**Application for Approval as a**

**CERTIFIED EMERGENCY MEDICAL DISPATCH RESOURCE**

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| **Mail Completed Application to:** | STATE 911 DEPARTMENT  151 Campanelli Drive, Suite A  Middleboro, MA 02346  ATTN: EMD PROGRAM |

**Date Application Submitted: **

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| **New Application**  *(Complete ALL SECTIONS of this application)* | **Change Application** (Please check one below)  ***Change in Location of EMD Center/Change in 911 Equipment***  *(Complete SECTIONS 1 and 2 of this application)*  ***Addition of a New PSAP*** *(Complete ALL SECTIONS)* |

**SECTION 1: Applicant Information**  
**Type of Entity:**

Primary PSAP

Regional PSAP

Regional Emergency Communications Center (RECC)

Wireless State Police PSAP

Secondary PSAP *(Not operated by a Private Safety Department)*

Limited Secondary PSAP *(Not operated by a Private Safety Department)*

Regional Secondary PSAP *(Not operated by a Private Safety Department)*

Secondary PSAP *(Operated by a Private Safety Department)*

Regional Secondary PSAP *(Operated by a Private Safety Department)*

Limited Secondary PSAP *(Operated by a Private Safety Department)*

Name of Entity/Applicant 

Street Address  City  Zip Code 

Mailing Address (if different)  City  Zip Code 

Contact Name  Email Address 

Business Phone  Business Fax 

Licensed by OEMS, if applicable:  **YES** *(Attach license to application)*  **NO**

**SECTION 2: EMD Program Information**

Emergency Medical Dispatch Protocol Reference System (EMDPRS) To Be Used:

APCO  PowerPhone  Priority Dispatch

Description of EMD Quality Assurance Program (Attach description/policy):





EMD Quality Assurance Case Review Process:  Record 911 Calls  Alternative Method (Attach description)





Location(s) where EMD will be provided (if different from street address listed in Section 1):



Description of the 911 Equipment to be used:



Number of Call Taking Positions:  ANI/ALI Displays Used:  **YES  NO**

Number of 911 Trunks 

Description of Method Used to Provide Patient Updates to First Responders En Route to Scene:





**If the certified EMD resource is/will be providing more than one municipality with EMD**

Please provide a list of the municipalities you are contracted with. Also, provide the annual medical (EMS) call volume broken down by day of week and hour of day.

**SECTION 3: Emergency Medical Dispatcher Information**

*Please complete the section below for* ***EACH*** *Emergency Medical Dispatcher working for your entity. Please include either* ***a completion date*** *or an* ***anticipated completion date for each certification.***  *Use additional sheets as necessary.*

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| **LAST NAME** | **FIRST NAME** | **CPR Certification** | **EMD Certification** |
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Each EMD Dispatcher is meeting / will meetthe enhanced 911 telecommunicator requirements as set forth in 560 CMR 5.08 or 560 CMR 5.04.  **YES  NO**

**SECTION 4: Affiliation with PSAP**

*This section acknowledges the affiliation the Applicant will have with the PSAP. The PSAP for which EMD will be provided must complete this section.*

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| **To Be Completed by PSAP for which EMD will be Provided**  Name of PSAP  PSAP Contact Name  Email Address  Business Phone  Business Fax  **The PSAP indicated above has requested that the Applicant serve as its certified EMD Resource:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorized Signatory for PSAP Date : |

**SECTION 5: Acknowledgments/Certifications of Applicant**

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| **To Be Completed by Applicant**  I hereby acknowledge that the Applicant will serve as the certified EMD resource for 911 calls that are routed to the PSAP as the alternate PSAP.  I hereby further acknowledge that the cost of equipment may not be covered by State 911 Department grant programs.  I hereby certify that the foregoing information is true and correct to the best of my knowledge and belief.  I understand that records disclosed to the State 911 Department may be or may become a public record and may not be protected from disclosure by law.  Name of Applicant  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorized Signatory for Applicant Date: |