



# Emergency Medical Services (EMS) Systems Emergency Medical Dispatch Agency Certification Application

Dispatch Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ ZIP Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_ EMS System Name: \_\_\_\_\_

EMS System Number: \_\_\_\_\_ Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ ZIP Code: \_\_\_\_\_

(EMSMD or EMSC)  
Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## INSTRUCTIONS

1. For an Emergency Medical Dispatch Agency to join an EMS System, please complete this application for submission to the EMS System. *Incomplete applications will be returned to the EMS System.*
2. All applications must be signed by the EMS System Medical Director, EMS System Coordinator, and Emergency Medical Dispatch Agency representative.
3. Please provide information on the application or attach additional pages as needed.
4. Please submit three completed copies, three-hole punched.





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1. Name and County of your 911 Emergency Telephone Services Board(s).
2. Name and contact information of your 911 Coordinator(s).
3. Include (attach) a map of the geographical area served by your agency; include area's with 911 service and/or seven-digit emergency contact numbers.
4. Provide the approximate population of the geographical area served by your dispatch agency?
5. Complete the attached EMD Employee Roster (Staffing) form ensuring the Illinois Department of Public Health certification numbers and expiration dates are included for each EMD Staff member. Attach a copy of a one-month staffing schedule.
6. Name of your Emergency Medical Dispatch Priority Reference System (EMDPRS).
7. List the entities your agency provides telecommunications for, such as any Sheriff, Police and Fire Departments, EMS agencies, and First Responders.
8. Describe the types of service your dispatch agency provides and the level of the operations, e.g. enhanced 911, basic 911, computer aided dispatch (CAD), computerized mapping, call forward, or call relay, etc.
9. Describe how your agency manages calls in the event of a call surge or Public Service Answering Point (PSAP) equipment failure, e.g. back-up PSAP, multiple PSAP, etc. (Attach a copy of your policy if you have one already in place).
10. Provide a sample of the documentation/record that is completed for each request for medical assistance as a result of handling a 911 EMD call.

11. (Your agency will need to work with the system to accomplish this)

Provide documentation that demonstrates the establishment of a continuous quality improvement (CQI) program under the approval and supervision of the EMS Medical Director. (Section 3.70 (b) (10) of the act the CQI program shall include, at a minimum the following:

- a. A quality assistance (assurance) review process used by the EMD agency to identify EMD compliance with the protocol.
- b. Random case review;
- c. Regular feedback of performance results to all EMDS;
- d. Availability of CQI reports to the Department upon requests; and
- e. Compliance with the confidentiality provisions of the Medical Studies Act [735 ICLS 5/8-2101].

## 12. Be Advised:

**A person, organization, or government agency may not represent itself as an Emergency Medical Dispatch Agency unless the person, organization, or government agency is certified by the Department as an Emergency Medical Dispatch Agency (Section 3.70 (b) (12) of the Act.**



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## EMERGENCY MEDICAL DISPATCH AGENCY AGREEMENTS

- A. We agree to allow the Department (IDPH), the EMS Medical Director or his designee, access to all records relating to the EMS System during any inspection, investigation or site survey to determine compliance with the EMS System Program Plan.
- B. We agree to follow the approved Emergency Medical Dispatcher Priority Reference System (EMDPRS) protocols as approved by the EMS Medical Director.
- C. We agree to follow the criteria established for Emergency Medical Dispatchers as outlined by the Emergency Medical Services (EMS) Systems Act (210 ILCS 50) Section 515.710 Emergency Medical Dispatcher and its components for Emergency Medical Agency Certification (Paragraph) (e).

Agency Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Notes or Comments:

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**EMS System Approval:** I have reviewed this application and verify this agency meets the protocol and staffing requirements of the EMS Systems Act and our EMS System Plan for the requested Emergency Medical Dispatch Agency Certification.

EMS System Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EMS Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Regional EMS Coordinator Review and Recommendation:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approve     Deny     Discuss with me

REMSC Notes or Comments:

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Number: \_\_\_\_\_

