RULES AND REGULATIONS

Title 28—HEALTH AND SAFETY

DEPARTMENT OF HEALTH

[28 PA. CODE CHS. 1001, 1003, 1005, 1007, 1009, 1011, 1013 AND 1015]

Emergency Medical Services

The Department of Health (Department) hereby adopts amendments to Part VII (relating to emergency medical services), to read as set forth in Annex A.

Purpose and Background

The Emergency Medical Services Act (EMS act) (35 P. S. §§ 6921—6938) establishes a comprehensive scheme for the regulation of emergency medical services (EMS) in this Commonwealth. It designates the Department as the lead agency for EMS in this Commonwealth and provides that the Department, in consultation with the Pennsylvania Emergency Health Services Council (PEHSC), may adopt regulations as necessary to carry out the purposes of the EMS act. The Department's regulations adopted under the EMS act are set forth in Part VII. Those regulations were adopted on July 1, 1989, and were last amended on September 2, 1995.

The 1995 amendments were adopted to facilitate the implementation of the act of October 5, 1994 (P. L. 557, No. 82) (Act 82). Act 82 amended the EMS act and authorized the Department to bypass certain rulemaking procedures to adopt interim regulations. That authorization was accompanied by the caveat that the Department later adopt through the customary rulemaking procedures regulations addressing the same subject matter.

As Act 82 was limited in scope, so too were the interim regulations adopted by the Department on September 2, 1995. Following its adoption of the interim regulations, the Department proposed comprehensive amendments to Part VII at 29 Pa.B. 903 (February 13, 1999). It announced therein that the Department was proposing regulations not only to meet its duty to subject to standard rulemaking procedures the regulations it had adopted through the interim rulemaking process, but also to amend the other regulations in Part VII as needed. The Preamble for the proposed rulemaking afforded a 30-day comment period.

Summary

Many comments to the proposed rulemaking were received. The comments and the Department's response to them appear in this summary of final rulemaking.

Chapter 1001. Administration of the EMS System

Subchapter A. General Provisions

Section 1001.1 (relating to purpose) explains the purpose of Part VII. No comments addressing this section were received. This section is adopted as proposed.

Section 1001.2 (relating to definitions) defines terms used in Part VII.

Comment

The last sentence in the definition of "ambulance call report," which addresses what the report is to contain and how it is to be formatted, contains substantive requirements more properly placed in a regulation pertaining to ambulance call reports.

Response

The Department agrees. It has removed this sentence from the proposed definition, and has addressed this matter in § 1001.41(a) (relating to data and information requirements for ambulance services).

Comment

The term "ambulance call report" should be changed to "EMS response report" because the term does not include reports of responses to calls made by quick response services (QRS).

Response

The Department accepts the recommendation in part, but not for the reason asserted. The proposed term is consistent with the statutory language. Section 5(b)(3) of the EMS act (35 P. S. § 6925(b)(3)) requires that responding ambulance personnel complete a report for each call to which an ambulance responds. QRS personnel will only be required to complete certain portions of the report when a QRS responds. See § 1015.1(a)(4) (relating to quick response services). Therefore, there is no need to broaden the defined term to suggest that the entire report is to be completed when the response is made by an EMS responder other than an ambulance service. Nevertheless, the Department does believe that a more appropriate and descriptive label should be given to the report. Therefore, the proposed name is replaced with "EMS patient care report."

Comment

The proposed definition of "board certification" does not recognize certifications in a medical specialty if the board issuing the certification is not recognized by either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). The Department should revise the definition or explain the reason for limiting the definition to certifications in medical specialties recognized by these two groups.

Response

The Department has decided to limit the definition, as proposed, to include only those certifications issued by boards recognized by the ABMS or the AOA. However, it has removed board certification in emergency medicine as a criterion for qualifying as a regional EMS council medical director, a medical command facility medical director and a medical command physician.

The proposed rulemaking did not include the certification in emergency medicine issued by the Board of Certification in Emergency Medicine (BCEM). The BCEM is recognized by the American Association of Physician Specialists (AAPS). The primary reason the Department had proposed to exclude the BCEM certification is that emergency medicine certifying boards recognized by the other two organizations, the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM), required, at that time, completion of a 3-year residency in emergency medicine for the certifications they issue, and the BCEM did not. Rather, at the time of the proposal, the BCEM would accept, in lieu of completion of a 3-year emergency medicine residency, completion of a primary care resi-

dency and full time emergency medicine practice for 5 years with a minimum of 7,000 hours dedicated to this practice. The BCEM has now revised its certification criteria to require completion of 3 years in an emergency medicine residency program for an initial BCEM certification.

The Department has elected to substitute completion of 3 years in an emergency medicine residency program for the proposed board certification in emergency medicine criterion. The Department considers completion of an intensive 3 years in an emergency medicine residency to be an appropriate qualifying criterion, without being supplemented by a document from a medical specialty board certifying excellence in emergency medicine. It does not, however, consider the prior practice tract criterion for BCEM certification to be equivalent to an intensive 3-year residency in emergency medicine. As will be explained in this Preamble, there are criteria alternative to the emergency medicine residency criterion which the Department has prescribed. Additionally, the Department includes a grandfather provision in the sections prescribing qualifying criteria for a regional EMS medical director, a medical command facility medical director and a medical command physician, §§ 1003.2—1003.4 (relating to regional EMS medical director; medical command facility medical director; and medical command physician).

Comment

The Department should revise the proposed definition of "board certification" to include the medical specialty certifications issued by the boards functioning under the umbrella of the AAPS, and in particular the board certification in emergency medicine issued by the BCEM.

Response

The Department rejects this recommendation, as the board certification in emergency medicine criterion has been removed from the final regulations. The Department is not sufficiently familiar with the qualifying criteria for other boards functioning under the umbrella of the AAPS to conclude that the certifications issued by those boards are equivalent to those issued by boards recognized by the ABMS and the AOA.

Comment

The proposed definition of "board certification" should not be altered to include the certification in emergency medicine issued by the BCEM.

Response

This comment is moot since the final-form regulations do not retain board certification in emergency medicine as a qualifying criterion for any position for which the Department prescribes qualifications.

Comment

Contrary to the proposal, the definition of "closest available ambulance" should not be deleted.

Response

The Department rejects the recommendation. The term is not used in the regulations. There is no need to define a term that does not appear.

Comment

The proposed definition of "direct support of EMS systems" is too narrow. It needs to reference research as a mechanism to evaluate and improve the EMS system.

Response

The Department agrees that research is part of the direct support of EMS systems, but only if it is used to help plan, initiate, maintain, expand or improve an EMS system. The Department believes that this concept is clearly conveyed in the proposed definition. Therefore, the Department has not made the recommended revision.

Comment

The definition of "EMT-paramedic" should state that it applies to an individual who is trained in accordance with the current EMT-paramedic NSC rather than the current EMT-NSC.

Response

The Department agrees. The term "NSC" means National standard curriculum. Both "EMT-NSC" and "EMT-paramedic NSC" are defined. The training EMTs are to receive is to be in accordance with the EMT-NSC, and the training EMT-paramedics are to receive is to be in accordance with the EMT-paramedic NSC. The Department has revised the definition to correct the error.

Comment

The definition of "emergency" should be revised to reflect the American College of Emergency Physician's prudent layperson's definition of "emergency" and to be consistent with definitions of "emergency" in several Pennsylvania statutes.

Response

The Department rejects the recommendation. The existing definition of "emergency" repeats the definition contained in section 3 of the EMS act (35 P. S. § 6923). The Department is not empowered to change the statutory definition. Moreover, within the context that "emergency" is used in the EMS act, a definition that incorporates a prudent layperson's assessment of an emergency is not appropriate. In determining whether an emergency exists and whether treatment and perhaps ambulance transportation to a receiving facility are required, prehospital personnel and medical command physicians need to rely upon their training and experience, not upon standards that a prudent layperson might use. For example, although a prudent layperson may believe that certain symptoms require emergency treatment at a hospital, trained EMS personnel should not use an ambulance to transport an individual with these symptoms to a hospital when they conclude that the individual's condition does not constitute an emergency and does not warrant immediate hospital treatment.

Comment

The meaning of "base station" in the definition of "Medical Command Base Station Course" is unclear. The Department should define "base station."

Response

The term "base station" refers to the hospital radio command console, which usually includes the radio, antenna and control methods. The medical command course includes instruction on various matters pertaining to medical command, including, but not limited, to base station direction. Moreover, the Department has historically labeled this course as the "Medical Command Course." The Department will continue using that title for the course. The term "base station" is removed from the proposed name of the course and is also deleted from other places where it appeared in the proposed rulemaking.

Comment

The Department's regulations repeatedly refer to "medical treatment protocols." In subparagraph (iv) of the definition of "medical coordination," the term that appears is "transfer and treatment protocols." The term "medical" should be inserted before "treatment."

Response

The Department agrees. The term "medical" was included in subparagraph (iv) in the proposed rulemaking the Department filed with the Legislative Reference Bureau. An error occurred in reprinting the proposed definition. The Department has corrected the error.

Comment

The definition of "medical command" should be modified to clarify that orders may be given to withhold treatment as well as to administer it.

Response

The Department agrees. It has added language to the definition to reflect that a medical command from a medical command physician may include medical instructions to a prehospital practitioner to withhold or discontinue treatment. This order should be given by a medical command physician only when EMS standards dictate that treatment will no longer be effective, or when the order is otherwise appropriate under law, such as under an advance directive for health care which directs that life sustaining procedures be withheld or withdrawn.

Comment

Contrary to the proposal, the definition of "medical service area" should not be deleted.

Response

The Department rejects the recommendation since the term is not used in Part VII.

Comment

The definition of "mutual aid response" should be removed because the use of the term may compromise EMS resource management at public service answering points (PSAPs) and promote inappropriate responses by ambulance services.

Response

The Department agrees with the comment. The Department has removed the proposed definition of "mutual aid response." This term is not used in the final-form regulations.

Comment

The definition of "patient" should be revised to describe an individual who is believed to need immediate medical attention rather than an individual who requires immediate medical attention.

Response

The Department agrees and has revised the definition so that the language "believed to be" applies to both "sick, injured, wounded or otherwise incapacitated and helpless" as well as "in need of immediate medical attention." Any person who is believed to be in one of these states requires immediate medical attention. That medical attention, in some cases, may be nothing more than a medical assessment of the individual's condition. Such an individual becomes a patient, for purposes of the EMS system, and an EMS patient care report needs to be completed for that individual even if the medical assessment leads to the determination that the individual does not require additional emergency medical treatment.

Comment

The definition of "prehospital personnel" should use the term "health professional" rather than separately list health professional physicians and prehospital registered nurses, since the statutory and regulatory definitions of "health professional" include both types of personnel.

Response

The Department has decided not to make the recommended revision. The Department recognizes that the definition of "health professional" does include both types of personnel. However, the definition of "prehospital personnel" is drafted to identify each type of prehospital practitioner separately, so that the reader is not required to resort to another regulation for further clarification. When the regulations refer to both types of practitioners, and distinguishing between the two does not enhance the regulation, the Department uses the term "health professional" to refer to them. The Department believes that the distinction here enhances the regulation.

Comment

In proposed § 1003.31 (relating to credit for continuing education) the term "prehospital practitioner" is used throughout, but nowhere is the term defined. Rather, the Department defines the term "prehospital personnel." The Department should delete the term "prehospital practitioner" from § 1003.31 and replace it with "prehospital personnel."

Response

The Department rejects the recommendation. The term "prehospital practitioner" is employed throughout the proposed regulations, not solely in proposed § 1003.31. The term "practitioner" is used to refer to a single individual, while the term "personnel" is used to refer to more than one individual. The proposed regulations the Department filed with the LRB included the statement that any one of the personnel listed in the definition of "prehospital personnel" is a "prehospital practitioner." The Department addressed both terms because of the dissimilarity between the words "practitioner" and "personnel." Due to the confusion caused by its removal from the published version of the proposed definition of "prehospital personnel," the Department has once again included in the final regulation the term "prehospital practitioner" and the clarification of its meaning.

Comment

Contrary to the proposal, the definition of "primary response area" should not be deleted.

Response

The Department rejects the recommendation. The term is not used in the regulations. Furthermore, the Department has been working with the General Assembly and other stakeholders in the Statewide EMS system to develop legislation that will regulate the process for public safety answering points (PSAPs) to dispatch EMS resources. The Department envisions that this legislation will use and define terms such as "primary responders" and "primary response areas." The inclusion of these terms in the Department's regulations might cause confusion.

Comment

Change the proposed term "public safety answering point (PSAP)" to some other term more recognizable to the EMS community, possibly "emergency operations center."

Response

The Department rejects this recommendation. The Department believes that "public safety answering point" is a term well-recognized by the EMS community as the communications center established to serve as the first point at which calls requesting emergency assistance are received. The Department also took into consideration that the Public Safety Emergency Telephone Act (35 P. S. §§ 7011—7021) and the Pennsylvania Emergency Management Agency, in its regulations, use the same term. See 35 P. S. § 7012 and 4 Pa. Code § 120b.102 (relating to definitions).

