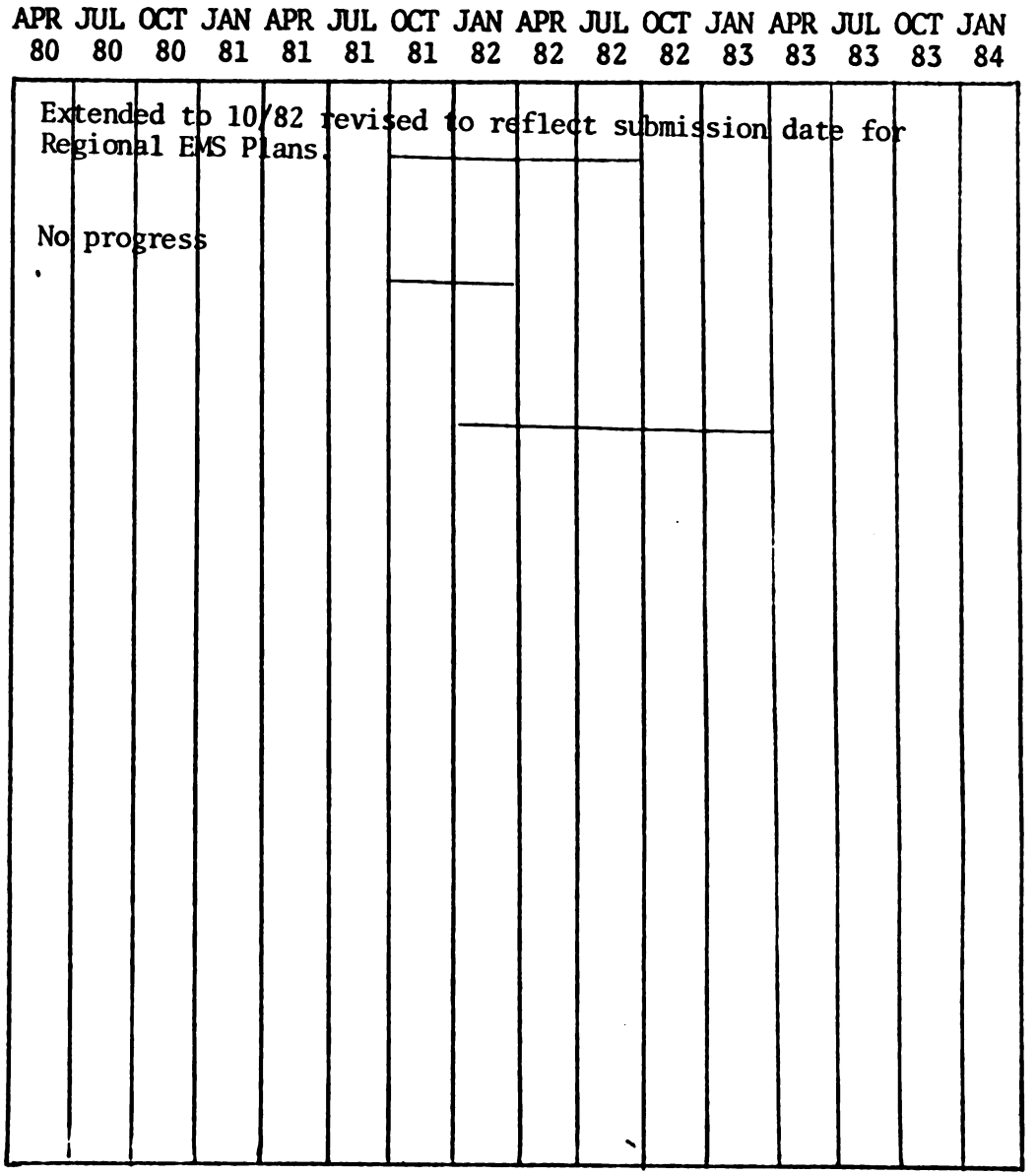
Objective 14.1: To promote the adoption and maintenance of formal Mutual Aid Agreements.

ACTIVITY

14.1.A. The RCC's will survey EMS providers in their region to identify existing Mutual Aid Agreements.

14.1.B. The EMS Commission with help from its supplementary agencies, will develop a "model" Mutual Aid Agreement.

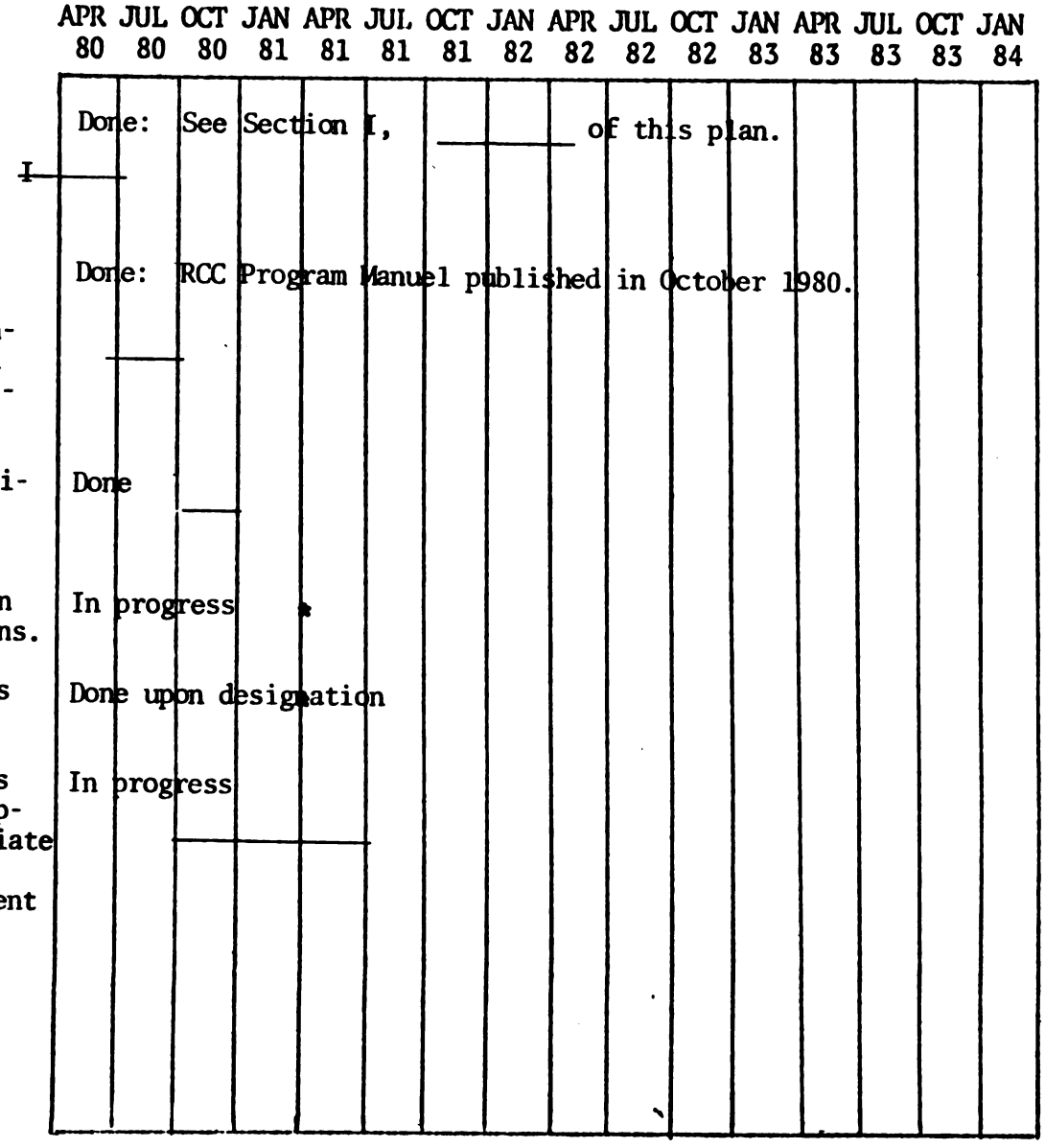
14.1.C. The RCC's will assist EMS providers in adopting Mutual Aid Agreements.



15. SYSTEM MANAGEMENT Sub-Goal: There will be established a management and administrative framework on a state and regional basis to insure the efficient delivery of emergency medical services which includes a hierarchy of authority, appropriate lines of communications, and definition of participant roles and responibilities.

Objective 15.1: To provide regional EMS systens management.

ACTIVITY



ACTIVITY

Objective 15.2: To provide professional staff support to the designated RCCS.

15.2.A. Under the present contract with the EMS Commission (effective until September 30, 1980), the present Regional Coordinators will provide assistance to the applying/developing RCCs.

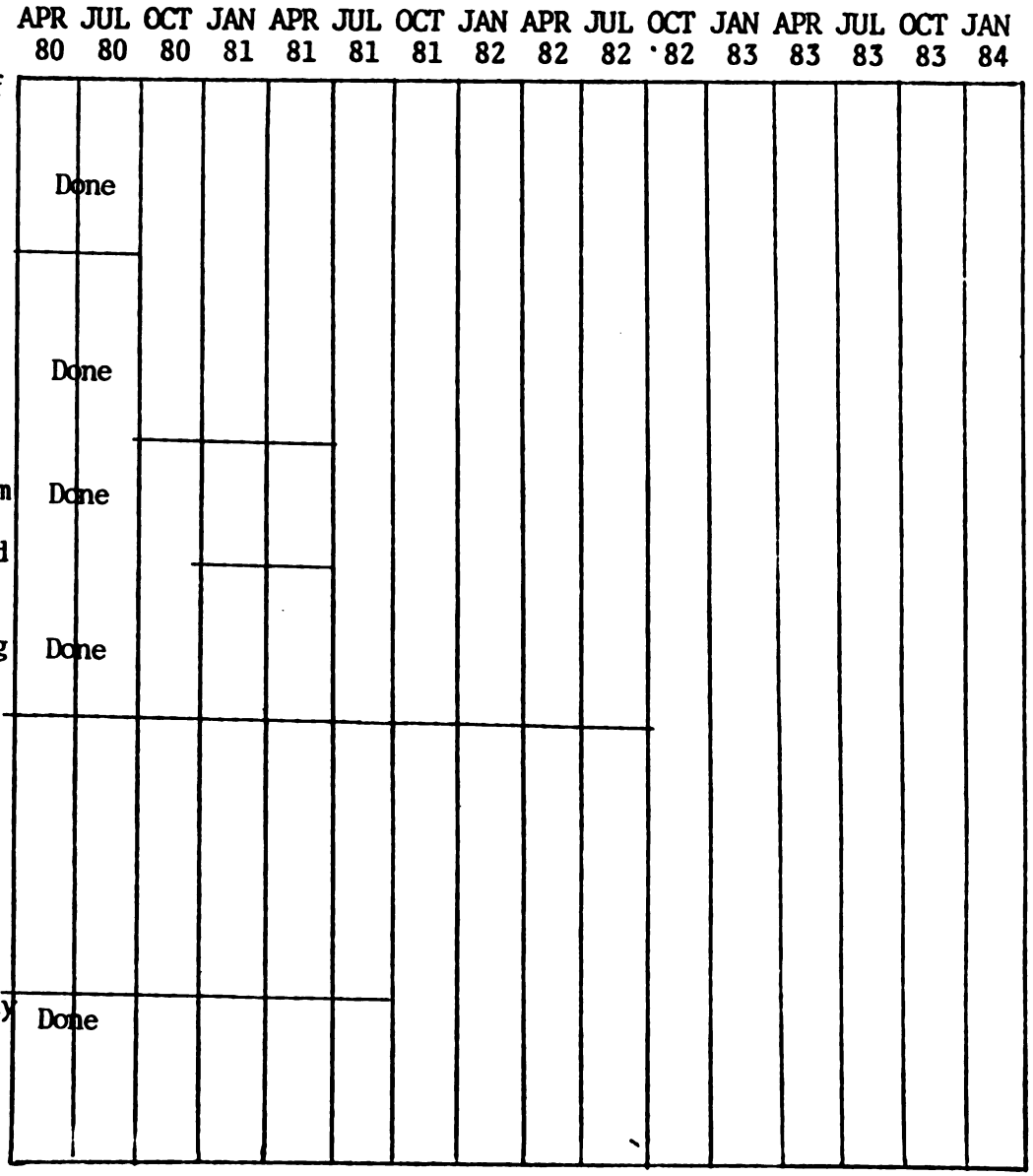
15.2.B. The EMS Commission will use its available funds to renew the present HSA contract through June 30, 1981.

15.2.C. The EMS Commission will seek funds from the 1981 General Assembly to maintain, on a continuing basis, a regional field staff.

15.2.D. The EMS Commission will explore funding alternatives from the Indiana Department of Traffic Safety to offset planning and administrative costs of the RCCs.

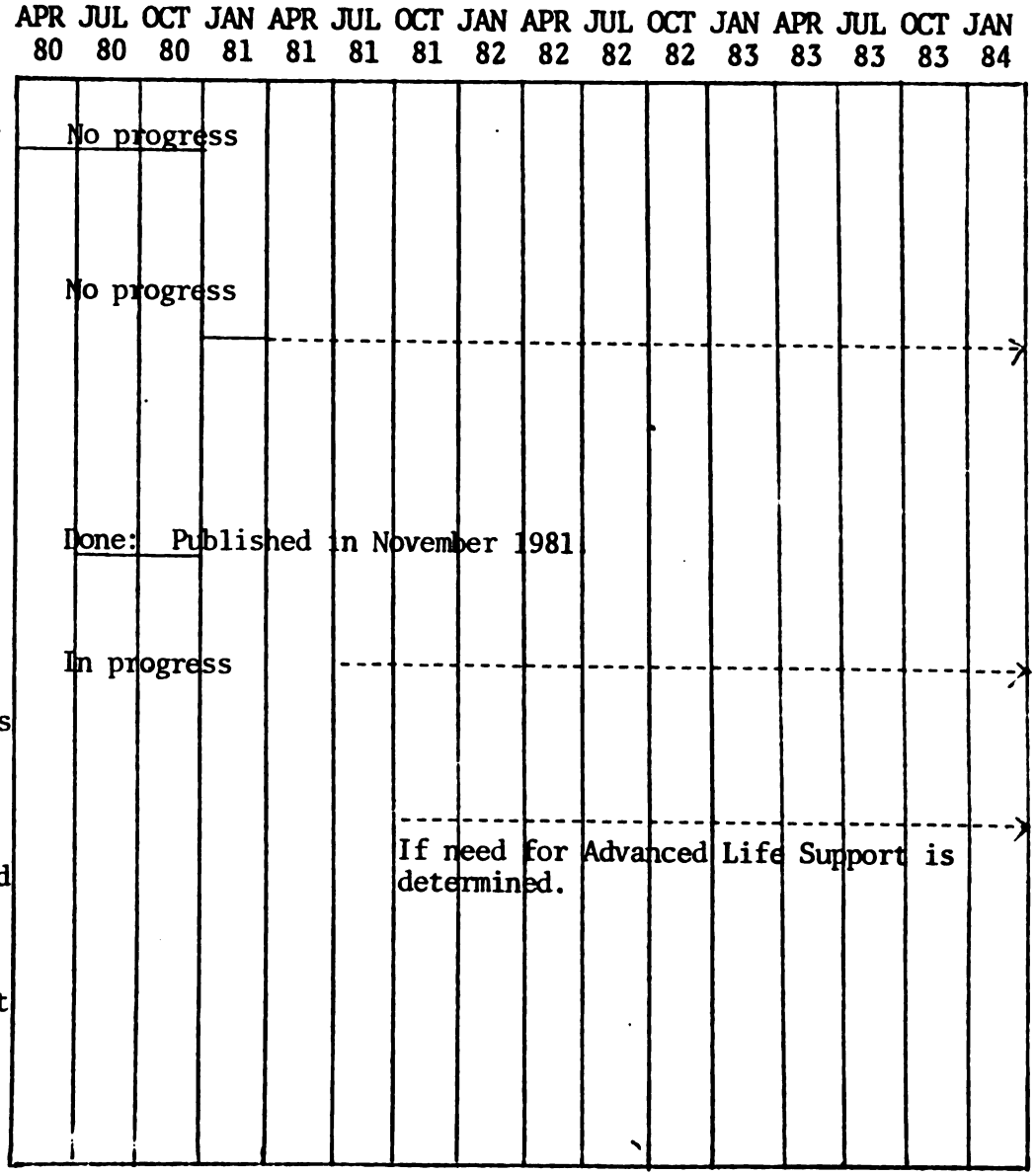
Objective 15.3: To provide continuing professional staff support to the EMS Commission.

15.3.A. The EMS Commission seek funding from the Indiana Department of Traffic Safety to continue the staff positions of Planning Associate and one clerical position.



ACTIVITY	APR 80	JUL 80	OCT 80	JAN 81	APR 81	JUL 81	OCT 81	JAN 82	APR 82	JUL 82	OCT 82	JAN 83	APR 83	JUL 83	OCT 83	JAN 84
15.3.B. The EMS Commission will seek funding from the Indiana General Assembly in the next biennial budget to assume fiscal responsibility for the Planning Associate and clerical position.	Done															
Objective 15.4: To designate regional practical examination teams to administer the practical skills examinations for EMT and Department of Transportation Refresher Courses.																
15.4.A. The EMS Commission will identify the role and responsibilities of the regional practical examination team.	Done															
15.4.B. The RCCs will designate regional practical examination teams.	In progress															
15.4.C. The Regional Coordinators and the RCCs will coordinate the administration of practical examinations.	In progress															
Objective 15.5: To conduct a statewide emergency medical services seminar.																
15.5.A. The EMS Commission will plan, develop, and conduct an EMS seminar every two years.	The first Indiana Conference on EMS was held in October 1980. Due to its success, the second conference was conducted in September 1981.															
Objective 15.6: To develop and distribute model written protocols for Basic Life Support and Advanced Life Support operations.																

ACTIVITY



15.6.A. The EMS Commission will review existing protocols and solicit input to formulate reasonable and appropriate operational protocols.

15.6.B. The EMS Commission will distribute these protocols to all concerned agencies and individuals.

Objective 15.7: To insure the smooth and efficient development of Advanced Life Support programs.

15.7.A. The EMS Commission will develop and publish an Advanced Life Support systems manual.

15.7.B. The RCCs will determine the regional need for Advanced Life Support utilizing the Advanced Life Support systems manual.

15.7.C. The RCCs will coordinate the development of Advanced Life Support systems regionally to meet the identified need in 15.7.B. (NOTE: Advanced Life Support needs assessment may determine that the regions cannot, at that time, support an Advanced Life Support effort.)

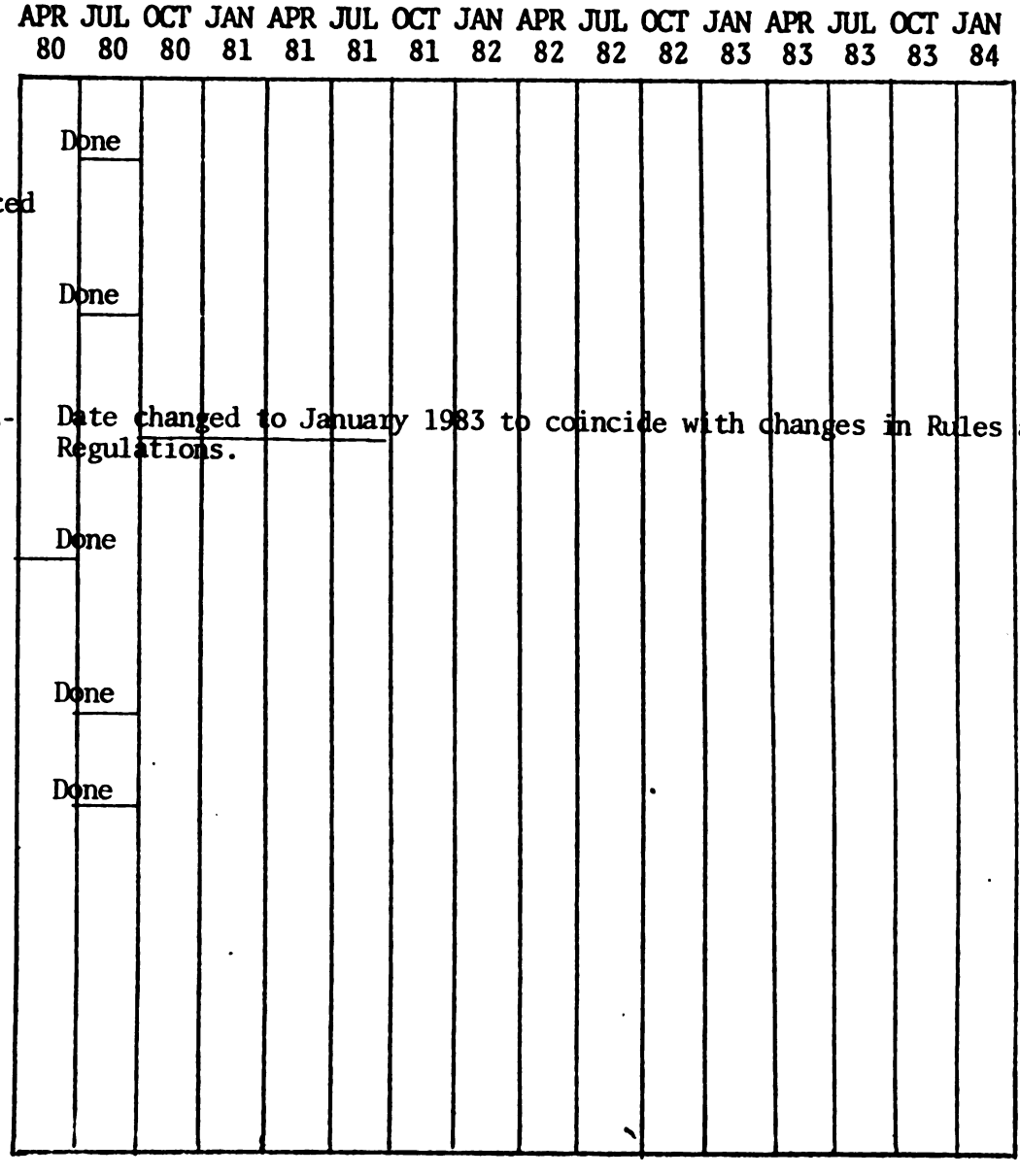
Objective 15.8: To evaluate the Emergency Medical Technician Test.

ACTIVITY	APR 80 – JAN 84
15.8.A. Indiana State University will provide computer services and conduct reliability and validity studies.	In December 1980, Indiana State University completed a study of the Indiana EMS system, done under contract to the EMSC.
15.8.B. Indiana State University will provide services necessary to prepare test forms, grade written tests, and print test scores and mailing lists.	In progress

Objective 15.9: To evaluate the Emergency Paramedic Examination.

15.9.A. Indiana State University will evaluate the examinations of some 163 Paramedic applicants for validity and reliability.	DONE
15.9.B. The Paramedic Test Construction and Evaluation Committee will review and revise current Paramedic Examination.	Done
15.9.C. The Paramedic Test Construction and Evaluation Committee will field test the revised examination.	Done
15.9.D. The Emergency Medical Services Commission will implement the revised Paramedic Examination.	Done effective January 1982
15.9.E. The Paramedic Test Construction and Evaluation Committee will develop a written examination for two levels of Advanced EMTs.	Done: Note that pursuant to the official rules and regulations, after January 1, 1983 there will only be one level of Advanced EMT.

ACTIVITY



VI. PROGRAM RESOURCE AND COMMITMENT SUMMARY

This section is divided into two parts. The first identifies, by activity, what entity(-ies) are involved in the implementation of each activity proposed in Section IV.

The second part of this section lists all entities cited in Section IV, and identifies which activities they are involved in.

Following is a key to the abbreviations used in this section.

ACEP	American College of Emergency Physicians
AHA	American Heart Association
ARC	American Red Cross
CD	Civil Defense
CIEMS	Central Indiana EMS Council
CIHSA	Central Indiana Health Systems Agency
EDNA	Emergency Department Nurses Association
EMSC	Emergency Medical Services Commission
IHA	Indiana Hospital Association
ISMA	Indiana State Medical Association
ISNA	Indiana State Nurses Association
ISP	Indiana State Police
ISU	Indiana State University
LETA	Law Enforcement Training Academy
NIEMS	Northeastern Indiana Emergency Medical Services
NIHSA	Northern Indiana Health Systems Agency
RCC's	Regional Coordination Centers
RMCC's	Regional Medical Communications Centers
SBOH	State Board of Health
SIHSA	Southern Indiana Health Systems Agency
State CDP	State Central Data Processing
TRIAS	Traffic Accident Investigations System Working Committee

ACTIVITY	RESOURCE
Activity 1.1.A	EMSC
Activity 1.1.B	EMSC
Activity 1.2.A	RCC's
Activity 1.2.B	RCC's
Activity 2.1.A	RCC's, local affiliates of ARC, local affilitates of AHA, EMS providers, high schools, hospitals, universities, community organizations, and civic organizations.
Activity 2.1.B	EMSC
Activity 2.2.A	RCC's, local affiliates of ARC, EMS providers, high schools, universities, hospitals, community organizations, and civic organizations.
Activity 2.2.B	EMSC
Activity 2.3.A	EMSC, IHA, NIHSA, CIHSA, SIHSA, CIEMS, NIEMS, and other entities deemed appropriate.
Activity 2.3.B	EMSC, RCC's
Activity 2.3.C	EMSC
Activity 2.4.A	EMSC
Activity 2.4.B	RCC's, LETA, EMS providers, and public safety agencies.
Activity 2.5.A	RCC's
Activity 2.5.B	RCC's, EMS providers, training institutions
Activity 2.6.A	RCC's
Activity 2.6.B	RCC's, training institutions

ACTIVITY	RESOURCE
Activity 2.7.A	RCC's
Activity 2.7.B	EMSC, RCC's, training institutions
Activity 2.8.A	RCC's
Activity 2.8.B	RCC's, Advanced Life Support training institutions
Activity 2.9.A	EMSC, concerned institutions, and appropriate nursing organizations
Activity 2.9.B	RCC's
Activity 2.9.C	RCC's
Activity 2.10.A	EMSC, Indiana Chapter of ACEP,
Activity 2.10.B	EMSC
Activity 2.10.C	RCC's
Activity 2.10.D	RCC's
Activity 2.11.A	EMSC
Activity 2.11.B	RCC's, EMSC trained extrication instructors
Activity 2.11.C	EMSC
Activity 2.12.A	EMSC, RCC's
Activity 2.12.B	EMSC, RCC's, LETA, and other concerned agencies
Activity 2.12.C	EMSC, Traffic Accident Investigations System Working Committee
Activity 2.13.A	EMSC, ISP, CD, SBOH

ACTIVITY	RESOURCE
Activity 2.13.B	EMSC
Activity 2.13.C	EMSC, RCC's
Activity 2.13.D	EMSC
Activity 3.1.A	RCC's
Activity 3.1.B	EMSC
Activity 3.1.C	EMSC
Activity 3.2.A	RCC's, RMCC's, hospitals, EMS providers, other appropriate agencies
Activity 3.2.B	RMCC's
Activity 3.2.C	RMCC's, sponsoring hospitals, supervising hospitals, EMS providers, appropriate interested and involved agencies.
Activity 3.2.D	RMCC's
Activity 3.3.A	EMSC
Activity 3.3.B	EMSC
Activity 3.3.C	EMSC
Activity 3.4.A	EMSC
Activity 3.4.B	EMSC
Activity 3.4.C	EMSC
Activity 3.5.A	EMSC
Activity 3.5.B	EMSC
Activity 3.5.C	EMSC

ACTIVITY	RESOURCE
Activity 3.6.A	EMSC
Activity 4.1.A	EMSC, RCC's
Activity 4.1.B	EMSC, RCC's, EMS providers
Activity 4.1.C	EMSC, RCC's, local units of governments, EMS providers
Activity 4.1.D	EMSC
Activity 4.2.A	EMSC
Activity 4.2.B	EMSC
Activity 5.1.A	EMSC
Activity 5.1.B	EMSC
Activity 5.1.C	EMSC, other appropriate agencies
Activity 5.1.D	EMSC
Activity 6.1.A	RCC's, RMCC's
Activity 6.1.B	EMSC
Activity 6.2.A	RCC's, EMS providers, public safety agencies
Activity 6.3.A	EMSC
Activity 6.3.B	EMSC
Activity 6.3.C	EMSC
Activity 6.3.D	EMSC
Activity 6.3.E	EMSC
Activity 6.3.F	EMSC
Activity 6.3.G	EMSC

