



**COMMONWEALTH OF MASSACHUSETTS  
DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HEALTH CARE QUALITY  
99 CHAUNCY STREET, 2<sup>ND</sup> FLOOR  
BOSTON, MA 02111-1212**

**Application for Licensure of a Medical Control Service**

*Responses to this application for licensure of the Medical Control Service will be used to assess your facility's compliance with regulatory requirements. Following receipt and review of the completed application a Department representative may contact the hospital to review the application, if necessary. **Instructions:** If the hospital plans to provide Medical Control Services at more than one campus, please complete a separate application for each location. Please refer to the enclosed regulations and definitions to assist you in completing this application. If the hospital does not intend to provide Medical Control Services please sign and only return Page 7 of the application.*

**Hospital Name** \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Campus Name** \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Hospital Contact Person**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Please identify annual Medical Control Service volume**

Calendar years:

2005 \_\_\_\_\_

2006 \_\_\_\_\_

## Application for Licensure of a Medical Control Service

*Please answer the following questions regarding the Medical Control Service.*

*Refer to the enclosed regulations and definitions to assist you.*

*If the response to any question is "No", please explain.*

	QUESTION	COMMENTS
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the hospital have an affiliation agreement with each ambulance service to which the hospital has agreed to provide medical control that meets the requirements of 105 CMR 170.300.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Is on-line medical direction available 24 hours a day, seven days a week to all services with which the hospital has an affiliation agreement.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the hospital maintain operational communications equipment and participate in communications plan development, where appropriate, in compliance with the Massachusetts Emergency Medical Services Radio Communications Plan.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Is all field communication of emergency on-line medical direction recorded by CMED, at the hospital, or by other means. Please indicate the means for recording in the "Comments" column.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Is a process for skill maintenance and review available to Emergency Medical Service (EMS) personnel employed by the service(s) with which the hospital has affiliation agreement(s).	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Are remedial training opportunities provided in the hospital emergency department and in operating rooms or skill laboratories, for remediation and education of all pertinent EMS skills and practices, including but not limited to, advanced airway management.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the hospital have a quality assurance/quality improvement (QA/QI) program including, but not limited to, regular review of trip records and other statistical data pertinent to the operation of the service(s) with which the hospital has affiliation agreement(s), in accordance with the hospital's QA/QI standards and protocols, in those cases in which Advanced Life Support (ALS) services were provided, or in which ALS staff established direct patient contact.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the hospital make available to the hospital's emergency department physicians and nurses and the EMS personnel employed by the service(s) with which the hospital has affiliation agreement(s), access to morbidity and mortality rounds and chart reviews at a frequency specified in the affiliation agreement.	

## Application for Licensure of a Medical Control Service

*Please answer the following questions regarding the Medical Control Service.  
Refer to the enclosed regulations and definitions to assist you.  
If the response to any question is "No", please explain.*

	QUESTION	COMMENTS
Yes <input type="checkbox"/> No <input type="checkbox"/>	Are policies and procedures provided through which the ambulance service may obtain medications from the hospital's pharmacy.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Is an Affiliate Hospital Medical Director (AHMD) designated.	<hr style="width: 100%;"/> Name of Affiliate Hospital Medical Director
Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Affiliate Hospital Medical Director board-certified in emergency medicine.	If the AHMD is not board certified in emergency medicine, please describe qualifications:
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the hospital ensure that the affiliate hospital medical director performs the duties specified in 105 CMR 130.1503, and meets the requirements set forth in 105 CMR 130.1504.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does each physician who provides on-line medical direction, including the affiliate hospital medical director, meet the following standards:  Current medical staff appointment and privileges to practice as a physician in the hospital's Emergency Department.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does such credentialing include demonstration of the following: <ol style="list-style-type: none"> <li>1. Education for proper provision of on-line medical direction, as evidenced by:               <ol style="list-style-type: none"> <li>(a) Successful completion of an Emergency Medicine residency program, or</li> <li>(b) Previous training and experience in medical direction.</li> </ol> </li> <li>2. Proficiency in the clinical application of the current EMS pre-hospital Statewide Treatment Protocols.</li> <li>3. Proficiency in EMS radio communications.</li> </ol>	

# Application for Licensure of a Medical Control Service

## List of Application Documents

**Please attach the following documents to the application and number each corresponding attachment:**

1. The name and address of each EMS (ambulance or emergency first response) Service with which the hospital has an affiliation agreement to provide medical control.
2. ED medical staff coverage schedules for medical direction 24 hours a day, seven days a week to all EMS (ambulance or emergency first response) Service(s) with which the hospital has an affiliation agreement (one month schedule as worked and one month projected schedule).
3. The names and qualifications of physicians who provide on-line medical direction pursuant to the affiliation agreement and the requirements set forth in 105 CMR 130.1504; (use attached DPH form for physician list)
4. A copy of the curriculum vitae of the affiliate hospital medical director.

