Emergency Services Supervisory Organization (ESSO)

Contents:

In order to process your request:

Mail your application and other documents to:

EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Emergency Services Supervisory Organization (ESSO)

When your application for Emergency Services Supervisory Organization (ESSO) is received by the Department of Health, it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

Indicate type of application—new, change of ownership, amended or renewal.

☐ **Indicate type of application- new, change of ownership, amended or renewal.**

- **New**—First time requesting approval as an Emergency Services Supervisory Organization (ESSO).
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of the Emergency Services Supervisory Organization (ESSO).
- **Amended**—Request the addition or elimination of information about the Emergency Services Supervisory Organization (ESSO).
- **Renewal**—Renew approval as an Emergency Services Supervisory Organization (ESSO).

☐ **Organization Type**: Please check the one organization that best applies to your organization.

☐ **1. Demographic Information:**
Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Mailing Address: Enter the organization's complete mailing address including city, state, zip code and county.

Physical Address: Enter the organization's physical street location including city, state, zip code and county.

Phone and Fax Numbers: Enter the organization's phone and fax number.

Email and Web Address: Enter the organization's email and service web addresses, if applicable.

☐ **2. Contact Information:**
Enter the name, phone number, and e-mail address of the EMS contact person. Include a Washington State credential number, if applicable.

☐ **3. Medical Oversight:**
Enter name of the County Medical Program Director and provide the name of the physician MPD-delegate if your organization has one.

☐ **4. Applicants Organization's Operations:**

On a separate attachment provide the information requested regarding the organizational plan.

☐ **5. EMS Personnel Information:** Indicate your EMS Service staffing model, see definitions below.

Paid: All staff are compensated

Volunteer: All staff are volunteer

Combination: A combination of any of the following:

Some staff are paid

Some staff are volunteer and receive some form of nominal compensation

Some staff are volunteer and receive no compensation

☐ **6. Level of Service and Hours of Operation:**

Enter the level of service provided, provide hours of operation. On a separate sheet provide the hours of operation for each EMS level of service provided by the organization

☐ **7. Applicant Organization's Personnel Credential Information:**

On a separate attachment provide the information requested regarding the organization's EMS personnel. Include full or part-time personnel.

☐ **8. Statements and Signatures:**
The organization's representative must read the affirmation statement thoroughly to ensure the provisions of this section are understood. Then, print and sign name and enter the date.

You may obtain information for your local council by contacting your local EMS system or the Regional EMS and Trauma Care Council administrator. A link is provided below which will allow you to determine which region your county is in and the other to provide you with regional council contact information.

Regional Map: **http://www.doh.wa.gov/hsqa/emstrauma/download/desigmap.pdf**

Regional Administrator: **http://www.doh.wa.gov/hsqa/emstrauma/regional.htm**

Washington State Department of HEALTH

Date Stamp Here

Emergency Services Supervisory Organization (ESSO) Application

This is for: ☐ New Application ☐ Renewal ☐ Change of Ownership ☐ Amendment

If renewal, change or amended, provide credential number:

Level of Care: (Check only one) ☐ BLS ☐ ILS ☐ ALS

Organization Type: (Check **one** that best applies to your organization.)

Law Enforcement:

County ☐ Municipal ☐ State Patrol ☐ Federal ☐

Search and Rescue: ☐ **Disaster Management Organization** ☐
(Application must include letter of endorsement from the county Sheriff's department or DEM representative.)

Business with Industrial Safety Team (exclusively on company property.) ☐

Diversion Center ☐ **Ski Patrol** ☐

1. Demographic Information

UBI #:		Federal Tax ID (FEIN) #:	
Applicant Organization Name: (Business name advertised on signs or web site.)			
Mailing Address:			
City:	State:	Zip Code:	County:
Physical Address: (If different from mailing address.)			
City:	State:	Zip Code:	County:
Phone (enter 10 digit #):		Fax (enter 10 digit #):	
Email Address:			
Web Address:			

2. Contact Information

EMS Service Supervisor:	Business Phone (enter 10 digit #):
WA State Credential number: (if applicable)	Alternate Phone (enter 10 digit #):
Email Address:	

3. Medical Oversight

Name of EMS County Medical Program Director:	Name of EMS MPD-Delegate: (if applicable)

4. Applicant Organization's Operation

Provide an operations plan that describes in detail the following:

1. Describe the mission of the organization. Include the hours of operation and any additional information that will help us understand the business model and why the organization needs certified EMS personnel on site. Include reasons for an increased level of patient care for injured employees above the level of Labor and Industry requirements defined in WAC 296-307-03905.