Comment

In the definition of "receiving facility" there is a void in the description of the training required of a physician who must be present and available in an emergency department for that emergency department to qualify as a receiving facility. In addition to being trained to manage cardiac, trauma and pediatric emergencies, as proposed, the physician should be required to have training in managing medical and psychiatric emergencies.

Response

The Department agrees with this comment. It has revised the proposed definition to require that the physician also be required to have training in managing medical and behavioral emergencies.

Comment

The definition of "receiving facility" should require that the physician who must be present and available in an emergency department have training in managing medical emergencies, but need not reference cardiac emergencies since those emergencies would be included in medical emergencies.

Response

The Department rejects this recommendation. The physician present and available in the emergency department needs to have significant training in the management of cardiac emergencies. Because cardiac patients represent a special subset of medical emergencies, the Department believes that the definition should specifically emphasize training of the physician to manage cardiac emergencies.

Comment

Because the definition of "service area" is used to identify the political subdivisions an ambulance service must notify when it is going out of business, and because any political subdivision that relies on an ambulance service should receive the notice, the definition of "service area" should be revised to remove the word "routinely" from the proposed language "area in which an ambulance service routinely provides service."

Response

The Department has adopted the definition as proposed. It has elected not to remove the term "routinely" because many ambulance services may be called upon to transport a patient to or from a facility or other location which is located in a municipality which does not rely upon the ambulance service and in which the ambulance service seldom does business. Moreover, that location may be quite some distance from where the ambulance service generally operates. It should not be considered to be a part of the service area of the ambulance service. However, there may be some municipalities where an ambulance service seldom operates, but for which it has committed to provide backup services as needed. The Department agrees with the focus of the comment that an ambulance service that is discontinuing operations should also provide notice to these municipalities. To address the concern expressed by the comment, the Department has revised proposed § 1005.15 (relating to discontinuation of service) to require an ambulance service to give notice to a political subdivision that relies upon it in addition to the political subdivisions in its service area.

Comment

The definition of "special event" should be expanded to deal with events that overtax local EMS resources.

Response

The Department agrees. It has expanded the proposed definition of "special event" to include activities conducted not only in areas where access by emergency vehicles might be delayed due to crowd or traffic congestion at or near the event, but also in areas in which the potential need for EMS exceeds local EMS capabilities.

Comment

The EMS act and § 1005.8 (relating to provisional license) make special provision for renewing provisional licenses issued to volunteer ambulance services. "Volunteer ambulance service" should be defined in the regulations since it is not defined in the EMS act.

Response

The Department agrees with this comment. The Department has added a definition to define the term "volunteer ambulance service" as it is defined in section 3 of the Volunteer Fire Company, Ambulance Service and Rescue Squad Assistance Act (72 P. S. § 3943.3). While the Department is not required to use this definition in its regulations, it believes that it is consistent with legislative intent to do so. Both the Volunteer Fire Company, Ambulance Service and Rescue Squad Assistance Act and section 12(m)(2) of the EMS act (35 P. S. § 6932(m)(2)) are provisions enacted by the Legislature to provide special assistance to an entity the Legislature has labeled as a "volunteer ambulance service." The Department believes that the Legislature intended the term to have the same meaning in both statutes. The Department has, however, added clarifying language to ensure that the definition is not construed to apply to a QRS.

Other Changes

The definition of "ambulance service affiliate number" is revised to reflect that the first two digits of the number will designate the county in which the ambulance service maintains its primary headquarters.

The words "ALS and BLS" are removed from the definition of "emergency medical services" as a description of the services comprising the defined term because the Department concludes that other support services, such as communication services, are also included. The EMS act does not use the language "ALS and BLS" in its definition of "emergency medical services." The Department has also revised the definition of "regional EMS council" to provide that it shall be representative of not only public, but also private entities that provide EMS. This makes the regulatory definition consistent with the statutory definition.

The Department has revised the definition of the proposed term "ambulance call report," which is now

"EMS patient care report," because the Department felt the proposed definition might cause confusion in implementation. The definition has been simplified to merely reflect that the report is a report of data and information relating to patient assessment and care. This definition tracts the statutory language better. Section 5(b)(3) of the EMS act provides that each ambulance service shall ensure that its responding personnel complete a report of patient data and information, as prescribed by the Department, for each call to which an ambulance responds. Section 1001.41 requires an ambulance service to complete the report as appropriate. If there is any patient assessment at all, even if the assessment leads to the conclusion that no further EMS is required, a report needs to be completed. The only situation when an ambulance would be involved when no report would be required is when there is a routine transport of a convalescent or other nonemergency case which does not give rise to patient care or even patient assessment. See 35 P. S. § 6932(e)(4) for provisions applicable to these transports.

The Department has also removed from this section the term "prehospital personnel training manual." The Department has replaced that term in the regulations by referring to a manual addressing the relevant subject matter without giving the manual a title. This affords the Department the flexibility to develop different guidance manuals to address different prehospital personnel subjects.

The Department has added a definition for "residency program." The meaning of this term is significant because §§ 1003.2—1003.4 include completion of a designated residency program or completion of 3 years in an emergency medicine residency program as criteria for qualifying to serve in different physician capacities in the Statewide EMS system.

Section 1001.3 (relating to applicability) identifies, in general terms, who is affected by Part VII. No comments addressing this section were received. This section is adopted as proposed.

Section 1001.4 (relating to exceptions) provides a process for persons to seek an exception to a regulatory requirement that is not also directly imposed by the EMS act.

Comment

Proposed subsections (a) and (c) address the Department granting exceptions to its regulations for justifiable reasons if, as set forth in subsection (f), the substantive standards of the regulation, are satisfied. The Department should either explain what a justifiable reason is or delete "justifiable reason" from subsections (a) and (c), and it should identify those standards of the regulation it considers to be substantive standards.

Response

The Department is deleting the term "justifiable reason" from subsections (a) and (c) and the term "substantive" from subsection (f). Upon further consideration of the proposed regulation, the Department concludes that these terms add nothing to the regulation. The basis for granting an exception is explained in subsection (a). The Department may grant an exception when the policy objectives and intentions reflected by the regulations are satisfied, or when compliance would create an unreasonable hardship and granting an exception would not impair the health, safety or welfare of the public. The Department has also reworded subsection (a) to more clearly articulate these criteria.

Comment

In the discussion of the definition of "board certification," the Department stated that if board certification was required under a particular regulation, and an individual did not have board certification, the Department could consider an application for an exception under this regulation and grant an exception if the candidate could establish that the certification the person received from another certifying agency was issued under standards equal to or greater than those referenced in the definition of "board certification." The Department should explain the phrase "standards equal to or greater than" and otherwise describe the process set forth in this section.

Response

The criteria for granting an exception is set forth in the regulation and discussed in the response to the preceding comment. While the Department perceives that it will not be granting exceptions on a routine basis, this section does permit the Department to grant an exception to any regulation in Part VII to the extent the regulation does not set forth a standard imposed by statute.

The reference in the preamble to the proposed regulations to an individual seeking an exception to the board certification criterion was used as an example of when this section might be employed. In these final regulations, a board certification criterion is retained only in § 1003.3(b)(2)(ii), but the example is still relevant. In acknowledging that the Department would grant an exception to the board certification requirement if the applicant obtained a certification meeting standards equal or greater to the standards used by the certifying bodies acceptable under the proposed definition of "board certification," the Department was recognizing that this would meet the policy objective of a regulation that includes board certification as a qualifying criterion.

Over the course of time certifying bodies other than those that satisfy the definition of "board certification" might come into existence. They may employ standards to certify the qualifications of medical specialists that are equal to or more stringent than the standards used by the recognized certifying bodies. Even existing certifying bodies that are not recognized under the definition might change their standards for granting certification so that those standards are equal to or more stringent than the standards that are currently acceptable to the Department.

Because it is not possible to envision all circumstances for granting an exception to each regulation to which an exception may be granted, it is not possible to list specific standards for granting an exception to each regulation with greater specificity than included in this regulation.

Section 1001.5 (relating to investigation) provides that the Department may investigate persons for compliance with the provisions of the EMS act and Part VII of the Department's regulations.

Comment

Section 5(b)(13) of the EMS act specifically authorizes the Department to investigate trauma centers and forward the results of its investigation to the Pennsylvania Trauma Systems Foundation (Foundation). The Department should explain its intent for providing that the Department will investigate other matters related to the EMS act and should identify its authority to do so.

Response

The Department's power to investigate violations of the EMS act is expressly derived from certain provisions of the EMS act and implicitly derived from other provisions of the statute. The Department believes that the reason the Legislature included a specific provision authorizing the Department to investigate trauma centers and share its results with the Foundation is that absent that express grant of authority the remaining language of the statute could not be read to grant that responsibility to the Department. While the Department is given the power to regulate most entities addressed by the EMS act, the express language of the statute dealing with trauma centers gives the Foundation, not the Department, the authority to regulate and set standards for trauma centers. See 35 P. S. § 6926.

Some of the provisions from which the Department derives its authority to investigate violations of the EMS act are section 2 of the EMS act (35 P. S. § 6922) (legislative intent to assure readily available and coordinated EMS and to maintain an effective and efficient EMS system); section 4(b) of the EMS act (35 P. S. § 6924(b)) (designates the Department as the Commonwealth lead agency for EMS); section 11(j.1) of the EMS act (35 P. S. § 6931(j.1)) (the Department is to investigate possible violations of prehospital personnel and pursue disciplinary action if appropriate); and section 12(l) of the EMS act (the Department is to pursue disciplinary action against ambulance services if they engage in proscribed conduct).

It is the intent of the Department to investigate complaints against prehospital personnel, as expressly authorized, and to investigate complaints against ambulance services, as implicitly authorized. However, the Department will also investigate complaints against other entities it regulates, such as medical command facilities, receiving facilities, EMS training institutes and continuing education sponsors, to ensure that they are satisfying the statutory requirements and Department regulations adopted under the EMS act which govern their operations. The Department will also conduct preliminary investigations of complaints of unlicensed entities acting as ambulance services and uncertified individuals functioning as prehospital personnel. This conduct is a summary offense under the EMS act. See 35 P. S. §§ 6935 and 6936. The Department will refer information that tends to show unlicensed or uncertified activity to criminal enforcement agencies, or may pursue judicial action to enjoin those activities. These investigations are supported by the statutory language designating the Department as the lead agency for EMS in this Commonwealth, and the legislative intent language that the EMS act operate to assure readily and coordinated EMS, to prevent premature death and reduce suffering and disability, and to maintain and assure an effective and efficient EMS system.

Comment

This regulation should be revised to assert that the Department will conduct its investigations in conjunction with the regional EMS councils.

Response

This recommendation is rejected. The Department will conduct most investigations in conjunction with a regional EMS council, but may conduct some investigations on its own. The Department's authority to employ regional EMS councils to assist it in conducting investigations is adequately addressed in §§ 1001.122 and 1001.123 (relating to purpose of regional EMS councils; and responsibilities).

Section 1001.6 (relating to comprehensive EMS development plan) is amended to provide that the regional EMS development plans will be incorporated into the Statewide EMS development plan. The section is also amended to require public notice and an opportunity for comment before the Department's adoption of a Statewide plan. No comments addressing this section were received. This section is adopted as proposed.

Section 1001.7 (relating to comprehensive regional EMS development plan) is new. It requires each regional EMS council to develop a regional plan for coordinating and improving the delivery of EMS in the region for which it has been assigned responsibility by the Department. It also requires the regional EMS council to give notice to the public and an opportunity for comment before submitting the plan to the Department for approval.

Comment

Requiring a regional EMS council to provide public notice and an opportunity for comment on a regional EMS development plan places an excessive burden on the planning process.

Response

The Department disagrees with the comment. This section is adopted as proposed.

Subchapter B. Award and Administration of Funding

The title of this chapter is revised to replace the term "Contracts" with "Funding." This change is made because the scope of this chapter is not confined to addressing the distribution of funds through contracts exclusively.

Section 1001.21 (relating to purpose) describes the purpose of the subchapter on funding. Section 1001.22 (relating to criteria for funding) identifies criteria for the distribution of EMSOF moneys. Section 1001.23 (relating to allocation of funds) identifies some of the factors that are considered in determining the amount of funds to be distributed to eligible recipients. No comments addressing these sections were received. These sections are adopted as proposed, except § 1001.22(a)(10) is revised by inserting "technician" and deleting "service" in the term "voluntary rescue service certification program." The Department administers a voluntary program for the certification of rescue technicians, not rescue services.

Section 1001.24 (relating to application for contract) pertains to applications for contracts to plan, initiate, maintain, expand or improve an EMS system. It is amended to clarify that the application process in the section applies only to contracts for these purposes.

Comment

Since both paragraphs (2) and (3) of the current regulation require applicants for funding to include information about their organizational structure, paragraph (3) may be redundant. Either the term "organizational structure" should be removed from paragraph (2) or paragraph (3) should be deleted.

