



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



Application for Recognition of Supplemental First Responder Status

Instructions and approval process:

1. Complete this application and submit the original, signed application and all attachments to:
Office of Emergency Medical Services
Department of Public Health
410 Capitol Ave., MS #12EMS
P.O. Box 340308
Hartford, CT 06134-0308

This shall include letters of support from the First Responder PSAR(s) and Chief Elected Official(s) for the affected geographic area (include as attachments).

2. Upon receipt, OEMS shall review the application for completeness.
3. OEMS shall forward requests for information to the applicant within thirty (30) business days of receipt of the application. The applicant shall forward such requested information to OEMS within ten (10) business days.
4. In the event requested information is not submitted within the required period of time, the application shall be considered to be withdrawn without prejudice.
5. OEMS shall render a decision on the application within ten (10) business days upon being deemed complete.
6. The applicant and affected first responder PSAR(s) shall receive written notification of such decision. OEMS shall notify the appropriate regional council(s) upon approval of any supplemental first responder.

If you have questions or need assistance, contact your Regional EMS Coordinator:

Region 1: Michele Connelly - (860) 509-7973
michele.connelly@ct.gov

Region 3: John Spencer - (860) 509-7981
john.spencer@ct.gov

Region 2: Judi Reynolds - (860) 509-7721
judith.reynolds@ct.gov

Region 4: Michael Rivers - (860) 509-8135
michael.rivers@ct.gov

Region 5: Jean Speck - (860) 509-7829
jean.speck@ct.gov

Please make a copy of the completed application and retain it for your records.



SUPPLEMENTAL FIRST RESPONDER APPLICATION

PROVIDER INFORMATION

1. Official legal Name of Service: _____

2. Business Address: _____

3. Mailing Address: _____

4. Telephone Numbers: Business: () _____ - _____

Emergency: () _____ - _____

Fax: () _____ - _____

5. Chief Executive Officer: Name: _____

Title: _____

Telephone (work) () _____ - _____

Telephone (home) () _____ - _____

Telephone (cell) () _____ - _____

Email: _____

6. Contact Person Name: _____

Title: _____

Telephone (work) () _____ - _____

Telephone (home) () _____ - _____

Telephone (cell) () _____ - _____

Email: _____



SUPPLEMENTAL FIRST RESPONDER APPLICATION

HISTORICAL RESPONSE TIME DATA

This section must detail historical response time data, including activation & response time (see definitions below) for the preceding 12 months. Please provide the name of the EMS dispatch agency that will activate supplemental first responder personnel and a description of the communications equipment (i.e. radios, pagers, etc.) to be used. If response time data for the preceding 12 months exists, please provide it on the following page. If activation time data for the preceding twelve months does not exist, please describe the plan for collecting such data in the future.

Name of EMS Dispatch Agency: _____

Telephone: () _____ - _____ Email: _____

Description of communications equipment that will activate supplemental first responder personnel:

DATE RANGE: From: ____/____/____ To: ____/____/____

ACTIVATION TIME = the measure of time, in minutes, from notification by dispatch to the supplemental first responder organization that an emergency exists, to the beginning of the response of supplemental first responder personnel.

RESPONSE TIME = the total measure of time, in minutes, from notification by dispatch to the supplemental first responder organization that an emergency exists, to arrival at the patient’s side.

ACTIVATION TIME		
TIME IN MINUTES	TOTAL RESPONSES	% OF RESPONSES
1-2		
2-3		
3-4		
>4		
TOTAL RESPONSES FOR PREVIOUS 12 MONTHS		100%

RESPONSE TIME		
TIME IN MINUTES	TOTAL RESPONSES	% OF RESPONSES
< or = 4		
4-5		
5-6		
6-7		
7-8		
>8		
TOTAL RESPONSES FOR PREVIOUS 12 MONTHS		100%



SUPPLEMENTAL FIRST RESPONDER APPLICATION

VEHICLE INFORMATION

The requested information shall be provided for *each* vehicle to be operated by the applicant service as a “supplemental first responder” vehicle. Do not include privately owned vehicles. **Note:** This page may be copied if additional space is needed.

