State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

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State Office of Commercial Ambulance Licensing & Regulation
653 West Pratt Street, Room 313
Baltimore, Maryland 21201-1528
O: (410) 706-8511 • FAX: (410) 706-8552

TO: Maryland Commercial Air Ambulance Services

FROM: Jeffrey B. Sexton, CCEMT-P, NRP
Director, SOCALR

DATE: April 1, 2016

SUBJECT: License Renewal

Enclosed is your annual renewal application. Please carefully read the instructions and complete all areas, ensuring that you have submitted all required information and documents. The fee schedule for the 2016-2017 licensing period (FY2017) is also enclosed in your annual renewal packet. It was not necessary to increase the licensing fees for the upcoming fiscal year, so air ambulance license fees will remain unchanged at $880 annually. Please submit a check in the appropriate amount payable to SOCALR. As a reminder, we have the ability to accept Visa and MasterCard payments. If you would like to take advantage of this convenience, please contact Ms. Michelle Bell at 410.706.3666.

Enclosed is a list of aircraft and base stations. Please verify that this list remains current and indicate any changes. You should also use this time as an opportunity to ensure that you have submitted affiliation paperwork for all of your current EMS provider employees, disaffiliated any who are no longer with your organization, and ensure maintenance of accurate personnel health and training records.

In accordance with §10-226 of the State Government Article and COMAR 30.09.05.03A, renewal applications need to be received no later than 14 calendar days prior to license expiration. Applications received after the close of business (16:30 hrs) on June 17, 2016, will not be processed until after June 30, 2016. This in turn will result in the company being out of service until we can process the application, schedule the inspection, and re-license the service and vehicles.

Encl: Renewal Application
FY 2017 Fee Schedule
Aircraft and Base Station List

IMPORTANT

**********Payment Changes**********

If you are paying by check, you must mail your check to the following address:

MIEMSS/SOCALR
P.O. Box 17684
Baltimore, MD 21297-1684

SOCALR is no longer able to accept payment in-person; you must mail all payments to the above address.

Applications (without funds) may still be forwarded to SOCALR directly via facsimile or mail.

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Office of Commercial Ambulance Licensing & Regulation
653 West Pratt Street
Baltimore, MD 21201-1536
Office: (410) 706-8511 - Fax: (410) 706-8552

Commercial Air Ambulance Services

Annual Renewal & Inspection Application Packet

Company Name:

For Office Use Only

Date Application Received ___/___/___

Date Licenses Issued ___/___/___

CAREFULLY READ THE INSTRUCTIONS AND COMPLETE ALL AREAS.
Ensure all boxes are checked and the required documents are included with the application submission.

DEADLINE:

- Submit the application by NO LATER THAN **June 17, 2016** (close of business)

MAILING ADDRESS *(Application ONLY)*:

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

PAYMENT METHODS:

- **CHECK**
  - Check should be made payable to "SOCALR"
  - If you are paying by **CHECK**, you MUST mail your **CHECK** to the following address:

MIEMSS/SOCALR
P.O. Box 17684
Baltimore, MD 21297-1684

** CHECKS WILL NOT BE ACCEPTED OR PROCESSED IF SENT TO THE MIEMSS/SOCALR OFFICE**

- **CREDIT CARD**
  - Please contact:

Ms. Michelle Bell, Office Manager
Education & Certification Office
Phone: (410) 706-3666

CAREFULLY READ THE INSTRUCTIONS AND COMPLETE ALL AREAS.

Ensure all boxes are checked and the required documents are included with the application submission.

SUBMIT THE REQUIRED INFORMATION AND DOCUMENTS: *Check if COMPLETE*

- ☐ Completely answer all questions
- ☐ Sign and date the Certification on the last page
- ☐ Submit the original application electronically
- ☐ Submit legible copies of Governmental Identification for all those listed on application
- ☐ Submit a copy of the check or certified check/money order, or make credit card payment in the correct amount
- ☐ Submit completed application along with the following attachments:
- ☐ **Signed Medical Director Agreement.** Your company and the medical director must engage in a Medical Director Agreement. This document must be signed by the EMS operational program medical director acknowledging the responsibilities required under COMAR Title 30. A copy of this agreement is attached to this packet.
- ☐ **Documentation from the Maryland Department of Assessments and Taxation:**
    a) All documents that verify the commercial ambulance service is registered in accordance with the Corporations and Associations Article, Annotated Code of Maryland and is in good standing with the Maryland Department of Assessments and Taxation
    b) All trade names recorded with the Maryland Department of Assessments and Taxation for this business entity, and if this business entity is a subsidiary, all trade names or names of all other subsidiaries recorded with the Maryland Department of Assessments and Taxation for the parent organization.
- ☐ **Certificates of insurance for:**
    a) **General Liability** greater than or equal to $1 million for each occurrence of bodily injury liability and $100,000 for each occurrence of property damage liability
    or
    General Liability equal to $1 million for each occurrence of combined bodily injury and property damage liability
    b) **Worker's compensation** insurance coverage, unless exempt, in the amount required by State worker's compensation statutes and regulations.
- ☐ **Copy of CAMTS accreditation certificate or letter.** Must indicate: a) mode of transport; b) patient type; and c) level of services.
- ☐ **Medical Review Committee Worksheet**. Complete the worksheet provided in the application and ensure names are placed in the proper designation. A Medical Review Committee is required in accordance with COMAR 30.03.04.03. It is the duty of the Medical Review Committee to carry out the quality assurance plan with the participation of the EMS operational program medical director.
- ☐ Current temporary or permanent motor vehicle registration certificates for each vehicle to be licensed.
- ☐ Name ALL proprietors/partners/owners and management personnel within the company.
- ☐ List ALL current or former trade names registered with the Maryland Department of Assessment and Taxation.
- ☐ List ALL addresses relevant to the company business including where vehicles will be stored, if different from the main office, and any other office locations.
- ☐ Ensure all current personnel are appropriately affiliated with your service.
- ☐ Review Fee Schedule and enclose check with appropriate amount.
- ☐ Sign and date the Application