ACTIVITY	RESOURCE
Activity 7.1.A	EMSC
Activity 7.2.A	EMSC
Activity 7.3.A	EMSC
Activity 8.1.A	RCC's
Activity 8.1.B	RCC's
Activity 8.1.C	EMSC
Activity 9.1.A	EMSC, IHA EMSS Committee, Indiana Chapter of ACEP
Activity 9.2.A	RCC's
Activity 9.2.B	RCC's, hospitals
Activity 10.1.A	EMSC
Activity 10.1.B	EMSC,State Central Data Processing or contractural agency
Activity 10.1.C	EMSC
Activity 10.1.D	EMSC
Activity 10.2.A	EMSC, State Central Data Processing or contractural agency
Activity 10.2.B	EMSC
Activity 10.2.C	EMSC, RCC's, EMS providers
Activity 10.3.A	EMSC
Activity 11.1.A	RCC's, local affiliates of ARC, local affiliates of AHA, EMS providers, high schools, universities, hospitals, community organizations, and civic organizations

ACTIVITY	RESOURCE
Activity 11.1.B	RCC's, local affiliates of ARC, EMS providers, high schools, universities, hospitals, community organizations, and civic organizations
Activity 11.2.A	EMSC
Activity 11.2.B	RCC's
Activity 11.3.A	EMSC
Activity 12.1.A	EMSC, complementary agencies
Activity 12.2.A	EMSC, complementary agencies
Activity 12.2.B	EMS, complementary agencies
Activity 13.1.A	RCC's
Activity 13.1.B	EMSC
Activity 13.1.C	RCC's, county authorities
Activity 12.2.A	EMSC
Activity 13.2.B	RCC's
Activity 14.1.A	RCC's
Activity 14.1.B	EMSC, complementary agencies
Activity 14.1.C	RCC's
Activity 15.1.A	EMSC
Activity 15.1.B	EMSC
Activity 15.1.C	EMSC
Activity 15.1.D	EMSC
Activity 15.1.E	EMSC

ACTIVITY	RESOURCE
Activity 15.1.F	EMSC
Activity 15.2.A	Regional Coordinators
Activity 15.2.B	EMSC
Activity 15.2.C	EMSC
Activity 15.2.D	EMSC
Activity 15.3.A	EMSC
Activity 15.3.B	EMSC
Activity 15.4.A	EMSC
Activity 15.4.B	RCC's
Activity 15.4.C	RCC's, Regional Coordinators
Activity 15.5.A	EMSC
Activity 15.6.A	EMSC
Activity 15.6.B	EMSC
Activity 15.7.A	EMSC
Activity 15.7.B	RCC's
Activity 15.7.C	RCC's
Activity 15.8.A	ISU
Activity 15.8.B	ISU

ACTIVITY	RESOURCE
Activity 15.9.A	ISU
Activity 15.9.B	Paramedic Test Construction and Evaluation Committee
Activity 15.9.C	Paramedic Test Construction and Evaluation Committee
Activity 15.9.D	EMSC
Activity 15.9.E	Paramedic Test Construction and Evaluation Committee
Activity 15.9.F	Paramedic Test Construction and Evaluation Committee
Activity 15.9.G	Paramedic Test Construction and Evaluation Committee
Activity 15.9.H	EMSC
Activity 15.9.I	Advanced Life Support Operations Committee
Activity 15.9.J	EMSC
Activity 15.9.K	EMSC

Hospitals	2.1. A 2.2. A 3.2. A 3.2. C 9.2. B 11.1.A 11.1.B
HSA's	2.3. A
IHA	2.3. A 9.1. A
ISMA	2.10.A
ISNA	2.9. A
ISP	2.13.A
ISU	15.8.A 15.8.B 15.9.A
LETA	2.4. B 2.12.B
Local Units of Government	14.1.C
NIEMS	2.3. A
Paramedic Test Construction and Evaluation Committee	15.9.B 15.9.C 15.9.E 15.9.F 15.9.G
PSA's	15.2.A
Regional Coordinators	15.2.A 15.4.B
RMCC's	3.2. A 3.2. B 3.2. C 3.2. D
SBOH	2.13.A
State CDP	10.1.B 10.2.A
TRAIS Committee	2.12.C
Training Institutions	2.5. B 2.6. B 2.7. B
Universities	2.1. A 2.2. A 11.1.A 11.1.B

EMT's, Advanced EMT's, and Paramedics by county of residence -- September 17, 1981

COUNTY	EMT's	Advanced EMT's	Paramedics	TOTAL
Adams	64	16	2	82
Allen	558	25	12	595
Bartholomew	99	0	0	99
Benton	76	0	0	76
Blackford	76	0	1	77
Boone	74	0	2	76
Brown	62	0	0	62
Carroll	124	0	3	127
Cass	62	0	1	63
Clark	109	0	0	109
Clay	36	0	1	37
Clinton	191	0	3	194
Crawford	38	0	0	38
Daviess	74	3	1	78
Dearborn	120	0	0	120
Decatur	33	0	0	33
Dekalb	97	2	3	102
Delaware	171	0	6	177
Dubois	90	0	0	90
Elkhart	209	23	15	247
Fayette	30	0	0	30
Floyd	48	0	0	48
Fountain	64	0	0	64
Franklin	66	0	0	66
Fulton	94	0	0	94
Gibson	99	0	1	100

COUNTY	EMT's	Advanced EMT's	Paramedics	TOTAL
Grant	252	1	6	259
Greene	68	0	0	68
Hamilton	151	0	5	156
Hancock	127	0	2	129
Harrison	83	0	0	83
Hendricks	201	0	3	204
Henry	122	1	0	123
Howard	147	0	0	147
Huntington	115	11	0	126
Jackson	32	0	0	32
Jasper	64	0	1	65
Jay	33	0	0	33
Jefferson	38	0	0	38
Jennings	23	0	0	23
Johnson	197	0	8	205
Knox	62	28	0	90
Kosciusko	158	15	0	173
LaGrange	64	8	0	72
Lake	660	0	43	703
LaPorte	114	0	15	129
Lawrence	93	0	0	93
Madison	376	0	2	378
Marion	1334	0	67	1401
Marshall	124	16	0	140
Martin	24	0	0	24
Miami	116	0	0	116
Monroe	116	0	1	117
Montgomery	204	0	1	205
Morgan	84	0	1	85

COUNTY	EMT's	Advanced EMT's	Paramedics	TOTAL
Newton	45	0	0	45
Noble	84	6	0	90
Ohio	29	0	0	29
Orange	52	0	0	52
Owen	46	0	0	46
Parke	60	0	0	60
Perry	22	0	0	22
Pike	55	0	0	55
Porter	217	0	22	239
Posey	78	0	0	78
Pulaski	19	0	1	20
Putnam	127	0	9	136
Randolph	60	0	0	60
Ripley	91	0	1	92
Rush	94	0	0	94
St. Joseph	319	6	27	352
Scott	9	0	0	9
Shelby	69	0	2	71
Spencer	87	0	2	89
Starke	90	0	2	92
Steuben	76	0	0	76
Sullivan	55	0	3	58
Switzerland	32	0	0	32
Tippecanoe	291	0	21	312
Tipton	49	0	0	49
Union	18	0	0	18
Vanderburgh	329	0	27	356
Vermillion	40	0	0	40

COUNTY	EMT's	Advanced EMT's	Paramedics	TOTAL
Vigo	156	0	0	156
Wabash	64	0	0	64
Warren	40	0	0	40
Warrick	102	0	4	106
Washington	66	0	0	66
Wayne	84	0	2	86
Wells	69	1	0	70
White	73	0	0	73
Whitley	121	2	4	127
TOTAL	11,510	164	339	12,013

TRAINING INSTITUTIONS - EMT
November 15, 1981

Adams	Adams County Memorial Hospital Decatur
Allen	I.V.T.C. Ft. Wayne
	Lutheran Hospital of Ft. Wayne Ft. Wayne
Bartholomew	Bartholomew County Hospital Columbus
Blackford	Blackford County Hospital Hartford City
Boone	Witham Memorial Hospital Lebanon
Clark	Clark County Memorial Hospital Jeffersonville
Clay	Clay County Hospital Brazil
Clinton	Clinton County Hospital Frankfort
Daviess	Daviess County Hospital Washington
Dearborn	Dearborn County Hospital Lawrenceburg
Decatur	Decatur County Memorial Hospital Greensburg
Delaware	Ball Memorial Hospital Muncie
	Ball State University Muncie
	I.V.T.C. Muncie
Dubois	Memorial Hospital Jasper
	St. Joseph's Hospital Huntingburg

Elkhart	Elkhart General Hospital Elkhart
	Goshen General Hospital Goshen
Fulton	Woodlawn Memorial Hospital Rochester
Gibson	Gibson General Hospital Princeton
Grant	Marion General Hospital Marion
	V.A. Hospital Marion
Hamilton	Riverview Hospital Noblesville
Hancock	Hancock County Memorial Hospital Greenfield
Harrison	Harrison County Hospital Corydon
Hendricks	Hendricks County Hospital Danville
Howard	I.V.T.C. Kokomo
	St. Joseph's Memorial Hospital Kokomo
Huntington	Huntington Memorial Hospital Huntington
Jefferson	I.V.T.C. Madison
Johnson	Johnson County Memorial Hospital Franklin
Knox	Good Samaritan Hospital Vincennes
	Vincennes University Vincennes
Kosciusko	Kosciusko Community Hospital Warsaw

LaGrange	LaGrange County Hospital LaGrange
Lake	Methodist Hospital of Gary Gary
	Our Lady of Mercy Hospital Dyer
	St. Catherine Hospital of East Chicago East Chicago
Laporte	I.V.T.C. Westville
	Laporte Hospital Laporte
Lawrence	Dunn Memorial Hospital Bedford
Madison	St. John's Medical Center Anderson
Marion	Community Hospital of Indianapolis Indianapolis
	Hawley Army Hospital Indianapolis
	I.V.T.C. Indianapolis
	Methodist Hospital of Indiana Indianapolis
	St. Vincent Hospital and Healthcare Center Indianapolis
	Wishard Memorial Hospital Indianapolis
Marshall	Marshall County Parkview Hospital Plymouth
Miami	Dukes Memorial Hospital Peru
Monroe	Bloomington Hospital Bloomington
Montgomery	Montgomery County Culver Union Hospital Crawfordsville

Morgan	Morgan County Memorial Hospital Martinsville
Noble	McCray Memorial Hospital Kendallville
Orange	Orange County Hospital Paoli
Parke	Rockville Community Schools Rockville
Perry	Perry County Memorial Hospital Tell City
Porter	Porter Memorial Hospital Valparaiso
Rush	Rush Memorial Hospital Rushville
St. Joseph	I.V.T.C. South Bend
	Memorial Hospital South Bend
	St. Joseph's Hospital Mishawaka
	St. Joseph's Hospital South Bend
Starke	Starke Memorial Hospital Knox
Sullivan	Mary Sherman Hospital Sullivan
Tippecanoe	I.V.T.C. Lafayette
	Lafayette Home Hospital Lafayette
	St. Elizabeth Hospital Medical Center Lafayette
Vanderburgh	Deaconess Hospital Evansville
	St. Mary's Medical Center Evansville

Vanderburgh (cont.)	Welborn Memorial Baptist Hospital Evansville
Vigo	Indiana State University Terre Haute
	Terre Haute Regional Hospital Terre Haute
Warrick	Warrick Hospital Boonville
Washington	Washington County Hospital Salem
Wayne	I.V.T.C. Richmond
	Reid Memorial Hospital Richmond
Wells	Wells Community Hospital Bluffton

PARAMEDIC TRAINING HOSPITALS
November 15, 1981

Adams	Adams County Memorial Hospital Decatur
Allen	Lutheran Hospital of Fort Wayne Fort Wayne
Elkhart	Elkhart General Hospital Elkhart
Grant	Marion General Hospital Marion
Lake	Methodist Hospital of Gary Gary
Marion	Methodist Hospital of Indiana Indianapolis
	St. Vincent Hospital and Healthcare Center Indianapolis
	St. Francis Hospital Center Beech Grove
	Wishard Memorial Hospital Indianapolis
Porter	Porter Memorial Hospital Valparaiso
St. Joseph	St. Joseph's Hospital South Bend
	Memorial Hospital of South Bend South Bend
Tippecanoe	St. Elizabeth Hospital Lafayette
	Lafayette Home Hospital Lafayette
Vanderburgh	Welborn Baptist Hosptial Evansville
	Deaconess Hospital Evansville
	St. Mary's Medical Center Evansville
Whitley	Whitley County Hospital Columbia City

EXTRICATION TRAINING

The Emergency Medical Services Commission has provided Extrication Training for the last three years. This training, which is provided by the Emergency Squad Training Institute with Owen B. Streeper as instructor, is a two-day workshop with the institute providing certification for completion of both days of training. To date, the Commission has trained nine hundred, thirty (930) persons with two hundred, twenty-eight (228) departments. This project is designed to train three individuals affiliated with each extrication service in the state. Then to have htese trained extricators instruct their squads in the state-of-the-art techniques that were learned in the workshop. 92% of all enrolled trainees have attended both sessions and received certification from the Emergency Squad Training Institute.

The Commission is planning to provide nine (9) more extrication classes in 1982, therefore, if your department is interested in hosting one of these classes, please contact Shaun P. Shannon, Transportation Director for details.

The Commission is distributing a slide/cassette teaching program, developed by the Emergency Squad Training Institute, to each designated Regional Coordination Center to assist in the instruction of squads. The Regional Coordination Centers will provide the necessary information when this instruction package becomes available in your region.

Below is a synopsis of the training programs provided in 1979, 1980 end 1981:

1979, 1980 & 1981

EXTRICATION WORKSHOP EVALUATION

WORKSHOP - 1979	HOST	CERTIFIED*	ATTENDEES	# OF DEPTS.
Wabash County	Wabahs Fire Department	20	23	13
Rush County	Rushville Fire Department	36	37	20
Marion County	Wayne Twp. Vol. Fire Dept.	29	30	15
Marshall County	Plymouth E.M.S.	30	38	19
Knox County	Vincennes Ambulance Serv.	37	47	19
Orange County	Orange County Sheriff	32	38	14
TOTAL		184	213	100

WORKSHOP - 1980	HOST	CERTIFIED*	ATTENDEES	# OF DEPTS.
Marshall County	Plymouth E.M.S.	36	40	15
Lake County	Hammond Fire Dept.	18	16	7
Allen County	Fort Wayne Fire Dept.	30	32	14
Lake (E. Chicago)	East Chicago Fire Dept.	30	30	9
Marion County	Indianapolis Fire Dept.	39	40	15
Decatur County	Greensburg Fire Dept.	40	44	17
Tippecanoe County	Lafayette Fire Dept.	38	43	15
Jackson County	Ross Ambulance Service	44	48	13
Knox County	Vincennes Ambulance Serv.	60	65	25
TOTAL		335	358	130

WORKSHOP - 1981	HOST	CERTIFIED*	ATTENDEES	# OF DEPTS.
Floyd County	New Albany Fire Dept.	34	43	15
Randolph County	Parker City Fire Dept.	47	56	16
Allen County	Wayne Twp. Fire Dept.	35	39	16
Monroe County	Bloomington Fire Dept.	38	38	18
Vanderburgh County	German Twp. Fire Dept.	36	38	13
Cass County	Logansport Fire Dept.	39	39	18
Lake County	Munster Fire Dept.	32	33	21
Vigo County	Honey Creek Fire Dept.	34	34	12
Marion County	Warren Twp. Fire Dept.	39	39	18
TOTAL		334	359	147

Average per class 0 38.75% Attendees
Certified per class - 35.54%
Departments per class - 15.7

92% of the participants attended class both days and were certified by the Emergency Squad Training Institute.

*By Emergency Squad Training Institute

1979, 1980 & 1981
EXTRICATION WORKSHOP EVALUATION

	TOTAL TRAINED	WORKSHOPS		
		1979	1980	1981
ADAMS COUNTY	13	3	4	6
Adams County Civil Defense	7			
Monroe Fire and Rescue	6			
ALLEN COUNTY	28	1	15	12
Arcola Fire Department	0			
Cedar Canyons Vol. Fire Dept.	4			
Adams Twp. Fire Dept. #3	4			
Huntertown Vol. Fire Company, Inc.	4			
Wayne Township Fire Department	3			
Wayne Township Fire Department #2	0			
New Haven Volunteer Fire Dept.	1			
St. Joseph Twp. Fire Department	5			
Fort Wayne Fire Department	4			
Poe Volunteer Fire Department	3			
Woodburn Fire Department	0			
Washington Twp. Vol. Fire Dept.	0			
Monroeville Fire and Rescue Unit	0			
BARTHOLOMEW COUNTY	12	0	8	4
Hope Volunteer Fire Department	2			
Columbus Fire Department	10			
BENTON COUNTY	7	0	8	9
Benton County Civil Defense	7			
Boswell Community Amb. Serv.	0			
BLACKFORD COUNTY	3	0	0	3
Montpelier Fire Department	0			
Hartford City Fire Department	3			
BOONE COUNTY	5	2	3	0
Center Township Fire Dept.	0			
Zionsville Fire and Rescue	1			
Lebanon Fire Department	4			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
BROWN COUNTY	4	1	1	2
Brown County Ambulance Serv., Inc.	2			
Trevlac Volunteer Fire Dept.	2			
CARROLL COUNTY	6	0	2	4
Burlington Volunteer Fire Dept.	2			
Delphi Volunteer Fire Dept.	4			
CASS COUNTY	11	0	2	9
Cass County Ambulance	3			
Galveston Volunteer Fire Dept.	3			
Logansport Fire Department	5			
CLARK COUNTY	14	2	3	9
Sellersburg Volunteer Fire Dept.	4			
McCulloch Vol. Fire Dept.	2			
Medic, Inc.	1			
Jeffersonville Fire Dept.	5			
Charlestown Vol. Fire Dept.	2			
Clarksville Fire Dept.	0			
CLAY COUNTY	3	0	1	2
Clay City-Harrison Twp. Fire Dept.	2			
Athens Ambulance Service	1			
Posey Township Fire Dept.	0			
CLINTON COUNTY	2	0	0	2
Frankfort Fire Dept.	0			
Michigan Township Vol. Fire Dept.	2			
Rossville Volunteer Fire Dept.	0			
CRAWFORD COUNTY	1	1	0	0
Crawford County Ambulance	1			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
DAVIESS COUNTY	4	2	2	0
Daviess County Ambulance Serv.	2			
Poindexter and Som Amb. Serv.				
Washington Fire Department				
DEARBORN COUNTY	3	2	0	1
Lawrenceburg Emergency Rescue Unit	0			
Dillsboro Emergency Unit	2			
Aurora Emergency Rescue, Inc.	0			
Bright Vol. Fire Department	1			
Aurora Fire Company #1 and #2	0			
DECATUR COUNTY	8	3	5	0
Greensburg Fire Department	8			
DEKALB COUNTY	4	2	0	2
Ashley Fire Department	0			
Auburn Fire Department	4			
Butler Fire Department	0			
Garrett Fire Department	0			
St. Joseph Fire Department	0			
DELAWARE COUNTY	18	4	4	10
Gaston Volunteer Fire Dept.	0			
Easton Fire Department	0			
Delaware County/Muncie E.M.S.	10			
Muncie Fire Department	0			
Daleville Fire Department	8			
DUBOIS COUNTY	9	0	2	7
Huntingburg Vol. Fire Dept.	0			
Jasper Fire Department	9			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
ELKHART COUNTY	3	1	2	0
Elkhart Fire Department	0			
Baugo Township Fire Dept.	2			
Goshen Fire Department	0			
Middlebury Civil Defense	0			
Concord Township Fire Dept.	0			
Wakarusa Fire Department	0			
Bristol Fire Department	0			
New Paris Fire Department	1			
Jefferson Twp. Vol. Fire and Amb.	0			
Nappanee Medical Serv. Dept.	0			
Cleveland Twp. Fire Dept.	0			
FAYETTE COUNTY	3	2	1	0
Fayette County Emergency First Aid	3			
FLOYD COUNTY	9	0	3	6
New Albany Fire Department	6			
Georgetown Vol. Fire Dept.	3			
FOUNTAIN COUNTY	1	1	0	0
Fountain County Ambulance Serv.	1			
FRANKLIN COUNTY	3	0	3	0
Franklin County E.M.S.	3			
FULTON COUNTY	10	2	4	4
Rochester Fire Department	10			
GIBSON COUNTY	13	7	3	3
Gibson County Ambulance Service	13			
GRANT COUNTY	4	0	2	2
Matthews Fire Dept. Rescue Squad	0			
Gas City Rescue Squad	0			
Marion Fire Department	4			
Van Buren Rescue Squad	0			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
GREENE COUNTY	11	1	4	6
Greene County Rescue Unit	5			
Linton Fire Department	3			
Richland-Taylor Twp. Fire Dept.	3			
HAMILTON COUNTY	12	4	4	4
Westfield Fire Department	1			
Carmel Fire Department	8			
Sheridan Vol. Fire Dept., Inc.	0			
Fishers Comm. Vol. Fire Dept.	1			
Noblesville Fire Department	2			
HANCOCK COUNTY	3	0	2	1
Sugar Creek Twp. Vol. Fire Dept.	0			
Greenfield Fire Dept.	0			
Wilkinson Vol. Fire Dept.	0			
Buck Creek Twp. Vol. Fire Dept.	0			
Fortville Fire Department	1			
Jackson-Blue River Twp. Fire Dept.	2			
HARRISON COUNTY	2	0	0	2
Ramsey Vol. Fire Fighters, Inc.	0			
Elizabeth Volunteer Fire Dept.	2			
HENDRICKS COUNTY	4	0	3	1
Plainfield Fire Dept.	3			
Brownsburg Fire Dept.	0			
Danville Fire Department	0			
Pittsboro Fire Department	1			
Pittsboro Fire Dept. Rescue	0			
Clayton Vol. Fire Dept.	0			
Amo Volunteer Fire Dept.	0			
Avon Volunteer Fire Dept.	0			
Hazelwood Volunteer Fire Dept.	0			
Town of Stilesville	0			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
HENRY COUNTY	10	2	4	4
New Castle/Henry Co. Police Emer. Unit	3			
Knightstown Vol. Fire Dept.	7			
Middletown Fire Dept.	0			
HOWARD COUNTY	14	4	6	4
Howard County Civil Defense	3			
Eastern Howard Emergency Serv.	0			
Kokomo Fire Department	9			
Indian Heights Vol. Fire Dept.	2			
	67			
HUNTINGTON COUNTY	5	0	2	3
Markle Vol. Fire Dept. & Rescue Unit	4			
Huntington Co. Police Department	1			
JACKSON COUNTY	16	1	13	2
Ross Med-Aid Service, Inc.	16			
JASPER COUNTY	6	0	5	1
Rensselaer Vol. Fire Dept.	5			
Remington Vol. Fire Dept.	0			
Wheatfield Fire Department	0			
Keener Twp. Fire Department	1			
JAY COUNTY	5	1	2	2
Jay County Civil Defense	5			
JEFFERSON COUNTY	7	4	0	3
Clifty Fire Dept. #6	5			
U.S. Army Jefferson Proving Ground	2			
Hanover Volunteer Fire Dept.	0			
JENNINGS COUNTY	2	0	2	0
Jennings County E.M.S.	2			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
JOHNSON COUNTY	9	1	4	4
White River Township Fire Dept.	3			
Bargersville Fire Dept.	0			
Edinburgh Fire Dept.	1			
Nineveh Vol. Fire Dept., Inc.	2			
Franklin Fire Dept.	2			
Greenwood Vol. Fire Dept.	0			
Amity Community Vol. Fire Dept.	1			
Whiteland Rural Fire Dept.	0			
KNOX COUNTY	24	10	12	2
Vincennes Ambulance Service	22			
Vincennes Fire Dept.	0			
Bicknell Fire Dept.	1			
Monroe City Ambulance Serv.	1			
KOSCIUSKO COUNTY	4	2	1	1
South Central Kosciusko E.M.S.	3			
Leesburg Fire Department	0			
Syracuse Fire Department	0			
North Webster E.M.S.	0			
Washington Twp. Fire Dept.	0			
Warsaw Fire Dept.	1			
Mentone Fire Department	0			
LAGRANGE COUNTY	0	0	0	0
LaGrange Fire Department	0			
LAKE COUNTY	63	9	36	18
Crown Point Fire Dept.	0			
St. John Fire Dept.	5			
U.S. Steel/Gary Works	4			
Dyer Fire Dept.	1			
Lake Dalecarlia Vol. Fire Dept.	1			
Hammond Fire Department	6			
Lake Station Volunteer Fire Dept.	5			

