State of Illinois
Illinois Department of Public Health

ALS EXPANDED SCOPE AND CRITICAL CARE TRANSPORT PROVIDER APPLICATION

EMS System: Identify Hospital	EMS System Number
EMS System Medical Director	EMS System Coordinator
SEMSV Medical Director Name	SEMSV Medical Director Email
Transport Provider Name	Transport provider Number
Transport Provider Address	Transport Provider Email
Transport Provider Contact Name	Transport Provider Contact Email
Level of care the Illinois Licensed Transport Provider is applying for: ☐ALS Expanded Scope ☐ Tier II Critical Care ☐Tier III Critical Care	

- Instructions: Clearly label all SMO's, protocols, policies, procedures, and documents.
    - Only new SMO's and policies need to be submitted.
- Attachments should be submitted in the sequence that they are requested.
- Copies of licenses and certificates need to be clear and legible.
- Do not submit the application until all the requested information is available and the packet is complete.
- Do not submit the plan without all the appropriate signatures. A stamped name will not be accepted.
- Incomplete or illegible applications will be returned without any action taken.
- Refer to Section 515.860 ALS Expanded Scope and Critical Care Transport for guidance.

Attachment A
Employee Roster CCT II

Service Provider Name: ______________________________ Date: __________________

Employee Name	Level	License Number	Illinois License Expiration Date	ACLS	PALS, or PEPP	ITLS or PHTLS	80 Hours of Didactic Education	(ALS Expanded Scope) Minimum 6 Months ALS Experience	(Teir II) 1 year ALS Experience	Certification cards and proof of required education is attached
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By signing below, I attest that all information provided is current and accurate.

______________________________________ ____________________

EMS Service Provider Signature and title Date

State of Illinois
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ALS EXPANDED SCOPE AND CRITICAL CARE TRANSPORT PROVIDER APPLICATION

Attachment B
Employee Roster CCT III

Service Provider Name: ______________________________________ Date: __________________

Employee Name	Level	License Number	Illinois License Expiration Date	ACLS	PALS, or PEPP	ITLS or PHTLS	NRP (Teir III)	80 Hours of Didactic Education	(Teir III) 2 years ALS Experience	Certification cards and proof of required education is attached
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By signing below, I attest that all information provided is current and accurate.

____ ____________________

EMS Service Provider Signature and title Date

Attachment C

Employee Roster ALS Expanded Scope

Service Provider Name: ______________________________ Date: ______________

Employee Name	Level	License Number	Illinois License Expiration Date	ACLS	PALS, or PEPP	ITLS or PHTLS	80 Hours of Didactic Education	(ALS Expanded Scope) Minimum 6 Months ALS Experience	Certification cards and proof of required education is attached
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ALS EXPANDED SCOPE AND CRITICAL CARE TRANSPORT PROVIDER APPLICATION

By signing below, I attest that all information provided is current and accurate.

_____ _____

EMS Service Provider Signature and title Date

Attachment D
Vehicle List and Description

Provider Name_____

Garage Address_____

City/State/Zip Code_____

List Each Vehicle

License Number	Last Four of VIN	Expiration Date	Identify as Primary or Back Up

Attachment E
Quality Assurance Program

To be in compliance with Section 515.860 Critical Care Transport requirements we agree to the following:

A) The transport provider shall develop a written Quality Assurance (QA) Plan approved by the EMS System and IDPH. The provider shall provide quarterly QA reports to the assigned EMS System for the first 12 months of operation and upon request

B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.

C) An EMS Medical Director shall oversee the QA Program.

D) The QA Plan shall evaluate all expanded scope of practice activity for medical appropriateness, accuracy and thoroughness of documentation. The review shall include at a minimum:

i) Review of transferring physician orders and evidence of compliance with those orders;

ii) Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;

iii) Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;

iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome.

v) Review of any Medical Control contact;

vi) Documentation that any unusual and adverse occurrences were promptly communicated to the EMS System; and

vii) A root cause analysis of all events or care inconsistent with standards. The EMS System educator shall assess and carry out a corrective action plan in a time frame identified by the EMS System and/or IDPH.

Vehicle Provider Director _____Date _____

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ALS EXPANDED S
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EMS System Medical Director _____Date _____