Commonwealth of Massachusetts
Massachusetts State 911 Department
* 151 Campanelli Dr * Middleboro, MA * 02346 *
* Phone: 508-828-2911 * Fax: 508-828-2585 * www.mass.gov/e911 *

Application for Approval as a

CERTIFIED EMERGENCY MEDICAL DISPATCH RESOURCE

Mail Completed Application to:

STATE 911 DEPARTMENT
151 Campanelli Drive, Suite A
Middleboro, MA 02346
ATTN: EMD PROGRAM

Date Application Submitted: _____

☐ **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**

For assistance or questions, please contact Charles Ashworth at 508-821-7301 or by email at EMD911@state.ma.us.

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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.

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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.*

LAST NAME	FIRST NAME	CPR Certification	EMD Certification

Each EMD Dispatcher is meeting / will meet the enhanced 911 telecommunicator requirements as set forth in 560 CMR 5.08 or 560 CMR 5.04. ☐ **YES** ☐ **NO**

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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.

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

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: _____

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