



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL AND TRAUMA PREVENTION
PO Box 47853 • Olympia, Washington 98504-7853

TO: EMS Affiliated Service Representative

FROM: Licensing and Certification Section

SUBJECT: Affiliated Service Information Update

On the back of this notice, is an *Affiliated Service Information Update* form. Please review and complete the form. The information you provide is necessary to keep your service records current. If you wish to drop your EMS affiliated agency status, please indicate by completing the information at the bottom of this notice.

An affiliated service is an organization that is not required to be licensed under Revised Code of Washington (RCW) 18.73 (www.doh.wa.gov/hsqa/emstrauma), but may be recognized by the Department of Health as a participant in the EMS and Trauma Care System. Affiliated services provide response for rescue and/or care of patients in accordance with approved regional and state trauma plans, regional patient care procedures, and local prehospital patient care protocols, but do not respond with an EMS vehicle.

Responsibilities of affiliated services are:

- Ensure EMS personnel associated with the service that have patient contact, are currently certified.
- Maintain a record of certification for all EMS personnel, which includes level of certification, and the expiration date of the certification.
- Follow all state and local laws, rules, protocols and patient care procedures to ensure standards for the health, safety and welfare of the citizens of this State.
- Follow medical control and protocols established by the county MPD.

If you have any questions, please contact us at 1-800-458-5281, extension 1, or (360) 236-2845.

AFFIRMATION:

_____ wishes to drop affiliated service status.
(Agency Name/Number)

(Signature/Date)

**Washington State
Department of Health
Office of EMS and Trauma System
AFFILIATED SERVICE INFORMATION UPDATE**

Service Name: _____ EMS Agency # : _____
(If known)

Address: _____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

Contact person: _____ Phone: _____

List the county/counties your service will operate in: _____

ORGANIZATION TYPE: (Check *one* that best applies to your organization)

Event Emergency Care Provider	()	Industrial	()	Law Enforcement	()
National Park	()	State Park	()	Forest Service	()
Military	()	Search & Rescue	()	Training Agency	()
County EMS Coordinator	()	Other (Please describe)	()		

PERSONNEL STATUS: Are your EMS personnel *primarily*: Paid () Volunteer ()
Number of employees that are: Paid () Volunteer ()

PERSONNEL INFO: Please provide *number* of personnel in each category below as appropriate:

1st Resp	()	EMT	()	IV Tech	()
AW Tech	()	IV/AW Tech	()	ILS Tech	()
ILS/AW Tech	()	Paramedic	()		

I/We hereby affirm and declare that the information provided is true and correct and that:

- We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures. Our certified EMS personnel utilize the DOH approved Medical Program Director (MPD) protocols.*
- I/We do not operate an Aid Vehicle or Ambulance.*

Person Completing Application

Owner/Operator Signature

Date