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____

Year: _____

Make: _____

Model: _____

Owner: _____

Vehicle ID Number (VIN): _____

License Plate Number: _____



SUPPLEMENTAL FIRST RESPONDER APPLICATION

CERTIFICATES OF MALPRACTICE AND MEDICAL LIABILITY INSURANCE

In accordance with CGS 19a-180, the following shall be the required limits for licensure and/or certification:

- (1) for damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident at least one million dollars,
- (2) for damage to property at least fifty thousand dollars, and
- (3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars.

In lieu of the limits set forth in subdivisions (1) to (3), inclusive, of this subsection, a single limit of liability shall be followed as follows:

- (A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and
- (B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars.

ATTACHMENTS REQUIRED:

Attach current insurance policy declarations page(s) verifying the minimum insurance requirements outlined above.



SUPPLEMENTAL FIRST RESPONDER APPLICATION

SIGNATURE PAGE

The Chief Executive Officer of each applicant supplemental first responder service must sign this page as an express condition for recognition to operate as a supplemental first responder.

(Name of applicant service)

I do hereby warrant and certify that the above-named EMS provider organization shall carry out its responsibilities as a supplemental first responder in accordance with Section 19a-179-4(a) of the Regulations of Connecticut State Agencies. Specifically, the above-named service shall provide at least the following at the scene of each EMS call to which it responds:

1. One Emergency Medical Responder (EMR) who is certified in accordance with section 19a-179-16(a) of the Regulations of Connecticut State Agencies.
2. A two-way radio compatible with the supplemental first responder dispatcher.
3. Bandaging material and dressings sufficient to control hemorrhage.
4. Oropharyngeal or mouth-to-mouth airways in infant, child and adult sizes. Such airways shall be non-rigid and non-metal in construction.
5. Portable oxygen administration apparatus with a thirty (30) minutes supply of oxygen (at seven (7) liters per minute flow rate), which is operable totally detached from the parent vehicle. Such oxygen administration unit shall be capable of accepting attachment to a nasal cannula, mouth/nose oxygen mask or as enrichment feed to a forced ventilation unit.

And, all First Responder vehicles listed in the Vehicle Information section of this application shall be equipped in compliance with the equipment standards published annually by the Commissioner pursuant to CGS 19a-177. The most current standard is attached.

All information provided within this application is, to the best of my knowledge, true and correct.