	TOTAL TRAINED	WORKSHOPS		
		1979	1980	1981
LAKE COUNTY (con't)				
Griffith Civil Defense	1			
East Chicago Fire Dept.	14			
Hobart Fire Dept.	1			
Lowell Volunteer Fire Dept.	0			
Tri-Creek Ambulance Service	0			
City of Gary Fire Dept.	1			
Munster Vol. Fire Dept.	10			
Highland Fire Department	2			
Schererville Vol. Fire Dept.	4			
Shelby Volunteer Fire Dept.	0			
Whiting Fire Department	3			
Cedar Lake Vol. Fire Dept.	1			
Black Oak Fire Dept.	0			
East Chicago Civil Defense/Aux. Police	3			
Ainsworth Deep River Fire Dept./Hobart	1			
Jones & Laughlin Steel Corporation	0			
Independence Hill Vol. Fire Dept.	0			
Lake Hills Fire Department	0			
Merrillville Fire Department	0			
LAPORTE COUNTY	2	0	1	1
Kankakee Twp. Fire Department	0			
LaPorte Fire Department	2			
Michigan City Fire Department	0			
Center Township Fire Department	0			
LAWRENCE COUNTY	5	3	0	2
Bedford Fire Department	5			
MADISON COUNTY	15	4	6	5
Frankton Vol. Amb. Serv., Inc.	0			
Richland Twp. Vol. Fire Dept.	0			
Alexandria Fire Department	2			
Anderson Fire Department	6			
Pipe Creek Twp. Vol. Fire Dept.	2			
Frankton Vol. Fire Dept.	0			
Pendleton Fire Dept.	2			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
MARION COUNTY	54	14	18	22
Bridgeport Vol. Fire Dept. #7	0			
Ben Davis Vol. Fire Dept. #4	2			
Pike Twp. Vol. Fire Dept.	6			
Indianapolis Fire Training Academy	8			
Warren Twp. Fire Dept.	4			
Wayne Twp. Vol. Fire Dept. #9	5			
Castleton Vol. Fire Dept., Inc.	3			
Beech Grove Fire Dept.	6			
Lawrence Vol. Fire Dept.	8			
Perry Twp. Fire Dept.	2			
Indianapolis Fire Department	2			
Washington Twp. Fire Dept.	3			
Wanamaker Fire Department	1			
Volunteer Fire Dept./Perry Twp., Inc.	0			
Acton Vol. Fire Dept.	0			
Franklin Twp. Vol. Fire Dept.	0			
Decatur Twp. Vol. Fire Dept.	3			
Fleming Garden Vol. Fire Dept., #3	1			
Speedway Fire Department	0			
Franklin Twp. Fire Dept. Co. #1	0			
MARSHALL COUNTY	27	12	11	4
Bremen Vol. Fire Department	4			
Plymouth E.M.S.	16			
LaPaz Fire Department	0			
Argos Fire Department	5			
Culver-Union Twp. Fire Dept.	1			
Bourbon Fire Department	1			
MARTIN COUNTY	5	2	3	0
Martin County Ambulance Serv.	5			
Martin County Civil Defense	0			
MIAMI COUNTY	7	2	2	3
Mexico Fire Department	1			
Peru Fire Department	2			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
MIAMI COUNTY (con't)				
Grissom Aire Force Base Fire Dept.	3			
Pipe Creek Twp. Fire Dept.	1			
MONROE COUNTY	13	0	4	9
Bloomington Fire Department	7			
Van Buren Twp. Vol. Fire Dept.	2			
Ellettsville Fire Department	2			
Bloomington Twp. Fire Department	2			
Perry Twp. Fire Department	0			
MONTGOMERY COUNTY	5	3	2	0
Crawfordsville Fire Department	4			
Linden Vol. Ambulance Serv.	0			
Walnut Twp. and Town of New Ross	0			
Wayne Twp. Vol. Rescue Service	0			
Ladoga Vol. Fire Department	1			
MORGAN COUNTY	0	0	0	0
Greeg Twp. Vol. Fire Department	0			
Morgan County Civil Defense	0			
Monroe Twp. Fire Department	0			
NEWTON COUNTY	0	0	0	0
Lincoln Twp. Vol. Fire Department	0			
Goodland Vol. Fire Department	0			
Ford's Sunoco	0			
NOBLE COUNTY	8	0	2	6
Kendallville Aux. Police/Civ. Def.	2			
Kendallville Fire Department	2			
LaOtto Fire Department	4			
Ligonier Vol. Fire Dept.	0			
OHIO COUNTY	0	0	0	0
Rising Fun Fire Department	0			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
ORANGE COUNTY	8	4	4	0
Orange County Civil Defense Unit	3			
Orange County Sheriff's Department	5			
OWEN COUNTY	6	2	2	2
Owen County E.M.S.	6			
PARKE COUNTY	4	1	3	0
Parke County E.M.S.	4			
Rockville Rescue Squad	0			
PERRY COUNTY	7	2	0	5
Perry County Civil Defense	7			
PIKE COUNTY	4	3	0	1
Pike County E.M.S.	4			
PORTER COUNTY	13	2	7	4
Valparaiso Fire Department	1			
Porter Fire Department	0			
Portage Twp. Vol. Fire Dept.	0			
Portage Fire Department	5			
Chesterton Fire Department	1			
Kouts Volunteer Fire Department	3			
Bethlehem Steel Corporation	1			
Midwest Steel Division	1			
POSEY COUNTY	7	0	4	3
Posey County Ambulance Service	5			
Wadesville Volunteer Fire & Rescue	2			
Mt. Vernon Fire Department	0			
PULASKI COUNTY	2	0	1	1
Ross Medi-Van, Inc.	2			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
PUTNAM COUNTY	2	2	0	0
Roachdale Vol. Fire Dept. & Rescue	0			
Cloverdale Vol. Fire Dept.	2			
Bainbridge Vol. Fire Dept.	0			
RANDOLPH COUNTY	28	3	7	18
White River Twp. Vol. Fire Dept.	10			
Union City/Ind. Life & Rescue	2			
Randolph County Ambulance Serv.	13			
Culberson Funeral Home	1			
Parker Fire Department	2			
Farmland Fire Department	0			
RIPLEY COUNTY	10	6	2	2
Sunman Volunteer Fire Dept.	2			
Southern Ripley Co. Life Squad Res..69	8			
RUSH COUNTY	15	10	2	3
Raleigh Community Vol. Fire Dept., Inc.	1			
Anderson Twp. Vol. Fire Dept.	5			
Posey Twp. Vol. Fire Dept.	3			
Rushville City Fire Department	4			
Glenwood Fire Department	2			
Carthage Vol. Fire Department	1			
ST. JOSEPH COUNTY	19	3	4	12
Penn Twp. South Fire Dept.	0			
Mishawaka Fire Dept. & Rescue	4			
Penn Twp. North Fire Dept.	3			
New Carlisle Vol. Fire Dept.	0			
City of Mishawaka E.M.S.	1			
Portage Twp. Fire Dept.	2			
Clay Twp. Fire Department	3			
South Bend Fire Department	2			
Walkerton Vol. Fire Department	2			
Liberty Twp. Fire Department	0			
Koontz Lake Fire Department	0			
Center Twp. Fire Department	1			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
ST. JOSEPH COUNTY (con't)				
Uniontown Twp. Fire Department	0			
Harris Twp. Fire Department	1			
Osceola Fire and Civil Defense	0			
SCOTT COUNTY	1	0	1	0
Austin Volunteer Fire Department	1			
SHELBY COUNTY	9	2	5	2
Waldron Vol. Fire Department	3			
Fountaintown Community Vol. Fire Dept.	2			
Shelbyville Fire Department	4			
SPENCER COUNTY	4	0	0	4
Spencer County Emergency Amb. Serv.	0			
Dale Volunteer Fire Department	4			
STARKE COUNTY	4	0	2	2
Knox Center Twp. Fire Department	2			
Bass Lake Fire Department	2			
Hamlet Fire Department	0			
STEUBEN COUNTY	4	2	2	0
Steuben County Sheriff's Department	4			
SULLIVAN COUNTY	2	2	0	0
Sullivan City Fire Department	2			
SWITZERLAND COUNTY	4	0	0	4
Craig-Jefferson Vol. Fire Dept.	4			
TIPPECANOE COUNTY	25	2	14	9
Wayne Twp. Vol. Fire Department	0			
Clarks Hill E.M.S.	0			
Wea Twp. Fire Department	4			
West Lafayette Fire Department	0			
Purdue University Fire Department	3			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
TIPPECANOE COUNTY (con't)				
Lafayette Fire Department	2			
Tippecanoe County Sheriff's Dept.	2			
Union Twp. Fire Department	0			
Tippecanoe Twp. Vol. Fire Dept.	3			
Stockwell Fire Department	3			
Romney Fire Department	0			
Dayton Fire Department	0			
Wabash Twp. Fire Department	6			
Buck Creek Fire Department	0			
Sheffield Twp. Fire Department	2			
TIPTON COUNTY	5	0	2	3
Tipton Fire Department	3			
Kempton Volunteer Fire Department				
UNION COUNTY	1	1	0	0
Liberty Fire Department	1			
VANDERBURGH COUNTY	19	5	4	10
Scott Twp. Vol. Fire Department	2			
German Twp. Vol. Fire Department	8			
Welborn Baptist Hospital	6			
Perry Twp. Vol. Fire Department	0			
Evansville Fire Department	0			
McCutchanville Fire Department	2			
Alexander Ambulance Service	1			
VERMILLION COUNTY	3	1	2	0
Cayuga Fire Department	3			

	TOTAL TRAINED	WORKSHOPS 1979	1980	1981
VIGO COUNTY	16	2	5	9
Honey Creek Vol. Fire Department	7			
Terre Haute Fire Department	4			
Seeleyville Vol. Fire Department	3			
West Terre Haute Vol. Fire Dept.	1			
Prairieton Vol. Fire Department	1			
St. Marys-of-the-Woods Fire Assoc.	0			
Otter Creek Vol. Fire Department	0			
WABASH COUNTY	2	2	0	0
Wabash Fire Department	2			
Manchester Fire Department	0			
WARREN COUNTY	0			
Warren County Ambulance Service	0			
Warren County Sheriff's Department	0			
WARRICK COUNTY	19	3	9	7
Warrick County E.M.S.? Warrick Hosp.	3			
Boonville Fire Department	1			
Newburgh Vol. Fire Department	7			
Yankeetown Vol. Fire Department	6			
Aluminum Company of America	2			
WASHINGTON COUNTY	8	2	2	4
Washington County Medical Service	4			
Hardinsburg Fire Department	2			
Salem/Washington Twp. Fire Dept.	2			
WAYNE COUNTY	6	0	6	0
Richmond Fire Department	2			
Hagerstown Fire Department	1			
Culberson Funeral Home	3			
Dublin Fire Department	0			
Cambridge City Fire Department	0			

	TOTAL TRAINED	WORKSHOPS		
		1979	1980	1981
WELLS COUNTY	2	1	0	1
Bluffton Rescue Unit/Fire Dept.	1			
Ossian Fire Department	1			
WHITE COUNTY	4	1	2	1
Monticello Fire Department	3			
Wolcott Volunteer Fire Department	1			
WHITLEY COUNTY	2	0	0	2
Churubusco Fire Department	0			
Columbia Twp. Vol. Fire Dept.	2			

VEHICLE INVENTORY

Date: November 15, 1981

Following is an inventory of all Emergency Medical Service Vehicles certified in the State of Indiana as emergency ambulances current to the above date.

CLASSIFICATION OF AMBULANCE TYPES

CLASSIFICATION	TYPE	DESCRIPTION
01	Extended Headroom Van (Federal Type II)	Can be GSA KKK-A-1822A; usually 58" or greater headroom in patient compartment and an exterior width of 75"-77"
02	Standard Van	Usually 51"-54" headroom in patient compartment and an exterior width of 75"-77"
03	Hearse Ambulance (Commercial Ambulance)	Headroom varies from 48"-54" in patient compartment
04	Specialty Vehicles	Usually MICU and Neonatal Ambulances (RV's, Travel Trailers, etc.)
05	Modular Truck (Type I) Modular Van (Type III)	Can be GSA KKK-A-1822A; usually 59" or greater headroom in patient compartment with an exterior width of 88" or greater
06	Suburban	
07	Box-type Ambulances	Non-modular; patient compartment cannot be replaced; exterior width usually 77" or greater
08	Other (Specify)	Including Air Ambulances

CLASSIFICATION OF AMBULANCES BY TYPE AND YEAR

CLASSIFICATION	TYPE	CERTIFIED AMBULANCES
01	Extended Headroom Van (Federal Type II)	459
02	Standard Van	52
03	Hearse Ambulance (Commercial Ambulance)	18
04	Specialty Vehicles	1
05	Modular Truck (Type I) Modular Van (Type III)	223
06	Suburban	1
07	Box-type Ambulances	7
08	Other (Specify)	5
TOTAL		766

YEAR	CERTIFIED AMBULANCES
1982	1
1981	56
1980	81
1979	117
1978	86
1977	142
1976	79
1975	73
1974	82
1973	26
1972	16
1971	1
1970	2
1969	0
1968	1
1967	0
1966	1
1965	0
1964	1
1963	1
TOTAL	766

Total ambulances that have 59" or greater headroom and 116" or greater patient compartment length = 665

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
ADAMS COUNTY						
Adams County Memorial Hospital	00780376	Berne	Mod III 05	Ford	X	1980
	00780568	Decatur	Mod III 05	Ford	X	1978
	00780123	Decatur	Van II 01	Dodge	X	1976
	00780124	Geneva	Van II 01	Dodge	X	1976
	00780125	Decatur	Van II 01	Dodge	X	1976
ALLEN COUNTY						
Adams Township Vol. Fire Dept.	00090462	New Haven	Van II 01	Dodge	X	1973
Arcola Vol. Fire Department	02740559	Arcola	Van II 01	Dodge	X	1978
Basic Life Transport	03420751	Ft. Wayne	Van II 01	Dodge	X	1975
	03420769	Ft. Wayne	Van II 01	Ford	X	1980
Cedar Canyon Vol. Fire Dept.	02850436	Grabill	Van II 01	Dodge	X	1974
Emergency One Corporation	03060538	Ft. Wayne	Van II 01	Dodge	X	1977
	03060479	Ft. Wayne	Van II 01	Dodge	X	1977
	03060687	Ft. Wayne	Mod III 05	Chevrolet	X	1977
Ft. Wayne E.M.S.	01770270	Ft. Wayne	Mod I 05	Chevrolet	X	1979
	01770272	Ft. Wayne	Mod III 05	Chevrolet	X	1979
	01770273	Ft. Wayne	Mod III 05	Ford	X	1980
	01770274	Ft. Wayne	Mod III 05	Chevrolet	X	1979
	01770289	Ft. Wayne	Mod III 05	Chevrolet	X	1979
Grabill Volunteer Fire Dept.	03100628	Grabill	Van II 01	Dodge	X	1974
Huntertown Fire Company, Inc.	02560402	Huntertown	Mod III 05	Ford	X	1977
Lutheran Hosp. of Ft. Wayne	03200509	Ft. Wayne	Mod III 05	Ford	X	1979
Maumee Twp. Vol. Fire Dept. EMS	00750643	Woodburn	Van II 01	Ford	X	1979
MediVan, Inc.	03300660	New Haven	Van 02	Dodge	X	1979
	03300348	New Haven	Mod III 05	Dodge	X	1974
	03300682	Ft. Wayne	Van 02	Plymouth		1978
Monroeville E.M.S.	00250038	Monroeville	Van II 01	Dodge	X	1976
Poe Volunteer Fire Department	03210384	Poe	Van II 01	Dodge	X	1973
St. Joseph Twp. Fire Dept.	00630097	Ft. Wayne	Mod III 05	Chevrolet	X	1979
Washington Twp. Vol. Fire Dept.	03370646	Ft. Wayne	Mod III 05	Ford	X	1979
Wayne Twp. Fire Department	02760426	Ft. Wayne	Van II 01	Dodge	X	1974
	02760710	Ft. Wayne	Van II 01	Dodge		1974
BARTHOLOMEW COUNTY						
Athens Ambulance Service	01130761	Columbus	Van 02	Chevrolet		1981
	01130697	Columbus	Van 02	Chevrolet		1980
	01130582	Columbus	Van II 01	Ford	X	1976
	01130637	Columbus	Van 02	Chevrolet		1980
	01130473	Columbus	Van II 01	Ford	X	1978
Columbus Fire Department	00650102	Columbus	Mod III 05	Chevrolet	X	1981
	00650101	Columbus	Mod I 05	Ford	X	1980
Hope Volunteer Fire Department	01780600	Hope	Van II 01	Dodge	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
BENTON COUNTY						
Benton County Emer. Ambu. Service	01710526	Fowler	Van II 01	Ford	X	1978
	01710265	Fowler	Van II 01	Dodge	X	1977
Boswell Comm. Amb. Service	00720586	Boswell	Van II 01	Chevrolet	X	1975
	00720117	Boswell	Van II 01	Dodge	X	1976
BLACKFORD COUNTY						
Blackford Emer. Amb. Trustees	01920293	Hartford City	Van II 01	Dodge	X	1977
	01920294	Montpelier	Van II 01	Ford	X	1983
	01920295	Hartford City	Van II 01	Dodge	X	1977
BOONE COUNTY						
Boone County Ambulance Service	03050713	Lebanon	Van II 01	Ford	X	1980
	03050471	Lebanon	Van II 01	Dodge	X	1974
	03050472	Lebanon	Van II 01	Dodge	X	1975
Zionsville Emer. Amb., Inc.	01300537	Zionsville	Van II 01	Ford	X	1980
	01300220	Zionsville	Van II 01	Ford	X	1976
BROWN COUNTY						
Cordry-Sweetwater Lot Owners	01580249	Nineveh	Van II 01	Dodge	X	1977
Southern Indiana Ambulance, Inc.	01790388	Nashville	Van 02	Chevrolet		1973
Bartholomew County	01790645	Columbus	Van II 01	Chevrolet	X	1977
	01790275	Nashville	Van II 01	Chevrolet	X	1975
Trevlac Vol. Fire Department	02380379	Beanblossom	Van II 01	Ford	X	1974
CARROLL COUNTY						
Burlington Vol. Fire Dept.	01590681	Burlington	Mod I 05	Chevrolet	X	1975
	01590250	Burlington	Van II 01	Dodge	X	1974
Carroll County E.M.S.	02390380	Camden	Van II 01	Dodge	X	1977
	02390381	Flora	Van II 01	Dodge	X	1977
	02390382	Delphi	Van II 01	Dodge	X	1977
CASS COUNTY						
Cass County Amb. Service	01900291	Logansport	Mod III 05	Ford	X	1979
	01900292	Logansport	Van II 01	Ford	X	1979
	01900476	Logansport	Van II 01	Dodge	X	1979
Galveston Vol. Fire Department	00900138	Galveston	Van II 01	Dodge	X	1974
	00900744	Galveston	Mod III 05	Ford	X	1981

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
CLARK COUNTY						
ıapman Funeral Home	02950632	Clarksville	Van II 01	Ford	X	1979
ɛdic, Inc.	02900604	Jeffersonville	Mod III 05	Chevrolet	X	1979
	02900573	Jeffersonville	Van II 01	Chevrolet	X	1978
	02900540	Jeffersonville	Van 02	Chevrolet		1979
	02900683	Jeffersonville	Van II 01	Ford	X	1980
ɛdical Transportation Service	02000622	Charlestown	Van II 01	Ford	X	1978
	02000621	Charlestown	Mod III 05	Ford	X	1978
ɛwberg-Marble Hill	03350657	Marble Hill	Van II 01	Chevrolet	X	1978
.R. Stewart & Sons Amb. Service	02400490	Sellersberg	Van II 01	Ford	X	1978
	02400694	Sellersberg	Van II 01	Dodge	X	1975
	02400693	Sellersberg	Van II 01	Dodge	X	1975
	02400385	Sellersberg	Van II 01	Ford	X	1976
ass, Inc.	01840416	Jeffersonville	Van II 01	Dodge	X	1977
	01840762	Jeffersonville	Van II 01	Chevrolet	X	1974
	01840350	Jeffersonville	Van II 01	Dodge	X	1975
CLAY COUNTY						
thens Ambulance Service, Inc.	03010529	Brazil	Van II 01	Dodge	X	1974
	03010465	Center Point	Van II 01	Dodge	X	1978
	03010528	Clay City	Van II 01	Ford	X	1981
	03010207	Brazil	Van 02	Chevrolet		1980
CLINTON COUNTY						
linton County E.M.S.	00370635	Frankfort	Van II 01	Ford	X	1980
	00370058	Frankfort	Van II 01	Dodge	X	1975
	00370063	Kirklin	Van II 01	Ford	X	1981
	00370116	Michigantown	Van II 01	Ford	X	1980
	00370118	Frankfort	Van II 01	Dodge	X	1975
	00370560	Mulberry	Van II 01	Dodge	X	1978
olfax Community E.M.S.	02330372	Colfax	Van II 01	Dodge	X	1977
olunteer Ambulance Service	01400325	Rossville	Mod III 05	Ford	X	1979
	01400213	Rossville	Van II 01	Dodge	X	1974
CRAWFORD COUNTY						
rawford County Ambulance Serv.	01800276	English	Van II 01	Dodge	X	1975
	01800277	Marengo	Van II 01	Dodge	X	1975
enbo Funeral Home	02940685	English	Van 02	Chevrolet		1975
DAVIESS COUNTY						
aviess County Amb. Service	02020328	Washington	Van II 01	Dodge	X	1977
	02020329	Washington	Van II 01	Dodge	X	1977
oindexter & Son Funeral Home	01560245	Washington	Van II 01	Ford	X	1975
	01560327	Washington	Van II 01	Dodge	X	1977
	01560495	Washington	Hearse 03	Cadillac		1974
	01560689	Odon	Van II 01	Dodge	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
DEARBORN COUNTY						
Area 12 Council on Aging, Inc.	02570403	Dillsboro	Van II 01	Chevrolet	X	1977
Aurora Emergency Rescue, Inc.	03120753	Aurora	Hearse 03	Cadillac		1966
	03120589	Aurora	Mod III 05	Chevrolet	X	1978
Dillsboro Emergency Unit	00380060	Dillsboro	Van II 01	Dodge	X	1974
Lawrenceburg Emergency Rescue	03130496	Lawrenceburg	Mod III 05	Dodge	X	1979
	03130497	Lawrenceburg	Mod III 05	Dodge	X	1979
North Dearborn Rescue Unit	00170011	Bright	Van II 01	Dodge	X	1975
Sparta Twp. Vol. Emergency Unit	00060007	Moores Hill	Van II 01	Dodge	X	1973
DECATUR COUNTY						
Decatur County Memorial Hospital	03020584	Greensburg	Van II 01	Chevrolet	X	1975
	03020466	Greensburg	Van II 01	Chevrolet	X	1977
DEKALB COUNTY						
DeKalb E.M.S.	01520574	Auburn	Mod III 05	Ford	X	1978
	01520232	Butler	Van II 01	Dodge	X	1975
	01520233	Auburn	Van II 01	Dodge	X	1975
	01520234	Garrett	Mod III 05	Ford	X	1981
DELAWARE COUNTY						
Albany/Delaware Twp. Ambulance	02030511	Albany	Mod III 05	Chevrolet	X	1978
	02030375	Albany	Van II 01	Chevrolet	X	1974
Ball State University	02580404	Muncie	Van II 01	Ford	X	1977
Delaware County/Muncie E.M.S.	02340374	Muncie	Mod III 05	Ford	X	1979
	02340373	Muncie	Mod III 05	Chevrolet	X	1978
	02340623	Muncie	Mod III 05	Ford	X	1980
	02340663	Muncie	Mod III 05	Chevrolet	X	1978
Eaton Ambulance Service	02890446	Easton	Van II 01	Dodge	X	1976
Gaston Vol. Fire Dept., Inc.	03160503	Gaston	Mod III 05	Chevrolet	X	1978
Med-Tec Ambulance	03360633	Muncie	Hearse 03	Cadillac		1974
	03360059	Muncie	Hearse 03	Cadillac		1972
	03360718	Muncie	Mod I 05	Chevrolet	X	1977
Procare Ambulance Service, Inc.	03410745	Muncie	Van II 01	Dodge	X	1976
	03410746	Muncie	Van II 01	Chevrolet	X	1975
	03410766	Muncie	Van II 01	Ford	X	1976
Salem Twp./Daleville EMS	00730585	Daleville	Mod III 05	Chevrolet	X	1978
DUBOIS COUNTY						
Memorial Hospital	02960431	Jasper	Mod III 05	Ford	X	1979
	02960456	Jasper	Van II 01	Dodge	X	1975
St. Joseph's Hospital	00740119	Huntingburg	Van II 01	Dodge	X	1975
	00740105	Huntingburg	Mod III 05	Ford	X	1979

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
ELKHART COUNTY						
stol Fire Department	02770642	Bristol	Mod III 05	Ford	X	1979
	02770742	Bristol	Van II 01	Dodge	X	1973
hart Fire Department	01350208	Elkhart	Mod III 05	Chevrolet	X	1976
	01350519	Elkhart	Mod III 05	Ford	X	1978
	01350206	Elkhart	Mod III 05	Chevrolet	X	1981
hen Civil Defense	02350695	Goshen	Van II 01	Dodge	X	1979
hen Fire Department	02040331	Goshen	Mod III 05	Ford	X	1979
	02040332	Goshen	Van II 01	Dodge	X	1974
kson Twp. Emergency Ambulance	01360209	New Paris	Mod 07	Dodge	X	1975
ferson Twp. Fire Department	01810278	Goshen	Van II 01	Chevrolet	X	1974
ical Dynamics	02880749	Elkhart	Van II 01	Dodge	X	1977
dlebury Civil Defense	00560087	Middlebury	Mod III 05	Chevrolet	X	1974
	00560088	Middlebury	Mod III 05	Chevrolet		1973
.S. Air	03260214	Elkhart	Air 08	Piper	X	1978
panee Medical Service Dept.	01070159	Nappanee	Mod III 05	Ford	X	1980
lo E.M.S., Inc.	01660515	Elkhart	Hearse 03	Pontiac		1968
	01660258	Elkhart	Mod 07	Dodge	X	1974
	01660666	Elkhart	Mod III 05	Ford	X	1979
arusa Ambulance Service	01370563	Wakarusa	Mod III 05	Chevrolet	X	1978
FAYETTE COUNTY						
ette Co. Emer. 1st Aid Unit	00480649	Connersville	Van II 01	Ford	X	1979
	00480501	Connersville	Van II 01	Dodge	X	1977
	00480079	Connersville	Van II 01	Dodge	X	1975
FLOYD COUNTY						
lical Transporatation Service	00980711	New Albany	Van II 01	Ford	X	1980
	00980149	New Albany	Van II 01	Dodge	X	1975
	00980512	New Albany	Mod III 05	Ford	X	1978
w Albany Fire Department	01940297	New Albany	Mod III 05	Chevrolet	X	1977
FOUNTAIN COUNTY						
ntain County Amb. Service	00220034	Veedersburg	Van II 01	Ford	X	1979
	00220616	Veedersburg	Van II 01	Ford	X	1979
	00220032	Veedersburg	Van II 01	Dodge	X	1976
	00220033	Veedersburg	Van II 01	Dodge	X	1976
FRANKLIN COUNTY						
nklin County E.M.S.	01080160	Laurel	Van II 01	Chevrolet	X	1975
	01080161	Drewersburg	Van II 01	Chevrolet	X	1975
	01080162	Brookville	Van II 01	Ford	X	1980
	01080163	Cedar Grove	Van II 01	Ford	X	1980

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
FULTON COUNTY						
Foster & Good Amb. Service	02970457	Rochester	Van 02	Chevrolet		1977
Fulton County E.M.S.	00920630	Rochester	Hearse 03	Oldsmobile		1970
	00920143	Rochester	Van II 01	Dodge	X	1977
	00920144	Rochester	Van II 01	Dodge	X	1977
	00920145	Rochester	Mod III 05	Dodge	X	1977
GIBSON COUNTY						
Gibson County Amb. Service	00820133	Princeton	Mod III 05	Chevrolet	X	1978
	00820134	Princeton	Mod III 05	Ford	X	1979
	00820132	Princeton	Mod III 05	Chevrolet	X	1978
GRANT COUNTY						
Devine Ambulance Service	02010588	Marion	Hearse 03	Cadillac		1970
Grant County E.M.S.	03320631	Matthews	Van II 01	Ford	X	1979
	03320558	Sweetser	Mod III 05	Chevrolet	X	1977
	03320557	Van Buren	Mod III 05	Chevrolet	X	1977
	03320556	Gas City	Mod III 05	Chevrolet	X	1977
	03320555	Fairmount	Mod III 05	Chevrolet	X	1977
	03320656	Upland	Van II 01	Ford	X	1980
Marion General Hospital	01330587	Marion	Van II 01	Chevrolet	X	1979
	01330425	Marion	Van II 01	Chevrolet	X	1977
	01330203	Marion	Mod III 05	Chevrolet	X	1975
	01330204	Marion	Mod III 05	Chevrolet	X	1975
Southwest Medic, Inc.	01340418	Swayzee	Mod III 05	Ford	X	1978
GREENE COUNTY						
Greene County Ambulance Service	00420066	Bloomfield	Van II 01	Chevrolet	X	1975
	00420067	Jasonville	Van II 01	Dodge	X	1977
	00420068	Solsberry	Van II 01	Chevrolet	X	1973
	00420069	Linton	Van II 01	Chevrolet	X	1975
HAMILTON COUNTY						
Carmel Fire Department	01320492	Carmel	Van 02	Chevrolet		1973
Fishers Comm. Vol. Fire Dept.	00970625	Fishers	Mod III 05	Ford	X	1979
	00290724	Carmel	Mod III 05	Ford	X	1980
Riverview Hospital	00290044	Noblesville	Mod III 05	Chevrolet	X	1976
	00290045	Noblesville	Mod III 05	Ford	X	1980
Sheridan Vol. Fire Department	02830658	Sheridan	Mod III 05	Ford	X	1979
Westfield Fire Department	00700115	Westfield	Van II 01	Dodge	X	1976
	00700485	Westfield	Mod III 05	Ford	X	1980

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
HANCOCK COUNTY						
Buck Creek Twp. Vol. Fire Dept.	01600251	Mt. Comfort	Van II 01	Chevrolet	X	1972
	01600252	Mt. Comfort	Van II 01	Dodge	X	1977
Condo & Son Funeral Home	00270727	Wilkinson	Van II 01	Ford	X	1980
	00270040	Wilkinson	Van II 01	Dodge	X	1978
Fishers Funeral Home	01740610	Fortville	Van 02	Dodge		1975
Greenfield Fire Department	02780427	Greenfield	Van II 01	Chevrolet	X	1973
	02780428	Greenfield	Mod III 05	Ford	X	1980
Ronald L. Seals Funeral Home	01820279	Fortville	Van 02	Ford		1976
Sugar Creek Vol. Fire Dept.	01610253	New Palestine	Mod III 05	Chevrolet	X	1976
HARRISON COUNTY						
Gehlbach & Royse Funeral Home	02590715	Corydon	Hearse 03	Cadillac		1973
Harrison County Hospital	03250524	Corydon	Van II 01	Chevrolet	X	1978
	03250049	Corydon	Mod 07	Int'l Harv.	X	1972
Ramsey Vol. Fire Dept., Inc.	00470078	Ramsey	Van II 01	Chevrolet	X	1978
HENDRICKS COUNTY						
Amo Volunteer Fire Department	01930296	Amo	Van II 01	Dodge	X	1974
Baker Funeral Home	01410720	Danville	Hearse 03	Cadillac		1974
Brownsburg Fire Department	01910692	Brownsburg	Van II 01	Ford	X	1980
Clayton Vol. Fire Department	00850388	Clayton	Van II 01	Ford	X	1979
Hazelwood Vol. Fire Department	01420126	Hazelwood	Van II 01	Ford	X	1979
Jones & Matthews Mortuary	00760266	Brownsburg	Van II 01	Dodge	X	1978
	00760212	Brownsburg	Hearse 03	Oldsmobile		1974
Plainfield Fire Department	00440071	Plainfield	Van II 01	Dodge	X	1975
	00440072	Plainfield	Van II 01	Dodge	X	1975
	00440271	Plainfield	Mod III 05	Ford	X	1981
Town of Stilesville	03230728	Stilesville	Van 02	Chevrolet		1974
Weaver Funeral Home	01430614	Danville	Van II 01	Ford	X	1979
HENRY COUNTY						
Butcher Funeral Home	00990150	Knightstown	Van II 01	Dodge	X	1977
Estell Funeral Home	01440177	Shirley	Van II 01	Dodge	X	1975
	01440577	Shirley	Van II 01	Dodge	X	1978
Greene's Funeral Home	01770453	Knightstown	Hearse 03	Oldsmobile		1975
Middletown Emergency Unit	00500627	Middletown	Mod III 05	Ford	X	1977
	00500082	Middletown	Van II 01	Chevrolet	X	1975
New Castle/Henry Co. Police	01000644	New Castle	Mod III 05	Ford	X	1979
	01000651	New Castle	Mod III 05	Ford	X	1979
	01000151	New Castle	Mod III 05	Dodge	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
HOWARD COUNTY						
Eastern Howard Emergency Serv.	00080018	Greentown	Van II 01	Dodge	X	1976
Howard County Civil Defense	00330712	Kokomo	Van II 01	Dodge	X	1973
	00330349	Kokomo	Van II 01	Chevrolet	X	1972
Howard Comm. Emergency Service	00130024	Kokomo	Van II 01	Ford	X	1981
	00130023	Kokomo	Van II 01	Ford	X	1980
Indiana Heights Vol. Fire Dept.	00140377	Kokomo	Mod III 05	Ford	X	1980
Kokomo Fire Department	00200028	Kokomo	Van II 01	Ford	X	1981
	00200423	Kokomo	Van II 01	Ford	X	1981
Russiaville Ambulance Service	02600406	Russiaville	Van 02	Dodge		1973
	02600147	Russiaville	Van II 01	Ford	X	1981
Kokomo Speedway Ambulance	00530686	Kokomo	Van II 01	Chevrolet	X	1974
HUNTINGTON COUNTY						
Huntington Memorial Hospital	00300047	Huntington	Van II 01	Ford	X	1979
	00300489	Huntington	Mod III 05	Ford	X	1978
	00300046	Huntington	Mod III 05	Ford	X	1979
Markle Vol. Fire Department	01830280	Markle	Mod III 05	Dodge	X	1975
Tri-Township Ambulance	03290545	Warren	Van II 01	Dodge	X	1978
JACKSON COUNTY						
Ross Med-Aid: Jackson County	00960739	Seymour	Van 02	Chevrolet		1973
Scott County	00960527	Scottsburg	Van II 01	Chevrolet	X	1974
Jackson County	00960732	Seymour	Van 02	Ford		1975
Jackson County	00960709	Brownstown	Van II 01	Ford		1976
Jackson County	00960521	Seymour	Mod III 05	Chevrolet	X	1975
Scott County	00960517	Austin	Van II 01	Chevrolet	X	1974
Scott County	00960572	Scottsburg	Van II 01	Ford	X	1976
JASPER COUNTY						
N. Jasper Co. Ambulance Service	00340120	DeMotte	Mod III 05	Chevrolet	X	1979
	00340053	DeMotte	Van II 01	Chevrolet	X	1975
	00340054	Wheatfield	Van II 01	Chevrolet	X	1975
S. Jasper Co. Ambulance Serivce	02280365	Remington	Van II 01	Dodge	X	1977
Steinke Ambulance Service	01500229	Rensselaer	Hearse 03	Cadillac		1975
	01500684	Rensselaer	Mod III 05	Ford	X	1977
JAY COUNTY						
Jay County E.M.S.	00210191	Portland	Mod III 05	GMC	X	1977
	00210029	Dunkirk	Van II 01	Ford		1981
	00210030	Dunkirk	Van II 01	Dodge	X	1976
	00210031	Portland	Van II 01	Ford	X	1981