**Please attach a concise narrative description of the following: (no more than one page per item)**

5. The process for skill maintenance and review for Emergency Medical Service (EMS) personnel employed by the EMS service(s) with which the hospital has affiliation agreement(s).
6. The process for remedial training opportunities in the hospital emergency department and in operating rooms or skill laboratories, for remediation and education of all pertinent EMS skills and practices, including, but not limited to, advanced airway management.
7. The quality assurance/quality improvement (QA/QI) program that includes, but is not limited to, regular review of trip records and other statistical data pertinent to the operation of the service(s) with which the hospital has an affiliation agreement(s), in accordance with the hospital's QA/QI standards and protocols, in those cases in which Advanced Life Support (ALS) services were provided or in which ALS staff established direct patient contact.
8. The process to ensure the hospital makes available to the hospital's emergency department physicians and nurses and the EMS personnel employed by the service(s) with which the hospital has affiliation agreement(s), morbidity and mortality rounds and chart reviews at a frequency specified in the affiliation agreement.
9. Protocols through which the EMS service may obtain medications from the hospital's pharmacy.
10. The methods to ensure that all on-line medical direction is in conformance with the EMS pre-hospital Statewide Treatment Protocols.
11. The orientation outline for physicians who provide on-line medical direction pursuant to the affiliation agreement, including but not limited to information regarding local EMS providers and point-of-entry plans.

# Application for Licensure of a Medical Control Service

## Attestation of the Affiliate Hospital Medical Director

### ***As the Affiliate Hospital Medical Director I attest that I:***

- (A) Provide oversight to, and ensure the clinical competency of, the EMS personnel employed by the service(s) with which the hospital has affiliation agreement(s), including, but not limited to, the following:
  - (1) Authorization to practice;
  - (2) Remedial education to those EMS personnel found to be deficient in clinical practice; and
  - (3) Notification to the Department of Public Health within 48 hours of any instance in which I suspend, revoke, or restrict in any manner the authorization to practice for an affiliate EMS service's Emergency Medical Technician (EMT) or EMS First Responder (EFR). Such notice will include the reason(s) for the suspension or revocation, and the remediation plan for the EMT or EFR.
- (B) Ensure that all on-line medical direction is in conformance with the EMS pre-hospital Statewide Treatment Protocols;
- (C) Provide appropriate orientation to all physicians who provide on-line medical direction pursuant to the affiliation agreement(s), including but not limited to information regarding local EMS providers and point-of-entry plans;
- (D) Coordinate the QA/QI program described in 105 CMR 130.1502(J) with the participation of the hospital's on-line medical direction physicians and the service medical director, if different from the affiliate hospital medical director;
- (E) Provide information requested by an EMS Regional Medical Director to enable him or her to monitor the hospital's affiliation agreements; and
- (F) Maintain appropriate skills and knowledge through continuing education and am Board certified in emergency medicine by ABEM or AOBEM.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

## Application for Licensure of a Medical Control Service

Please use additional copies of this form as necessary.

List Names of Affiliate Hospital Medical Director and all physicians who provide on-line medical direction				
Last date of appointment or reappointment to medical staff				
MD license number				
MD license expiration date				
Successfully completed an emergency medicine residency program?				
Board Certified Emergency Medicine?				
Other Board certification? Specify.				
Training and experience in medical direction?				
Proficiency in the clinical application of the current EMS pre-hospital Statewide Treatment Protocols?				
Proficiency in EMS radio communications?				

I attest that this information is accurate and true.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME (Printed or typed) \_\_\_\_\_

TITLE \_\_\_\_\_

# APPLICATION FOR LICENSURE OF A MEDICAL CONTROL SERVICE

Hospital Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

The undersigned **REQUESTS** licensure of the Medical Control Service as defined in 105 CMR 130.1501 (see attached definitions), and attests that the information contained in this application and attached materials is accurate and true.

Chief Executive Officer or Designee Signature \_\_\_\_\_

Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

The undersigned **DOES NOT REQUEST** licensure of the Medical Control Service as defined in 105 CMR 130.1501 (see attached definitions).

Chief Executive Officer or Designee Signature \_\_\_\_\_

Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_

Title \_\_\_\_\_

**Please return the completed Application and applicable attachments to the Department of Public Health by March 2, 2007. Mail the documents to:**

Mr. Dennis Corbett  
Massachusetts Department of Public Health  
Division of Health Care Quality  
99 Chauncy Street, 2<sup>nd</sup> Floor  
Boston, MA 02111