Response

The Department agrees. The Department has deleted paragraph (3).

Section 1001.25 (relating to technical assistance) provides that the Department may provide technical assistance to contractors and subcontractors to assist them in carrying out their contracts. It also identifies some of the technical assistance resources the Department may make available.

Comment

The purpose of the last sentence in subsection (a), which states that "special consideration shall be given to contractors in rural areas," is unclear. The Department should either revise the sentence to clarify its purpose, or delete it.

Response

The Department agrees that the sentence is unclear. It has revised it to clarify that special consideration will be given to contractors in rural areas to assist them with matters such as recruitment, retention of prehospital personnel, and other matters identified in subsection (a). Special consideration will be extended in recognition that rural areas may lack sufficient manpower and other resources to perform EMS projects unless they receive some additional help.

Other Changes

The Department has revised subsection (c)(3) to read "information management resources" instead of "management information resources." The resources to which the Department intends to refer are those involved in managing information.

Section 1001.26 (relating to restrictions on contracting) prohibits the Department from contracting with more than one regional EMS council to exercise responsibility for any part of the same EMS region, and provides that a contractor does not have the right to have a contract renewed.

Section 1001.27 (relating to subcontracting) addresses rights and restrictions on the authority of an entity that enters into a contract with the Department under the EMS act to enter into subcontracts for the performance of contracted duties.

No comments addressing these sections were received. These sections are adopted as proposed.

Section 1001.28 (relating to contracts with the Council) is new. It is added to clarify that some of the provisions in the subchapter do not apply to Department contracts with Pennsylvania Emergency Health Services Council (PEHSC). It also provides that the Department will contract with PEHSC to provide it with the funds PEHSC needs to perform the duties imposed upon it by the EMS act, and may contract with PEHSC for it to assist the Department in complying with the EMS act.

Comment

The Department should not be providing PEHSC with money from Emergency Medical Services Operating Fund (EMSOF).

Response

This section does not use the term "EMSOF." Nevertheless, in response to the concern asserted, it is noted that an express statutory direction relating to the distribution of EMSOF moneys, added by Act 82, is that some of the moneys be distributed by the Department to PEHSC. See section 14(d) of the EMS act (35 P. S. § 6934(d)).

Subchapter C. Collection of Data and Information

Section 1001.41 addresses an ambulance service's responsibility to complete an EMS patient care report and to keep the report confidential. This section has been revised to delete the data elements previously specified. The required data elements will be identified in the EMS patient care report form or in computer software. As discussed previously in responding to a comment pertaining to the proposed definition of "ambulance call report," the data elements are revised from time to time by the Department, in consultation with PEHSC.

Some of the data identify patient condition and treatment, while other data provide information on how well the EMS system is functioning. This section requires the ambulance service to provide the data solicited by the form. The Department will publish in the *Pennsylvania Bulletin* a notice specifying the required data elements and which data are to be handled in a confidential manner. Superseding notices will be published as needed. All information contained in the notice will be available on the Department's website.

This section also requires that certain patient information solicited by the EMS patient care report be reported immediately to a receiving facility. It prescribes the time in which an EMS patient care report is to be completed after termination of services to the patient, and imposes a duty upon an ambulance service to establish a policy prescribing who is to complete the report on behalf of the ambulance service. The *Pennsylvania Bulletin* notice will designate the data that are to be reported immediately to the receiving facility.

Comment

The regulation should specify where ambulance services may obtain copies of the required contents and format for the EMS patient care report.

Response

The Department agrees with this recommendation. Subsection (a) has been revised as previously explained. In addition, it has been revised to relate that paper report forms may be secured from regional EMS councils and that the Department will maintain a list of the software that it has determined to be acceptable. The Department already maintains such a list and encourages software venders to provide the Department with software products they believe should be included on the list so that the Department can evaluate those products and determine if they are acceptable.

Comment

If the Department chooses to require an ambulance service to complete and submit an EMS patient care report within 24 hours of concluding service, as proposed, the Department should explain the need for the 24-hour requirement and whether there may be exceptions to this reporting standard.

Response

The completion and submission of an EMS patient care report within a 24-hour time frame is required because patient information, in addition to that which is designated for immediate transmission, needs to be promptly provided to hospital personnel to facilitate the comprehensive care of the patient. Often patients will require care to address problems that were not a priority during the resuscitation phase, but which will impact their quality of life and functionality if not addressed prior to discharge. Hospital stays are increasingly short, decreasing the opportunity for discovery of additional care needs and minimizing the time to coordinate the intervention required to address them. It would be in the patient's best interest if the information would be provided to the hospital immediately, but transmission of the information within 24 hours seems most reasonable when balancing that interest against the burdens imposed upon prehospital personnel.

The Department may grant exceptions to the 24-hour reporting requirement, but has chosen not to include that statement in the regulation itself. Section 1001.4 provides that the Department may grant a request for an exception to any regulatory standard if the standard does not repeat a statutory requirement. The Department has adopted § 1001.4 to avoid having to include, in several regulations, language stating that exceptions to a standard may be granted.

Comment

The regulation should identify all of the acceptable methods for submitting and transmitting the data in the ambulance call report to the receiving facility.

Response

The Department agrees that acceptable methods for transmitting the data should be identified in the regulation. However, because of the lack of uniformity in receiving facilities of both equipment that could be used to receive the data and of the security of data received through the equipment, and because of different hospital policies and procedures for maintaining the confidentiality of patient information, the Department is unable to amend the regulation to identify a data-transmission method that would be uniformly acceptable. Therefore, the Department has amended subsection (d) to permit an ambulance service to report the data to a receiving facility in any manner which is acceptable to the receiving facility and which ensures the confidentiality of information which the Department has designated as confidential.

Comment

The Department should retain in the regulation the list of data the report form will solicit.

Response

This is not necessary. The report form will change from time to time. Published notices and the form, itself, will identify all information that needs to be reported.

Comment

If this section is to require an ambulance service to provide essential patient information to the hospital before the ambulance departs from the hospital, the regulation needs to define the information that is essential for immediate transmission.

Response

As previously explained, the Department will publish a notice in the *Pennsylvania Bulletin*, and issue superseding notices as necessary, to identify the information that is essential for immediate transmission.

Comment

The Department should add a section under this subchapter to require an ambulance service to retain a copy of an EMS patient care report for a specified period of time, preferably 7 years from the date of service or 1 year following the age of majority, whichever is later, which is the same period of time during which medical doctors are required to maintain medical records under the State Board of Medicine regulation in 49 Pa. Code § 16.95 (relating to medical records).

Response

The Department agrees with the recommendation to include a provision requiring ambulance services to retain copies of the EMS patient care report for a specified period of time. The Department has added subsection (f) to require an ambulance service to retain a copy of the record for a minimum of 7 years.

Other Changes

The Department has revised subsection (a) to specify that the ambulance service is to file a copy of the EMS patient care report within 30 days with the regional EMS council that exercises responsibility for the region in which the responding ambulance is based. Also, wherever the term "ambulance call report" appeared in the proposed regulations, the Department has replaced it with "EMS patient care report." This substitution is made throughout the final-form regulations.

Section 1001.42 (relating to dissemination of information) identifies the circumstances under which an EMS patient care report may be released. This section has been revised to provide that persons who prepare or secure data from an EMS patient care report by virtue of their participation in the Statewide EMS system are required to prohibit access to only those data elements designated as confidential by the Department in the body of the EMS patient care report.

Comment

The designation of people to whom and circumstances under which the EMS patient care report or confidential information contained in that report may be disclosed should be revised as follows:

1. Subsection (a)(3) should permit disclosure "to the patient or the following authorized persons: the patient's duly appointed attorney-in-fact; court-appointed guardian of the patient's person and/or estate if the patient has been adjudicated as an incapacitated person; the patient's parent or legal guardian if the patient is a minor; the executor/executrix or administrator/administratrix of the patient's estate; or to such other third party as the patient or other authorized person shall direct in a writing signed by the patient or authorized person."

2. Subsection (a)(4) should permit disclosure "under an order, subpoena or other lawful process of a court of competent jurisdiction."

3. Subsection (a)(7) should be added to authorize disclosure "to a health care provider to whom responsibility for the patient's care has been transferred or to another health care provider insofar as necessary to facilitate that provider's treatment of the patient."

Response

The Department agrees with the focus of this comment and has added language to achieve the intended results. In subsection (a)(3), instead of listing all of the examples identified in the comment, the Department uses the umbrella language "a person who is authorized to exercise the rights of the patient with respect to securing the information, such as the patient's duly appointed attorney-in-fact." This approach avoids the risk that the regulation fails to list a person that should be listed. In subsection (a)(4), the Department uses the term "order" as general language, and again provides an example. The example, a subpoena, which is recognized under the Rules of Civil Procedure as an order of the court, is accompanied by language which excludes a subpoena as authorization for release of the information when the information is the type that cannot be released under a subpoena. For example, the Confidentiality of HIV-Related Information Act (35 P. S. §§ 7601—7612) prohibits the release of confidential HIV-related information under a subpoena. Subsection (a)(7) has been added to clarify that the EMS

patient care report may be released to a health care provider to whom a patient's medical record may be released under law.

Subchapter D. Quality Improvement Program

The title of this subchapter is amended to substitute "Improvement" for "Assurance." The term "quality improvement" has generally replaced "quality assurance" in the health care industry.

This subchapter is amended to clarify that the quality improvement program operated by the Department and regional EMS councils is to be limited to monitoring and data collection activities. Section 5(b)(10) of the EMS act empowers the Department to establish a quality improvement program only for the purpose of "monitoring the delivery of [EMS]."

Section 1001.61 (relating to components) describes the purpose and parameters of the quality improvement program the Department is coordinating for the Statewide EMS system.

Comment

The terms "medical care," "prehospital personnel" and "providers of EMS," which are used in the proposed amendment of this section, need to be defined.

Response

"Prehospital personnel" and "providers of EMS" are defined in § 1001.2. "Medical care" does not need to be defined. The section makes it clear that the medical care to which it refers is that which is provided "in the delivery of EMS . . . by prehospital personnel and providers of EMS."

Section 1001.62 (relating to regional programs) provides that each regional EMS council shall develop a regional quality improvement program and requires that each program include certain features.

Comment

A regional EMS council should oversee the process, but not conduct the quality improvement audits itself.

Response

A regional EMS council will oversee the data collection process. Its review of the quality improvement effort of participants in the EMS system, such as ambulance services, ALS service medical directors, medical command facilities and receiving facilities, will require that it coordinate the data collection process. The process of collecting that data will rarely require a regional EMS council employe to personally visit a provider of EMS.

Sections 1001.63 and 1001.64 (relating to medical command facilities; and ambulance services), which previously required medical command facilities and ambulance services to participate in the quality improvement program, are replaced with § 1001.65 (relating to cooperation). No comments addressing these sections were received. Sections 1001.63 and 1001.64 are rescinded as proposed.

Section 1001.65 requires all persons and entities authorized by the Department to participate in the Statewide EMS system to provide the Department and the regional EMS councils with data and reports requested by them to monitor the delivery of EMS as part of quality improvement oversight.

Comment

The one sentence comprising this section is too long. It should be separated into at least two sentences.

Response

The Department agrees. The Department has replaced the proposed sentence with two shorter sentences.

Comment

The subchapter should include a provision requiring medical command facilities to provide ambulance services with patient information to assist the ambulance services in their quality improvement initiatives.

Response

The Department rejects compelling medical command facilities to engage in this conduct, but encourages them to work with ambulance services to help ambulance services in their quality of care reviews. Patient diagnosis and treatment information secured after the transport of the patient to a receiving facility should be shared on a need-to-know basis exclusively. Otherwise, it should not be disclosed without the patient's consent. However, the medical command facility should provide aggregate data and anecdotal information to ambulance services to assist quality of care reviews conducted by ambulance services.

Subchapter E. Trauma Centers

This subchapter, comprised of §§ 1001.81—1001.84, was adopted by the Department under its duty under section 5(b)(12) of the EMS act to integrate trauma centers into the Statewide EMS system. No comments addressing these sections were received. They are adopted as proposed.

Subchapter F. Requirements for Regional EMS Councils and the Council

Section 1001.101 (relating to governing body) specifies standards for the governing bodies of PEHSC and regional EMS councils. It is adopted as proposed.

Comment

The provision that a regional EMS council may be a unit of local government should be retained.

Response

This recommendation is rejected because this provision is included in § 1001.124 (relating to composition).

Sections 1001.102 and 1001.103 (relating to council director; and personnel) are deleted. These sections had specified duties of directors of regional EMS councils and PEHSC, and written policies and procedures that are to be in place for both. The rescission is consistent with Executive Order 1996-1. These regulations were burdensome and did not serve a compelling interest. There are also viable nonregulatory alternatives that may be pursued to implement the standards that were included in these regulations if that becomes necessary. If the Department concludes that specific personnel and work policies are required for PEHSC or a regional EMS council to complete a project, the Department may include those terms in the body of the contract covering the project. A few comments were received endorsing the proposed rescission of these sections.