COMPANY INFORMATION

Name of Commercial Air Service (*registered with the Maryland DAT*):

*SOCALR may **not** issue a license to an applicant whose name is confusingly similar to another doing business in Maryland*

Type of Services Performed: (check more than one box is applicable)

☐ Rotor Wing (RW) ☐ Fixed Wing (FW)

☐ Advanced Life Support (ALS) Service ☐ Specialty Care Transport (SCT) Service ☐ Neonatal Service

Principle Physical Business Address

Name and Title of Contact Person:	Office Telephone Number:	Cell Telephone Number:
Street Address:		Suite/Apt. Number:
City, State, Zip Code:		Fax Number:

Mailing Address

Street Address:	PO Box or Suite Number:
City, State, Zip Code:	

Business Identification:

☐ Sole Proprietorship
☐ Corporation
☐ Limited Partnership
☐ General Partnership
☐ Joint Venture
☐ Other, please describe: _____

Medicaid Number:	Medicare Number:
CLIA Number (if applicable) : ****MUST ATTACH COPY OF WAIVER ISSUED****	Federal Tax Identification Number:

Resident Agent		
Name of Resident Agent (RA) on file with the Charter Division of Maryland Department of Assessments and Taxation:		
Street Address:		City, State, Zip Code:
RA Phone Number:	RA Cellphone Number:	RA Email Address:

Trade Names *List ALL current names registered with the Maryland Department of Assessment and Taxation.* *Attach additional pages if necessary.*	
1.	2.
3.	4.
5.	6.

Physical Locations *Provide the physical address for each location the air ambulance service intends to operate, including, where aircraft are based, records are kept, supplies are stored, crews are quartered, or from where aircraft are dispatched.*	
1. Street Address: City, State, Zip Code:	Location Use:
2. Street Address: City, State, Zip Code:	Location Use:
3. Street Address: City, State, Zip Code:	Location Use:
4. Street Address: City, State, Zip Code:	Location Use:
5. Street Address: City, State, Zip Code:	Location Use:
6. Street Address: City, State, Zip Code:	Location Use:

Have you, any of the principals, owners, operators, managers, or any person in this application ever been **suspended from Medicare or Medicaid, indicted for or convicted of Medicare or Medicaid fraud or any other crime?**

☐ No ☐ Yes

If yes, attach an additional sheet that includes: person's name, title, and details of the event.

Denied or Revoked: Have you, any of the principals, owners, operators, managers, or any person in this application ever owned, operated or had a financial interest (directly or indirectly) in any application or license for any Taxi, Limo, Ambulette, Invalid Coach, Mobility Assistance Vehicle, BLS Ambulance, ALS Ambulance or Other Health Care Service or any other business which was denied, revoked, suspended, under indictment for or convicted of Medicare and/or Medicaid fraud or any other crime?

☐ No ☐ Yes

If yes, attach an additional sheet that includes: person's name, title, address of the service and details of the event.

Management & Officers

Attach additional pages if necessary.

Owner:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:
Name and Title:	Primary Telephone Number:	Email Address:

Medical Director		
Name: (Last, First)		Maryland Physician License #: ****MUST ATTACH COPY OF LICENSE****
Address:		Federal DEA License #: ****MUST ATTACH COPY OF LICENSE****
City, State, Zip Code:		Email Address: ****REQUIRED****
Telephone Number:	Cell Telephone Number:	Fax Number:
Has the Medical Director approved and signed the Medical Director Agreement? ☐ No ☐ Yes ****MUST BE ATTACHED****		
Associate Medical Director *(if applicable)*		
Name: (Last, First)		Maryland Physician License #: ****MUST ATTACH COPY OF LICENSE****
Address:		Federal DEA License #: ****MUST ATTACH COPY OF LICENSE****
City, State, Zip Code:		Email Address: ****REQUIRED****
Telephone Number:	Cell Telephone Number:	Fax Number:
Has the Medical Director approved and signed the Medical Director Agreement? ☐ No ☐ Yes ****MUST BE ATTACHED****		

Aircraft List – Rotor Wing *(Provide information only on those aircraft that routinely operate in Maryland.)*				
Designation Number:	Make/Model:	Serial Number:	FAA Number:	Location
1.				
2.				
3.				
4.				
5.				
6.				
7.				
Aircraft List – Fixed Wing *(Provide information only on those aircraft that routinely operate in Maryland.)*				
Designation Number:	Make/Model:	Serial Number:	FAA Number:	Location
1.				
2.				
3.				
4.				
5.				