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
JEFFERSON COUNTY						
Athens Ambulance Service, Inc.	01310620	Madison	Van II 01	Chevrolet	X	1974
	01310590	Madison	Van 02	Chevrolet		1978
	01310583	Madison	Van 02	Chevrolet		1980
JENNINGS COUNTY						
Rescue 20/Jennings Co. Emer. Amb.	00390595	North Vernon	Van II 01	Chevrolet	X	1978
	00390061	North Vernon	Van II 01	Chevrolet		1973
	00390062	North Vernon	Van II 01	Chevrolet		1974
JOHNSON COUNTY						
Edinburgh Fire Department	00860135	Edinburgh	Van II 01	Chevrolet	X	1977
	00860464	Edinburgh	Van II 01	Ford	X	1979
Franklin Fire Department	02750422	Franklin	Van II 01	Chevrolet	X	1972
	02750661	Franklin	Mod III 05	Ford	X	1979
Franklin Flying Field (Air)	03400707	Franklin	Air 08	Aztec		1975
	03400705	Franklin	Air 08	Piper		1976
	03400706	Franklin	Air 08	Navajo		1978
Greenwood Vol. Fire Department	01120172	Greenwood	Van II 01	Dodge	X	1976
Myers Ambulance Service	00680108	Greenwood	Mod III 05	Ford	X	1978
	00680109	Greenwood	Van II 01	Ford	X	1981
	00680244	Greenwood	Van II 01	Ford	X	1981
	00680281	Greenwood	Van II 01	Dodge	X	1975
	00680444	Greenwood	Mod I 05	Chevrolet	X	1980
New Whiteland Fire Department	01670259	New Whiteland	Van II 01	Chevrolet		1974
Princes Lake Ambulance Assoc.	00840703	Princes Lake	Van II 01	Dodge	X	1978
KNOX COUNTY						
Anderson-Poindexter Funeral Home	01370504	Sanborn	Van 02	Dodge	X	1974
Gordon E. Utt Funeral Home	01850282	Oaktown	Mod III 05	Ford	X	1974
McClure Funeral Home	00310205	Bicknell	Van II 01	Ford	X	1981
	00310389	Bicknell	Hearse 03	Oldsmobile		1974
Vincennes Ambulance Service	00280043	Vincennes	Mod III 05	Ford	X	1981
	00280561	Vincennes	Van 02	Ford	X	1979
	00280052	Vincennes	Van 02	ford		1979
	00280549	Vincennes	Van II 01	Ford	X	1978
	00280477	Vincennes	Van II 01	Ford	X	1978
	00280478	Vincennes	Van II 01	Ford	X	1978
	00280041	Vincennes	Mod III 05	Dodge	X	1976
	00280042	Monroe City	Van II 01	Dodge	X	1974
Wampler-Shaw Funeral Home, Inc.	02210708	Bicknell	Van 02	Dodge		1974

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
KOSCIUSKO COUNTY						
4-Way Ambulance Emer. Service	02420626	Mentone	Van II 01	Dodge	X	1974
Milford Emergency Service	01200702	Milford	Van II 01	Chevrolet		1974
Multi-Township E.M.S.	02430562	Warsaw	Van II 01	Dodge	X	1974
	02430390	Warsaw	Van II 01	Dodge	X	1977
	02430770	Warsaw	Mod III 05	Ford	X	1981
	02430391	Warsaw	Van II 01	Dodge	X	1977
North Webster E.M.S.	02050673	North Webster	Mod III 05	Ford	X	1979
	02050333	North Webster	Van II 01	Dodge	X	1974
Pierceton-Washington-Monroe EMS	02860437	Pierceton	Van II 01	Dodge	X	1976
S. Central Kosciusko EMS	02440392	Silver Lake	Van II 01	Dodge	X	1977
Syracuse Fire Department	02060334	Syracuse	Mod III 05	Ford	X	1979
LAGRANGE COUNTY						
LaGrange County Hospital	08160546	LaGrange	Van II 01	Dodge	X	1977
	08160283	LaGrange	Van II 01	Dodge	X	1977
	08160284	LaGrange	Mod III 05	Ford	X	1981
	08160285	Shipshewana	Van II 01	Dodge	X	1977
Stroh Vol. Fire Department	02460603	Stroh	Van II 01	Dodge	X	1977
LAKE COUNTY						
Amoco Oil Company	03110487	Whiting	Mod III 05	Dodge	X	1978
Cedar Lake Ambulance Service	02450010	Cedar Lake	Van II 01	Dodge	X	1979
	02450393	Cedar Lake	Mod III 05	Chevrolet	X	1980
Chartered ambulance Service	00180488	Griffith	Van II 01	Dodge	X	1977
	00180664	Griffith	Mod III 05	Dodge	X	1974
Courtesy Ambulance Service	02790647	Merrillville	Van II 01	Dodge	X	1974
	02970602	Merrillville	Mod 07	Ford	X	1974
Crown Point EMS	03340567	Crown Point	Mod III 05	Chevrolet	X	1979
East Chicago Health Department	02290367	East Chicago	Van II 01	Dodge	X	1979
	02290654	East Chicago	Van II 01	Dodge	X	1979
	02290366	East Chicago	Van II 01	Dodge	X	1976
Fagen-Miller Funeral Gardens	01150533	Highland	Van II 01	Dodge	X	1978
	01150178	Griffith	Van II 01	Ford	X	1979
	01150319	Griffith	Van II 01	Chevrolet	X	1975
	01150179	Highland	Van II 01	Ford	X	1981
Gary Fire Department	01440217	Gary	Mod III 05	Ford	X	1979
	01440215	Gary	Mod III 05	Ford	X	1979
	01440475	Gary	Mod III 05	Ford	X	1977
	01440216	Gary	Mod III 05	Chevrolet	X	1976
City of Hammond Fire Department	01720653	Hammond	Mod III 05	Ford	X	1978
	01720571	Hammond	Mod III 05	Chevrolet	X	1978
	01720756	Hammond	Mod III 05	Ford	X	1981
	01720513	Hammond	Mod III 05	Chevrolet	X	1977
Highland Fire Department	00260039	Highland	Van II 01	Chevrolet	X	1977
City of Hobart	02630743	Hobart	Van II 01	Ford	X	1981
	02630733	Hobart	Van II 01	Dodge	X	1976

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
LAKE COUNTY (Continued)						
Inland Steel Co. Medical Dept.	01450219	East Chicago	Mod III 05	Chevrolet	X	1977
Lake Station Vol. Fire Department	02910569	Lake Station	Van II 01	Chevrolet	X	1978
	02910447	Lake Station	Mod III 05	Chevrolet	X	1978
Merrillville E.M.S.	03330565	Merrillville	Mod III 05	Ford	X	1978
	03330566	Merrillville	Mod III 05	Ford	X	1978
Munster Fire Department	02200353	Munster	Mod III 05	Chevrolet		1976
	02200757	Munster	Mod III 05	Ford	X	1981
Patient Transfer, Inc.	02300599	Gary	Van II 01	Chevrolet	X	1979
	02300369	Gary	Van II 01	Chevrolet	X	1978
	02300370	Gary	Van II 01	Chevrolet	X	1980
	02300368	Gary	Van II 01	Chevrolet	X	1978
	02300636	Gary	Van II 01	Chevrolet	X	1977
Town of Schererville	02410386	Schererville	Mod III 05	Ford	X	1979
Tri-Creek Ambulance Service	01950164	Lowell	Mod III 05	Chevrolet	X	1978
	01950298	Lowell	Mod III 05	Chevrolet	X	1974
U.S. Steel Corp/Gary Works	00230035	Gary	Mod I 05	GMC	X	1979
	00230036	Gary	Mod I 05	GMC	X	1979
Whiting Fire Department	01510231	Whiting	Mod III 05	Chevrolet	X	1977
Youngstown Steel & Tube Company	02920448	East Chicago	Van II 01	Dodge	X	1977
LAPORTE COUNTY						
LaPorte County E.M.S.	01460218	Michigan City	Mod III 05	Ford	X	1981
	01460224	LaPorte	Van II 01	Ford	X	1979
	01460222	Wanatah	Mod III 05	Ford	X	1980
	01460688	Michigan City	Mod III 05	Ford	X	1980
	01460752	LaPorte	Van 02	Ford		1980
	01460463	LaPorte	Mod III 05	Chevrolet	X	1977
LAWRENCE COUNTY						
Dunn Memorial Ambulance	01750629	Bedford	Van II 01	Dodge	X	1975
	01750267	Bedford	Mod III 05	Ford	X	1977
	01750269	Bedford	Van II 01	Chevrolet	X	1976
	01750722	Bedford	Hearse 03	Cadillac		1974

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
MADISON COUNTY						
AID Ambulance at Anderson	01490765	Anderson	Van II 01	Ford	X	1981
	01490725	Anderson	Van II 01	Ford	X	1981
	01490364	Anderson	Van II 01	Ford	X	1980
	01490424	Anderson	Van II 01	Ford	X	1980
	01490640	Anderson	Van II 01	Ford	X	1976
	01490228	Anderson	Van II 01	Ford		1977
Alexandria Fire Department	02070335	Alexandria	Van II 01	Dodge	X	1976
	02070230	Alexandria	Van II 01	Ford	X	1981
Anderson Fire Department	01090613	Anderson	Van II 01	Ford	X	1979
	01090166	Anderson	Van 02	Chevrolet		1975
	01090167	Anderson	Mod III 05	Chevrolet	X	1977
	01090168	Anderson	Van II 01	Ford	X	1978
Chesterfield Vol. Fire Department	00510083	Chesterfield	Van II 01	Ford	X	1980
Copher & Fesler Funeral Home	01680260	Elwood	Van II 01	Dodge	X	1977
Delco-Remy	02220330	Anderson	Van 02	Chevrolet		1974
Dunnichay Funeral Home	02620407	Elwood	Van II 01	Dodge	X	1977
Elwood Fire Department	01480226	Elwood	Van II 01	Dodge	X	1977
Frankton Vol. Ambulance Service	01240192	Frankton	Van II 01	Dodge	X	1975
	01240193	Frankton	Van II 01	Ford	X	1981
Jackley-Landrum Funeral Home	00520114	Elwood	Van 02	Ford		1975
Lapel Emer. Amb. Service, Inc.	00490081	Lapel	Van II 01	Chevrolet	X	1975
	00490665	Lapel	Mod III 05	Dodge	X	1977
Markleville/Adams Twp. Emer. Amb.	01010701	Markleville	Van II 01	Chevrolet		1973
	01010152	Markleville	Van II 01	Chevrolet	X	1974
Pendleton Emer. Ambulance Service	00410064	Pendleton	Van II 01	Chevrolet	X	1975
	00410065	Pendleton	Van II 01	Ford	X	1979
Pro-Med Services, Inc.	03440758	Anderson	Van II 01	Ford	X	1981
	03440768	Indianapolis	Mod III 05	Ford	X	1981
Richland Twp. Vol. Fire Dept.	01020153	Anderson	Van II 01	Chevrolet	X	1977
Summitville/Van Buren Twp.	00590093	Summitville	Mod III 05	Chevrolet	X	1977
	00590383	Summitville	Mod III 05	Chevrolet	X	1973

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
MARION COUNTY						
Acton Vol. Fire Department	01730336	Indianapolis	Van II 01	Dodge	X	1973
Ambulance Indpls. Dispatch, Inc.	01530578	Indianapolis	Van II 01	Ford	X	1978
	01530579	Indianapolis	Van II 01	Ford	X	1978
	01530696	Indianapolis	Van II 01	Ford	X	1977
	01530236	Indianapolis	Van II 01	Ford	X	1979
	01530237	Indianapolis	Van II 01	Ford	X	1981
	01530290	Indianapolis	Van II 01	Ford	X	1980
	01530458	Indianapolis	Van II 01	Ford	X	1980
	01530239	Indianapolis	Van II 01	Ford	X	1977
	01530241	Indianapolis	Van II 01	Ford	X	1977
	01530674	Indianapolis	Van II 01	Ford	X	1979
	01530675	Indianapolis	Van II 01	Ford	X	1978
	01530677	Indianapolis	Van II 01	Ford	X	1979
	01530048	Indianapolis	Van II 01	Ford	X	1980
Hamilton County	01530676	Noblesville	Van II 01	Ford	X	1978
Morgan County	01530235	Martinsville	Van II 01	Ford	X	1976
Morgan County	01530481	Martinsville	Van II 01	Ford	X	1976
Morgan County	01530238	Martinsville	Van II 01	Ford	X	1977
City of Beech Grove Fire Dept.	00120530	Beech Grove	Mod III 05	Ford	X	1977
	00120491	Beech Grove	Van II 01	Chevrolet	X	1973
Castleton Vol. Fire Dept., Inc.	01290759	Castleton	Mod III 05	Ford		1980
	01290200	Castleton	Van II 01	Chevrolet	X	1972
	01290454	Castleton	Van II 01	Ford	X	1978
Clermont Community V.F.D.	00880137	Clermont	Van II 01	Dodge	X	1977
Decatur Twp. Vol. Fire Dept.	00930534	Camby	Mod III 05	Chevrolet	X	1977
	00930678	Camby	Van II 01	Dodge		1974
	00930679	Camby	Mod III 05	Ford	X	1981
E.M.A.S., Inc.	02080612	Indianapolis	Van II 01	Dodge	X	1973
Emergency Ambulance Service	02730667	Indianapolis	Van 02	Ford		1979
Fleming Gardens Vol. Fire Dept.	02490395	Indianapolis	Van II 01	Dodge	X	1977
Franklin Twp. VFD, Bunker Hill	01210591	Indianapolis	Mod III 05	Chevrolet	X	1978
Franklin Twp. VFD #1, Wanamaker	00950148	Indianapolis	Van II 01	Chevrolet		1972
Indiana University Hospitals	01180684	Indianapolis	Mod III 05	Ford		1979
Lawrence Vol Fire Department	01960624	Lawrence	Van II 01	Ford	X	1979
	01960301	Lawrence	Mod III 05	Chevrolet	X	1977
	01960300	Lawrence	Van II 01	Chevrolet	X	1974
	01960299	Lawrence	Van II 01	Ford	X	1980
Methodist Hospital, Inc.	00320173	Indianapolis	Air Amb.08	Bolkow CBS		1974
Mickleyville Vol. Fire Dept.	02090452	Indianapolis	Mod 07	Chevrolet	X	1977
Midwest Transport Ambulance Serv.	00030704	Indianapolis	Van II 01	Chevrolet	X	1975
Oak Park Volunteer Fire Dept.	01990324	Indianapolis	Van II 01	Dodge	X	1975
Parr-Lance Ambulance	02180103	Indianapolis	Van II 01	Ford	X	1976
	02180607	Indianapolis	Van II 01	Ford	X	1977
	02180737	Indianapolis	Van II 01	Ford	X	1977
	02180608	Indianapolis	Van II 01	Ford	X	1976
	02180738	Indianapolis	Van II 01	Dodge	X	1974
	02180609	Indianapolis	Van II 01	Ford	X	1976
	02180611	Indianapolis	Van II 01	Ford	X	1976
	02180351	Indianapolis	Van II 01	Ford	X	1976

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
MARION COUNTY (Continued)						
Perry Twp. Fire Department	00770470	Indianapolis	Mod III 05	Chevrolet	X	1980
	00770122	Indianapolis	Mod III 05	Chevrolet	X	1977
Pike Twp. Vol. Fire Dept.	02840634	Indianapolis	Van II 01	Ford	X	1979
	02840435	Indianapolis	Mod 07	Ford	X	1977
Warren Twp. Fire Department	02470450	Indianapolis	Mod III 05	Chevrolet	X	1976
	02470220	Indianapolis	Van II 01	Ford		1980
	02470050	Indianapolis	Van II 01	Ford	X	1980
	02470659	Indianapolis	Van II 01	Ford	X	1979
Washington Twp. Fire Department	00940146	Indianapolis	Mod III 05	Ford	X	1981
	00940221	Indianapolis	Mod III 05	Ford	X	1981
	00940499	Indianapolis	Mod I 05	Ford	X	1981
Wayne Twp. Vol. Fire Dept. 08	02640409	Indianapolis	Mod 07	Ford	X	1978
Wayne Twp. Vol. Fire Dept. 09	00090009	Indianapolis	Mod III 05	Ford	X	1978
Wishard Memorial Hospital/Amb.	01970320	Indianapolis	Mod III 05	Ford	X	1979
	01970322	Indianapolis	Van II 01	Ford		1979
	01970311	Indianapolis	Mod III 05	Ford	X	1979
	01970648	Indianapolis	Van II 01	Ford	X	1979
	01970596	Indianapolis	Van II 01	Ford	X	1979
	10960314	Indianapolis	Van II 01	Ford	X	1979
	01970313	Indianapolis	Van II 01	Ford	X	1979
	01970307	Indianapolis	Van II 01	Ford	X	1979
	01970321	Indianapolis	Van II 01	Ford	X	1979
	01970305	Indianapolis	Van II 01	Ford	X	1979
	01970308	Indianapolis	Van II 01	Ford	X	1979
	01970304	Indianapolis	Van II 01	Ford	X	1979
	01970303	Indianapolis	Van II 01	Ford		1980
	01970316	Indianapolis	Van II 01	Ford		1980
	01970318	Indianapolis	Van II 01	Ford	X	1980
	01970593	Indianapolis	Mod III 05	Ford	X	1980
	01970594	Indianapolis	Mod III 05	Ford	X	1977
	01970317	Indianapolis	Van II 01	Ford	X	1980
	01970315	Indianapolis	Van II 01	Ford	X	1980
	01970312	Indianapolis	Van II 01	Ford	X	1980
	01970309	Indianapolis	Van II 01	Ford	X	1980
	01970302	Indianapolis	Mod III 05	Ford	X	1980
	01970306	Indianapolis	Van II 01	Ford	X	1977
	01970680	Indianapolis	Mod III 05	Ford	X	1979
Volunteer Fire Dept./Perry Twp.	03430755	Indianapolis	Mod III 05	Ford	X	1975

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
MARSHALL COUNTY						
Argos Comm. Amb. Service	01470225	Argos	Mod III 05	Chevrolet	X	1977
Bourbon Community E.M.S.	02100337	Bourbon	Mod III 05	Ford	X	1977
Culver Union Twp. Ambulance Serv.	01100025	Culver	Mod III 05	Ford	X	1979
	01100767	Culver	Mod III 05	Ford	X	1981
Fishler Ambulance Service	01190451	Bremen	Mod III 05	Dodge	X	1975
	01190184	Bremen	Van II 01	Dodge	X	1976
Plymouth Community Ambulance Serv.	01690261	Plymouth	Van II 01	Dodge	X	1977
	01690262	Plymouth	Mod III 05	Ford	X	1981
Tippecanoe Ambulance Service, Inc.	02480394	Tippecanoe	Hearse 03	Cadillac		1973
MARTIN COUNTY						
Martin Company Ambulance Service	02110338	Loogootee	Van II 01	Chevrolet	X	1977
	02110339	Shoals	Van II 01	Chevrolet	X	1977
MIAMI COUNTY						
Converse Ambulance Corporation	01030154	Converse	Van II 01	Dodge	X	1975
Miami County Ambulance Service	01040155	Peru	Van II 01	Dodge	X	1977
	01040156	Peru	Van II 01	Dodge	X	1977
	01040157	Bunker Hill	Van II 01	Dodge	X	1977
	01040158	Macy	Van II 01	Dodge	X	1977
	01040714	Peru	Van II 01	Ford	X	1980
Peru Fire Department	02190352	Peru	Van II 01	Dodge	X	1973
MONROE COUNTY						
Medicare's, Inc.	03270468	Bloomington	Van II 01	Ford	X	1980
	03270542	Bloomington	Van II 01	Dodge	X	1973
Bloomington Hospital Amb. Serv.	00110750	Bloomington	Van II 01	Ford	X	1978
	00110022	Bloomington	Mod III 05	Chevrolet	X	1975
	00110021	Bloomington	Mod III 05	Ford	X	1979
	00110020	Bloomington	Mod III 05	Ford	X	1979
	00110019	Bloomington	Van II 01	Ford	X	1978
Bloomington Twp. Fire Dept.	02800201	Bloomington	Van 02	Ford		1975
Stone Ambulance Service	02930449	Bloomington	Van 02	Dodge		1976

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
MONTGOMERY COUNTY						
City of Crawfordsville Fire Dept.	00020615	Crawfordsville	Mod III 05	Chevrolet	X	1981
	00020460	Crawfordsville	Van II 01	Dodge	X	1975
	00020459	Crawfordsville	Van II 01	Dodge	X	1975
Health Facilities Amb. Serv., Inc.	02810432	Crawfordsville	Mod III 05	Chevrolet	X	1973
Linden Vol. Amb. Service, Inc.	02650410	Wingate	Van II 01	Dodge	X	1977
	02650411	Linden	Van II 01	Dodge		1975
S & W Rescue Service, Inc.	03070483	New Market	Van II 01	Dodge	X	1977
Walnut Twp. & Town of New Ross	02360719	New Ross	Van 02	Plymouth		1975
Wayne Twp. Vol. Rescue Service	02230354	Waynetown	Van II 01	Dodge	X	1977
MORGAN COUNTY						
AIM Ambulance Service	03150747	Martinsville	Van 02	Ford		1981
	03150523	Martinsville	Van II 01	Ford	X	1980
	03150502	Martinsville	Van 02	Ford		1977
Gregg Twp. Vol. Fire Dept.	01380210	Wilbur	Van II 01	Chevrolet		1972
	01380484	Wilbur	Hearse 03	Oldsmobile		1972
Morgan County Rescue Service	02370730	Mooresville	Van 02	Dodge		1975
	02370378	Martinsville	Van 02	Ford		1976
	02370731	Morgantown	Van 02	Dodge		1973
	02370729	Martinsville	Van II 01	Ford		1973
NEWTON COUNTY						
Crane Funeral Home	02500396	Goodland	Van 02	Chevrolet		1977
Newton Company Ambulance Service	02510443	Kentland	Van 02	Chevrolet		1979
	02510441	Kentland	Van 02	Chevrolet		1979
	02510442	Goodland	Van 02	Chevrolet		1978
	02510398	Kentland	Mod III 05	Dodge	X	1975
NOBLE COUNTY						
Noble County E.M.S.	02120340	Kendallville	Van II 01	Dodge	X	1974
	02120341	Wolf Lake	Van II 01	Dodge	X	1976
	02120342	Albion	Mod III 05	Ford	X	1980
	02120399	Kendallville	Mod III 05	Ford	X	1977
	02120400	Kendallville	Van II 01	Dodge	X	1974
	02120401	Rome City	Van II 01	Dodge	X	1975
	02120214	Ligonier	Mod III 05	Ford		1980
OHIO COUNTY						
Rising Sun/Ohio Co. Rescue Service	01700263	Rising Sun	Van II 01	Chevrolet		1972
	01700264	Rising Sun	Mod III 05	Ford	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
ORANGE COUNTY						
range County Ambulance Service	00460077	Paoli	Van II 01	Dodge		1977
	00460075	W Baden Springs	Van II 01	Dodge		1977
	00460076	Paoli	Van II 01	Dodge		1977
OWEN COUNTY						
wen County E.M.S.	00360056	Spencer	Van II 01	Ford	X	1980
	00360057	Spencer	Van II 01	Dodge	X	1976
PARKE COUNTY						
rke County Ambulance Service	01110169	Rockville	Van II 1	Dodge	X	1977
	01110170	Rockville	Van II 01	Dodge	X	1977
	01110171	Rockville	Mod III 05	Ford		1980
Central Ind. Amb. Serv., Inc.	03460474	Rockville	Hearse 03	Cadillac		1971
PERRY COUNTY						
rry County Emer. Amb. Service	00800130	Tell City	Van II 01	Dodge	X	1976
	00800131	Cannelton	Van II 01	Dodge	X	1976
PIKE COUNTY						
ike County E.M.S.	00150638	Petersburg	Van II 01	Ford	X	1979
	00150012	Winslow	Van II 01	Dodge	X	1975
	00150013	Petersburg	Van II 01	Dodge	X	1975
	00150014	Spurgeon	Van II 01	Dodge		1977
	00150015	Otwell	Van II 01	Dodge		1977
one & Webster Engineering	00430070	Petersburg	Van 02	Chevrolet		1971

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
PORTER COUNTY						
Ambulance Transfer, Inc.	00400197	Valparaiso	Van II 01	Dodge	X	1974
	00400618	Valparaiso	Van II 01	Ford	X	1979
	00400619	Valparaiso	Van II 01	Ford	X	1979
Bethlehem Steel Corporation	01650498	Chesterton	Mod III 05	Chevrolet	X	1977
Midwest Steel Division	03240408	Portage	Mod III 05	Interna'l	X	1974
North Porter Co. Ambulance Comm.	00050564	Chesterton	Mod III 05	Ford	X	1978
	00050006	Chesterton	Van II 01	Chevrolet	X	1974
	00050005	Chesterton	Mod III 05	Ford	X	1980
Portage Fire Department	00660639	Portage	Mod III 05	Chevrolet	X	1978
	00660104	Portage	Mod III 05	Chevrolet	X	1978
Portage Twp. Vol. Fire Dept.	00670106	Valparaiso	Mod III 05	Chevrolet	X	1973
	00670107	Valparaiso	Mod III 05	Chevrolet	X	1974
Porter County E.M.S. - Area 3	02240551	Valparaiso	Mod III 05	Chevrolet	X	1978
	02240356	Valparaiso	Mod III 05	Chevrolet	X	1978
	02240355	Valparaiso	Mod III 05	Chevrolet	X	1978
POSEY COUNTY						
General Electric Company	03220662	Mt. Vernon	Mod III 05	Chevrolet	X	1979
Posey County Sheriff	00570090	N. Harmony	Mod III 05	Chevrolet	X	1979
	00570089	Mt. Vernon	Van II 01	Ford	X	1981
	00570091	Mt. Vernon	Van II 01	dodge	X	1975
	00570434	Poseyville	Van II 01	Ford	X	1981
PULASKI COUNTY						
Ross Medi-Van	02130672	Francesville	Van II 01	Dodge	X	1976
	02130746	Winamac	Van II 01	Ford		1976
	02130343	Winamac	Van II 01	Dodge	X	1973
PUTNAM COUNTY						
P.M.H. Ambulance, Inc.	01570248	Roachdale	Van II 01	Ford	X	1980
Hendricks County	01570247	North Salem	Mod III 05	Ford	X	1973
Montgomery County	01570246	Ladoga	Van II 01	Dodge	X	1977
Putnam County Operation Life	01160440	Greencastle	Van II 01	Ford	X	1980
	01160180	Cloverdale	Van II 01	Ford	X	1981
	01160181	Greencastle	Van II 01	Dodge	X	1977
	01160080	Greencastle	Van II 01	Ford	X	1981