2. Describe how the organization will use certified EMS providers and what type of medical activities they will be performing.

3. Describe how the certified EMS providers working for the organization are notified of a patient on site.

4. Describe how and when 911 will be contacted and the criteria for which 911 will be contacted.

5. Describe how coordination with local EMS responding to an emergency occurs. Include a description of any barriers or restrictions that EMS services responding to a 911 call may encounter and how those barriers or restrictions will be mitigated.

6. Describe how patients are moved on site during incidents.

7. Describe how the organization will collaborate with the local EMS & Trauma Care Council and county MPD(s) for quality assurance, planning, and coordination of patient care and transport.

8. Describe how the certified EMS personnel will maintain education and skills necessary for EMS recertification.

5. Personnel Status

Staffing Model: (check one) Paid ☐ Volunteer ☐ Combination ☐

Number of EMS personnel that are: _____Paid _____Volunteer

6. Level of Service and Hours of Operation

Identify highest level of service provided by the organization: ☐ BLS ☐ ILS ☐ ALS

On a separate sheet provide the hours of operation for each EMS level of service provided by the organization.

7. Applicant Organization's Personnel Credential Information:

On a separate attachment, provide the following:

The name, credential number, and level of certification (EMR, EMT, AEMT or Paramedic) for all Washington State Department of Health certified EMS personnel in your organization who will be engaged in providing emergency care, include full or part-time personnel. For EMTs with IV or supraglottic airway endorsements, identify as EMT-IV or EMT-SGA. This endorsement is on their certification card.

8. Statements and Signatures

Applying Organization Statement and Signature

I/We hereby affirm and declare that the information provided on this application is true and correct, and agree this organization:

1. Will not operate an Aid or Ambulance service and understands to do so would require a state license; and
2. Will operate in a manner that is consistent with the Washington State Triage tools; EMS and Trauma Care Council Regional Plan, pre-hospital Patient Care Procedures, and department approved County Operating Procedures; and
3. Will ensure that our certified EMS personnel are familiar with and utilize DOH approved county Medical Program Director (MPD) patient care protocols and follow medical direction when our certified EMS personnel provide patient care; and
4. If using providers with provisional certifications our EMS service is following requirements listed in provisional emergency services provider certification – eligibility RCW 18.71.097; and
5. Will participate with the local and regional EMS & Trauma care system for planning, coordination, and quality improvement activities; and
6. Will require EMS personnel to participate in educational programs to meet required state education necessary for recertification; and
7. Ensure that the certified EMS personnel will comply with all applicable statutes and rules while performing their assigned duties with our organization; and
8. Provide necessary medical equipment to EMS providers so they can provide care at their level of certification.

Organization Representative Name (Print):	Signature:
Organization Representative Title (Print):	Date:

Local EMS & Trauma Care Council Chair Statement and Signature

(Regional EMS & Trauma Care Council Chair Signature is required if a local EMS & Trauma Care Council does not exist)

Only the Department of Health may approve an EMS Service Supervisory Organization (ESSO):

_____ We recommend approval. This applicant conducts activities essential to public safety in coordination and collaboration with the EMS & trauma care system. The organization is participating in coordination with the EMS & Trauma Care system and has been made aware of our county operating procedures & regional patient care procedures.

_____ We **do not** recommend approval of this application (attach memo for details).

Organization Representative Name (Print):	Signature:	Date:

Medical Program Director Statement and Signature

_____ I recommend approval. This applicant conducts activities essential to public safety in coordination and collaboration with the EMS & trauma care system. The organization is participating in coordination with the EMS & Trauma Care system and has been made aware of the MPD policies and patient care protocols.

_____ I do not recommend approval of this application (attach memo for details).

EMS County Medical Program Director (MPD):	Signature:	Date:

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Emergency Medical Services and Trauma System Laws, RCW 18.71

Emergency Medical Services and Trauma System Laws, RCW 18.73

Emergency Medical Services and Trauma System Rules, WAC 246-976

Online

Emergency Medical Services and Trauma System , Web Page