Owner/Operator Certification

By my signature below I hereby affirm under the penalties of perjury that;

(a) There has been no attempt for the purpose of obtaining or attempting to obtain a license, to knowingly and willfully:

(i) Falsify, conceal, or omit a material fact,

(ii) Make any false, fictitious, incomplete, or fraudulent statements or representations,

(iii) Make or use any false writing document, or entry knowing the same to contain any false, fictitious, fraudulent statement, and

(b) The signer is authorized by the commercial ambulance service identified on the application to sign the application form to execute the sworn statement.

Name of Applicant: (Last, First)	Title:
Signature:	Date:

MEDICAL DIRECTOR AGREEMENT

I, the undersigned physician, acknowledge that I have received and reviewed copies of the: (a) Commercial Ambulance Services regulations (COMAR 30.09); (b) Emergency Medical Services Operational Programs regulations (COMAR 30.03) and; (c) "Maryland Medical Protocols for Emergency Medical Providers", which is a document incorporated by reference in Title 30. I further attest that I meet the qualifications of an EMS Operational Program Medical Director as stated in COMAR 30.03.03.03B and agree to serve as Medical Director for

_____ upon its licensure as a(n) AIR

(Name of ambulance service)

commercial ambulance service in accordance with the requirements of COMAR 30.09.

Furthermore, I agree to assume the following physician responsibilities as outlined in COMAR 30.03.03, including:

(a) Medical oversight of patient care, (COMAR 30.03.03C (1) (a)).
(b) Approve, participate in and provide medical expertise for the commercial ambulance service in:
  (i) A comprehensive quality assurance plan covering all aspects of EMS patient care (COMAR 30.03.03C(1)(b)(i));
  (ii) Standard operating procedures for the EMS operational program under the "Maryland Medical Protocols for Emergency Medical Providers" (COMAR 30.03.03C(1)(b)(ii));
  (iii) Credentialing of EMS providers (COMAR 30.03.03C(1)(b)(iv));
  (iv) Review and approval of medical equipment used by the commercial ambulance service (COMAR 30.03.03C(1)(b)(v)); and
  (v) All aspects of the commercial ambulance service operations which impact patient care, including planning, development and operations (COMAR 30.03.03C(1)(b)(vi)).
(c) Timely approval of applications to MIEMSS for licensure and certification and renewal of licensure and certification for all EMS providers affiliated with the above named commercial ambulance service, (COMAR 30.03.03C91)(c)).
(d) Provider training including:
  (i) remedial and continuing educational programs (COMAR 30.03.03C(1)(iii)); and
  (ii) skills review which meets the provider recertification and relicensing requirements (COMAR 30.09.07.02E(2)).
(d) Review patient care disciplinary matters concerning EMS providers working for the commercial ambulance service. (COMAR 30.03.03C(1)(d)).

I agree to notify the State Office of Commercial Ambulance Licensing and Regulation of any change in address or telephone number and to notify the State Office of Commercial Ambulance Licensing immediately upon termination of my status as Medical Director for the above named service, as required in COMAR 30.09.

I acknowledge that all medical direction to the EMS providers of the above named commercial ambulance service, shall be in accordance with the "Maryland Medical Protocols for Emergency Medical Services Providers" (COMAR 30.03.03.02).

Printed Name of Medical Director:	Date:
Signature:	
Maryland Physician License #: ****MUST ATTACH COPY OF LICENSE****	Federal DEA License #: ****MUST ATTACH COPY OF LICENSE****

MEDICAL REVIEW COMMITTEE WORKSHEET	
Please complete what is applicable to your company. (PRINT or TYPE). The chairperson must be the Medical Director or ALS coordinator for an ALS company. An EMT-B may be used for a BLS company.	
Company Name:	**License #:**

Chairperson of MRC:	Contact #:
Title:	Email Address:
Signature:	

Medical Director:	Contact #:
Signature:	Email Address:

Quality Assurance Officer:	Contact #:
Signature:	Email Address:

Paramedic:	Contact #:	Email Address:
CRT:	Contact #:	Email Address:
EMT:	Contact #:	Email Address:
EMR:	Contact #:	Email Address:
RN:	Contact #:	Email Address:
Dispatcher:	Contact #:	Email Address:

Use additional pages if necessary.

The Medical Director MUST be present and an active member of a Medical Review Committee meeting.