Subchapter G. Additional Requirements for Regional EMS Councils

Sections 1001.121, 1001.122 and 1001.124 (relating to designation of regional EMS councils; purpose of regional EMS councils; and composition) specify the criteria the Department will consider in designating regional EMS councils, the responsibility of regional EMS councils to assist the Department in administering the EMS act and Part VII of the Department's regulations, and the types of

entities that may serve as regional EMS councils. No comments addressing these sections were received. They are adopted as proposed.

Section 1001.123 identifies the major responsibilities of regional EMS councils.

Comment

Proposed paragraph (3) required regional EMS councils to advise PSAPs and political subdivisions of any recommended dispatching criteria that may be developed by the Department, or by the regional EMS council as approved by the Department. Does this pertain to the order in which available EMS resources are to be dispatched, or to the type of EMS resources (ALS or BLS) to be dispatched? Are there any appeal mechanisms if this pertains to the order in which similarly qualified ambulance services are to be dispatched?

Response

The duty imposed by this subsection applies to both types of dispatching criteria. The Department expects PSAPs to follow Statewide and regional medical treatment protocols in determining whether to dispatch BLS or ALS resources. Regional EMS councils may also recommend medical dispatch protocols. As to the order of dispatch, neither the Department nor regional EMS councils have statutory authority to dictate to PSAPs which ambulance service among similarly licensed services to dispatch first. Consequently, any guidance the Department or regional EMS councils develop in this area would not impose any duty upon PSAPs and political subdivisions and would not be subject to appeal.

Comment

The last sentence in proposed paragraph (14), which reads "Recruitment of volunteer expertise available shall be requested when needed," does not make sense.

Response

The Department agrees. It has revised the language to provide that regional EMS councils shall recruit volunteers as needed.

Comment

Proposed paragraph (20), which stated that one of the functions of a regional EMS council is to perform duties, other than those specifically listed, as deemed appropriate by the Department, should conclude with the language "regarding the responsibilities of regional EMS councils."

Response

The Department agrees with the concern expressed, however it has opted to insert somewhat different language than what was suggested. The Department is authorized to enter into contracts with regional EMS councils "for the initiation, expansion, maintenance and improvement of [EMS] systems which are in accordance with the Statewide [EMS] development plan." See 35 P. S. § 6930(a). This is the language the Department has added to the paragraph, which has been renumbered as paragraph (21).

Comment

Since the Office of Inspector General of the United States Department of Health and Human Services issued an opinion that the restocking of ambulances by hospitals may constitute illegal remuneration under the Federal antikickback statute, 42 U.S.C.A. § 1320a-7(b), and then later issued opinions that the restocking of ambulances by hospitals through a coordinated system of care might not be a violation, it might enhance the Statewide EMS system to add as an additional responsibility of regional EMS councils, the duty "to formulate plans, policies and procedures for the restocking of nonreusable ambulance supplies, medications and/or linens by hospitals to whom patients are brought by licensed ambulance services."

Response

The Department rejects the recommendation because the Department does not want to direct regional EMS councils to promote a restocking program which the Office of Inspector General of the Department of Health and Human Services may conclude violates the Federal antikickback statute. However, the Department will pursue this matter further with the Federal agency and may revise the regulation in the future to include such a provision.

Other Changes

Proposed paragraph (18), which referenced a medical command authorization being removed by an ALS ambulance service, has been corrected to reference removal of medical command authorization by the "ALS service medical director" for the ambulance service. One comment was received commending inclusion of the requirement in paragraph (18) that regional EMS councils are to notify medical command facilities and ALS service medical directors of an EMT-paramedic who loses medical command authorization. Minor clerical changes have been made to proposed paragraphs (1) and (19).

The Department received a comment to § 1003.4, that the proposed provisions in that regulation that address a regional EMS council's role in approving physicians as medical command physicians should be removed from that regulation and inserted in this one. The Department has rejected that recommendation for reasons that are explained in the response to that comment under § 1003.4. However, the Department has added a new paragraph (20) to relate that the approval of medical command physicians under § 1003.4(c)(2) is a function of a regional EMS council.

Section 1001.125 (relating to requirements) deals with matters such as the composition of the regional EMS council when it is a nongovernmental body, and the composition of its advisory council when it is a governmental body. This section is amended to require that if a regional EMS council is a unit of local government it shall have an advisory council representative of the professions and organizations designated in the EMS act's definition of "emergency medical services council," as well as health consumer representation, and that if the regional EMS council is a public or nonprofit organization, its governing body shall satisfy the same representation requirements. One comment questioned inclusion of the word "major" in describing certain organizations that should have representation on regional EMS councils. That word was taken directly form the statutory definition, and is retained. The Department received no other comment addressing this regulation.

Subchapter H. Additional Requirements for the Council

Sections 1001.141—1001.143 (relating to duties and purpose; meetings and members; and disasters) address requirements for PEHSC in addition to those enumerated in § 1001.101. No comments were received on these sections. The Department has adopted them as proposed.

Subchapter I. Research in Prehospital Care

Section 5(b)(3) and (4) of the EMS act contemplate that the Department will permit data collected through the Statewide EMS system to be used for research to identify

possible options for improving the system. The Department's planning responsibilities imply that the Department may authorize research to aid it in making planning decisions. This subchapter addresses the procedures for providers of EMS to engage in clinical research investigations or studies that relate to direct patient care in the Statewide EMS system. Section 1001.161 (relating to research) is amended to revise the research proposal review process.

Comment

The Department should explain why it needs to review research proposals for merit before it refers proposals to PEHSC and regional EMS councils.

Response

A regional EMS council may not be aware of research the Department has approved or initiated in different parts of this Commonwealth. Based upon the type of research being conducted, the Department may not want to have that research duplicated in another part of this Commonwealth, or may want to recommend a modification of the proposal to supplement existing research. Also, both regional EMS councils and PEHSC receive EMSOF moneys through the Department to pay for their reviews of research proposals. The Department may eliminate the wasteful allocation of the resources of both entities if it concludes that it is clearly not worthwhile to pursue the proposed research. The Commonwealth Emergency Medical Director will be involved in the Department's preliminary review of the research proposal. One change that is made to this section is that the last sentence in subsection (b) is revised to clarify that the review of a research proposal by a regional EMS council and PEHSC is to begin after the Department requests them to proceed with the review.

Chapter 1003. Personnel

This chapter addresses qualifications and responsibilities of persons involved in the Statewide EMS system. It also addresses the disciplinary process for prehospital personnel, the medical command authorization process, continuing education requirements and options and the accreditation standards for sponsors of continuing education.

Subchapter A. Administrative and Supervisory EMS Personnel

Section 1003.1 (relating to Commonwealth Emergency Medical Director) specifies the duties of the Commonwealth Emergency Medical Director.

Comment

Proposed subsection (a)(5) lacks clarity due to its length and the subjects covered. The regulation would be clearer if the subject matter is addressed in two paragraphs.

Response

The Department agrees that proposed subsection (a)(5) could be written to provide greater clarity. The proposed paragraph deals with the Commonwealth Emergency Medical Director's role relative to regional medical treatment protocols and patient transfer protocols. However, not addressed is the Commonwealth Emergency Medical Director's role relative to the Statewide BLS medical treatment protocols. The Department has corrected that oversight by addressing the Commonwealth Emergency Medical Director's role relative to regional medical treatment protocols in paragraph (5), the Statewide BLS medical treatment protocols in paragraph (6) and patient transfer protocols in paragraph (7). The remaining paragraphs are renumbered.

Other Changes

As discussed in response to a comment under § 1001.161 (relating to research), the Commonwealth Emergency Medical Director will be involved in the review of research proposals pertaining to the Statewide EMS system. That role is set forth in subsection (a)(11).

As the Department has eliminated all references to "base station" in the regulations, the Department has revised subsection (b)(3) so that it states that the Commonwealth Emergency Medical Director will need to have knowledge regarding "medical command," rather than "base station" direction of prehospital personnel. No other revisions have been made to the proposal.

Section 1003.2 (relating to regional EMS medical director) specifies the duties of regional EMS medical directors. It is revised to clarify that the regional EMS medical director does not function independent of the regional EMS council except when acting upon appeals from adverse medical command authorization decisions. That is the only function the EMS act expressly assigns to a regional EMS medical director. See 35 P. S. § 6931(d)(2)(iv) and (e.1)((4).

Comment

Proposed subsection (a)(1) and (3)—(6) state that the regional EMS medical director's duty is to "assist" the regional EMS council in performing certain functions. It is not clear how the regional EMS medical director will provide the assistance. These paragraphs should be made clearer regarding how the regional EMS medical director is to provide the assistance.

Response

The Department rejects the recommendation. As stated in the Preamble to the proposed regulations, the Department wants to avoid micromanaging the regional EMS councils, some of which are units of county government. These paragraphs are designed to apprise both regional EMS councils and their medical directors that the Department expects the regional EMS medical directors to be involved in certain types of activities of the regional EMS councils. How that involvement is structured is left up to the regional EMS councils. If the Department deems it necessary to impose certain requirements on that relationship for the purpose of performing specific work, it will include those requirements in the contracts it negotiates with the regional EMS councils. None of the paragraphs mentioned in the comment include responsibilities imposed upon regional EMS medical directors by the EMS act.

Changes

Subsection (b) is revised by the rescission of paragraph (2), which provided that the Secretary could waive the board certification in emergency medicine requirement for a regional EMS medical director upon request of a regional EMS council. This provision is not needed in light of the removal of the board certification in emergency medicine criterion.

With the rescission of paragraph (2), there is no need for the first paragraph under subsection (b) to be preceded by the paragraph (1) designation. The Department has removed that designation and has revised subsection (b) by redesignating the remaining provisions in the subsection.

Former subsection (b)(1)(v) included board certification in emergency medicine as a criterion for qualifying as a regional EMS medical director. In that provision, now subsection (b)(5), the Department has replaced the board

certification in emergency medicine criterion with the requirement that the physician shall have either completed 3 years in a residency program in emergency medicine or have served as a medical command physician in this Commonwealth prior to October 14, 2000. The reason for this change was previously discussed in addressing comments pertaining to the definition of "board certification." Additional explanation is provided in the response to the first comment discussed under the next section.

In subsection (b)(3), the term "base station" is replaced with "medical command" and "emergency units" is replaced with "personnel."

Section 1003.3 (relating to medical command facility medical director) specifies the qualifications and responsibilities of a medical command facility medical director.

Comment

As the regulation is proposed, a physician who is not certified in emergency medicine by a medical specialty certification board recognized by the ABMS or the AOA cannot qualify as a medical command physician.

Response

This is not accurate either as subsection (b)(1)(ii) (now subsection (b)(2)) was proposed or as it has been finally adopted. Certification in emergency medicine from a board recognized by one of the two entities mentioned in the proposed definition of "board certification" would not have been required if the physician had received board certification in surgery, internal medicine, family medicine, pediatrics or anesthesiology. Some physicians who had received the BCEM certification, which was not previously accepted by the Department as a board certification in emergency medicine, are functioning as medical command facility medical directors currently. Each of them has a board certification in one of the medical specialties identified in subsection (b)(2)(iii).

Notwithstanding the subsection (b)(2)(iii) alternative criterion for becoming a medical command facility medical director, the Department has decided to remove board certification in emergency medicine as one alternative criterion for qualifying as a medical command facility medical director, and to replace it with two alternative qualifying criteria. Those alternatives are that the physician shall have successfully completed 3 years in a residency program in emergency medicine or have served as a medical command physician in this Commonwealth prior to October 1, 2000.

The Department has concluded that completion of a 3-year emergency medicine residency or satisfaction of subsection (b)(2)(iii) should be the entry alternatives available to physicians who seek to become a medical command facility medical director in this Commonwealth for the first time. Consequently, it has revised subsection (b)(2) to require that any physician who is not already a medical command physician will need to satisfy one of these standards.

The Department recognizes that some physicians who are already in the system as medical command physicians have not met the standards in subsection (b)(2)(i), or even (b)(2)(iii) as it has been modified. While the Department is not fully comfortable with the qualifications those physicians had to demonstrate to qualify as medical command physicians, as it now believes that those qualifications need to be upgraded or revised, it has had to weigh that discomfort against the chaos that would occur if the Department were to now disqualify as medical command physicians and medical command facility medical directors many physicians who have functioned in those capacities in the EMS system for some time. The Department has concluded that the proper balance is achieved if those physicians who are already functioning in the EMS system as medical command physicians and medical command facility medical directors are permitted to continue to function in those positions without having met either the subsection (b)(2)(i) or (iii) standards. Also considered was the "on-the-job" experience these physicians have accumulated. Consequently, the Department has made those standards applicable to only those physicians who have not served as a medical command physician prior to October 14, 2000.