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
RANDOLPH COUNTY						
berson-Reynard Funeral Home	00350074	Modoc	Van II 01	Ford	X	1979
ndolph County Civil Defense	03380100	Winchester	Van II 01	Chevrolet	X	1972
ndolph County Sheriff's Amb.	02720419	Winchester	Van II 01	Dodge	X	1976
	02720420	Winchester	Van II 01	Dodge	X	1976
	02720740	Winchester	Van 02	Ford		1974
	02720671	Winchester	Van II 01	Ford	X	1980
ion City Indiana Life & Rescue	01050461	Union City	Mod III 05	Chevrolet	X	1978
	01050748	Union City	Van II 01	Dodge	X	1976
RIPLEY COUNTY						
tesville Volunteer Fire Dept.	01620597	Batesville	Van II 01	Dodge	X	1978
	01620254	Batesville	Van II 01	Dodge	X	1975
s-Carr-Moore Funeral Home	01980323	Milan	Van 02	Chevrolet		1977
Ripley Co. Life Sqd./Rescue 69	03280544	Versailles	Van II 01	Dodge	X	1977
	03280543	Versailles	Van II 01	Dodge	X	1977
nman Area Life Squad, Inc.	00040004	Sunman	Mod III 05	Dodge	X	1975
RUSH COUNTY						
n J. Todd Funeral Home	00830165	Carthage	Van II 01	Chevrolet	X	1974
	00830518	Carthage	Sub 06	Chevrolet		1977
leigh Comm. VFD, Inc.	03090735	Mays	Van II 01	Chevrolet	X	1974
	03090486	Mays	Van II 01	Chevrolet	X	1977
sh County E.M.S.	02660412	Milroy	Van II 01	Dodge		1977
odd Funeral Home	00800129	Rushville	Van II 01	Dodge	X	1974
	00800550	Rushville	Van II 01	Dodge	X	1974
ST. JOSEPH COUNTY						
llard Ambulance Service, Inc.	02980736	Mishawaka	Van II 01	Dodge	X	1975
e Bendix Corporation	02820605	North Carlisle	Mod III 05	Ford	X	1978
	02820433	South Bend	Mod III 05	Chevrolet	X	1977
mmunity Emergency Amb. Service	00600094	North Carlisle	Mod III 05	Ford	X	1976
	00600553	North Carlisle	Mod III 05	Ford	X	1978
isinger Colonial Chapel	01630547	South Bend	Van II 01	Dodge	X	1978
	01630255	South Bend	Van II 01	Ford	X	1981
berty Township	01870286	North Liberty	Mod III 05	Ford	X	1977
fe Ambulance, Inc.	02310455	South Bend	Van II 01	Dodge	X	1979
	02310387	South Bend	Mod III 05	Dodge	X	1976
	02310371	South Bend	Van II 01	Ford		1977
Gann Ambulance Division	01260575	South Bend	Van 02	Chevrolet		1979
	01260196	South Bend	Mod I 05	Chevrolet	X	1978
	01260198	South Bend	Van II 01	Ford	X	1980
	01260652	South Bend	Van II 01	Chevrolet	X	1976

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
ST. JOSEPH COUNTY (Continued)						
City of Mishawaka E.M.S.	01250194	Mishawaka	Van II 01	Dodge	X	1976
	01250195	Mishawaka	Van II 01	Dodge	X	1979
O.C. Emergency Ambulance Service	03080223	Osceola	Hearse 03	Ford		1964
	03080700	Osceola	Van II 01	Dodge	X	1973
South Bend Fire Department	01390211	South Bend	Mod I 05	Chevrolet	X	1976
	01390212	South Bend	Mod I 05	Chevrolet	X	1979
	01390717	South Bend	Mod I 05	Chevrolet	X	1979
Union North Amb. Service, Inc.	00610095	Lakeville	Van II 01	Dodge	X	1975
	00610421	Lakeville	Van II 01	Dodge	X	1974
Walkerton-Polk-Lincoln-Johnson	02670641	Walkerton	Van II 01	Chevrolet		1976
	02670413	Walkerton	Mod III 05	Ford	X	1977
Warner Funeral Home	00620096	Osceola	Van II 01	Dodge	X	1976
	00620227	Osceola	Mod I 05	Chevrolet	X	1975
	00620096	Osceola	Mod III 05	Ford	X	1980
SCOTT COUNTY						
SHELBY COUNTY						
Fountaintown Community VFD	01880287	Fountaintown	Van II 01	Dodge	X	1977
City of Shelbyville	01760771	Shelbyville	Mod III 05	Ford	X	1981
Trans-Med Ambulance	02520734	Shelbyville	Van 02	Dodge		1972
	02520525	Shelbyville	Van II 01	Dodge	X	1974
	02520592	Shelbyville	Van II 01	Ford	X	1979
	02520128	Shelbyville	Van II 01	Ford	X	1977
	02520003	Shelbyville	Van II 01	Ford	X	1978
SPENCER COUNTY						
Indiana & Michigan Electric Co.	02180505	Rockport	Mod III 05	Chevrolet	X	1978
Spencer Co. Emer. Amb. Service	01640256	St. Meinrad	Van II 01	Chevrolet	X	1977
	01640257	Rockport	Van II 01	Chevrolet	X	1977
	01640690	Rockport	Mod III 05	Ford	X	1979
STARKE COUNTY						
Starke Co. Ambulance Service	00540085	Knox	Van II 01	Dodge	X	1976
	00540344	North Judson	Van II 01	Dodge	X	1977
	00540086	Knox	Van II 01	Dodge	X	1976
	00540514	Walkerton	Van II 01	Dodge	X	1976
	00540084	Hamlet	Van II 01	Dodge	X	1976

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
STEUBEN COUNTY						
Steuben County Sheriff's Dept.	02870580	Angola	Van 02	Chevrolet		1979
	02870581	Angola	Van 02	Chevrolet		1979
	02870438	Angola	Van II 01	Ford	X	1980
	02870439	Angola	Van II 01	Ford	X	1980
SULLIVAN COUNTY						
Carlisle Lyons Comm. Amb., Inc.	00240037	Carlisle	Van II 01	Dodge	X	1974
Sullivan County E.M.S.	00010001	Sullivan	Van II 01	Ford	X	1979
	00010516	Sullivan	Van II 01	Dodge	X	1974
	00010002	Sullivan	Mod III 05	Dodge	X	1974
	00010606	Sullivan	Van II 01	Ford	X	1980
SWITZERLAND COUNTY						
Switzerland Co. Emer. Unit, Inc.	02250357	Patriot	Van II 01	Dodge	X	1977
	02250358	Enterprise	Van II 01	Dodge	X	1977
	02250359	Vevay	Van II 01	Dodge	X	1974
TIPPECANOE COUNTY						
Clarks Hill Vol. Fire Dept.	03040469	Clarks Hill	Van II 01	Dodge	X	1974
Grady B. Jones Conv. Trans.	00710617	Lafayette	Van II 01	Dodge	X	1974
Purdue University Fire Dept.	01270199	West Lafayette	Mod III 05	Ford	X	1977
St. Elizabeth Hosp. Med. Center	00190601	Lafayette	Mod III 05	Chevrolet	X	1978
	00190027	Lafayette	Mod III 05	Ford	X	1978
	00190026	Lafayette	Van II 01	Dodge	X	1974
Tippecanoe Emer. Amb. Service	00070598	Lafayette	Mod III 05	Chevrolet	X	1978
	00070405	Lafayette	Mod III 05	Ford	X	1977
	00070008	Lafayette	Van II 01	Dodge	X	1974
Wayne Twp. Vol. Fire Dept.	02530536	West Point	Van II 01	Dodge	X	1974
TIPTON COUNTY						
Leatherman-Morris Funeral Home	01540242	Tipton	Van II 01	Dodge	X	1976
Porter Ambulance Service	00550467	Tipton	Van II 01	Dodge	X	1975
Sharpsville Comm. Ambulance	00160698	Sharpsville	Van II 01	Ford	X	1981
Young-Nichols Funeral Home, Inc.	01550243	Tipton	Van II 01	Dodge	X	1975
	01550754	Tipton	Van II 01	Ford	X	1981
UNION COUNTY						
Union County EMT Unit	00580092	Liberty	Van II 01	Dodge	X	1974
	00580051	Liberty	Mod III 05	Ford	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
VANDERBURG COUNTY						
Alexander Ambulance Service, Inc.	02150347	Evansville	Mod III 05	Ford	X	1978
	02150346	Evansville	Mod III 05	Ford	X	1978
	02150345	Evansville	Mod III 05	Dodge	X	1979
	02150535	Evansville	Van II 01	Ford	X	1980
B & H Wheelchair	03310554	Evansville	Van II 01	Ford	X	1981
Comaier Service, Inc.	01280681	Evansville	Van II 01	Ford	X	1980
	01280682	Evansville	Van II 01	Ford	X	1976
	01280716	Evansville	Van II 01	Ford	X	1980
Evansville Fire Department	02680414	Evansville	Van II 01	Dodge	X	1976
	02680416	Evansville	Mod III 05	Chevrolet	X	1979
	02680415	Evansville	Mod III 05	Chevrolet	X	1979
	02680480	Evansville	Van II 01	Dodge	X	1973
Evansville/Vanderburgh Co. CD.	02140691	Evansville	Mod III 05	Dodge	X	1974
Pierre Funeral Home	01890288	Evansville	Van II 01	Ford	X	1979
Welborn Baptist Hospital	03190508	Evansville	Mob. Hm.04	GMC		1978
VERMILLION COUNTY						
Vermillion Co. Emergency Amb.	01220185	Clinton	Van II 01	Chevrolet	X	1981
	01220186	Clinton	Van 02	Chevrolet		1980
	01220187	Cayuga	Van 02	Chevrolet		1980
VIGO COUNTY						
Chambers Ambulance Service	02550726	Terre Haute	Hearse 03	Cadillac		1963
Terre Haute Fire Department	00640531	Terre Haute	Van II 01	Dodge	X	1978
	00640532	Terre Haute	Van II 01	Dodge	X	1978
	00640098	Terre Haute	Van II 01	Chevrolet	X	1972
	00640099	Terre Haute	Van II 01	Chevrolet	X	1975
Vigo County Ambulance Service	03140541	Terre Haute	Van II 01	Dodge	X	1977
	03140522	Terre Haute	Van II 01	Ford	X	1979
	03140500	Terre Haute	Van II 01	Dodge	X	1977
	03140670	Terre Haute	Van II 01	Ford	X	1980
WABASH COUNTY						
Bender Funeral Home	02690417	N. Manchester	Van 02	Chevrolet		1976
Delaughter Mortuary	00870136	N. Manchester	Van II 01	Dodge	X	1974
Wabash Fire Department	01060175	Wabash	Mod III 05	Ford	X	1979
	01060176	Wabash	Mod III 05	Ford	X	1979
	01060174	Wabash	Van II 01	Ford	X	1977

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
WARREN COUNTY						
rren Co. Amb. Service, Inc.	00790576	Williamsport	Van II 01	Dodge	X	1977
	00790127	Williamsport	Mod III 05	Chevrolet	X	1974
WARRICK COUNTY						
uminum Company of America	01270510	Newburgh	Van II 01	Dodge	X	1977
rrick County E.M.S.	00690111	Boonville	Van II 01	Dodge	X	1976
	00690113	Chandler	Van II 01	Ford	X	1979
	00690326	Newburgh	Van II 01	Ford	X	1980
	00690668	Boonville	Van II 01	Ford	X	1979
	00690112	Boonville	Van II 01	Dodge	X	1976
	00690548	Boonville	Mod III 05	Ford	X	1980
WASHINGTON COUNTY						
shington Co. Med. Services	02260360	Hardinsburg	Van II 01	Ford	X	1977
	02260361	Salem	Van II 01	Ford	X	1977
	02260362	Salem	Van II 01	Ford	X	1977
WAYNE COUNTY						
D Ambulance, Inc.	02270429	Richmond	Van II 01	Ford	X	1979
	02270430	Richmond	Van II 01	Ford	X	1979
	02270493	Richmond	Van II 01	Ford	X	1978
	02270363	Richmond	Van II 01	Ford	X	1979
lberson-Gray Funeral Home	00450073	Hagerstown	Van II 01	Ford	X	1980
	00450055	Hagerstown	Van II 01	Dodge	X	1974
sher-Waskom Mortuary	02320310	Cambridge City	Van II 01	Dodge	X	1975
ward Ambulance Service	03000741	Cambridge City	Van II 01	Dodge	X	1975
	03000764	Cambridge City	Van II 01	Ford	X	1980
rshall Funeral Home	02540397	Dublin	Van II 01	Chevrolet	X	1972
	02540669	Dublin	Van II 01	Chevrolet	X	1979
WELLS COUNTY						
lls Community Hospital	01230188	Ossian	Mod III 05	Ford	X	1981
	01230189	Bluffton	Mod III 05	Ford	X	1980
	01230190	Bluffton	Van II 01	Dodge	X	1975
	01230763	Bluffton	Van II 01	Ford	X	1980

PROVIDER	VEHICLE #	LOCATION	TYPE	MAKE	KKK	YEAR
WHITE COUNTY						
City of Monticello Fire Dept.	00100016	Monticello	Mod II 05	Chevrolet	X	1978
	00100506	Monticello	Mod III 05	Chevrolet	X	1977
	00100017	Monticello	Van II 01	Chevrolet	X	1974
Wolcott Vol. Fire Department	02700650	Wolcott	Van II 01	Ford	X	1979
WHITLEY COUNTY						
Krider-Workman Amb. Service	00890721	Churubusco	Van II 01	Chevrolet		1974
Whitley Co. Memorial Hospital	00910655	Columbia City	Mod III 05	Ford	X	1979
	00910139	Columbia City	Van II 01	Dodge	X	1976
	00910140	Columbia City	Van II 01	Dodge	X	1976
	00910141	South Whitley	Van II 01	Dodge	X	1976
	00910142	Columbia City	Mod III 05	Chevrolet	X	1976
OUT-OF-STATE						
D.G.A., Inc. d/b/a Daley's Amb.	03390699	Dolton, IL	Van II 01	Ford	X	1979
Union City/Ohio Fire Department	02710183	Union City	Mod III 05	Ford	X	1979
and Emergency Squad	02710182	Union City	Mod III 05	Chevrolet	X	1977

PROVIDER INVENTORY

Date: November 15, 1981

Following is an inventory of all Emergency Medical Service Providers certified in the State of Indiana current to the above date.

Extrication refers to a provider which carries more extrication tools than required by regulation and/or is primary or only extrication service available in the provider's coverage area.

CLASSIFICATION OF EMS PROVIDER TYPES

CLASSIFICATION	TYPE	DESCRIPTION
01	Commercial Service	Private sector ambulance (not funeral home unless separate incorporated entity)
02	Funeral Home	This classification takes precedence over classes 01 and 07
03	Paid Fire Department	Class takes precedence over 09 type only if EMTs are paid; not if chief or administration is only paid (4 or more paid or enough to operate with paid personnel)
04	Volunteer Fire	This class takes precendence over 07 and 09 types unless separate incorporated entity
05	Police Department	
06	Sheriff's Department	
07	Volunteer Ambulance	Separate entity with no affiliation with another class (can be receiving governmental subsidy)
08	Hospital Operated	Can be receiving governmental subsidy
09	Governmental EMS Department	Can be either county, municipality, or township
10	Industrial	
11	First Responder	
12	Physician (EMT Classification ONLY)	
13	Civil Defense	
14	No Affiliation (EMT Classification ONLY)	
15	Other (Specify)	

PROVIDER INVENTORY CONTINUED

TOTALS:

Type	Total Providers
01	56
02	41
03	34
04	67
05	03
06	03
07	56
08	31
09	31
10	13
11	0
12	0
13	05
14	-
15	02
TOTAL	342

SERVICE PROVIDED (TOTALS)

Basic Life Support	342
Advanced EMT	19
Paramedic	34
Extrication	162

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
ADAMS COUNTY						
Adams County Memorial Hospital	08	5		X	X	
ALLEN COUNTY						
Adams Township Fire Department	04	1	X	X		
Arcola Volunteer Fire Department	04	1	X	X		
Basic Life Transport	01	2		X		
Cedar Canyons Volunteer Fire Dept.	04	1	X	X		
Emergency One Corporation	01	3		X	X	
Fort Wayne E.M.S.	09	5	X	X	X	X
Grabill Volunteer Fire Department	07	1		X		
Huntertown Vol. Fire Company, Inc.	04	1	X	X		
Lutheran Hospital of Fort Wayne	08	1		X		
Maumee Township Vol. Fire Dept.	04	1		X		
MediVan, Inc.	01	3	X	X		
Monroeville E.M.S.	07	1	X	X		
Poe Volunteer Fire Department	04	1	X	X		
St. Joseph Twp. Fire Dept., Inc.	04	1	X	X		
Washington Twp. Vol. Fire Dept.	04	1	X	X		
Wayne Township Fire Department	04	2	X	X		
BARTHOLOMEW COUNTY						
Athens Ambulance Service, Inc.	01	5	X	X		
Columbus Fire Department	03	2	X	X		
Hope Volunteer Fire Department	04	1	X	X		
BENTON COUNTY						
Benton County Emergency Amb. Serv.	07	2		X		
Boswell Community Ambulance Serv.	07	2	X	X		
BLACKFORD COUNTY						
Blackford Emer. Ambulance Trustees	07	3		X		
BOONE COUNTY						
Boone County Ambulance Service	08	3		X		X
Zionsville Emergency Amb., Inc.	07	2	X	X		
BROWN COUNTY						
Cordry-Sweetwater V.F.D. and Amb.	04	1		X		
Southern Indiana Ambulance	01	3	X	X		
Trevlac Volunteer Fire Department	04	1	X	X		
CARROLL COUNTY						
Burlington Vol. Fire Department	04	2	X	X		
Carroll County E.M.S.	09	3	X	X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
CASS COUNTY						
Cass County Ambulance	08	3	X	X		
Galveston Vol. Fire Department	03	2	X	X		
CLARK COUNTY						
Chapman Funeral Home	02	1		X		
J.R. Stewart & Son's Amb. Serv.	01	4		X		
Medic, Inc.	01	4	X	X		
Medical Transportation Service	01	2	X	X		
Newberg-Marble Hill	10	1		X		
Tass, Inc.	01	3		X		
CLAY COUNTY						
Athens Amb. Service, Inc. (Clay)	01	4	X	X		
CLINTON COUNTY						
Clinton County E.M.S.	09	6	X	X		
Colfax Community E.M.S.	07	1		X		
Volunteer Ambulance Service, Inc.	07	2		X		
CRAWFORD COUNTY						
Crawford County Ambulance Service	09	2		X		
Denbo Funeral Home, Inc.	02	1		X		
DAVIESS COUNTY						
Daviess County Ambulance Service	01	2	X	X		
Poindexter & Son Ambulance Service	02	4	X	X		
DEARBORN COUNTY						
Area 12 Council on Aging	15	1		X		
Aurora Emergency Rescue, Inc.	07	2	X	X		
Dillsboro Emergency Unit	07	1	X	X		
Lawrenceburg Emergency Rescue Unit	04	2	X	X		
North Dearborn Rescue Unit	07	1		X		
Sparta Township Emergency Unit	07	1		X		
DECATUR COUNTY						
Decatur County Memorial Hospital	08	2		X		
DEKALB COUNTY						
DeKalb Emergency Medical Service	08	4		X	X	X

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
DELAWARE COUNTY						
Albany/Delaware Twp. Amb. Service	07	2		X		
Ball State University	05	1		X		
Daleville/Salem Township E.M.S.	07	1	X	X		
Delaware County/Muncie E.M.S.	09	4	X	X		
Eaton Ambulance Service	07	1	X	X		
Gaston Volunteer Fire Department	04	1	X	X		
MED-TEC	01	3		X		
Pro-Care Ambulance Service, Inc.	01	3		X		
DUBOIS COUNTY						
Memorial Hospital	08	2		X		
St. Joseph's Hospital	08	2		X		
ELKHART COUNTY						
Bristol Fire Department	04	2	X	X	X	
Elkhart Fire Department	03	3	X	X		X
Goshen Civil Defense	13	1		X		
Goshen Fire Department	03	2	X	X	X	
Jackson Twp. Emergency Amb. Serv.	07	1		X		
Jefferson Twp. Vol. Fire & Amb.	04	1	X	X		
Medical Dynamics	01	1		X		
Middlebury Civil Defense	13	2	X	X		
M.T.S. Air, Inc.	01	1		X		
Nappanee Medical Services Dept.	09	1	X	X	X	
Osolo E.M.S.	07	3	X	X		
Wakarusa Ambulance Department	09	1	X	X		
FAYETTE COUNTY						
Fayette County Emer. 1st Aid Unit	09	3	X	X		
FLOYD COUNTY						
Medical Transportation Service	01	3		X		
New Albany Fire Department	03	1	X	X		
FOUNTAIN COUNTY						
Fountain County Ambulance Service	09	4	X	X		
FRANKLIN COUNTY						
Franklin County E.M.S.	09	4		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
FULTON COUNTY						
Foster & Good Ambulance Service	01	1		X		
Fulton County E.M.S.	08	4	X	X		
GIBSON COUNTY						
Gibson County Ambulance Service	09	3	X	X		
GRANT COUNTY						
Devine Ambulance Service	02	1		X		
Grant County E.M.S.	09	6	X	X		
Marion General Hospital Amb. Serv.	08	4		X		X
Southwest Medic, Inc.	07	1		X		
GREENE COUNTY						
Greene County Ambulance Service	09	4		X		
HAMILTON COUNTY						
Carmel Fire Department	03	1	X	X		
Fishers Community Vol. Fire Dept.	04	1	X	X		
Riverview Hospital	08	3		X		X
Sheridan Vol. Fire Dept., Inc.	04	1	X	X		
Westfield Fire Department	04	2 1(AID)	X	X		
HANCOCK COUNTY						
Buck Creek Twp. Vol. Fire Dept.	04	2	X	X		
Condo & Son, Inc.	02	2		X		
Fisher Funeral Home	02	1		X		
Greenfield Fire Department	03	2	X	X		
Ronald Seals Funeral Home	02	1		X		
Sugar Creek Twp. Vol. Fire Dept.	04	1	X	X		
HARRISON COUNTY						
Ghelbach & Royse Funeral Home	02	1	X	X		
Harrison County Hospital	08	2		X		
Ramsey Vol. Fire Fighters, Inc.	04	1	X	X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
HENDRICKS COUNTY						
Amo Volunteer Fire Department	04	1	X	X		
Baker Funeral Home	02	1		X		
Brownsburg Fire Department	04	1	X	X		
Clayton Vol. Fire Department	04	1	X	X		
Hazelwood Vol. Fire Department	04	1	X	X		
Jones-Matthews Mortuary	02	2		X		
Plainfield Fire Department	03	3	X	X		
Town of Stilesville	04	1	X	X		
Weaver Funeral Home	02	1		X		
		1 (PMH)	1			
HENRY COUNTY						
Butcher Funeral Home	02	1		X		
Estell Funeral Home	02	2		X		
Greene's Funeral Home	02	1	X	X		
Town of Middletown Emergency Unit	07	2	X	X		
New Castle/Henry County Police	05	3	X	X		
HOWARD COUNTY						
Howard County Civil Defense	13	2	X	X		
Eastern Howard Emergency Serv., Inc.	07	1	X	X		
Howard County Emergency Service	08	2		X		
Indian Heights Vol. Fire Dept.	04	1	X	X		
Kokomo Fire Department	03	2	X	X		
Russiaville Ambulance Service	07	2		X		
Kokomo Speedway Ambulance	15	1				
HUNTINGTON COUNTY						
Huntington Memorial Hospital	08	3		X	X	
Markle VFD and Rescue	04	1	X	X		
Tri-Township Ambulance Service	07	1		X		
JACKSON COUNTY						
Ross Med-Aid Service, Inc.	01	7	X	X		
		4 Jackson				
		3 Scott				