Date

Chief Executive Officer Signature



SUPPLEMENTAL FIRST RESPONDER APPLICATION

2015 CONNECTICUT MINIMUM BASIC LEVEL FIRST RESPONDER VEHICLE EQUIPMENT LIST

CHANGES INDICATED IN BOLD

QTY	EQUIPMENT DESCRIPTION
1	Portable oxygen administration apparatus with 30 minutes supply at 7 lpm flow rate, which is operable totally detached from parent vehicle. Such unit shall be capable of accepting attachment to a nasal cannula, mouth/nose mask or as enrichment feed to a forced ventilation unit.
1	Adequate length oxygen tubing. May be separate or incorporated into each of the delivery devices listed below.
2	Adult Nasal Cannulas
1	Child Nasal Cannula
2	Adult non-rebreathing transparent masks
1	Child non-rebreathing transparent mask
1	Adult BVM (Hand-operated, self-re-expanding bag [>1000 ml] with oxygen reservoir/accumulator and tubing, valve (clear, disposable, operable in cold weather) and transparent adult mask
1	Child BVM (Hand-operated, self-re-expanding bag [450-750 ml] with oxygen reservoir/accumulator, valve (clear, disposable, operable in cold weather) and transparent child mask. Suitable substitute for BLS units only: mouth-barrier ventilation devices that allow for ventilation of both infants and children.
1	Infant mask for BVM. Labeling may vary but should be sized to accommodate appropriate seal on full-term infants (<5 kg or 11 lb). Suitable substitute for BLS units only: mouth-barrier ventilation devices that allow for ventilation of both infants and children.
1	Neonatal mask for BVM. Labeling may vary but should be sized to accommodate appropriate seal on low-birth weight infants (<2.5 kg or 5.5 lb). Suitable substitute for BLS units only: mouth-barrier ventilation devices that allow for ventilation of both infants and children.
1	Complete set infant to adult sized oropharyngeal airways
2	Sterile multitrauma dressing 10x30" or larger
5	Abdominal dressing, 5"x9" or larger
1	Roll of self-adhering elastic bandage suitable for applying a pressure dressing
10	4" x 4" gauze sponges or suitable size
4	Gauze rolls
2	Sterile 3" x 8" or larger occlusive dressings, or equivalent sufficient to permit an air-tight seal of wounds to the chest cavity
2	Triangular bandages with a minimum of two safety pins
1	Hypoallergenic roll of adhesive tape
1	Roll athletic-type adhesive tape
2	Arterial tourniquets (commercially manufactured)
1	Sterile burn sheet
500 mL	Sterile saline solution for irrigation (plastic bottle or bag)
1	Adult Sphygmomanometer (with standard adult and large adult cuffs)
1	Adult stethoscope
1	Heavy scissors or shears for cutting clothing, belts, boots, etc.
1	Battery operated, hand-carried flashlight suitable for illuminating both a localized work area or walkway. Rechargeable or has extra set of batteries. Penlights do not meet this requirement.
1	Thermal blanket. "Bath blanket" does not meet this requirement.
1	Complete SMART triage pack
	Single-use examination gloves, non-sterile, 4 pairs of appropriately sized gloves per crewmember (must meet NFPA 1999 requirements found at www.nfpa.org)
1	Disposable isolation gown
1	Disposable isolation coverall. Must be fluid resistant or impermeable with sealed seams.
1	Face protection (for example, surgical mask)

All quantities represent minimums believed to be adequate for a provider to render care on a single medical/trauma response. MCIs, prolonged transports or multiple consecutive responses may require additional supplies. Services may need to carry additional supplies and/or establish restocking procedures to assure adequate supplies are available for all responses.



SUPPLEMENTAL FIRST RESPONDER APPLICATION

2015 CONNECTICUT

CHANGES INDICATED IN BOLD

MINIMUM **BASIC LEVEL FIRST RESPONDER** VEHICLE EQUIPMENT LIST

QTY	EQUIPMENT DESCRIPTION
1	Single-use (disposable) transparent full face shield
1	Eye protection (full peripheral glasses or goggles)
1	Pairs of single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least mid-calf. Suitable substitute: Single-use (disposable) fluid-resistant or impermeable shoe covers if they will be used in combination with a coverall with integrated socks. Boot and shoe covers should allow for ease of movement and not present a slip hazard.
1	Waterless hand cleanser, commercial antimicrobial (towelette, spray, liquid)
1	Disposable biohazard bag
1 per crew member	Disposable respiratory protection - appropriately sized to crew member based on fit-testing - filtration standard N95 or better.
1	At least 5 lb. or larger ABC UL fire extinguisher
1	Emergency Response Guidebook (most recent edition - electronic or hardcopy)
3	Traffic signaling devices (reflective material triangles or other reflective, non-igniting devices.) Suitable substitute: a minimum of 3 hours duration red burning flares.
1 per crew member	Reflective safety wear for each crewmember (must meet or exceed ANSI/ISEA performance class II or III if working within the right of way of any federal-aid highway (visit www.reflectivevest.com/federalhighwayruling.html for more information))
Reminder: Services must review applicable OSHA standards and carry all required personal protective equipment.	
Strongly recommended, not required: 1 SMART triage Command Kit per Agency.	

All quantities represent minimums believed to be adequate for a provider to render care on a single medical/trauma response. MCI's, prolonged transports or multiple consecutive responses may require additional supplies. Services may need to carry additional supplies and/or establish restocking procedures to assure adequate supplies are available for all responses.