Comment

Proposed subsection (b)(1)(ii) would substantially duplicate proposed § 1003.4(b)(2). Subsection (b)(1)(i) would require a medical command facility medical director to be a medical command physician. The minimum qualifications for a medical command physician are found in proposed § 1003.4(b). Proposed subsection (b)(1)(ii) should be amended to specify only qualifications in addition to the minimum qualifications for a medical command physician.

Response

Proposed subsection (b)(1)(ii) (now subsection (b)(2)) cannot be amended to specify only qualifications in addition to the minimum qualifications for a medical command physician, because there is more than one set of criteria by which a physician may qualify as a medical command physician. Proposed § 1003.4(b)(2)(ii) proposed alternative criteria to qualify as a medical command physician. Likewise, subsection (b)(2) includes alternative criteria by which a physician may qualify as a medical command facility medical director. Moreover, the alternatives in the two provisions are not quite the same.

However, the Department concludes that proposed subsection (b)(1)(ii) lacked clarity and has revised subsection (b)(2) to address that concern. It has also divided subsection (b)(2) into subparagraphs (i)—(iii) to identify the three alternative qualifying criteria.

Comment

Does a medical command facility medical director need to take the ACLS course every 2 years even if there is no change in the course?

Response

Yes, if the physician qualifies under subsection (b)(2)(iii) rather than subsection (b)(2)(i) or (ii).

Other Changes

Proposed subsection (b)(2) is repealed for the same reason that § 1003.2(b)(2) is repealed. This repeal causes proposed subsection (b)(1)(i)—(vi), to be renumbered as subsection (b)(1)—(6).

Proposed subsection (b)(1)(iv) (now subsection (b)(4))) is reworded from requiring "experience in base station direction of prehospital emergency units" to requiring "experience in providing medical command direction to prehospital personnel."

Section 1003.4 specifies the qualifications and responsibilities of a medical command physician.

Comment

As proposed, a physician who does not have a board certification in emergency medicine cannot qualify as a medical command physician.

Response

This understanding is not accurate, but the issue is now moot, as board certification in emergency medicine has not been retained as a criterion for qualifying as a medical command physician. Both as proposed and adopted, this section permits a physician without a board certification in emergency medicine, or any other board certification, to qualify as a medical command physician. This is no different than the historical practice.

Comment

Section 1001.4 does not appear to apply to granting exceptions to the criteria in the proposed section for qualifying as a medical command physician, particularly the board certification criterion.

Response

This observation is not accurate. None of the criteria to qualify as a medical command physician are directly imposed by the EMS act. Therefore, the Department may grant exceptions to any of the criteria in accordance with § 1001.4. The same is true for the criteria to qualify as a medical command facility medical director in § 1003.3. The Department may grant an exception to the board certification criterion in § 1003.3(b)(2)(iii) even though it is already presented in the regulation as an alternative to other criteria.

Comment

Proposed subsection (b)(2) concludes with the phrase "or other programs determined by the Department to meet or exceed the standards of those programs." It is not clear what other programs would meet or exceed the standards of board certification in emergency medicine, or whether that language even applies to the board certification in emergency medicine. The Department should explain what other programs will meet or exceed the standard of board certification in emergency medicine and clarify which programs need to be taken only once.

Response

This comment illustrates that proposed subsection (b)(2) was not clearly written. The Department did not intend to have the previously quoted language apply to the proposed board certification in emergency medicine criterion. It has redrafted paragraph (2) by dividing it into subparagraphs (i)—(iii). The previously quoted language now appears only in subsection (b)(2)(iii). The language has been revised to identify those programs that need to be taken only once.

The language pertaining to meeting or exceeding the standards of the programs is also included in this subparagraph. Because of the nature of the courses involved, many programs may exist or be developed which duplicate, or include as a component, the subject matter contained in these courses. If these programs are brought to the Department's attention, the Department will maintain a record of them. Physicians seeking to qualify as a medical command physician, who had not completed a course specified in subsection (b)(2)(iii), would be approved without having to go through the § 1001.4 process if they completed one of these programs.

Comment

The Department should explain the effect of subsection (b)(2) on existing medical command physicians and those who require medical command physician status for their positions who are not board certified, and should also explain the effect on the EMS systems that currently employ medical command physicians who are not board certified.

Response

Subsection (b)(2) will not significantly impact physicians who are or seek to become medical command physicians. Previously, physicians did not require board certification in emergency medicine to become medical command physicians. There have been regulatory alternatives to the board certification criterion. That has not changed with respect to the new standard of having completed 3 years in an emergency medicine residency program.

Physicians who had received no board certification in emergency medicine had been required to be currently certified in advanced cardiac life support (ACLS) and advanced trauma life support (ATLS). Maintaining certification requires repeated completion of these courses. These standards are revised to require the physician to have taken or taught an ACLS course within the preceding 2 years, and to have completed at least once the ATLS course, and either the advanced pediatric life support (APLS) course or the pediatric advanced life support (PALS) course.

The criteria for becoming a medical command physician have been revised, but are no more stringent or burdensome under this regulation than they have been. Physicians who are medical command physicians on October 14, 2000, will be able to continue to serve as medical command physicians. Physicians who have not previously served as medical command physicians in this Commonwealth will be able to serve in that capacity by satisfying the criteria in subsection (b)(2)(i) or (iii). No comment was received contending that those standards in subsection (b)(2)(iii) are too burdensome. One comment was received supporting the changes.

As to the effect on EMS systems that currently employ medical command physicians who are not board certified in emergency medicine, there should be no impact since those physicians are grandfathered into the systems under subsection (b)(2)(ii).

Comment

Proposed subsection (c)(2) and (3), which provide parameters for a regional EMS council to employ in approving medical command physicians, should be moved to Chapter 1001, Subchapter G (relating to additional requirements for regional EMS councils). Proposed subsection (d)(1) and (2) set forth requirements for medical command facilities and regional EMS councils, not the medical command physician, and should be moved to Chapter 1001, Subchapter G and Chapter 1009 (relating to medical command facilities).

Response

The Department prefers to address the subsection (c) mechanisms for approving medical command physicians in the specific section of the regulations that pertains to medical command physicians. The Department believes that most people who are interested in ascertaining how medical command physicians are approved will look first to this section rather than to a section that addresses regional EMS council responsibilities in a general fashion or that pertains to medical command facilities.

Subsection (d) pertains to notifications that medical command facilities and regional EMS councils are required to provide pertaining to medical command physicians. Both relate to the approval of medical command physicians. Again, this is the reason for the retention in this section of the subsection (d) provisions. In the first instance, a medical command facility is required to alert

a regional EMS council that its medical command physicians intend to provide medical command in the region. Those physicians will require the regional EMS council's approval as medical command physicians unless they will only be giving medical command in that region to patients whose treatment originates in a region in which they are already approved. The second provision, providing for a regional EMS council to notify the Department of its approval of a medical command physician, completes the approval loop. However, to facilitate realization that these provisions are contained in this section, the Department has revised the subsection (d) heading to read "Notice requirements of medical command facility and regional EMS council."

Comment

Proposed subsection (c)(2)(ii) would permit a regional EMS council to approve a physician as a medical command physician if the physician completed the voluntary medical command certification program administered by the Department, instead of establishing to the regional EMS council that the physician satisfied the criteria in proposed subsection (b)(1)—(6). The Department should explain for which of the criteria in proposed subsection (b)(1)—(6) completion of the voluntary program would serve as a substitute.

Response

The Department administers and will continue to administer the voluntary program so that the Department determines through the program that all of the criteria in subsection (b)(1)—(6) are satisfied. Virtually all physicians who secure approval to function as a medical command physician do so by completing the voluntary medical command physician certification program administered by the Department.

Comment

Proposed subsection (c)(3) requires a physician seeking approval as a medical command physician to establish that he will be working under the auspices of a medical command facility. The Department should revise the proposal to state how the physician is to demonstrate compliance with this requirement.

Response

The Department agrees with this comment. The Department considers a medical command physician to function under the auspices of a medical command facility when the physician has an arrangement with the facility to provide medical command on its behalf while on duty for the facility, under the direction of its medical director, and under its policies and procedures. It has revised subsection (c)(3) to include this clarification.

Comment

Proposed subsection (c)(3)(i) permits a regional EMS council to grant a waiver to Department recognition of a facility as a medical command facility. The Department should explain why this waiver is permitted.

Response

The topic of "recognition" of a medical command facility can be somewhat confusing. This is because the EMS act does not require a facility to secure recognition from the Department to function as a medical command facility. Seeking recognition from the Department is optional. The Department believes that this is a weakness of the EMS act. Nevertheless, without securing that recognition the medical command facility would not enjoy the limited civil liability protection afforded by section 11(j)(4) of the EMS act. Consequently, to date, all medical command facilities that operate in this Commonwealth have secured recognition from the Department.

No waiver to Department "recognition" of a medical command facility is authorized by the regulation. The regulation does not permit regional EMS councils to grant "recognition" status to medical command facilities.

This section authorizes a regional EMS council to determine whether a facility meets Department-prescribed standards for a medical command facility in the course of the regional EMS council determining whether a physician affiliated with that facility should be approved as a medical command physician. Subsection (b)(2) provides that to be approved as a medical command physician a physician must function under the auspices of a medical command facility. The regional EMS council needs to determine whether the physician seeking approval from it as a medical command physician satisfies that requirement. To make that determination, the regional EMS council must determine whether the facility identified by the physician is, in fact, a medical command facility. To qualify as a medical command facility, the facility must satisfy all of the requirements for a medical command facility which have been prescribed by the Department in § 1009.1 (relating to operational criteria). Therefore, if the facility the physician identifies has not received Department recognition as a medical command facility, it becomes incumbent upon the regional EMS council to determine whether the facility has met the criteria prescribed by the Department.

Comment

The proposal should be modified so that it permits a physician to meet the ACLS course requirement by teaching the course. Also, the regulation should be modified to not require the physician to complete the ACLS course if the physician has completed a course providing more comprehensive ACLS training.

Response

The Department agrees. It has revised the text of subsection (b)(2)(iii) accordingly.

Comment

Contrary to the proposal, medical command physicians should not be required to provide medical command to prehospital personnel from other parts of this Commonwealth. Those prehospital personnel should be required to contact a medical command physician operating in the EMS region in which they normally function.

Response

The recommendation is rejected. The Department has received complaints from ambulance services that transport initially stable patients over long distances, that when emergencies arise during transport, and communication with a customary medical command physician cannot be established, medical command physicians unfamiliar with the ambulance service and its prehospital personnel will sometimes decline to provide necessary medical command. This cannot be permitted. Prehospital personnel need to have access to a medical command physician at all times. The recommendation is impractical to implement based upon current communications technology and the costs associated with securing long distance access to medical command physicians.

Other Changes

Errors occurred in proposed subsection (b)(3) in labeling the years of residency training referenced in that para-

graph. The Department has corrected the errors by inserting the term "graduate" where appropriate. The Department has also removed the term "base station" in subsection (b)(6).

Section 1003.5 (relating to ALS service medical director) specifies the criteria a physician needs to satisfy to become an ALS service medical director and the responsibilities of an ALS service medical director.

Comment

Subsection (a)(1)(ii) should be revised to insert the word "service" after the first time "ambulance" appears in that subparagraph, and the language "providing guidance" should be removed because it repeats the introductory language in paragraph (1).

Response

The absence of the term "ambulance" was an error and has been corrected. Although the introductory language in subparagraph (ii) does, to some extent, repeat the introductory language in paragraph (1), the Department has not removed it because the repetition makes sense within the structure of the paragraph, particularly when considering how subparagraphs (i), (iii) and (iv) are worded.

Other Changes

The term "base station" is removed from subsection (b)(2) and (5) and is replaced with "medical command" in paragraph (2).

Subchapter B. Prehospital and Other Personnel

Section 1003.21 (relating to ambulance attendant) is amended to explain the ambulance attendant's role as a staff member of an ambulance service and to identify the skills an ambulance attendant may perform when serving on an ambulance crew.

Comment

The American Red Cross does not offer an advanced first aid course. The reference to that course in this section should be changed.

Response

The American Red Cross does not offer a course that it labels "Advanced First Aid." Nevertheless, the reference in this section to "advanced first aid course" is retained as a generic label. The definition of "ambulance attendant" in section 3 of the EMS provides that for an individual to be considered an ambulance attendant that person must have completed a course in advanced first aid sponsored by the American Red Cross or an equivalent program approved by the Department. Although the American Red Cross does not offer a course that it labels "advanced first aid," it does offer courses that are an advanced first aid course or include comprehensive training in advanced first aid, and which are simply not titled "advanced first aid," such as its Emergency Response Course.

Comment

There is no support in the EMS act for the proposal to permit an ambulance attendant to use an automated external defibrillator (AED) even if under the approval of the ambulance service medical director.