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
JASPER COUNTY						
Northern Jasper County Ambulance	07	3		X		
Southern Jasper County Ambulance	07	1		X		
Steinke Ambulance Service	02	2		X		
JAY COUNTY						
Jay County E.M.S.	09	4		X		
JEFFERSON COUNTY						
Athens Ambulance Service, Inc.	01	3		X		
JENNINGS COUNTY						
Jennings County E.M.S.	09	3	X	X		
JOHNSON COUNTY						
Edinburg Fire Department	04	2	X	X		
Franklin Fire Department	03	2	X	X		
Greenwood Volunteer Fire Dept.	04	1	X	X		
Myers Ambulance Service, Inc.	01	5		X		X
Franklin Flying Field (Air)	01	3		X		
New Whiteland Fire Department	04	1		X		
Princes Lakes Ambulance Association	07	1		X		
KNOX COUNTY						
Anderson-Poindexter Funeral Home	02	1		X	X	
Gordon E. Utt Funeral Home	02	1		X	X	
McClure Funeral Home	02	2		X	X	
Vincennes Ambulance Service	01	8		X	X	
Wampler-Shaw Funeral Home, Inc.	02	1		X	X	
Vincennes Fire (Non-Transport)					X	
KOSCIUSKO COUNTY						
4-Way Ambulance Service	07	1		X		
Milford Emergency Services, Inc.	07	1		X		
Multi-Township E.M.S.	09	4		X	X	
North Webster E.M.S.	07	2	X	X		
Pierceton-Washington-Monroe	07	1		X		
South Central Kosciusko E.M.S.	07	1	X	X		
Syracuse Fire Department	04	1	X	X		
LAGRANGE COUNTY						
LaGrange County Hospital	08	4		X	X	
Stroh Volunteer Fire Department	04	1		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
LAKE COUNTY						
Amoco Oil Company	10	1		X		
Town of Hobart	03	2	X	X		
Cedar Lake Vol. Ambulance Service	07	2		X		
Chartered Ambulance Service	01	2		X		
Courtesy Ambulance Service	01	2		X		
Crown Point E.M.S.	09	1		X		X
East Chicago Health Department	09	3	X	X		X
Fagen-Miller Funeral Gardens	02	4		X		
City of Gary Fire Department	03	4	X	X		X
Hammond Fire Department	03	4	X	X		
Highland Fire Department	04	1	X	X		
Inland Steel Co., Medical Dept.	10	1		X		X
Town of Schererville	04	1		X		
Lake Station Vol. Fire Department	04	2	X	X		
Merrillville E.M.S.	09	2		X		X
Munster Fire Department	04	2	X	X		
Patient Transfer, Inc.	01	5		X		
Tri-Creek Ambulance Service	09	2	X	X		X
U.S. Steel Corp./Gary Works	10	2	X	X		
Whiting Fire Department	03	1	X	X		
Jones & Laughlin Steel Corporation	10	1	X	X		
LAPORTE COUNTY						
LaPorte County E.M.S.	09	6		X		X
LAWRENCE COUNTY						
Dunn Ambulance Service	08	4		X		
MADISON COUNTY						
Aid Ambulance at Anderson, Inc.	01	6	X	X		
Alexandria Fire Department	03	2	X	X		
Anderson Fire Department	03	4	X	X		
Chesterfield Vol. Fire Department	04	1	X	X		
Copher & Fesler Funeral Home	02	1		X		
Delco-Remy	10	1		X		
Dunnichay Funeral Home	02	1		X		
Elwood Fire Department	03	1	X	X		
Frankton Vol. Ambulance Service	07	2	X	X		
Jackley-Landrum Funeral Home	02	1		X		
Lapel Emergency Ambulance Service	04	2	X	X		
Pendleton Emergency Ambulance	04	2	X	X		
Pro-Med Services, Inc.	01	2		X		
Markleville/Adams Twp. Emer. Amb.	07	2		X		
Richland Twp. Vol. Fire Dept.	04	1	X	X		
Summitville Van Buren Twp. E.M.S.	04	2	X	X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
MARION COUNTY						
Acton Volunteer Fire Department	04	1	X	X		
Ambulance Indpls. Dispatch, Inc.	01	17	X	X		X
Beech Grove Fire Department	03	2	X	X		
Castleton Vol. Fire Dept., Inc.	03	3	X	X		
Clermont Community V.F.D.	04	1	X	X		
Decatur Twp. Vol. Fire Department	04	3	X	X		
Emergency Ambulance Service	01	1		X		
E.M.A.S., Inc.	01	1		X		
Fleming Gardens V.F.D. Co. #3	04	1	X	X		
Franklin Twp. Fire Dept. Co. #1	04	1	X	X		
Franklin Twp. V.F.D. #3 Bunker Hill	04	1	X	X		
Indiana University Hospitals	08	1		X		
Lawrence Volunteer Fire Department	04	4	X	X		
Methodist Hospital of Indiana	08	1		X		
Mickleyville Vol. Fire Department	04	1	X	X		
Midwest Transport Amb. Serv., Inc.	01	1		X		
Oak Park Vol. Fire Dept. #14	14	1	X	X		
Parr-Lance Ambulance	01	8		X		
Perry Township Fire Department	03	2	X	X		X
Pike Township Vol. Fire Department	03	2	X	X		
Volunteer Fire Dept./Perry Twp., Inc	04	1	X	X		
Warren Township Fire Department	03	4	X	X		
Washington Township Fire Department	03	3	X	X		X
Wayne Township Fire Dept. Co. #8	04	1	X	X		
Wayne Township Vol. Fire Dept. #9	04	1	X	X		
Wishard Hospital Ambulance Division	08	24		X		X
MARSHALL COUNTY						
Argos Community Ambulance Service	07	1		X		
Bourbon Community E.M.S.	07	1		X		
Culver Union Twp. Ambulance Service	07	2		X		
Mishler Ambulance Service	01	2		X		
Plymouth Community Ambulance Service	09	2	X	X	X	
Tippecanoe Ambulance Service	07	1		X		
MARTIN COUNTY						
Martin County Ambulance Service	01	2	X	X		
MIAMI COUNTY						
Converse Ambulance Corporation	07	1		X		
Miami County Ambulance Service	08	5		X		
Peru Fire Department	03	1	X	X		
MONROE COUNTY						
All-Care's, Inc.	01	2		X		
Bloomington Hospital Amb. Service	08	4	X	X		
Bloomington Township Fire Department	03	2		X		
Home Ambulance Service	01	1		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
MONTGOMERY COUNTY						
awfordsville Fire Department	03	3	X	X		
ealth Facilities Amb. Serv., Inc.	01	1		X		
inden Volunteer Ambulance Service	07	2	X	X		
-W Rescue Service, Inc.	07	1		X		
alnut Township & Town of New Ross	04	1		X		
ayne Township Volunteer Ambulance	07	1	X	X		
		1 (PMH)				
MORGAN COUNTY						
I.M. Ambulance Service	01	3		X		
regg Township Vol. Fire Department	04	2	X	X		
organ County Rescue Service	07	4	X	X		
		3 (AID)				
NEWTON COUNTY						
ane Funeral Home Ambulance Service	02	1		X		
ewton County Ambulance Service	09	4		X		
NOBLE COUNTY						
oble County E.M.S./McCray Hospital	08	7		X	X	
OHIO COUNTY						
ising Sun Ohio County Rescue Unit	07	2	X	X		
ORANGE COUNTY						
range County Ambulance Service	08	3		X		
OWEN COUNTY						
wen County E.M.S.	09	2	X	X		
PARKE COUNTY						
arke County Ambulance Service	09	3		X		
est Central Ind. Amb. Serv., Inc.	01	1		X		
PERRY COUNTY						
erry County Emergency Amb. Service	08	2		X		
PIKE COUNTY						
ike County E.M.S.	09	5	X	X		
tone & Webster Engineering	10	1		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
PORTER COUNTY						
Ambulance Transfer, Inc.	01	3		X		
Bethlehem Steel Corporation	10	1	X	X		
Midwest Steel Division	10	1	X	X		
North Porter County Amb. Community	09	3		X		X
Portage Fire Department	03	2	X	X		X
Portage Township Vol. Fire Dept.	04	2	X	X		
Porter County E.M.S./Area III	09	3		X		X
POSEY COUNTY						
Posey County Sheriff's Emer. Amb.	06	4	X	X		
General Electric Company	10	1		X		
PULASKI COUNTY						
Ross Medi-Van, Inc.	01	3	X	X		
PUTNAM COUNTY						
P.M.H. Ambulance, Inc.	04	3		X		
Putnam County Operation Life	07	4		X		X
RANDOLPH COUNTY						
Culberson-Reynard Funeral Home	02	1	X	X		
Randolph County Civil Defense	13	1		X		
Randolph County Sheriff Amb. Serv.	06	4	X	X		
Union City Community Ambulance	04	2	X	X		
RIPLEY COUNTY						
Batesville Vol. Fire Dept., Inc.	04	2		X		
Laws-Carr-Moore Funeral Home	02	1		X		
Southern Ripley County Life Squad	07	2	X	X		
Sunman Area Life Squad, Inc.	07	1		X		
RUSH COUNTY						
John J. Todd Funeral Home	02	2		X		
Raleigh Community V.F.D., Inc.	04	2	X	X		
Rush County E.M.S.	04	1		X		
Todd Funeral Home	02	2		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
ST. JOSEPH COUNTY						
Allard Ambulance Service, Inc.	01	1		X		
The Bendix Corporation	10	2		X		
Community Emergency Amb. Service	07	2		X		
Huisinger Colonial Chapel	02	2		X		
Liberty Township	07	1		X	X	
Life Ambulance, Inc.	01	3		X		
McGann Ambulance Division, Inc.	01	4		X		X
City of Mishawaka E.M.S.	09	2	X	X		X
N.C. E.M.S.	01	2		X		
South Bend Fire Department	03	3	X	X		X
Union North Ambulance Service, Inc.	07	2		X		
WPLJ Ambulance Service	07	2	X	X		
Warner Funeral Home	02	3		X		
SHELBY COUNTY						
Fountaintown Community V.F.D.	04	1	X	X		
City of Shelbyville	05	1	X	X		
Trans-Med Ambulance	01	5		X		
SPENCER COUNTY						
Indiana & Michigan Electric Co.	10	1		X		
Spencer County Emer. Amb. Service	07	3	X	X		
STARKE COUNTY						
Starke County Ambulance Service	09	5		X		
STUEBEN COUNTY						
Stueben County Sheriff Department	06	4	X	X		
SULLIVAN COUNTY						
Carlisle Lions Community Ambulance	07	1		X		
Sullivan County Ambulance Service	08	4		X		X
SWITZERLAND COUNTY						
Switzerland County Emergency Unit	07	3		X		
TIPPECANOE COUNTY						
Clarks Hill E.M.S.	04	1	X	X		
Grady B. Jones Conv. Transfer	01	1		X		
Purdue University Fire Department	03	1	X	X		
St. Elizabeth Hospital Med. Center	08	3		X		X
Tippecanoe Emer. Ambulance Service	08	3		X		X
Wayne Township Vol. Fire Department	04	1	X	X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
TIPTON COUNTY						
Leatherman-Morris Funeral Home	02	1		X		
Porter Ambulance Service	02	1		X		
Sharpsville Community Ambulance	07	1		X		
Young-Nichols Funeral Home, Inc.	02	2		X		
UNION COUNTY						
Union County EMT Unit	07	2		X		
VANDERBURGH COUNTY						
Alexander Ambulance Service, Inc.	01	4	X	X		X
B & H Wheelchair	01	1		X		
Comaier Services, Inc.	01	3		X		
Evansville Fire Department	03	4	X	X		X
Evansville/Vanderburgh Co. C.D.	13	1		X		
Pierre Funeral Home, Inc.	02	1		X		
Welborn Baptist Hospital	08	1	X	X		X
VERMILLION COUNTY						
Vermillion County Emer. Amb. Serv.	01	3		X		
VIGO COUNTY						
Chambers Ambulance Service	01	1		X		
Terre Haute Fire Department	03	4	X	X		
Vigo County Ambulance Service	01	4		X		
WABASH COUNTY						
Bender Funeral Home, Inc.	02	1		X		
DeLaughter Mortuary	02	1		X		
Wabash Fire Department	03	3	X	X		
WARREN COUNTY						
Warren County Ambulance Service	09	2	X	X		
WARRICK COUNTY						
Aluminum Company of America	10	1	X	X		
Warrick County E.M.S./Warrick Hosp.	08	7	X	X		X
WASHINGTON COUNTY						
Washington County Medical Services	01	3		X		

PROVIDER	TYPE	# OF VEHICLES	EXTRICATION	BLS PROVIDER	ADVANCED EMT PROVIDER	PARAMEDIC
WAYNE COUNTY						
Aid Ambulance at Richmond, Inc.	01	4		X		X
Culberson/Gray Funeral Home	02	2	X	X		
Fisher-Waskom Mortuary	02	1		X		
Marshall Funeral Home	02	2		X		
Howard Ambulance Service	02	2		X		
WELLS COUNTY						
Wells Community Hospital	08	4		X		
WHITE COUNTY						
Monticello Fire Department	03	3	X	X		
Wolcott Volunteer Fire Department	07	1	X	X		
WHITLEY COUNTY						
Krider-Workman Ambulance Service	02	1		X		
Whitley County Memorial Hospital	08	5		X		X
OUT-OF-STATE						
Union City Fire Dept. & Emer. Squad	04	2	X	X		
D.G.A., Inc. d/b/a/ Daley's Amb.	01	1		X		

AMBULANCE PROVIDERS BY TYPE
11-15-81

COUNTY	Pop/Sq.Mi.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total Number of Vehicles	Total Number of Providers	Extrication Power Tools	Extrication Providers
ADAMS	85.9								1								5	1	1	2
ALLEN	438.7	3			9			2	1	1							26	16	10	13
BARTHOLOMEW	161.9	1		1	1												8	3	2	2
BENTON	25.0							2									4	2	1	2
BLACKFORD	93.2							1									3	1	1	2
BOONE	85.4							1	1								5	2	1	3
BROWN	38.8	1			2												5	3	1	2
CARROLL	52.7				1					1							5	2	2	2
CASS	88.6			1					1								5	2	2	2
CLARK	231.3	4	1								1						15	6	4	6
CLAY	68.3	1															4	1	1	3
CLINTON	77.5							2		1							9	3	2	3
CRAWFORD	31.5		1							1							3	2	0	1
DAVIESS	64.7	1	1														6	2	1	3
DEARBORN	112.1				1			4								1	8	6	0	5
DECATUR	64.4								1								2	1	1	1
DEKALB	91.8								1								4	1	3	4
DELAWARE	324.7	2			1	1		3		1							16	8	3	5
DUBOIS	79.1								2								4	2	2	2
ELKHART	293.4	2		2	2			2		2				2			19	12	10	11
FAYETTE	131.5									1							3	1	1	1
FLOYD	410.5	1		1													4	2	1	3
FOUNTAIN	47.9									1							4	1	1	1
FRANKLIN	49.8									1							4	1	0	1
FULTON	52.5	1							1								5	2	1	1
GIBSON	66.6									1							3	1	1	1
GRANT	192.2		1					1	1	1							12	4	3	4
GREENE	55.4									1							4	1	2	3
HAMILTON	205.4			1	3				1								9	5	4	5
HANCOCK	144.1		3	1	2												9	6	3	6
HARRISON	56.9		1		1				1								4	3	2	2
HENDRICKS	167.4		3	1	5												13	9	5	10
HENRY	133.3		3			1		1									9	5	3	3
HOWARD	296.6			1	1			2	1					1		1	11	7	3	4
HUNTINGTON	96.5				1			1	1								5	3	1	2
JACKSON	70.2	1															4	1	0	1
JASPER	46.5		1					2									6	3	1	4
JAY	60.2									1							4	1	1	1
JEFFERSON	83.1	1															3	1	3	3
JENNINGS	60.6									1							3	1	1	1

AMBULANCE PROVIDERS BY TYPE
Page Two

COUNTY	Pop/Sq.Mi.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total Number of Vehicles	Total Number of Providers	Extrication Power Tools	Extrication Providers
JOHNSON	245.2	2		1	3			1									15	7	3	8
KNOX	81.1	1	4														13	5	3	4
KOSCIUSKO	110.3				1			5		1							11	7	3	6
LAGRANGE	67.1				1				1								5	2	1	1
LAKE	1019.4	3	1	4	4			1		4	4						45	21	20	25
LAPORTE	179.0									1							6	1	4	4
LAWRENCE	92.5								1								4	1	2	1
MADISON	307.6	2	3	3	5			2			1						30	16	5	10
MARION	1952.1	5		6	12				3								84	26	19	21
MARSHALL	88.4	1						4		1							9	6	2	6
MARTIN	31.9	1															2	1	3	2
MIAMI	105.6			1				1	1								7	3	1	4
MONROE	254.9	2		1					1								9	4	3	5
MONTGOMERY	70.0	1		1	1			3									10	6	1	5
MORGAN	128.1	1		1				1									12	3	1	3
NEWTON	35.9		1							1							5	2	1	2
NOBLE	86.0								1								7	1	1	4
OHIO	58.8							1									2	1	0	1
ORANGE	41.5								1								3	1	1	2
OWEN	40.6									1							2	1	1	1
PARKE	36.8	1								1							4	2	1	2
PERRY	50.4								1								2	1	0	1
PIKE	40.2									1	1						6	2	0	1
PORTER	281.9	1		1	1					2	2						15	7	5	8
POSEY	64.1						1				1						5	2	2	4
PULASKI	30.6	1															3	1	0	0
PUTNAM	59.5				1			1									5	2	2	3
RANDOLPH	65.6		1		1		1							1			8	4	2	6
RIPLEY	55.2		1		1			2									6	4	2	2
RUSH	47.9		2		2												7	4	1	6
ST. JOSEPH	518.8	4	2	1				4		1	1						29	13	9	14
SCOTT	105.8																3	0	0	1
SHELBY	97.5	1			1	1											7	3	2	3
SPENCER	48.7							1			1						4	2	0	2
STARKE	71.0									1							5	1	2	4
STEUBEN	79.9						1										4	1	1	1
SULLIVAN	46.2							1	1								5	2	1	1
SWITZERLAND	32.4							1									3	1	1	1
TIPPECANOE	243.4	1		1	2				2								10	6	4	15
TIPTON	64.4		3					1									5	4	1	2

AMBULANCE PROVIDERS BY TYPE
Page Three

COUNTY	Pop/Sq.Mi.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total Number of Vehicles	Total Number of Providers	Extrication Power Tools	Extrication Providers
UNION	40.8							1									2	1	1	1
VANDERBURG	695.1	3	1	1					1					1			15	7	5	7
VERMILLION	69.3	1															3	1	1	1
VIGO	270.8	2		1													9	3	10	7
WABASH	92.1		2	1													5	3	0	2
WARREN	24.4									1							2	1	1	2
WARRICK	106.1								1		1						7	2	1	5
WASHINGTON	42.5	1															3	1	1	3
WAYNE	187.8	1	4														11	5	2	5
WELLS	69.0								1								4	1	2	2
WHITE	48.0			1				1									4	2	1	2
WHITLEY	77.8		1						1								6	2	2	2
OUT-OF-STATE	NA	1			1												3	2	NA	NA
TOTALS		**56**	**41**	**34**	**67**	**3**	**3**	**56**	**31**	**31**	**13**	**0**	**-**	**5**	**-**	**2**	**766**	**342**	**220**	**363**

EXTRICATION INVENTORY

DATE: November 15, 1981

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
ADAMS COUNTY	13			
Decatur Fire Department				
Monroe Fire and Rescue		1		
ALLEN COUNTY	28			
Adams Twp. Fire Dept. #3		1		
Arcola Fire Department				
Cedar Canyons Vol. Fire Dept.				
Ft. Wayne Fire Department		2		
Huntertown Vol. Fire Co., Inc.			1	
Monroeville Fire & Rescue Unit		1		
New Haven Vol. Fire Dept.				
Poe Vol. Fire Dept.		1		
St. Joseph Twp. Fire Dept., Inc.		1		
Washington Twp. Vol. Fire Dept.		1		
Wayne Twp. Fire Dept. #1			1	
Wayne Twp. Fire Dept. #2		1		
Woodburn Fire Dept.				
BARTHOLOMEW COUNTY	12	1	Cummins Engine Co., Inc.	
Columbus Fire Dept.		1		
Hope Volunteer Fire Department				
BENTON COUNTY	7			
Benton County Civil Defense				
Boswell Community Amb. Serv.		1		
BLACKFORD COUNTY	3			
Hartford City Fire Department		1		
Montpelier Fire Department				

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
BOONE COUNTY	5			
Center Twp. Fire Department		1		
Lebanon Fire Department				
Zionsville Fire and Rescue				
BROWN COUNTY	4			
Southern Indiana Amb. Serv., Inc.			1	
Trevlac Vol. Fire Department				
CARROL COUNTY	6			
Burlington Vol. Fire Dept.		1		
Delphi Vol. Fire Department		1		
CASS COUNTY	11			
Cass County Ambulance				
Galveston Vol. Fire Dept.		1		
Logansport Fire Dept.		1		
CLARK COUNTY	14			
Charlestown Vol. Fire Department				
Clarksville Fire Department		1		
Jeffersonville Fire Department			1	
McCulloch Vol. Fire Department		1		
Medic, Inc.				
Sellersburg Vol. Fire Dept.		1		
CLAY COUNTY	3			
Athens Ambulance Service		1		
Clay City-Harrison Twp. Fire Dept.				
Posey Township Fire Department				

ROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
CLINTON COUNTY	2			
ankfort Fire Department		1		
chigan Twp. Vol. Fire Dept.		1		
ossville Vol. Fire Department				
CRAWFORD COUNTY	1			
awford County Ambulance				
DAVIESS COUNTY	4			
aviess County Ambulance Service				
oindexter and Son Amb. Service				
shington Fire Department			1	
DEARBORN COUNTY	3			
urora Emergency Rescue, Inc.				
rora Fire Company #1 and #2				
ight Volunteer Fire Department				
llsboro Emergency Unit				
awrenceburg Emergency Rescue Unit				
DECATUR COUNTY	8			
eensburg Fire Department		1		
DEKALB COUNTY	4			
shley Fire Department				
burn Fire Department		1		
tler Fire Department			1	
arrett Fire Department			1	
DELAWARE COUNTY	18			
laware County/Muncie E.M.S.				
ton Fire Department		1		
aston Volunteer Fire Department		1		
ncie Fire Department		1		
lem Twp/Daleville Fire Department				

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
DUBOIS COUNTY	9			
Huntingburg Volunteer Fire Dept.		1		
Jasper Fire Department		1		
ELKHART COUNTY	3			
Baugo Twp. Fire Department				
Bristol Fire Department		1		
Cleveland Twp. Fire Department		1		
Concord Twp. Fire Dept., Inc.		1		
Elkhart Fire Department		2		
Goshen Fire Department				
Jefferson Twp. Vol. Fire & Amb.		1		
Middlebury Civil Defense		1		
Nappanee Medical Service Dept.		1		
New Paris Fire Department		1		
Wakarusa Fire Department		1		
FAYETTE COUNTY	3			
Fayette County Emer. 1st Aid Unit		1		
FLOYD COUNTY	9			
Floyd County Civil Defense				
Georgetown Vol. Fire Department				
New Albany Fire Department		1		
FOUNTAIN COUNTY	1			
Fountain County Ambulance Service		1		
FRANKLIN COUNTY	3			
Franklin County E.M.S.				
FULTON COUNTY	10			
Rochester Fire Department			1	
GIBSON COUNTY	13			
Gibson County Ambulance Service		1		

OVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
GRANT COUNTY	4			
s City Rescue Squad		1		
arion Fire Department		1		
tthews Fire and Rescue Department		1		
n Buren Rescue Squad				
GREENE COUNTY	11			
reen County Ambulance Service		1		
nton Fire Department		1		
chland-Taylor Twp. Fire Dept.				
HAMILTON COUNTY	12			
rmel Fire Department		1		
shers Community Vol. Fire Dept.		1		
oblesville Fire Department		1		
eridan Vol. Fire Dept., Inc.				
stfield Fire Department		1		
HANCOCK COUNTY	3			
uck Creek Twp. Vol. Fire Dept.		1		
rtville Fire Department				
eenfield Fire Department		1		
ckson-Blue River Twps. Fire Dept.				
ugar Creek Twp. Vol. Fire Dept.		1		
lkinson Vol. Fire Department				
HARRISON COUNTY	2			
lizabeth Vol. Fire Department		1		
msey Vol. Fire Fighters, Inc.		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
HENDRICKS COUNTY	4			
Amo Volunteer Fire Department				
Avon Volunteer Fire Department		1		
Brownsburg Fire Department		1		
Clayton Vol. Fire Department				
Danville Fire Department		1		
Hazelwood Vol.. Fire Department				
Pittsboro Fire Department				
Pittsboro Fire Department Rescue		1		
Plainfield Fire Department			1	
Stilesville Fire Department				
HENRY COUNTY	10			
Knightstown Vol. Fire Department				
Middletown Fire Department		1		
New Castle/Henry Co. Police Emer.		2		
HOWARD COUNTY	14			
Eastern Howard Emergency Service				
Howard County Civil Defense				
Indian Heights Vol. Fire Dept.		1		
Kokomo Fire Department		2		
HUNTINGTON COUNTY	5			
Huntington County Police Dept.		1		
Markle Vol. Fire Dept. & Rescue Unit				
JACKSON COUNTY	16			
Ross Med-Aid Service, Inc.				
JASPER COUNTY	6			
Keener Township Fire Department				
Remington Vol. Fire Department				
Rensselaer Vol. Fire Department		1		
Wheatfield Fire Department				

ROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
JAY COUNTY	5			
ay County Civil Defense			1	
JEFFERSON COUNTY	7			
ifty Fire Department #6		1		
nover Volunteer Fire Dept.		1		
.S. Army Jefferson Proving Ground		1		
JENNINGS COUNTY	2			
nnings County E.M.S.				
JOHNSON COUNTY	9			
nity Community Vol. Fire Dept.				
rgersville Fire Department		1		
inburgh Fire Department		1		
ranklin Fire Department				
reenwood Vol. Fire Department		1		
neveh Vol. Fire Dept., Inc.				
iiteland Rural Fire Department				
hite River Twp. Fire Dept.				
KNOX COUNTY	24			
cknell Fire Department		1		
onroe City Ambulance Service				
incennes Ambulance Service		1		
ncennes Fire Department		1		
KOSCIUSKO COUNTY	4			
eesburg Fire Department				
ntone Fire Department			1	
rth Webster E.M.S.				
outh Central Kosciusko E.M.S.				
yracuse Fire Department		1		
rsaw Fire Department		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
LAGRANGE COUNTY	0			
LaGrange Fire Department		1		
LAKE COUNTY	63			
Ainsworth Deep River Fire Dept.		1		
Black Oak Fire Department			1	
Cedar Lake Vol. Fire Dept.			1	
Crown Point Fire Department		1		
Dyer Fire Department		1		
E. Chicago Civil Def./Aux. Police				
East Chicago Fire Department		1		
City of Gary Fire Department		1		
Griffith Civil Defense				
Hammond Fire Department		1		
Highland Fire Department		1		
Hobart Fire Department #1		1	1	
Independence Hill Vol. Fire Dept.		1		
Jones & Laughlin Steel Corp.				
Lake Dalecarlia Vol. Fire Dept.				
Lake Hills Fire Department			1	
Lake Station Vol. Fire Dept.		1		
Lowell Vol. Fire Department		1		
Merrillville Fire Department			1	
Munster Vol. Fire Department		1		
St. John Fire Department		1		
Schererville Vol. Fire Dept.		2		
Shelby Vol. Fire Department				
U.S. Steel/Gary Works				
Whiting Fire Department				
LAPORTE COUNTY	2			
Center Township Fire Department			1	
Kankakee Township Fire Department		1		
LaPorte Fire Department		1		
Michigan City Fire Department		1		
LAWRENCE COUNTY	5			
Bedford Fire Department		2		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
MADISON COUNTY	15			
Alexandria Fire Department				
Anderson Fire Department		2		
Chesterfield Vol. Fire Dept.		1		
Elwood Fire Department				
Frankton Vol. Fire Dept.				
Lapel Fire Department				
Pendleton Fire Department		1		
Pipe Creek Twp. Vol. Fire Dept.		1		
Richland Twp. Vol. Fire Dept.				
Summitville/Van Buren Twp. EMS				
MARION COUNTY	54	1	Fort Benjamin Harrison	
Acton Vol. Fire Department				
Beech Grove Fire Department		1		
Ben Davis Vol. Fire Department #4				
Bridgeport Vol. Fire Department #7		1		
Castleton Vol. Fire Dept., Inc.		1		
Decatur Twp. Vol. Fire Dept.		1		
Fleming Garden Vol. Fire Dept.		1		
Franklin Twp. Fire Dept., Com. #1				
Franklin Twp. Vol. Fire Dept. #2				
Indianapolis Fire Department		4		
Indpls., Fire Training Academy				
Indpls. Intern'l Airport Fire Dept.		1		
Lawrence Vol. Fire Department		2		
Perry Township Fire Department		2		
Pike Twp. Vol. Fire Department		1		
Speedway Fire Department		1		
Vol. Fire Dept./Perry Twp., Inc.				
Wanamaker Fire Department		1		
Warren Township Fire Department		1		
Washington Twp. Fire Department		1		
Wayne Twp. Vol. Fire Department #9		1		
MARSHALL COUNTY	27			
Argos Fire Department				
Bourbon Fire Department				
Bremen Vol. Fire Department			1	
Bulver-Union Twp. Fire Dept.				
LaPaz Fire Department				
Plymouth E.M.S.		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
MARTIN COUNTY	5	2 Crane Naval Base		
Martin County Amb. Service		1		
Martin County Civil Defense				
MIAMI COUNTY	7			
Grissom Air Force Base F.D.				
Mexico Fire Department				
Peru Fire Department		1		
Pipe Creek Twp. Fire Dept.				
MONROE COUNTY	13			
Bloomington Fire Dept.		2		
Bloomington Twp. Fire Dept.				
Ellettsville Fire Department				
Perry Twp. Fire Department				
Van Buren Twp. Vol. Fire Dept.		1		
MONTGOMERY COUNTY	5			
Crawfordsville Fire Dept.		1		
Ladoga Vol. Fire Department				
Linden Vol. Amb. Service				
Walnut Twp. and Town of New Ross				
Wayne Twp. Vol. Rescue Service				
MORGAN COUNTY	0			
Gregg Twp. Vol. Fire Dept.				
Monroe Twp. Fire Department		1		
Morgan County Civil Defense				
NEWTON COUNTY	0			
Goodland Vol. Fire Department				
Lincoln Twp. Vol. Fire Dept.		1		

ROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
NOBLE COUNTY	8			
endallville Aux. Police/C.D.		1		
ndallville Fire Department				
Otto Fire Department				
igonier Vol. Fire Department				
OHIO COUNTY	0			
sing Sun Fire Department				
ORANGE COUNTY	8			
range County Civil Defense Unit				
range County Sheriff's Dept.		1		
OWEN COUNTY	6			
en County E.M.S.		1		
PARKE COUNTY	4			
arke County E.M.S.				
ckville Rescue Squad		1		
PERRY COUNTY	7			
erry County Civil Defense				
PIKE COUNTY	4			
ike County E.M.S.				
PORTER COUNTY	13			
ethlehem Steel Corporation				
hesterton Fire Department		1		
uts Vol. Fire Department		1		
idwest Steel Division				
ortage Fire Department				
rtage Twp. Vol. Fire Dept.		1		
rter Fire Department		1		
alparaiso Fire Department		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
POSEY COUNTY	7			
Marrs Township Fire Department		1		
Mt. Vernon Fire Department		1		
Posey County Ambulance Service				
Wadesville Vol. Fire & Rescue				
PULASKI COUNTY	2			
PUTNAM COUNTY	2			
Bainbridge Vol. Fire Department		1		
Cloverdale Vol. Fire Department		1		
Roachdale Vol. Fire Dept. & Rescue				
RANDOLPH COUNTY	28			
Culberson Funeral Home				
Farmland Fire Department				
Parker Fire Department				
Randolph County Ambulance Service				
Union City/Indiana Life & Rescue		1		
White River Twp. Vol. Fire Dept.		1		
RIPLEY COUNTY	10			
So. Ripley Co. Rescue 69		1		
Sunman Vol. Fire Department		1		
RUSH COUNTY	15			
Anderson Twp. Vol. Fire Dept.				
Carthage Vol. Fire Department				
Glenwood Fire Department				
Posey Twp. Vol. Fire Department				
Raleigh Comm. Vol. Fire Dept., Inc.				
Rushville City Fire Department		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
ST. JOSEPH COUNTY	19	1		St. Joseph Airport Authority
Center Township Fire Department		1		
Clay Twp. Fire Department		1		
Harris Township Fire Department		1		
Liberty Twp. Fire Department				
City of Mishawaka E.M.S.				
Mishawaka Fire Dept. & Rescue		1		
New Carlisle Vol. Fire Dept.				
Osceola Fire & Civil Defense				
Penn Twp. North Fire Department		1		
Penn Twp. South Fire Department		1		
Portage Twp. Fire Department				
South Bend Fire Department		1		
Uniontown Twp. Fire Department				
Walkerton Vol. Fire Department			1	
SCOTT COUNTY	1			
Austin Volunteer Fire Dept.				
SHELBY COUNTY	9			
Fountaintown Comm. Vol. F.D.				
Shelbyville Fire Department		1		
Waldron Vol. Fire Department		1		
SPENCER COUNTY	4			
Dale Volunteer Fire Department				
Spencer Co. Emerg. Amb. Serv.				
STARKE COUNTY	4			
Bass Lake Fire Department				
Hamlet Fire Department		1		
Knox Center Twp. Fire Dept.		1		
Koontz Lake Fire Department				
STEUBEN COUNTY	4			
Steuben County Sheriff's Dept.		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOL
SULLIVAN COUNTY	2			
Sullivan City Fire Department		1		
SWITZERLAND COUNTY	4			
Craig-Jefferson Vol. Fire Dept.		1		
TIPPECANOE COUNTY	25			
Buck Creek Fire Department				
Clarks Hill E.M.S.				
Dayton Fire Department				
Lafayette Fire Department		1		
Purdue University Fire Dept.				
Romney Fire Department				
Sheffield Township Fire Dept.				
Stockwell Fire Department				
Tippecanoe County Sheriff's Dept.		1		
Tippecanoe Twp. Vol. Fire Dept.				
Union Township Fire Department				
Wabash Township Fire Department		1		
Wayne Twp. Vol. Fire Dept.				
Wea Twp. Fire Department				
West Lafayette Fire Department		1		
TIPTON COUNTY	5			
Kempton Vol. Fire Department		1		
Tipton Fire Department				
UNION COUNTY	1			
Liberty Fire Department		1		
VANDERBURG COUNTY	19			
Alexander Ambulance Service				
Evansville Fire Department		2		
German Twp. Vol. Fire Dept.				
McCutchanville Fire Dept.		1		
Perry Twp. Vol. Fire Dept.				
Scott Twp. Vol. Fire Dept.		1		
Welborn Baptist Hospital			1	

OVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
VERMILLION COUNTY	3			
ayuga Fire Department		1		
VIGO COUNTY	16	1	Hulman Airport	
ney Creek Vol. Fire Dept.		1		
ter Creek Vol. Fire Department				
rairieton Vol. Fire Department				
. Marys-of-the-Woods Fire Assoc.				
eleyville Vol. Fire Dept.		1		
erre Haute Fire Department		6		
st Terre Haute Vol. Fire Dept.		1		
WABASH COUNTY	2			
nchester Fire Department				
abash Fire Department				
WARREN COUNTY	0			
rren County Ambulance Serv.		1		
arren County Sheriff's Dept.				
WARRICK COUNTY	19			
uminum Company of America				
onville Fire Department				
ewburgh Volunteer Fire Dept.				
rrick County EMS/Warrick Hosp.		1		
nkeetown Vol. Fire Department				
WASHINGTON COUNTY	8			
ardinsburg Fire Department		1		
lem/Washington Twp. Fire Dept.				
shington County Medical Service				
WAYNE COUNTY	6			
ambridge City Fire Department				
lberson Funeral Home				
blin Fire Department		1		
agerstown Fire Department				
chmond Fire Department		1		

PROVIDER	TRAINED	HURST TOOLS	LUKAS TOOLS	OTHER POWER TOOLS
WELLS COUNTY	2			
Bluffton Rescue Unit/Fire Dept.		1		
Ossian Fire Department		1		
WHITE COUNTY	4			
Monticello Fire Department		1		
Wolcott Volunteer Fire Dept.				
WHITLEY COUNTY	2			
Churubusco Fire Department		1		
Columbia Twp. Vol. Fire Dept.		1		

*TOTAL PRCVIDERS	362
*TOTAL HURST TOOLS	200
*TOTAL LUKAS TOOLS	20

**Indiana Totals Only

September 11, 1981

The following figures are based upon the official 1980 census and total Indiana population of 5,490,179.