Response

The Department's proposed regulations were published at almost the same time the good Samaritan civil immunity for use of AED statute (42 Pa.C.S. § 8331.2) went into effect. Clearly, persons such as ambulance attendants have the authority to use an AED under that statute. However, when they are responding to an emergency as part of an ambulance crew, a patient is entitled to expect greater control and oversight over the ambulance attendant's use of an AED than the patient might expect if the same individual responded to the emergency as a good Samaritan. Subsection (c)(11) is revised, however, to clarify that a BLS ambulance service that employs AEDs needs to secure the services of a physician who directs its use of AEDs rather than a physician who is required to function as an overall medical director for the BLS ambulance service.

Comment

The Department should reconsider the proposed removal of the requirement that an ambulance attendant be at least 16 years of age. Furthermore, if a regulation addressing one type of prehospital practitioner includes a minimum age requirement, all regulations pertaining to certification requirements for preshospital personnel should include a minimum age requirement.

Response

The Department received similar comments for its other regulations that present criteria for qualifying as a type of prehospital practitioner. The comment will not be repeated in the discussion of the comments to those other regulations.

As explained in the Preamble to the proposed rulemaking, the Department proposed to delete the 16 years of age criterion that had been in this regulation because the EMS act sets no age requirement for an ambulance attendant. The age requirement for an ambulance attendant is regulated by the child labor laws in the Commonwealth, not the EMS act. The child labor laws prohibit a minor under 16 years of age from serving as an ambulance attendant. See sections 2 and 7.3(g) of the Child Labor Law (43 P. S. §§ 42 and 48.3). The Department decided not to repeat in its regulations the age requirement of the Child Labor Law because the Department does not administer that law and because that law may change. However, in consideration of the concern that has been expressed, the Department has amended subsection (a) to state that one of the criteria for serving as an ambulance attendant is satisfying the age requirement for an ambulance attendant under the Child Labor Law. The reason a specific minimum age requirement is included in some of the other regulations, such as § 1003.22(b)(1)(ii) (relating to first responder), is that the age for that type of preshospital practitioner is expressly established by the EMS act. See 35 P. S. § 6931(a.1)(2)(ii).

Comment

Courses in advanced first aid other than those offered by the American Red Cross should be accepted and mentioned in the regulation.

Response

Other courses may be accepted by the Department. The Department will not list them in this section because the list could change. The Department, in consultation with a technical advisory committee of PEHSC, publishes a notice in the *Pennsylvania Bulletin* listing those courses from time to time under the definition of "ambulance attendant" and the responsibility imposed upon the Department under the nonmedical good Samaritan civil immunity statute (42 Pa.C.S. § 8332).

Other Changes

Since the American Red Cross does not offer a specific course labeled "advanced first aid," the Department has

had to look at courses it does offer which teach advanced first aid skills. However, some of those courses may emphasize different advanced first aid skills and some may go beyond advanced first aid skills and offer training in skills that an ambulance attendant should not be performing. Consequently, the Department proposed in subsection (c)(13) to publish in the *Pennsylvania Bulletin*, at least annually, a list of skills taught in the American Red Cross courses which are truly advanced first aid skills, and then to permit an ambulance attendant to perform only the skills among those listed for which the ambulance attendant actually received training. The Department has sought to clarify this paragraph by dividing it into subparagraphs, and by adding the statement that an ambulance attendant may not perform a skill taught in a course approved by the Department under that paragraph (which may include skills in addition to advanced first aid skills) unless the skill is contained in the list of advanced first aid skills the Department publishes in the *Pennsylvania Bulletin*.

The Department has revised proposed subsection (c)(3) to remove the language "resuscitation mask, nasal cannula, nonrebreather mask and bag valve mask" to specify how an ambulance attendant may administer oxygen. As revised, this provision authorizes an ambulance attendant to administer oxygen only in a manner consistent with the ambulance attendant's training.

The Department has substituted "skills" for "services" in various places in this section. The reason for this revision is discussed in response to the next comment.

Section 1003.22 (relating to first responder) specifies the qualifications and functions of a first responder.

Comment

Instead of using the term "BLS services" the regulation should use the term "BLS objectives."

Response

The term "service" has the potential to cause confusion because it is sometimes used to refer to an ambulance organization (for example, BLS ambulance service) and other times used to refer to the procedures performed by prehospital personnel (for example, BLS services). Here it is used to refer to the latter. However, the EMS act also uses this term in both contexts. In fact, two of the terms defined in section 3 of the EMS act are "ambulance service" and "basic life support services." While the context of the sentence should clearly convey how the term is being used, the Department has revised this regulation to substitute the term "skills" for "services" in several places.

Comment

The intent of subsection (e)(4) is not clear. It appears to state that some courses are offered which may not be counted as continuing education credits or may not be used to expand the scope of the first responder's duties. The Department should amend subsection (e)(4) to clarify its intent.

Response

The Department agrees with the comment. Proposed subsection (e)(4) was not designed to address what courses are or are not acceptable for continuing education credit. The Department has revised subsection (e)(4) to clarify its intent.

The Department certifies first responders. One criterion for certification is that the individual must have completed a first responder training course approved by the Department. However, just as it recognizes for ambulance attendants, courses that provide training in addition to that which is appropriate for an ambulance attendant, the Department will also recognize, for first responder certification purposes, courses that meet or exceed the standards of a first responder training course that the Department has approved. A person who completes such a course will be able to qualify for first responder certification, but may perform skills for which that person has received training only if those skills are also taught in a Department-approved course. The Department will publish a list of these skills at least annually.

At present, the benchmark for courses approved by the Department for first responder training is the Emergency Response Course taught by the American Red Cross—which is also the American Red Cross's course in advanced first aid—the course establishing the scope of practice for an ambulance attendant. The Department is also developing its own first responder course and has recognized a few other courses for first responder training.

A first responder's scope of practice may, in the future, exceed that of an ambulance attendant. This would occur if the Department develops or approves courses for first responder training which teach skills in addition to those taught in an advanced first aid course sponsored by the American Red Cross.

If that occurs, additional skills will be added to the list of first responder skills published by the Department. However, a first responder may have taken a training course before those additional skills were added to the approved training. The regulation requires the first responder to receive training in the listed skills before performing them, but permits the first responder to receive that training through continuing education rather than by completing a revised first responder training course.

The Department has revised proposed subsection (e)(2) to more clearly convey these standards. It has divided the proposed paragraph into subparagraphs and has added the statement that a first responder, regardless of which course he has taken, may not perform a skill unless the skill is contained in the list of first responder skills published by the Department in the *Pennsylvania Bulletin*.

Comment

First responders have liability protection under the EMS act. The proposed sentence that states the section does not prohibit a first responder from providing EMS as a good Samaritan should be removed. This sentence may encourage a prehospital practitioner to attempt to bypass systematic responses orchestrated through the EMS system.

Response

No change is made. The same comment is made to several of the sections pertaining to prehospital personnel. It will be addressed here in a generic manner and will not be repeated in the discussion of the other sections.

While first responders and other prehospital personnel are afforded limited civil liability protection under sections 11(j)(2) and 13 of the EMS act (35 P. S. §§ 6931(j)(2) and 6933), that protection may only apply when the prehospital practitioner is responding to an emergency within the scope of the EMS act, that is, as part of the crew of an ambulance or on behalf of a QRS. There may be occasions, however, when a first responder or other

prehospital practitioner is off duty and comes upon an emergency as an individual. It is not clear whether the civil liability protection afforded by the EMS act would apply in that case. However, if it would not, the individual would be afforded the limited civil liability protection given by the good Samaritan statute provided the prehospital practitioner satisfies the statutory requirements to qualify for good Samaritan status. The questioned sentence is included in the section to encourage prehospital practitioners to act as good Samaritans if there is a need to do so. It does not authorize, nor is it intended to encourage, first responders and other prehospital personnel to circumvent systematic responses to emergencies by dispatched ambulance services and QRSs.

Section 1003.23 (relating to EMT) specifies the qualifications and role of an EMT.

Comment

Although proposed subsection (e)(2) would allow an EMT to transport a patient with an intravenous catheter, it would not permit the EMT to transport the patient with medication running. Prohibiting transportation of a patient with medication running is overly restrictive. An exception should be made to allow the transport of a patient with an intravenous catheter with medication running if continued running of the medication is part of the patient's normal outpatient protocol.

Response

The Department agrees. It has revised subsection (e)(2) to permit the transport of a patient with an intravenous catheter with medication running if the medication is part of the patient's normal treatment plan, and the care is consistent with the Statewide BLS medical treatment protocols.

Comment

The intent of proposed subsection (e)(3) is not clear. It appears to state that some courses are offered which may not be counted as continuing education credits or may not be used to expand the scope of the EMT's duties. The Department should amend subsection (e)(3) to clarify its intent.

Response

The Department agrees. The same comment was made to proposed § 1003.22(e)(4). The Department has revised proposed subsection (e)(3) and added a subsection (f) to include provisions similar to those made to § 1003.22(e)(4) for reasons similar to those discussed in responding to the comment to proposed § 1003.22(e)(4).

Section 1003.23a (relating to EMS instructor certification) is new. Current provisions for EMT instructor certification have been removed from § 1003.22 and, with some revision, have been inserted in this section. There is no statutory provision directing the Department to issue EMS instructor certifications. However, the Department offers this certification program to potential instructors to improve the quality of training in EMS training institutes. There was some discussion of this section in the comments, but no recommendation for change was received.

Changes

Subsection (a)(6) is revised to include current certification as a CPR instructor as an alternative qualifying criterion to current certification in CPR.

Subsection (b)(3) is revised to permit the applicant for renewal of an EMS instructor certification to document conducting 60 hours of teaching during the previous 3 years rather than 20 hours of teaching in each of those years. The paragraph has also been revised to clarify that the teaching may be in EMS or rescue courses.

Subsection (b)(4) is revised to remove the term "current" in referring to certification as an EMT-paramedic. Unlike some of the certifications issued by the Department, certification as an EMT-paramedic is permanent.

Subsection (b)(6) is revised to postpone the requirement of taking an EMS instructor update program, as a condition for renewal of EMS instructor certification, until October 7, 2003. It will take some time for the Department and regional EMS councils to develop and administer these programs.

Section 1003.24 (relating to EMT-paramedic) specifies the qualifications and role of an EMT-paramedic.

Comment

The Preamble to the proposed rulemaking states that subsection (c) (relating to transition of EMT-paramedic I and EMT-paramedic II certification to EMT-paramedic certification) would be deleted, but there is no beginning bracket in the annex to that preamble before subsection (c) to show that the subsection would be removed. This needs to be corrected in final rulemaking.

Response

The Department agrees. A bracket was included before the prior text of subsection (c) in the proposed rulemaking the Department filed with the LRB to indicate that the Department was proposing to repeal that language and substitute new text in its place. An error occurred in reprinting the proposed revisions to the section. The Department has corrected the error.

Comment

The intent of proposed subsection (d)(19) is not clear. It appears to state that some courses are offered which may not be counted as continuing education credits or may not be used to expand the scope of the EMT-paramedic's duties. The Department should amend subsection (d)(19) to clarify its intent.

Response

The Department agrees. The same comment was made to proposed §§ 1003.22(e)(4) and 1003.23(e)(3). The Department has revised proposed subsection (d)(19) and added a subsection (e) to include provisions similar to those made to § 1003.22(e)(4) for reasons similar to those discussed in responding to the comment to proposed § 1003.22(e)(4).

Comment

Because an EMT-paramedic requires medical command authorization from an ALS service medical director as a precondition to performing ALS skills, this regulation should state that an EMT-paramedic may not perform ALS skills when staffing a BLS ambulance.

Response

The same comment was made with respect to prehospital registered nurses. It will not be repeated in the discussion of § 1003.25b (relating to prehospital registered nurses).

The recommended revision is not made. Subsection (d) does state that the ALS skills set forth in the subsection may be performed by an EMT-paramedic only if the EMT-paramedic has medical command authorization. Medical command authorization is not issued to prehospi-

tal personnel who work for BLS ambulance services. Section 1003.28(a) (relating to medical command authorization) states that the ALS service medical director's grant of medical command authorization to an EMT-paramedic or prehospital registered nurse applies only to the ALS ambulance service for which that physician makes the decision. Moreover, the contention that an EMT-paramedic or prehospital registered nurse may not perform ALS skills on a BLS ambulance is not entirely correct. Either prehospital practitioner may perform ALS skills on a BLS ambulance when that practitioner responds to an emergency on behalf of an ALS ambulance service for which the practitioner has medical command authorization, and then enters the BLS ambulance to attend to the patient during transport of the patient to a receiving facility by the BLS ambulance.

Comment

The Department should maintain a list of advanced skills that are not taught in EMT-paramedic training courses, which an EMT-paramedic could perform with additional training, continuing education and medical director approval. Similar provisions should also be made for EMTs and first responders.

Response

The Department rejects the recommendation. An ALS service medical director may apply for an exception to the scope of practice limitations imposed upon an EMT-paramedic, under § 1001.4 (relating to exceptions), if an ALS service medical director wants an EMT-paramedic to be able to perform, for a specific ALS ambulance service, skills in addition to those taught in an EMT-paramedic training course and believes that the EMT-paramedic is qualified to do so. EMTs and first responders may also apply for an exception to their scope of practice limitations.