The following counties or communities have Paramedic level service available to them.

Counties	Population
Allen (Partial)	172,196
Boone	36,446
Dekalb	33,606
Elkhart (Partial)	86,204
Grant (Partial)	46,123
Hamilton	82,381
Johnson (Partial)	39,854
Lake (Partial)	273,046
LaPorte	108,632
Marion	765,233
Porter	119,816
Putnam	29,163
St. Joseph	241,617
Sullivan	21,107
Tippecanoe	121,702
Vanderburgh ✔	167,515
Warrick ✔	41,474
Whitley	26,215
TOTAL	2,412,330 (44%)

The following areas have Advanced EMT service available as their only form of Advanced Life Support. (NOTE: There are different levels or types of services provided by Advanced EMT providers)

County	Population	
Adams County	29,619	
Allen (Partial)	122,159	
Elkhart.County (partial)	51,126	
Huntington County	35,596	
Knox County	41,838	
Kosciusko County (partial)	30,979	
LaGrange County	25,550	
Noble County	35,443	
TOTAL	372,310	(7%)

DATE: September 1, 1981

County	Sq. mi/Co.	Population	Pop./Sq. mi.	EMTs/Co.	Pop./EMT	Ambulances/Co.	Sq. mi./Amb.	Pop./Amb.
Adams	345	29,619	85.9	89	332.8	5	69.0	5923.8
Allen	671	294,335	438.7	568	518.2	25	26.8	11773.4
Bartholomew	402	65,088	161.9	100	650.9	8	50.3	8136.0
Benton	409	10,218	25.0	69	148.1	4	102.3	2554.5
Blackford	167	15,570	93.2	67	234.4	3	55.7	5190.0
Boone	427	36,446	85.4	72	506.2	5	85.4	7289.2
Brown	319	12,377	38.8	57	217.1	4	79.8	3094.3
Carroll	374	19,722	52.7	136	145.0	5	74.8	3944.4
Cass	415	40,936	98.6	61	671.1	5	83.0	8187.2
Clark	384	88,838	231.3	107	830.3	15	25.6	5922.5
Clay	364	24,862	68.3	39	637.5	4	91.0	6215.5
Clinton	407	31,545	77.5	196	160.9	9	45.2	3505.0
Crawford	312	9,820	31.5	34	288.8	3	104.0	3273.3
Daviess	430	27,836	64.7	81	343.7	6	71.7	4639.3
Dearborn	306	34,291	112.1	107	320.5	8	38.3	4286.4
Decatur	370	23,841	64.4	31	769.1	3	123.3	7947.0
DeKalb	366	33,606	91.8	103	326.3	4	91.5	8401.5
Delaware	396	128,587	324.7	169	760.9	15	26.4	8572.5
Dubois	433	34,238	79.1	97	353.0	4	108.3	8559.5
Elkhart	468	137,330	293.4	248	553.8	19	24.6	7227.9
Fayette	215	28,272	131.5	27	1047.1	3	71.7	9424.0
Floyd	149	61,169	410.5	46	1329.8	4	37.3	15292.3
Fountain	397	19,033	47.9	64	297.4	4	99.3	4758.3
Franklin	394	19,612	49.8	66	297.2	4	98.5	4903.0
Fulton	368	19,335	52.5	92	210.2	5	73.6	3867.0
Gibson	498	33,156	66.6	99	334.9	3	166.0	11052.0
Grant	421	80,934	192.2	251	322.4	12	35.1	6744.5
Greene	549	30,416	55.4	71	428.4	4	137.3	7604.0
Hamilton	401	82,381	205.4	135	610.2	9	44.6	9153.4
Hancock	305	43,939	144.1	125	351.5	9	33.9	4882.1
Harrison	479	27,276	56.9	73	373.6	4	119.8	6819.0
Hendricks	417	69,804	167.4	195	358.0	12	34.8	5817.0
Henry	400	53,336	133.3	114	467.9	10	40.0	5333.6
Howard	293	86,896	296.6	140	620.7	11	26.6	7899.6
Huntington	369	35,596	96.5	122	291.8	5	73.8	7119.2
Jackson	520	36,523	70.2	36	1014.5	4	130.0	9130.8
Jasper	562	26,138	46.5	58	450.7	6	93.7	4356.3
Jay	386	23,239	60.2	34	683.5	4	96.5	5809.8
Jefferson	366	30,419	83.1	34	894.7	3	122.0	10139.6

County	Sq. mi/Co.	Population	Pop./Sq. mi.	EMTs/Co.	Pop./EMT	Ambulances/Co.	Sq. mi./Amb.	Pop./Amb.
Jennings	377	22,854	60.0	26	879.0	3	125.7	7618.0
Johnson	315	77,240	245.2	191	406.5	15	21.0	5149.3
Knox	516	41,838	81.1	88	475.4	13	39.7	3218.3
Kosciusko	540	59,555	110.3	180	330.9	10	54.0	5955.5
LaGrange	381	25,550	67.1	65	393.1	5	76.2	5110.0
Lake	513	522,965	1019.4	665	786.4	45	11.4	11621.4
LaPorte	607	108,632	179.0	109	996.6	6	101.2	18105.3
Lawrence	459	42.472	92.5	94	451.8	5	91.8	8494.4
Madison	453	139,336	307.6	347	401.5	32	14.2	4354.3
Marion	392	765,233	1952.1	1,348	567.7	83	4.7	9219.7
Marshall	443	39,155	88.4	143	273.8	9	49.2	4350.6
Martin	345	11,001	31.9	27	407.4	2	172.5	5500.5
Miami	377	39,820	105.5	104	382.9	7	53.9	5688.6
Monroe	386	98,387	254.9	115	855.5	10	38.6	9838.7
Montgomery	507	35,501	70.0	205	173.1	10	50.7	3550.1
MOrgan	406	51,999	128.1	90	577.8	12	33.8	4333.3
Newton	413	14,844	35.9	43	345.2	5	82.6	2968.8
Noble	412	35,443	86.0	92	385.3	7	58.9	5063.3
Ohio	87	5,114	58.8	25	204.6	2	43.5	2558.5
Orange	450	18,677	41.5	53	352.4	3	150.0	6225.7
Owen	390	15,840	40.6	45	352.0	2	195.0	7920.0
Parke	445	16,372	36.8	46	355.9	4	111.3	4093.0
Perry	384	19,346	50.4	22	879.4	2	192.0	9673.0
Pike	335	13,465	40.2	53	254.1	6	55.8	2244.2
Porter	425	119,816	281.9	216	554.7	15	28.3	7987.7
Posey	412	26,414	64.1	73	361.8	5	82.4	5282.8
Pulaski	433	13,258	30.6	21	631.3	3	144.3	4419.3
Putnam	490	29,163	59.5	142	205.4	5	98.0	5832.6
Randolph	457	29,997	65.6	60	500.0	8	57.1	3749.6
Ripley	442	24,398	55.2	99	246.4	6	73.6	4066.3
Rush	409	19,604	47.9	81	242.0	7	58.4	2800.6
St. Joseph	466	241.617	518.5	293	824.6	29	16.1	8331.6
Scott	193	20,422	105.8	6	3403.7	3	64.3	6807.3
Shelby	409	39,887	97.5	68	586.6	7	58.4	5698.1
Spencer	396	19,361	48.9	76	254.8	4	99.0	4840.3
Starke	310	21,997	71.0	88	250.0	5	62.0	4399.4
Steuben	309	24,694	79.9	72	343.0	4	77.3	6173.5
Sullivan	457	21,107	46.2	62	340.4	5	91.4	4221.4
Switzerland	221	7,153	32.4	39	183.4	3	73.7	2384.3
Tippecanoe	500	121,702	243.4	305	399.0	10	50.0	12170.2
Tipton	261	16,819	64.4	39	431.3	4	65.3	4204.8

County	Sq. mi/Co.	Population	Pop./Sq. mi.	EMTs/Co.	Pop./EMT	Ambulances/Co.	Sq. mi./Amb.	Pop./Amb.
Union	168	6,860	40.8	19	361.1	2	84.0	3430.0
Vanderburgh	241	167,515	695.1	351	477.3	16	15.1	10469.7
Vermillion	263	18,229	69.3	38	479.7	3	87.7	6076.3
Vigo	415	112,385	270.8	161	698.0	9	46.1	12487.2
Wabash	398	36,640	92.1	66	555.2	5	79.6	7328.0
Warren	368	8,976	24.4	40	224.4	2	184.0	4488.0
Warrick	391	41,474	106.1	96	432.0	7	55.9	5924.9
Washington	516	21,932	42.5	54	406.1	3	172.0	7310.7
Wayne	405	76,058	187.8	87	874.2	11	36.8	6914.4
Wells	368	25,401	69.0	71	357.8	4	92.0	6350.3
White	497	23,867	48.0	67	356.2	4	124.3	5966.8
Whitley	337	26,215	77.8	122	214.9	6	56.2	4369.2
Indiana	36,184	5,490,179	151.7	11,541	475.7	764	47.4	7189.1

KITCHENS, T.
DOESN'T HAVE NATIONAL STANDARDS

-- PROGRAM MANUAL --

REGIONAL COORDINATION CENTERS

FOR

EMERGENCY MEDICAL SERVICES

INDIANA EMS COMMISSION
315 State Office Bldg.
Indianapolis, IN 46204

(317) 232-3980

INTRODUCTION

Pursuant to it's enabling legislation, which recognized that "the provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare, the Indiana Emergency Medical Services Commission is empowered to develop and promote a comprehensive system of EMS.

Throughout the statute, reference is made to the Commission's responsibility to develop the EMS system in cooperation with regional and local agencies and entities. Therefore, as the State EMS Plan was developed, emphasis was placed upon the determining of specific needs, problems, solutions, and methodologies at the regional and local level through the efforts of "Regional Coordination Centers" (RCC's).

The purpose of the Program Manual, then, is to explain the role, structure, and designation process of these Regional Coordination Centers.

Readers are urged to contact the EMS Commission should questions or the need for clarification and/or assistance arise.

OVERVIEW

The State EMS Plan, adopted by the EMS Commission on March 21, 1980, provides the over-all conceptual framework within which a comprehensive system of EMS may be developed in Indiana.

The plan addresses all 15 federally identified EMS system components, plus Systems Management which is recognized as a 16th. Some of the objectives and activities in the Plan are very specific (e.g. citizen targeted training, extrication, and communications). Others are more general in nature, and will require the Regional Coordination Centers to develop a more specific plan for their areas, based upon the size, population, present level of EMS system sophistication, and available resources in each region.

The reasons for the State EMS Plan being so structured, and for RCC's to be created are two-fold. First, as stated in the Plan, the EMS Commission does not have the resources to effectively identify and resolve every local and regional EMS problem or need. Secondly, and perhaps more importantly, regarding the development of the RCC's, the State of Indiana and the EMS Commission have historically endeavored to permit local communities, counties, and regions to set their own levels of performance (consistent with the official Rules and Regulations), and to seek their own methods of meeting the needs of their region, while receiving assistance and guidance from the State.

The EMS Commission wishes to see the development of RCC's which in turn will assist, promote, and guide the orderly development of an EMS system throughout the State. It is understood that once an comprehensive system of EMS is developed in the State, the RCC's will remain in existence to guide and maintain the system.

AUTHORITY

The Regional Coordination Centers for Emergency Medical Services, to be created locally throughout the ten (10) Commission identified regions, will, when designated, have the authority and responsibility to develop a plan for the implementation of a coordinated regional EMS system that encompasses the system components and the duties and responsibilities as defined in the State's Comprehensive Plan for Emergency Medical Services.

Following Commission approval of the Regional Implementation Plan, each RCC, based upon the authority inherent in its management structure and Commission designation, shall be responsible for guiding to fulfillment, each goal of the Regional Implementation Plan and for continued planning as the system becomes more sophisticated and initial goals are reached.

While Commission endorsement provides basic support, the majority of the authority of each RCC will flow from their management structure and the planning and implementation policies and procedures approved through the decision-making process of the regional system itself.

It must be understood that the Commission cannot delegate its statutory responsibilities. However, the Commission may grant an RCC review and comment authority for appropriate system components.

GENERAL STRUCTURE OF RCC'S

Given the fact that the RCC's are being created in order to assure local development of, and responsibility for the regional EMS system, the structure of the RCC's themselves is very important.

Each RCC must have a Regional Board of Directors or EMS Advisory Council which is broadly representative of its region. One reason for this is that by incorporating many individuals with various backgrounds and interests into its management structure, including local governmental officials, the RCC may gain a true perception of the region's needs and resources. Secondly, to successfully implement any comprehensive system of EMS, the providers of the system must have a meaningful role in its design.

It is strongly recommended that the RCC be organized such that its policy-making decisions are directed by the Regional Board of Directors or EMS Advisory Council. Only in this way can all constituents of the region be assured that the RCC is truly responsive to the needs of the region.

It is recognized, though, that some applying entities (e.g. single hospital applications) cannot legally give complete authority to their EMS Advisory Council, due to their corporate structure. In these instances, the legal corporate Board of Directors shall submit, in writing, an explanation of the degree of their commitment to the recommendations of the EMS Advisory Council.

Another feature of the Regional Coordination Centers for Emergency Medical Services is their need to be duly-chartered, Indiana not-for-profit corporations. The reasons for this are two-fold. First, and most importantly, the RCC should clearly be governed by a spirit of public service, not by a profit-making motive. Secondly, in order for the RCC to receive financial assistance from any governmental of quasi-governmental agency, it will have to be a not-for-profit corporation.

APPLICATION AND SELECTION PROCESS

Introduction As previously stated, there are different ways in which an RCC can be organized, and in which it can identify and help meet the needs of its region. For these reasons, and to properly allow the applicant for designation to express itself, the Commission has designed the application as a Request for a Proposal (RFP).

Format In order to assure that certain vital information is received from each applicant, the Commission has decided that all applications for designation must thoroughly describe each of the following:

1) The management/organizational structure of the proposed Regional Coordination Center.

2) The applicant's work program to identify the EMS system needs of the region, develop an EMS plan to meet those needs, and fulfill the roles and responsibilities of an RCC.

3) The applicant's proposed administrative and planning budget for 18 months following designation.

Specific information required to be addressed in each of the three areas is detailed in the next section of this manual.

In addition, each application for designation must contain a mission statement or statement of policy explaining briefly why the application is being made and explaining the organization's overall commitment to EMS system success.

Schedule In order to fairly evaluate each application and to insure that an appropriate entity is designated in each region, all applications for RCC designation will be managed as follows, guided by the accompanying time-table:

October 1, 1980 RCC Manual will be distributed and applications made available.

October 1, 1980 through January 31, 1981

1. EMS Commission and staff will explain RCC application process and the role of RCC's in the Indiana EMS system.

2. EMS Commission staff and regional coordinators will be available to answer questions of a technical nature to assist applicant's in preparing their proposals.

3. Applications for designation accepted.

October 18 through 19, 1980 "Workshop on Guidelines for Preparation of Regional Coordination Center Application" at State EMS Conference.

December 1, 1980 After December 1, 1980, each applicant may schedule an appointment for application review by the staff for completeness and general clarity. This procedure is for the benefit of the applicant, since after February 1, 1981, there will be no opportunity to revise applications.

February 1, 1981 Deadline for receipt of applications.

February 1 through April 1, 1981 A committee appointed by the Commission will review the applications and prepare recommendations.

April, 1981 Recommendations for RCC designation presented to EMS Commission. EMS Commission designates RCC's.

Evaluation of Applications Applications will be evaluated as follows:

A committee appointed by the EMS Commission will evaluate the applications. Individual sections of the applications will be judged for thoroughness and appropriateness (based upon guidelines contained in Description of Individual Section of Applications, see page 5) and a numerical score given to each. Maximum available points for each of the sections are:

I.	MANAGEMENT/ORGANIZATIONAL STRUCTURE	300
II.	WORK PROGRAM TO IDENTIFY AND MEET THE NEEDS OF THE REGION	500
III.	FINANCIAL INFORMATION	200
	TOTAL	1,000

Selection of RCC's After evaluation of all applications, the Committee's recommendations for designation will be presented to the Commission before their April 1981 meeting. At that meeting the Commission may designate RCC's. However, if no application for designation is received from a region, or if no application received is deemed appropriate, the Commission will pursue an alternative means for the establishment of an RCC in the region.

Following the April meeting, notice of the Commission's decisions will be mailed to all applicants, ambulance service providers, and hospitals in the State.

By June 1, an informational meeting for the new RCC's will be held in Indianapolis. A contract between the RCC's and the EMS Commission will be presented for review at that time.

A copy of the application for designation as a Regional Coordination Center may be obtained by writing to:

Michael A. Lanning
Planning Director
EMS Commission
315 State Office Building
Indianapolis, IN 46204

For informational purposes, a description of each section of the application is presented.

DESCRIPTION OF INDIVIDUAL SECTIONS OF THE APPLICATION

I. MANAGEMENT/ORGANIZATIONAL STRUCTURE

One of the paramount factors that will determine the ultimate success or failure of an RCC is its structure. The body that directs the activities of the RCC should be large enough and representative enough of the entire region to at least meet the guidelines that follow. It is recognized, though, that a very large board or council may be difficult to convene on a regular basis. For this reason, if the applying RCC wishes to have its representatives of each individual county select one or two members to sit on a region-wide "executive" board or council, they should so state, with justification on its application.

Further, individual letters of substance from all provider organizations (ambulance, hospitals, etc.) in the region should be included in this section, stating the organization's willingness to recognize that the applicant as the EMS coordination center for the region, if it receives the designation. NOTE: This last statement in no way limits any provider from endorsing more than one application from his region. To do so could put competing applicants in the position of bidding for endorsements, which is not the Commission's intent.

Section I of applications received shall address the following:

A. EMS Advisory Council/Board of Directors

1. Evidence of being duly-chartered, not-for-profit corporation pursuant to the provisions of Indiana statutes

2. Council/Board must be geographically representative of the region

3. Identify membership by type (provider, consumer, etc.), number of each, and name, qualification, and affiliation of each member

   a. Providers (Ambulance, Hospital, First Responders)

      1. Administrative

      2. "Line" personnel (actively involved in emergency patient care)

   b. Local governmental officials (County, City/Town)

   c. Other public safety agencies in the region (Red Cross, Civil Defense, etc.)

   d. Consumers

4. Authority

5. Relationship (if EMS Advisory Council is different from corporate board of directors)

B. Staff

1. Organizational Chart

2. Relationship to Board of Directors (and EMS Advisory Council if they are separate)

3. Job Descriptions

   a. Executive Director/Lead Planner

   b. Physician Advisor to the RCC

   c. Clerical/Support Staff

   d. Others

4. Names and qualifications of personnel

II. WORK PROGRAM TO IDENTIFY AND MEET THE NEEDS OF THE REGION

This section of the application will contain the work program of the potential RCC for the first year and one half (until October 1, 1982) following designation. This is not the Regional EMS Plan which the RCC will develop and submit to the Commission no later than October, 1982; nor is it to be merely a reiteration of the State EMS Plan. It should, rather, describe in detail how and when specific tasks will be accomplished to fulfill the roles and responsibilities of the RCC, and determine the EMS system needs of the region and to develop an adequate and appropriate plan to meet those needs (the Regional Implementation Plan).

The work program should be organized by component, to assist the applicant in conceptualizing the system. It is recognized that actions in all 16 components may not be undertaken during the first 18 months, however, the application must address each component. In addition, if it is found that any of the roles and responsibilities do not readily fit into a component area, they must be addressed separately.

For ease of reference and to guide the RCC applicant, the roles and responsibilities and RCC activities outlined in the State EMS Plan are repeated here, the activities presented in chronological order.

Roles and responsibilities for Regional Coordination Centers:

1. Include other agencies, organizations, institutions, and committees with EMS responsibilities within the region in the RCC's administrative or operational structure, as required by the Commission.

2. Develop a plan for the management and operation of the Regional Coordination Center. (RCC)

3. Develop a plan for EMS for the region consistent with the comprehensive State Plan, and taking into consideration the recommendations of their EMS Council or board.

4. Develop a mechanism/plan for assuring and evaluating the success of the implementation of all plan components.

5. Provide feedback to the EMS Commission on its data collection activities.

6. Identify a Regional Medical Communications Center for approval by the Commission, to assist in the development and implementation of a Regional Communications Plan.

7. Develop a plan for the placement of primary response transportation (both Basic Life Support and Advanced Life Support) vehicles necessary to provide a maximum 20 minute response time for 95% of all responses; and assist in implementation of the plan.

8. Develop a plan to assure the availability of secondary transportation vehicles.

9. Periodically identify training needs of: dispatchers, citizen and Public Safety Agency first responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians, Emergency Paramedics, Refresher and continuing education primary instructors, systems managers, Emergency and Critical Care Nurses, Emergency Physicians and Extrication Personnel.

10. Define an annual and long range plan to assure the meeting of those needs.

11. Be willing to provide office space and clerical support to the Regional Coordinator in return for his/her assistance giving staff support to the RCC.

12. Store, distribute, and maintain Emergency Medical Services Commission owned films, training equipment, etc.

13. Maintain a file of Primary Instructors and other qualified individuals who are willing to speak to classes.

14. Publish a regional newsletter of upcoming classes, 20-Hour Refresher Courses, and in-services, open positions, changes in provider (hospital and ambulance) policies, major road changes, etc.

15. Assist other agencies, organizations, and individuals within the region with public information and education.

16. Advise the Emergency Medical Services Commission of deficiencies in either quantity and/or quality of courses/classes within the region.

17. Be responsible for providing review and comment on all training course applications from the region.

ACTIVITY		START	ATTAIN
2.4.B.	Emergency Medical Service First Responder Training Courses will be conducted throughout the state through the efforts of the RCC's, the Law Enforcement Training Academy, and local EMS providers and public safety agencies.	April 1981	On-Going
4.1.A.	The EMS Commission with the RCC's will determine areas currently exceeding the 20 minute response objective.	April 1981	October 1981
4.1.C.	The EMS Commission and the RCC's will assist local units of government and providers in developing methods to improve response times where needed.	April 1981	On-Going
6.1.A.	The RCC, with the Regional Medical Communication Center, will endeavor to coordinate frequencies in the region between public safety agencies and Emergency Medical Service providers.	April 1981	On-Going
11.2.B.	The RCC's will develop a methodology to address public information and education priorities for each region.	April 1981	July 1981
13.2.B.	The RCC's will issue news releases as necessary, to inform the general public of disaster plans, procedures, and drills in their area.	April 1981	On-Going
1.2.A.	The RCC will compare the manpower inventory developed by the EMS Commission with staffing schedules and determine where the need for additional manpower exists.	May 1981	October 1981
2.5.A.	The RCC's will determine the need for Dispatcher training in their region.	May 1981	October 1981
2.6.A.	The RCC's will determine the need for EMT and DOT Refresher Training Courses in their regions.	May 1981	October 1981
2.7.A.	The RCC's will determine the need for Primary Instructors in their regions.	May 1981	October 1981
2.8.A.	The RCC's will determine the need for and scope of Advanced Life Support training regionally.		

ACTIVITY		START	ATTAIN
2.9.B.	The RCC's will determine Emergency and Critical Care nursing training needs regionally.	May 1981	October 1981
2.10.C.	The RCC's will identify the need for training of Emergency Department Physicians based upon the skill levels developed in Activity 2.10.A.	May 1981	October 1981
2.11.B.	EMS Commission trained extricaiton instructors within each extrication service provider organization will conduct training and continuing education programs for all extrication personnel at their organization in cooperation with the RCC's.	May 1981	On-Going
2.12.A.	The EMS Commission and theRCC's will identify the need for emergency driving training regionally.	May 1981	October 1981
3.1.A.	The RCC's will recommend, the Commission approval, Regional Medical Communication Centers.	July 1981	October 1981
6.2.A.	The RCC's will encourage periodic meetings between public safety agencies and EMS providers.	July 1981	On-Going
8.1.A.	The RCC's will identify those institutions and agencies in their region that do have written policies pertaining to non-discriminatory access to care.	July 1981	October 1981
8.1.B.	The RCC's will encourage and work with those entities who do have such policies to develop them.	July 1981	January 1982
15.4.B.	The RCC's will designate regional practical examination teams.	July 1981	October 1981
15.4.C.	The Regional Coordinators and the RCC's will coordinate the administration of practical examinations.	July 1981	On-Going
15.7.B.	The RCC's will determine the regional need for Advanced Life Support utilizing the Advanced Life Support systems manual.	July 1981	On-Going
2.1.A.	Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.	October 1981	On-Going

ACTIVITY		START	ATTAIN
2.2.A.	Local affiliates of the ARC, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic First Aid classes, in cooperation with the RCC, to meet the identified needs of the region.	October 1981	On-Going
.5.B.	The RCC will coordinate the provision of Dispatcher training based on the identified need.	October 1981	April 1983
2.6.B.	The EMS Commission approved training institutions, coordinated through the RCC, will conduct EMT and DOT Refresher Courses to meet the identified need.	October 1981	October 1983
2.8.B.	The RCC's will coordinate the regional training activity of Advanced Life Support training institutions to meet the identified need.	October 1981	On-Going
2.9.C.	The RCC's will coordinate the provision of Emergency and Critical Care continuing education programs based on the identified need.	October 1981	April 1983
2.10.D.	The RCC's will coordinate the provision of training programs for Emergency Department Physicians to meet the identified need.	October 1981	July 1983
2.12.B.	The EMS Commission will cooperate with the Law Enforcement Training Academy, the RCC's, and other concerned agencies in conducting Emergency Driving classes to meet the identified needs.	October 1981	July 1983
2.13.C.	The EMS Commission will provide technical assistance to the RCC's to coordinate the provision of Hazardous Material courses regionally.	October 1981	On-Going
11.1.A.	Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.	October 1981	On-Going
11.1.B.	Local affiliates of the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic first aid classes, in cooperation with the RCC, to meet the identified needs of the region.	October 1981	On-Going

ACTIVITY		START	ATTAIN
13.1.A.	The RCC's will identify existing provider, local, county and regional disaster plans.	October 1981	April 1982
14.1.A.	The RCC's will survey EMS providers in their region to identify existing Mutual Aid Agreements.	October 1981	April 1982
15.7.C.	The RCC's will coordiante the development of Advanced Life Support systems regionally to meet the identified need in 15.7.B. (NOTE: Advanced Life Support needs assessment may determine that the regions cannot, at that time, support an Advanced Life Support effort.)	October 1981 (If need for ALS is determined)	On-Going
3.2.A.	The RMCC will coordinate the planning, development and operation of EMS communications systems within the region, in cooperation with the RCC, local hospitals, EMS providers and other appropriate agencies.	January 1982	July 1982
9.2.A.	The RCC's will identify those hospitals in their region that do have written transfer protocols.	January 1982	July 1982
14.1.C.	The RCC's will assist EMS providers in adopting Mutual Aid Agreements.	January 1982	April 1983
9.2.B.	The RCC's will encourage and work with those hospitals that do not have written transfer protocols to adopt them.	July 1982	April 1983
1.2.B.	After designation each RCC will conduct a regional manpower inventory update every two years. Results of this inventory will be reported to the Commission.	July 1983	October 1983

III. FINANCIAL INFORMATION

The final section of the application consists of three sub-parts: operating budget for the first 18 month post-designation planning effort, the anticipated/committed source of funds for the operating budget, and letters of support documenting the commitment and scope of commitment of the sources cited.