Comment

As an addendum to the preceding comment, the regulation should not include performing central venous cannulation, urinary catheterization and the use of gastric tubes. These are types of procedures that should be limited to EMT-paramedics with additional training.

Response

The recommendation is rejected. These are skills that have been taught in EMT-paramedic NSC for many years. Also, an ALS service medical director is required to determine the competency of the EMT-paramedic to perform these skills before granting and renewing medical command authorization to the EMT-paramedic.

Section 1003.25a (relating to health professional physician) is revised to eliminate conditions the section previously specified for a physician to function as a health professional physician. The EMS act's definition of "health professional" states that a physician qualifies to function in that capacity if the physician has "education and continuing education in [ALS] and prehospital care." See 35 P. S. § 6923. It does not provide for the Department to certify health professional physicians or to set standards physicians would be required to meet to serve as health professional physicians. No comment addressing this section was received. This section is adopted as proposed.

Section 1003.25b specifies the qualifications and role of a prehospital registered nurse.

Comment

Subsection (c) proposes that the scope of practice of a prehospital registered nurse include the scope of practice of an EMT-paramedic and other ALS services authorized by the Professional Nursing Law. The Professional Nursing Law does not mention ALS services. Either delete the acronym "ALS" from subsection (c), or explain how it applies.

Response

The Department agrees that the term "ALS" is not required and has deleted it from subsection (c).

Comment

The scope of practice of prehospital registered nurses and EMT-paramedics should be the same. Delete any reference to expanding that scope of practice in accordance with the Professional Nursing Law (63 P. S. §§ 211—225.5).

Response

This recommendation is rejected. Section 11(e.1)((7) of the EMS act provides that consistent with the provisions of the EMS act a prehospital registered nurse's scope of practice is governed by the Professional Nursing Law and 49 Pa. Code Chapter 21 (relating to State Board of Nursing). A prehospital registered nurse should be authorized to perform those nursing skills which exceed the scope of practice of an EMT-paramedic, but which facilitate the provision of EMS to a patient, when authorized by a medical command physician through either direct medical command orders or standing treatment protocols.

Other Changes

In subsection (c)(3) the Department has inserted the term "medical" before "treatment protocols."

Section 1003.26 (relating to rescue personnel) pertains to the Department's certification of rescue personnel. It is amended to clarify that the Department approves courses for rescue personnel and issues certifications to persons who complete those courses. Receipt of such a certification is not, however, required by law as a precondition to freeing an entrapped person. The Department is granted no regulatory oversight over rescue activities under the EMS act. The Department approves rescue programs and issues rescue technician certificates as a public service, in an effort to ensure that there are a sufficient number of personnel throughout this Commonwealth who have appropriate training and skills to perform rescues. The certification merely reflects the Department's opinion that the person is qualified to perform the rescues taught in the approved course. The section clarifies that receiving a rescue technician certification issued by the Department is not a legal precondition to performing rescues.

No comments addressing this section were received. This section is adopted as proposed.

Section 1003.27 (relating to disciplinary and corrective action) identifies the grounds for discipline against prehospital personnel, the rules applicable to disciplinary proceedings, and the sanctions the Department may impose when discipline is warranted. No comments to this section were received. The section is adopted as proposed except "personnel" is replaced by "practitioner" in subsection (a)(15).

Section 1003.28 (relating to medical command authorization) specifies the criteria for an ALS service medical director to grant medical command authorization, and the procedures for EMT-paramedics and prehospital regis-

tered nurses to appeal ALS service medical director decisions to deny, restrict or remove medical command authorization.

Comment

The first two sentences of subsection (b)(3) and the last sentence of subsection (c)(2) are unclear. They would be clearer if they were broken into shorter sentences, or when appropriate, a list of requirements.

Response

The Department has attempted to make this section clearer by dividing the specified sentences in subsection (b)(3) into shorter sentences, and by revising the referenced sentence in subsection (c)(2) so that it lists requirements.

Comment

If the decision of the ALS service medical director is overturned by the regional EMS medical director or the Department, it is unclear as to who takes legal responsibility for the future actions of the EMT-paramedic. The ALS service medical director, who believed the preshospital practitioner to be deficient in the ability to care for patients, should not be responsible. The Department should clarify who will serve as the ALS service medical director of the prehospital practitioner whose medical command authorization is reinstated.

Response

It is beyond the scope of the Department's statutory authority to do what is being requested. The EMS act provides that the decision of the ALS service medical director to remove an individual's medical command authorization may be overturned by the regional EMS medical director or the Department. Conceivably, the ALS service medical director's decision could even be overturned by the Commonwealth or the Supreme Court of Pennsylvania. If the ALS service medical director's decision is overturned, the ALS service medical director will need to either accept the decision, appeal it and attempt to secure a stay, or no longer function as the medical director for the ALS ambulance service with which the practitioner is employed. The matter of civil responsibility for actions of the prehospital practitioner is not a matter regulated by the Department and cannot be addressed in the Department's regulations. These concerns should be addressed to the Legislature rather than to the Department.

Comment

In subsection (e) the proposal to remove the authority to appeal the restriction of medical command authorization should be rejected.

Response

The Department rejects the recommendation. Section 11(d) and (e.1) of the EMS act addresses appeals of decisions to remove medical command authorization. Proposed subsection (c)(3) clarifies that the type of restriction that an ALS service medical director may place on medical command authorization, short of removal of that authorization, may not preclude the prehospital practitioner from performing any of the skills included within the scope of the individual's certification or recognition which are also permitted by the medical treatment protocols for the region. In essence, the restrictions may only impose additional safeguards, such as additional supervision. This is not action for which the EMS act grants any appeal rights.

Comment

This section should be revised to permit a regional EMS medical director to appoint a hearing officer.

Response

The recommendation is rejected. The EMS act places the decisionmaking responsibility on the regional EMS medical director. The regional EMS medical director cannot delegate that responsibility to another person. The regional EMS medical director may, however, assign another person to conduct the hearing as long as the regional EMS medical director reviews the entire record and personally decides the matter. Section 1003.29 (relating to continuing education requirements) specifies the continuing education requirements and options for prehospital personnel.

Comment

In subsections (a)(1) and (b)(1) the Department should clarify whether the proposed medical and trauma continuing education requirements are applicable to only the first full certification following October 14, 2000, or whether they also apply to all subsequent recertifications.

Response

The proposed trauma and medical continuing education requirements are adopted as proposed. They will apply not only to the first full certification period, but to all subsequent recertifications. The language has been revised to clarify that intent.

Other Changes

In subsections (c) and (d) the Department had proposed that the medical and trauma continuing education requirements for EMT-paramedics and prehospital registered nurses commence in 1999. The Department has revised these subsections to provide that these requirements will commence in 2002. This amount of deferral time from the date of adoption of these new requirements is more realistic from an administrative perspective for the Department, regional EMS councils and continuing education sponsors.

Section 1003.30 (relating to accreditation of sponsors of continuing education) specifies the criteria that needs to be satisfied for an organization to serve as a continuing education sponsor.

Comment

Contrary to the proposal in subsection (d), the Department should not permit continuing education sponsors to assign credit to the courses they offer.

Response

The Department does not currently permit continuing education sponsors to assign credit to the courses that they offer. However, the Department wants to retain that option. As proposed, a continuing education sponsor could assign credit for a course only under express authorization from the Department. The continuing education sponsor would be required to comply with the regulatory criteria in doing so. This section is adopted as proposed.

Section 1003.31 (relating to credit for continuing education) is new. It defines what constitutes a credit hour and time units of instruction for which credit will be awarded. It also provides for continuing education credit to be awarded for teaching, self study courses and other courses not presented in a classroom setting, and for courses offered by organizations with National or State

accreditation to provide education. Additional matters addressed are how continuing education credits are to be reported to prehospital personnel, and the procedure for resolving disputes when a prehospital practitioner believes that he has not received credit that has been earned.

Comment

This section uses the term "prehospital practitioner" but that term is not defined in the regulations.

Response

This comment was addressed in the discussion of comments to § 1001.2. The term is used throughout the regulations and is now defined in § 1001.2.

Comment

Clarify what is meant by the statement in proposed subsection (a) that credit may not be received for other than 30 or 60-minute units of instruction, however the course shall be at least 60 minutes in length.

Response

The Department believes that the statement is clear. It has not revised the language. One credit hour is awarded for each 60 minutes of instruction. A continuing education course must be at least 60 minutes in length. If the course extends beyond 60 minutes, no credit will be given for education in other than 30 or 60-minute increments. For example, a course that provides instruction for 90 minutes will be assigned 1 1/2 credits; a course that provides instruction for 100 minutes will also be assigned 1 1/2 credits.

Changes

In subsection (c) the proposed language "a training institute for prehospital personnel accredited by the Department" is replaced with "an EMS training institute." The term "EMS training institute" is defined in § 1001.2 to mean the same as the language it replaces.

Section 1003.32 (relating to responsibilities of continuing education sponsors) is new. This section specifies responsibilities of a continuing education sponsor with respect to keeping records of attendance, reporting attendance, having a mechanism for course evaluation, retaining records, monitoring compliance, and making available various reports and records to the Department.

Section 1003.33 (relating to advertising) is also a new section. It addresses how a continuing education sponsor may advertise a course approved by the Department, as well as a course for which Department approval is being sought, but has not yet been obtained.

Section 1003.34 (relating to withdrawal of accreditation or course approval) is another new section. It provides for the Department to withdraw accreditation, downgrade accreditation to provisional status, or withdraw approval of a continuing education course applicable to any future presentation of the course.

No comments addressing these sections were received. Sections 1003.32—1003.34 are adopted as proposed, except the text of § 1003.32(a) is replaced with language addressing the procedure for securing approval of a new continuing education course. As a result of this addition, the text of proposed § 1003.32(a)—(h) is moved to subsections (b)—(i).

The Department proposed to delete Subchapter C (relating to air ambulance personnel), and address much of the subject matter of this subchapter in Chapter 1007 (relating to the licensing of air ambulance services-rotorcraft). No comments addressing the proposed repeal of this subchapter were received. Subchapter C is rescinded.

Chapter 1005. Licensing of BLS and ALS Ground Ambulance Services

This chapter specifies the licensure and operating criteria for ground ambulance services.

Section 1005.1 (relating to general provisions) is amended to state that Chapter 1005 applies to ground ambulance services. A later chapter, Chapter 1007, pertains to air ambulance services.

Comment

The first word "No" in the second sentence of subsection (a) is bracketed in the *Pennsylvania Bulletin* to show the proposed deletion of that word. A replacement word such as "A" needs to be inserted as the first word of the sentence. Also, the word "exempted" is deleted in the *Pennsylvania Bulletin* version of the regulation. Without it, the sentence makes no sense. That term needs to be inserted. Similar revisions also need to be made to § 1007.1(a) (relating to general provisions for licensing of air ambulance services).

Response

The Department agrees that revisions are required to subsection (a) as recommended. The proposed language the Department submitted to the LRB for subsection (a) was different than the actual language published. Errors occurred in printing the revised language. The Department has corrected the errors. The language in proposed § 1007.1(a) is somewhat different than that contained in subsection (a). That language is appropriate and does not require revision.

Comment

Subsection (c)(1) labels an ALS ambulance that transports patients as a mobile intensive care unit vehicle. The labeling of an ambulance that does not have the capability to perform a 12 lead electrocardiogram, do any invasive monitoring whatsoever, and is not required to carry pulse oximetry equipment, as a "mobile intensive care unit," is incorrect and misleading to the public.

Response

The Department agrees. The term "mobile intensive care unit" has been employed for many years, but that does not make the use correct. The Department believes that the term exaggerates the function of a transporting ALS ambulance. The Department has revised the term by substituting "ALS" for "intensive."

Section 1005.2 (relating to applications) identifies information solicited by an application for an ambulance service license and the process for an entity to apply for an ambulance service license and an amendment of a license.

Comment

Does this section permit an entity to apply for an ambulance service license to operate in an area that is already serviced by an ambulance service?

Response

An entity may apply for an ambulance service license to operate in an area that is already serviced by an ambulance service. This section does not address that issue.

However, no provision of the EMS act or Part VII of the Department's regulations prohibits the application.

Comment

Contrary to the proposal, the Department should not revise subsection (a)(5) to delete solicitation of information on mutual aid agreements.

Response

This recommendation is rejected. The provision is being removed because the existence of mutual aid agreements is not material to whether the applicant should be licensed. However, the removal of the provision soliciting information on mutual aid agreements has no bearing upon whether an ambulance service may continue to have mutual aid agreements with other ambulance services. It bears noting, nevertheless, that an ambulance service may not use a mutual aid agreement as a mechanism to shift its licensure responsibilities to another ambulance service. For example, an ALS ambulance service may not satisfy the requirement that it operate 24 hours-a-day, 7 days-a-week, by discontinuing its operations for periods of time and arranging for another ALS ambulance service to respond to its calls during those periods.