To provide operating revenue, EMS regional centers nationwide have been very innovative. Funding has been secured either in full or in part from local industries and foundations, hospitals, county and city councils, and public fund-raising events and solicitations.

The 1981 Indiana Highway Safety Plan calls for the availability of $15,000 for each eligible region to be used for reimbursement of planning personnel costs incurred in the portion of the planning period April 1, 1981 through September 30, 1981.

Continued funding beyond September 30, 1981 is subject to review and approval of a similar Highway Safety Task for the period October 1, 1981 through September 30, 1982. These periods of time correspond with the stated maximum anticipated regional plan development period, and the federal fiscal years. The Commission will request $30,000 for each eligible region for fiscal year 1982.

The Highway Safety Program funding is a cost reimbursement process for eligible expenses incurred, as defined in the required contract between the EMS Commission and eligible RCC's. Thus, each RCC will have to obtain the necessary financial resources to support their activity until reimbursement is provided.

It must be clearly understood that the availability of these planning funds is subject to approval of the Highway Safety Project by the Office of Traffic Safety and approval by the Attorney General and Governor of Indiana of each individual contract between the RCC's and the Commission.

This funding was secured to additionally support the planning effort for those regions that have not received Section 1203 implementation monies through the Federal EMS Systems Act of 1973, etc., administered by the Department of Health, Education, and Welfare (now Health and Human Services).

While the application evaluation process awards fewer points in the Financial Information section, the Commission reiterates its belief that the RCC's must have a sound fiscal basis to enable them to meet their commitment to EMS system development.

The following are sample questions from the application for designation as an RCC. A copy of the application may be obtained by writing to:

Michael A. Lanning
Planning Associate
EMS Commission
315 State Office Building
Indianapolis, IN 46204

I. MANAGEMENT/ORGANIZATIONAL STRUCTURE

A. Describe the general nature of your organization (e.g. coalition of EMS Providers, Public Safety Agencies, and Consumers, a consortium of hospitals, a single hospital, etc.). You may attach a copy of your Articles of Incorporation if you wish. (30 POINTS)

B. Regional EMS Advisory Council/Corporate Board of Directors. (List the membership of your governing body -- and of the EMS Advisory Council if the two are separate -- and their affiliation, city of residence, and city of employment.) (45 POINTS)

C. Describe the relationship between your Board of Directors, Regional EMS Advisory Council, and Executive Board. (These may all be the same body.) (30 POINTS)

D. Describe the policy-making authority of your Regional EMS Advisory Council and/or Executive Board. (Address both if your organization has both.) (45 POINTS)

E. Relationship of staff to governing body -- Narrative. Also attach a copy of your organizational chart. (35 POINTS)

F. Names and qualifications of staff (if known at present). (20 POINTS)

G. Job descriptions of staff (attach copies). (25 POINTS)

H. Letters of support from providers in the region (attach). (40 POINTS)

I. Additional pertinent information. (30 POINTS)

II. WORK PROGRAM TO IDENTIFY THE NEEDS OF THE REGION

Describe how your organization will, between April, 1981 and October 1, 1982:

A. Identify the EMS system needs of your region.

B. Develop a realistic, time-framed EMS plan for the region based upon the RCC activities of the State EMS Plan, the needs of the region, and the sixteen components of the EMS system.

C. Fulfill, or plan to fulfill, the roles and responsibilities of a Regional Coordination Center.

Address 16 Components	150 points
Address 17 Roles and Responsibilities	150 points
Overall Quality, Depth, and Appropriateness of Work Program	200 points
TOTAL SECTION II	500 points

III. FINANCIAL INFORMATION

A. Eighteen month (designation until October 1, 1982) operating budget. (Identify expenditures by type and salaries by position.) (75 POINTS)

B. Source of funds and amount. (List by source the funds to be received for RCC operations.) (75 POINTS)

C. Attach letters documenting commitment of funds by sources identified above. (50 POINTS)

GUIDELINES FOR DEVELOPMENT

OF

REGIONAL EMS PLANS

INTRODUCTION AND PURPOSE

Congratulations upon your designation as a Regional Coordination Center for Emergency Medical Services. Your organization may now proceed to fulfill the roles and responsibilities of an RCC, and thereby guide the providers in your region toward the development of regional policies, procedures, and plans.

As you are aware, RCC's state-wide will benefit all participants in the EMS system, including the patient. By including personnel and agencies from all aspects of EMS in their decision-making processes, RCC's will improve access to the EMS system, identify manpower and training needs, ease and streamline resolution of problems, and provide a means by which regional protocols and policies may be formalized. Common to, and binding together all of these will be your Regional EMS Plan which will identify how, when, and by whom each identified need will be met. The Regional EMS Plan will also identify not only what makes the region unique, but what accomplishments have been made in the region toward development of a comprehensive EMS system.

The purpose of this set of guidelines is to help you develop your Regional EMS Plan, and to help you develop it in a format compatible with other Regional EMS Plans and the State EMS Plan.

It is important that each RCC work closely with the EMS Commission in order to assure the timely development of Regional EMS Plans that are acceptable in format and content.

Prior to the October 1, 1982 date that the Regional EMS Plans are submitted to the Commission for approval, we will be reviewing each RCC's progress toward developing the plan, and will assist you in fulfilling your responsibilities as an RCC.

PROGRAM OVERVIEW / HISTORY

In 1974, the EMS Commission appointed one "Regional Hospital" in each of the State's 14 economic regions to serve as the focal point for training, communications, and data collection. Through a contractual agreement with the EMS Commission, each hospital provided EMT training for its region, and many reviewed initial and refresher course applications and assisted ambulance service providers in improving their services.

However, by 1979 two problems became apparent. The 14 regions that the Commission adopted as EMS regions had originally been identified in 1968 as Economic Planning and Development Regions. Their appropriateness as emergency medical services regions, based upon naturally existing patient flow patterns, was questioned. To be effective and to benefit EMS providers, a region must be comprised of an area that shares some common features. Paramount among these is a "catchment area" of emergency patient flow, although population centers and geographic features also play a role. Therefore, through a contract with the Indiana Hospital Association and Indiana Univeristy, the Commission authorized a retrospective study of patient flow in the state. Based upon this study the Commission identified ten EMS regions in Indiana and adopted them in September 1980.

The Commission, while recognizing the accomplishments of the Regional Hospitals, realised that to be truly effective and responsive to the region, the entity charged with planning and coordinating for the region must have the input and support of the region. Hence the Regional Coordination Center program was begun.

The RCC program is consistent with the Commission's philosophy of permitting local communities, counties, and regions set their own level of system sophistication (consistent with the "Official Rules and Regulations for Operation and Administration of Emergency Medical Services"), and to seek their own methods of meeting the EMS needs of their region, while receiving assistance and guidance from the state.

Regional Coordination Centers have been delegated the authority and responsibility to develop a Regional EMS Plan compatible in format with the State EMS Plan. The Commission's enabling legislation charges the Commission with assisting in the development of a state-wide system of EMS, in cooperation with regional and local entities (e.g.RCC's). Each RCC is responsible for fulfilling each goal of its Regional EMS Plan, and for continued planning as the system develops. The Regional EMS Plan will assist the Commission, as the state lead agency, in developing a state-wide system of EMS that reflects the needs of each region.

While Commission endorsement provides basic support, the majority of the authority of each RCC flows from its management structure and the planning and implementation policies and procedures approved through the regional system.

It must be understood that the Commission cannot delegate its statutory responsibilities. However, you will be granted review and comment authority for appropriate system components.

THE REGIONAL EMS PLAN

Much has been said and written about Regional Coordination Centers and Regional EMS Plans. Before getting into the actual format of the Regional Plans, it is appropriate to explain and emphasize the reasons for developing them.

1. To identify the currently available EMS resources in the region. (This will not only facilitate planning, but will also be of benefit in disaster response, and in indicating the progress to date in developing an EMS system)

2. To identify the EMS needs of the region.

3. To formalize presentation of identified needs to the fiscal authority of individual providers.
(for example: County Commissioners and Councils, Hospital Boards, etc.)

4. To formally present the identified EMS needs to each provider in the region.

5. To provide for evaluation of grant applications from the region.

6. To determine the appropriateness of initial training and refresher courses in the region, prior to Commission approval.

7. To provide input to the State EMS Plan as it is updated, incorporating and reflecting the needs of the regions.

For the Regional EMS Plans to accomplish the above, they must be structured in a manner that:

1. Clearly indicates the EMS needs of the region and the mechanisms necessary to meet those needs, and

2. Is compatible in format and content with the other regions' plans and the State's Comprehensive Plan for Emergency Medical Services.

By being so structured, the Regional EMS Plans will be meaningful and will allow aggregation with other regional plans to provide a true state-wide EMS picture in the revised State EMS Plan.

FORMAT AND CONTENT OF REGIONAL PLANS

The Regional EMS Plans, developed by the RCC's and submitted to the EMS Commission by October 1, 1982, will contain the regional equivalent of the following sections of the State of Indiana Comprehensive Plan for Emergency Medical Services.

I. Organization for EMS Planning and Implementation

This section will present a comprehensive description of the organizational structure of the Regional Coordination Center, its different boards and advisory councils, and how they interrelate. It will include:

1. Authority -- Describe the structure of the RCC and its relationship to other agencies, organizations, and providers both within and outside the region. Also describe the RCC's authority, and source of authority.

2. Staff structure of Regional Coordination Center -- May be presented by chart or diagram

3. Function Identification and Description -- Relate to I. 2. above

4. Planning Area Identification -- Describe the region in terms of its make-up by county, city, and other appropriate political sub-divisions

5. Advisory Groups -- List and describe complementary agencies, groups, and boards, both governmental and private that participate in and cooperate with the RCC

6. Legislation -- Discuss local, county, and regional laws and ordinances that pertain to the provision or planning of EMS. Also discuss planned EMS legislation in the region.

II. Planning Information

1. EMS Resources -- This section will contain a comprehensive description of the current EMS capabilities in the region, and will include:

   1.1 Manpower -- The currently trained, certified, and working personnel in each of the following areas will be identified.

      a. Citizens with CPR training

      b. Citizens with first aid training

      c. Public Safety Agency EMS First Responders

      d. EMS dispatchers

      e. EMT's

      f. Advanced EMT's

      g. Paramedics

      h. Emergency department nurses (RN and LPN)

      i. Critical care unit nurses (RN and LPN)

      j. Emergency department physicians

      k. EMS system management personnel

      l. Extrication personnel

      m. Instructors for all categories of manpower

   1.2 Training -- The number of conducted, approved, and planned training programs for each personnel type will be listed for the fiscal year October 1, 1981 to September 30, 1982, including dates, location, and class size.

   1.3 Transportation -- Each emergency ambulance, rescue vehicle, and extrication vehicle in the region should be identified by location.

   1.4 Facilities -- Each emergency care facility, its location, and its 1981 Commission categorization will be listed.

   1.5 Communications -- VHF (High and Low) and UHF frequencies used in the provision or coordination of EMS in the region should be listed, along with what agency (-ies) use that frequency.

1.6 Consumer Participation -- Documentation of participation by the non-EMS lay public in EMS planning for the region will be given.

1.7 Access to Care -- Hospitals and ambulance services with written policies pertaining to non-discriminatory access to care will be identified in this section.

1.8 Public Information and Education -- List and describe EMS public information and education activities in the region.

1.9 Disaster Linkages -- Regional, county, ambulance service, and hospital formal, written disaster plans will be listed in this section.

1.10 Mutual Aid Agreements -- Mutual aid agreements between ambulance services in contiguous areas will be identified.

2. Description of Program Area -- This section must present a comprehensive picture of the region. It should contain information with regard to:

2.1 Demographic Information

a. Population of the region and the counties and cities within the region (1980).

b. Population densities of the above.

2.2 Area Characteristics

a. Roads -- including mileage by type (interstate, county, etc.)

b. High accident locations

c. Geographic features of the region

d. Climatic conditions in the region

e. Economic and social conditions

f. Disease characteristics

g. Hazardous conditions (naturally occurring and man-made)

h. Other factors (e.g. seasonal tourist influx, etc.)

III. EMS System Components and Affecting Regional and Local Standards

Each of the following components of an EMS system should be listed along with any applicable ordinances, or regional policies or protocols that have been developed.

1. Manpower

2. Training

3. Communications
4. Transportation
5. Facilities
6. Critical Care Units
7. Public Safety Agencies
8. Consumer Participation
9. Access to Care
10. Transfer of Patients
11. Coordinated Medical Recordkeeping
12. Public Information and Education
13. Evaluation
14. Disaster Linkages
15. Mutual Aid Agreements
16. System Management

IV. Program Objectives and Implementation

This section of the Regional EMS Plan, like the State EMS Plan, will contain the actual goals, objectives, and activities planned by the RCC. There will be 16 subsections in this section, one for each component of the EMS system.

The format for this section of the Regional EMS Plan will be:

a. Goal -- The over-all goal of the EMS system, from the State EMS Plan

b. Component Sub-Goal -- Also from the State EMS Plan

c. Discussion *

d. Objective **

e. Discussion *

f. Activity **

*Discussion: Discussion in this section will identify the difference between the resources of the region and the optimal status of the region, considering among other things the unique aspects of the region and its EMS delivery system. These differences will be the needs of the region and will result in identification of objectives. Discussion under objectives will result in identification of activities.

** Objective/Activity: Each RCC must address and fulfill each RCC objective and activity contained in the State EMS Plan. It is important that each RCC identify and plan to meet other objectives and activities unique to its region. Activities must be sufficient to meet the stated objectives and must clearly indicate who (or what agency) is responsible for for each activity.

As a point of departure for development of the Regional EMS Plan, on the following pages are presented the RCC activities of the State EMS Plan. The dates referenced are based upon RCC designation of April 10, 1981.

MANPOWER		START	ATTAIN
1.2.A.	The RCC will compare the manpower inventory developed by the EMS Commission with staffing schedules and determine where the need for additional manpower exists.	May 1981	October 19
1.2.B.	After designation each RCC will conduct a regional manpower inventory update every two years. Results of this inventory will be reported to the Commission.	July 1983	October 19
TRAINING			
2.4.B	Emergency Medical Service First Responder Training Courses will be conducted throughout the state through the efforts of the RCC's, the Law Enforcement Training Academy, and local EMS providers and public safety agencies.	April 1981	On-Going
2.5.A.	The RCC's will determine the need for Dispatcher training in their region.	May 1981	October 19
2.6.A.	The RCC's will determine the need for EMT and DOT Refresher Training Courses in their regions.	May 1981	October 19
2.7.A.	The RCC's will determine the need for Primary Instructors in their regions.	May 1981	October 19
2.8.A.	The RCC's will determine the need for and scope of Advanced Life Support training regionally.		
2.9.B.	The RCC's will determine Emergency and Critical Care nursing training needs regionally.	May 1981	October 19
2.10.C.	The RCC's will identify the need for training of Emergency Department Physicians based upon the skill levels developed in Activity 2.10.A.	May 1981	October 19
2.11.B	EMS Commission trained extricaiton instructors within each extrication service provider organization will conduct training and continuing education programs for all extrication personnel at their organization in cooperation with RCC's.	May 1981	On-Going
2.12.A	The EMS Commission and the RCC's will identify the need for emergency driving training regionally.	May 1981	October 19

TRAINING		START	ATTAIN
2.1.A.	Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.	October 1981	On-Going
2.2.A.	Local affiliates of the ARC, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic First Aid classes, in cooperation with the RCC, to meet the identified needs of the region.	October 1981	On-Going
2.5.B	The RCC will coordinate the provision of Dispatcher training based on the identified need.	October 1981	April 1983
2.6.B.	The EMS Commission approved training institutions, coordinated through the RCC, will conduct EMT and DOT Refresher Courses to meet the identified need.	October 1981	October 1983
2.8.B.	The RCC's will coordinate the regional training activity of Advanced Life Support training institutions to meet the identified need.	October 1981	On-Going
2.9.C.	The RCC's will coordinate the provision of Emergency and Critical Care continuing education programs based on the identified need.	October 1981	April 1983
2.10.D.	The RCC's will coordinate the provision of training programs for Emergency Department Physicians to meet the identified need.	October 1981	July 1983
2.12.B.	The EMS Commission will cooperate with the Law Enforcement Training Academy, the RCC's, and other concerned agencies in conducting Emergency Driving classes to meet the identified needs.	October 1981	July 1983
2.13.C.	The EMS Commission will provide technical assistance to the RCC's to coordinate the provision of Hazardous Material courses regionally.	October 1981	On-Going

COMMUNICATIONS

3.1.A.	The RCC's will recommend, for Commission approval, Regional Medical Communication Centers.	July 1981	October 1981
3.2.A.	The RMCC will coordinate the planning, development and operation of EMS communications systems within the region, in cooperation with the RCC, local hospitals, EMS providers and other appropriate agencies.	January 1982	July 1982

TRANSPORTATION

4.1.A.	The EMS Commission with the RCC's will determine areas currently exceeding the 20 minute response objective.	April 1981	October 1981
4.1.C.	The EMS Commission and the RCC's will assist local units of government and providers in developing methods to improve response times where needed.	April 1981	On-Going

PUBLIC SAFETY AGENCIES

6.1.A.	The RCC, with the Regional Medical Communication Center, will endeavor to coordinate frequencies in the region between public safety agencies and Emergency Medical Service providers.	April 1981	On-Going
6.2.A.	The RCC's will encourage periodic meetings between public safety agencies and EMS providers.	July 1981	On-Going

ACCESS TO CARE

8.1.A.	The RCC's will identify those institutions and agencies in their region that do have written policies pertaining to non-discriminatory access to care.	July 1981	October 1981
8.1.B.	The RCC's will encourage and work with those entities who do not have such policies to develop them.	July 1981	January 1982

TRANSFER OF PATIENTS

9.2.A.	The RCC's will identify those hospitals in their region that do have written transfer protocols.	January 1982	July 1982
9.2.B.	The RCC's will encourage and work with those hospitals that do not have written transfer protocols to adopt them.	July 1982	April 1983

PUBLIC INFORMATION AND EDUCATION		START	ATTAIN
11.2.B.	The RCC's will develop a methodology to address public information and education priorities for each region.	April 1981	July 1981
11.1.A.	Local affiliates of the American Heart Association and the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations, in cooperation with the RCC, will conduct CPR classes to meet the identified needs of the region.	October 1981	On-Going
11.1.B.	Local affiliates of the American Red Cross, local EMS providers, high schools, universities, and various community and civic organizations will conduct basic first aid classes, in cooperation with the RCC, to meet the identified needs of the region.	October 1981	On-Going
DISASTER LINKAGES			
13.2.B.	The RCC's will issue news releases as necessary, to inform the general public of disaster plans, procedures, and drills in their area.	April 1981	On-Going
13.1.A.	The RCC's will identify existing provider, local, county and regional disaster plans.	October 1981	April 1982
MUTUAL AID AGREEMENTS			
14.1.A.	The RCC's will survey EMS providers in their region to identify existing Mutual Aid Agreements.	October 1981	April 1982
14.1.C.	The RCC's will assist EMS providers in adopting Mutual Aid Agreements.	January 1982	April 1983
SYSTEM MANAGEMENT			
15.4.B.	The RCC's will designate regional practical examination teams.	July 1981	October 1981
15.4.C.	The Regional Coordinators and the RCC's will coordinate the administration of practical examinations.	July 1981	On-Going
15.7.B.	The RCC's will determine the regional need for Advanced Life Support utilizing the Advanced Life Support systems manual.	July 1981	On-Going

SYSTEM MANAGEMENT CONTINUED		START	ATTAIN
15.7.C.	The RCC's will coordinate the development of Advanced Life Support systems regionally to meet the identified need in 15.7.B. (NOTE: Advanced Life Support needs assessment may determine that the regions cannot, at that time, support an Advanced Life Support effort.)	October 1981 (If need for ALS	On-Going is determi

V. Implementation Schudule

This section will list the date each activity contained in Section IV will be started, and when each will be completed or attained. Increments in the Implementation Schedule will be quarterly, as follows:

October 1, 1982 to December 31, 1982

January 1, 1983 to March 31, 1983

April 1, 1983 to June 30, 1983

July 1, 1983 to September 30, 1983

The Regional EMS Plan, submitted to the EMS Commission by October 1, 1982, may extend past September 1983 if identified activities warrant it to. Also, since October 1, 1982 is the final date for submission of Regional EMS Plans, an RCC may wish to complete its planning sooner, and begin its implementation schedule on July 1, 1982.

VI. Program Resource and Commitment Summary

This section of the Regional EMS Plan will be in two parts. The first will list each activity of the regional plan and identify who is responsible for and/or involved in its implementation.

The second section of the Program Resource and Commitment Summary will identify all agencies and entities involved in the plan's implementation and list their specific responsibilities, ay activity.

VII. Budget Schedule

Again, each activity of the Regional EMS Plan will be listed. Next to each will be cost for implementation of the activity, both to the responsible entity (-ies) and to the RCC. It should be noted if these monies are committed, or anticipated. If the source of the funding it separate from the RCC or the responsible entity, this should be so noted.

VIII. Appendix (-ies)

Addition data or supplementary material may be appended to the Regional EMS Plan if deemed appropriate.

CONCLUSION

These guidelines have been written to assist you in developing your Regional EMS Plan. They are, however, intended to be just that -- guidelines. They are not intended to be all inclusive, or to be a set of questions that would allow you to write a regional plan by merely responding "yes" or "no". There is the assumption that the staff of each RCC is reasonably familiar with emergency medical services in Indiana, and with the principles of planning. That is how the Regional Coordination Centers were identified.

If at any time questions arise concerning development of the Regional EMS Plan, or its implementation, do not hesitate to contact the EMS Commission office.

COUNTY EMS APPROPRIATION FOR CALENDAR 1980

Adams	$ 130,000	Greene	$ 204,216
Allen	-0-	Hamilton	30,000
Bartholomew	74,655	Hancock	50,000
Benton	40,730	Harrison	102,313
Blackford	RS	Hendricks	-0-
Boone	75,000	Henry	80,000
Brown	38,500	Howard	45,000
Carroll	70,000	Huntington	"Not Available"
Cass	75,000	Jackson	84,000
Clark	80,000	Jasper	56,953
Clay	199,626	Jay	226,000
Clinton	223,295	Jefferson	60,250
Crawford	120,955	Jennings	56,953
Daviess	60,000	Johnson	-0-
Dearborn	3,500	Knox	72,000
Decatur	60,000	Kosciusko	-0-
DeKalb	80,500	LaGrange	96,100
Delaware	366,000	Lake	"Not Available"
Dubuois	60,000	LaPorte	447,714
Elkhart	-0-	Lawrence	-0-
Fayette	78,000	Madison	-0-
Floyd	12,000	Marion	"Not County Function"
Fountain	77,316	Marshall	-0-
Franklin	3,000	Martin	50,250
Fulton	66,434	Miami	60,000
Gibson	342,220	Monroe	112,500
Grant	45,000	Montgomery	-0-

Morgan	$ 2,500	Starke	$ -0-
Newton	18,894	Steuben	-0-
Noble	82,602	St. Joseph	200,000
Ohio	5,000	Sullivan	RS - 60,000
Orange	70,000	Switzerland	25,000
Owen	135,254	Tippecanoe	150,000
Parke	150,862	Tipton	36,000
Perry	25,000	Union	6,000
Pike	189,098	Vanderburgh	-0-
Porter	718,000	Vermillion	75,000
Posey	Sep. Bdgt. - 160,732	Vigo	72,894
Pulaski	88,800	Wabash	46,000
Putnam	90,000	Warren	60,425
Randolph	156,993	Warrick	319,657
Ripley	-0-	Washington	80,000
Rush	30,000	Wayne	120,000
Scott	70,000	Wells	15,000
Shelby	53,280	White	91,800
Spencer	29,000	Whitley	162,456
			$7,812,227

N.B. For various reasons, this list does not include the EMS appropriations of the following counties:

Huntington
Lake
Marion

Also, it should be noted that this list does not represent the total EMS expenses for the State, as a part of the total expenses are offset by collected revenue.

Finally, many cities and towns operate emergency ambulance services and their appropriations are not listed.

SOURCE: Indiana Farm Bureau, County Governmental Statistical Report, 1980

COUNTY EMS APPROPRIATIONS FOR CALENDAR 1981

The following list of county EMS appropriations is from the Indiana Farm Bureau 1981 County Government Statistical Report. Farm Bureau collected data for the report by means of a survey which was sent to all 92 Hoosier Counties. Neither the Emergency Medical Services Commission nor the State Board of Tax Commissioner's accept any responsibility for the accuracy of the information.

Adams	$ 140,000	Gibson	$ 357,120
Allen	0.00	Grant	0.00
Bartholomew	17,500	Greene	221,415
Benton	53,029	Hamilton	108,000
Blackford	3,500	Hancock	55,000
Boone	94,000	Harrison	100,000
Brown	42,350	Hendricks	-0-
Carroll	70,000	Henry	No app. under per ser.
Cass	100,000	Howard	45,000
Clark	80,000	Huntington	"Not Available"
Clay	160,000	Jackson	-0-
Clinton	243,267	Jasper	56,953
Crawford	115,705	Jay	136,550
Daviess	76,000	Jefferson	85,000
Dearborn	14,000	Jennings	75,000
Decatur	60,000	Johnson	-0-
Dekalb (Purch. of Amb. Not incl.)	106,505	Knox	72,000
Delaware	625,998	Kosciusko	-0-
Dubois	60,000	LaGrange	81,000
Elkhart	0.00	Lake	-0-
Fayette	110,000	LaPorte	461,235
Floyd	12,000	Lawrence	-0-
Fountain	89,768	Madison	0.00
Franklin	3,000	Marion	"Not County Agency"
Fulton	71,464	Marshall	-0-

Martin	$ 55,000	Shelby	$ 57,600
Miami	80,000	Spencer	48,110
Monroe	0.00	Starke	183,541
Montgomery	-0-	Steuben	In Sheriff Budget
Morgan	0.00	St. Joseph	201,000
Newton	175,463	Sullivan	60,000
Noble	103,815	Switzerland	20,000
Ohio	5,000	Tippecanoe	247,400
Orange	-0-	Tipton	36,000
Owen	73,160	Union	10,000
Parke	-0-	Vanderburgh	0.00
Perry	25,000	Vermillion	100,000
Pike	199,996	Vigo	30,000
Porter	1,000,000	Wabash	50,000
Posey	187,121	Warren	80,725
Pulaski	94,800	Warrick	486,387
Putnam	86,000	Washington	80,000
Randolph	171,210	Wayne	136,000
Ripley	100,000	Wells	10,000
Rush	36,000	White	86,000
Scott	70,000	Whitley	188,202
			$ 8,784,889

N.B. For various reasons, The County Governmental Statistical Report, did not include the EMS appropriations for the following counties:

Henry
Huntington
Marion
Steuben

Also, it should be noted that this list does not represent the total EMS expenses for the State, as a part of the total expenses are offset by collected revenue.

Finally, many cities and towns operate emergency ambulance services and their appropriations are not listed.