Comment

A regional EMS council should not be required to conduct an onsite survey of an applicant for ambulance service licensure until it determines that the application is complete.

Response

The Department agrees. It did not provide otherwise in the proposed rulemaking. Nevertheless, upon additional consideration of this section, the Department concludes that further elaboration of the licensure mechanics is required. The Department has revised subsection (b)(2) to provide that the regional EMS council is to return an incomplete application to the applicant. It has also revised that paragraph to state that a regional EMS council will return to an applicant an inaccurate application, before conducting an onsite survey, when it determines the inaccuracy of any information provided in the application that is verifiable without the regional EMS council conducting an onsite survey. A regional EMS council should not be wasting its resources in conducting an onsite survey when an application needs to be returned to the applicant for the purpose of correcting errors. The Department has revised subsection (c) to state that a regional EMS council is to conduct an onsite survey only after it has received a complete application and has verified the accuracy of the information included in the application which it is able to verify without conducting an onsite inspection.

Comment

In subsection (a)(5) instead of providing that the license application will include information pertaining to an emergency service area an ambulance service commits to serve. It should provide that the license application shall identify the emergency service area the ambulance service would be available to serve.

Response

The Department agrees that solicitation of information as to where an ambulance service is available or plans to serve is more appropriate, especially if ambulance service dispatch legislation is passed. The Department has revised subsection (a)(5) and subsection (d) accordingly.

Comment

Subsection (a)(9) should not require the applicant to divulge whether it intends to place its ambulances under systems status management practices rather than at specific building locations.

Response

The Department disagrees with the comment. Subsection (a)(9) is adopted as proposed. Systems status management is a process whereby an ambulance service locates its ambulances in different locations on different days and at different times so that it will be closer to anticipated calls for emergency assistance based upon historical patterns of requests for ambulance assistance. For example, during the normal business workweek it may place an ambulance near an area where business is concentrated. It may place the same ambulance at other locations when those businesses are not in full operation.

Some of the criteria for licensure are that the ambulance service will operate in a safe and efficient manner and that its ambulances will be adequately staffed. See 35 P. S. § 6932(h)(2), (3) and (4). To make those determinations, the Department needs information regarding how the ambulance service intends to operate.

Comment

In proposed subsection (e), which requires an ambulance service to apply for and secure an amendment of its license before substantively altering the location or operation of its ambulances within a region, the words "physical building" should be inserted before "location."

Response

The Department rejects the recommendation. As discussed in the response to the previous comment, an ambulance service may elect to employ systems status management as its means for placing ambulances. Since the location of its ambulances would not be constant, the location of its physical building location would not be very significant. This is particularly true with respect to the duty to meet statutory staffing requirements. The Department is required to determine that an applicant will satisfy statutory staffing standards. The Department makes that determination after considering information such as where the ambulance service conducts operations and where its personnel are located. When an ambulance service intends to conduct operations a great distance from where it had previously operated, the service may not be able to do so for all required times with the same complement of prehospital personnel. The Department needs to determine that the ambulance service is capable of operating appropriately under those circumstances before the ambulance service commences those operations.

Other Changes

In subsection (a)(2) the Department has replaced the word "licensure" with "license."

The Department has added under subsection (a)(10), which relates that the license application will solicit the names, titles and summary of responsibilities of persons who will be staffing the ambulance service as officers, directors or other officials, and information as to any misdemeanor or felony convictions, or disciplinary sanctions, that have been imposed against them. Section 12(h)(1) of the EMS act (35 P. S. § 6932(h)(1)) provides that one criterion for licensure is that the ambulance service will be staffed by responsible persons. The Department needs information such as that specified in subsec-

tion (a)(10) to be able to make the assessment of whether the applicant for an ambulance service license will be staffed by responsible persons.

The Department has revised subsection (b) to provide procedures for an applicant to secure a single license to locate ambulances and conduct operations in multiple EMS regions. This is a departure from the previous regulations. They required a separate license for ambulance service operations in each region where an ambulance service stations its ambulances. The change in regulatory requirements to require an entity to secure a single license covering all of its ambulance service operations in this Commonwealth will be discussed in greater detail under § 1005.5 (relating to licensure).

The Department has also removed the text of proposed subsection (d), which pertained to placing a new ambulance in operation, moved the text of proposed subsection (e) to subsection (d) and inserted new text in subsection (e) to describe application procedures for an ambulance service to amend its license to enable it to expand its operations into another EMS region.

Section 1005.2a (relating to change in ambulance fleet) is new. It deals with the subject matter that the Department had proposed to address in § 1005.2(d). Subsection (a) requires an ambulance service to submit a modification of ambulance fleet form to the appropriate regional EMS council before placing an additional or permanent replacement ambulance in operation. It also provides that an ambulance service may not operate the ambulance unless it is authorized to do so by the Department following inspection of the ambulance. These requirements are consistent with the legislative intent that before an ambulance is placed into service it is to be determined by the Department to be "adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered." See 35 P. S. § 6932(h)(2). If there is an extraordinary event that requires an ambulance service to secure a permanent replacement ambulance immediately, the ambulance service may seek an exception to the prior inspection requirement under § 1001.4.

Sometimes an ambulance breaks down and an ambulance service needs to replace it on a temporary basis immediately to continue serving the public. The acquisition of a new or replacement ambulance is an expected event and affords the ambulance service ample time to provide a regional EMS council with advance notice and an opportunity to conduct an inspection before the ambulance needs to be used. On the other hand, the need to secure a temporary replacement ambulance may arise unexpectedly. Consequently, the Department has adopted subsection (b) to permit an ambulance service to operate a temporary replacement ambulance without securing prior approval from the Department. The ambulance service will be required to file a temporary change of vehicle form with the appropriate regional EMS council no later than 24 hours after placing the temporary replacement ambulance in operation. The form may be filed by facsimile, electronic or regular mail. Upon receiving the form the regional EMS council will issue a letter authorizing use of the temporary replacement for 7 days, but may later extend that time period. The regional EMS council will conduct an inspection of the temporary ambulance if it will be used for more than a few days.

Section 1005.3 (relating to right to enter, inspect and obtain records) pertains to an ambulance service's duty to permit employes of the Department or regional EMS councils to conduct inspections, review the applicant's or ambulance service's policies, and secure copies of records from it. It clarifies that the ambulance service has a duty to permit the review and that its failure to do so constitutes misconduct and a basis for discipline. No comments to this section were received. The Department has corrected a typographical error. Otherwise, this section is adopted as proposed.

Section 1005.4 (relating to notification of deficiencies to applicants) pertains to how the Department and a regional EMS council interact with an applicant if there are deficiencies following an onsite inspection.

Changes

No comments addressing this section were received. Nevertheless, the Department has revised proposed subsection (a) to clarify that it applies when a regional EMS council completes an onsite inspection under either an application for a license or an application for an amendment of a license. Proposed subsection (e) is revised to clarify that the Department will act upon a license application within 30 days after the inspection process has been completed, unless the Department requires additional time to complete an investigation of those qualifications of an applicant which cannot be determined through the inspection process. The Department's experience is that additional time is most frequently required to determine whether persons staffing the ambulance service are responsible persons. This is particularly true if the Department becomes aware of criminal or disciplinary information not previously provided by the applicant to the regional EMS council.

Section 1005.5 (relating to licensure) identifies the indicia of licensure issued to an ambulance service and directs ambulance services where to place those items. This section also specifies some of the information included in the license certificate, and provides for the consolidation into one license a person's multiple licenses to operate ambulance services in this Commonwealth.

Comment

A certificate of need should be required as part of the licensure process because an over abundance of ambulance services results in a dilution of the skill base of prehospital personnel.

Response

The recommendation is rejected. Section 12(h)(1)—(5) of the EMS act establish five criteria that need to be met for an applicant to secure an ambulance service license. Demonstrating a "need" for the applicant to become an ambulance service and operate in a particular area is not one of the criteria. The Department is not permitted to add additional licensure criteria by regulation.

Changes

In subsection (b) the Department has added a sentence to explain that it will issue a new license certificate if there is a need to change information on an existing license certificate. For example, this would occur if an ambulance service that had been licensed to provide BLS services only becomes licensed to also provide ALS services.

Subsection (g) is added to provide that the Department will consolidate into a single license a person's multiple licenses to operate an ambulance service in this Commonwealth. The Ambulance Association of Pennsylvania has endorsed this shift in policy. While the Department

believes that all entities that have more than one ambulance service license will welcome this change, it has drafted subsection (g) to afford an affected organization 60 days after October 14, 2000, to object to the consolidation and advance reasons in support of the objection. The license consolidations will not occur for 90 days after October 14, 2000. The Department will rule upon any objection that is filed with it in a timely manner before consolidating the licenses of the objecting person. Under § 1005.2, after October 14, 2000, any person that seeks to station and operate ambulances in more than one EMS region will need to submit a single application for licensure if not already licensed. If the person is already licensed but not conducting operations in multiple regions, it will need to apply for an amendment of its license.

Section 1005.6 (relating to out-of-State providers) recognizes the statutory permission for ambulance services not licensed in this Commonwealth to transport patients from outside the borders of this Commonwealth to facilities situated inside this Commonwealth's borders.

Comment

This section states that "ambulance services located or headquartered outside of this Commonwealth that regularly engages in the business of providing emergency medical care and transportation of patients from within this Commonwealth . . ." are required to be inspected and licensed by the Department. First, the word "engages" should be "engage." Second, the term "regularly" is vague. The Department should explain whether all out-of-state providers that provide service in this Commonwealth are required to be inspected and licensed by the Department.

Response

The Department agrees with that part of the comment questioning use of the word "engages." It has replaced "engages" with "engage."

As to the second part of the comment, section 12(t)(3) of the EMS act permits some ambulance services that are located or headquartered outside this Commonwealth to engage in limited operations in this Commonwealth without securing a license from the Department. The statutory provision is written in a confusing manner, but as the Department interprets it, that provision permits an ambulance service located or headquartered outside of this Commonwealth to operate within this Commonwealth without a license issued by the Department only if it is transporting patients from locations outside of this Commonwealth to locations within this Commonwealth. The Department has added a sentence to clarify this. Moreover, the exemption is extended only if the transports do not occur "routinely." Under section 6 of the EMS act, operation of an ambulance service without a license is a summary offense. The Department proposed to use the word "regularly" rather than "routinely" because it believed that persons would understand that term better. However, as the courts, not the Department, make summary offense determinations, the Department has reconsidered replacing the term "routinely" with "regularly," and has reinserted the term that is employed in the statute.

Section 1005.7 (relating to services owned and operated by hospitals) reiterates provisions in section 12(r) of the EMS act (35 P. S. § 6932(r)) which permit institutions licensed as hospitals by the Department to operate their own ambulance service without securing a separate license from the Department to operate an ambulance service. In all other matters, the ambulance service operations of hospitals are subject to the EMS act and this part. No comments addressing this section were received. This section is adopted as proposed.

Section 1005.7a (relating to renewal of ambulance service license) is new. It explains that the criteria for the renewal of a license are the same as the criteria for securing an initial license if an initial license had been sought at the time the renewal was required. A time period for filing a renewal application prior to the expiration of a current license is specified. No comments addressing this section were received. This section is adopted as proposed.

Section 1005.8 pertains to the license the Department is permitted to issue to an ambulance service when it fails to meet multiple minor licensure requirements, or even a significant requirement, if the Department considers the operation of the ambulance service to be in the public interest. Section 12(m) of the EMS act permits the Department to issue a provisional license for 6 months and to renew it for an additional 6 months under regulations established by the Department, except a renewal may be for 12 months if the ambulance service is a volunteer BLS ambulance service, or a volunteer fire department or rescue service that operates a BLS ambulance service.

Comment

The EMS act and these regulations provide that if a BLS ambulance service is a volunteer ambulance service the Department may renew a provisional license for 12 months. Nowhere in the EMS act or in the regulations is a "volunteer ambulance service" defined. The regulations should define the term.

Response

The Department agrees with this comment. As previously discussed in reviewing the revisions to proposed § 1001.2, the Department has added a definition for "volunteer ambulance service."

Other Change

As will be discussed under § 1005.10 (relating to licensure and general operating standards), the Department has revised its proposed regulations to permit an ambulance service to maintain a duty roster or a staff availability schedule. This section has been revised to provide that the Department will require an ambulance service to maintain a duty roster if it issues the ambulance service a provisional license because of its failure to meet staffing standards or to apprise PSAPs when it is unable to respond to an emergency. This change was recommended by PEHSC after it reviewed the Department's change to proposed rulemaking to allow ambulance services to maintain a staff availability schedule instead of a duty roster.

Section 1005.9 (relating to temporary license) pertains to the license that the Department is permitted to issue to an ALS ambulance service that cannot provide service 24 hours-a-day, 7 days-a-week. No comments addressing this section were received.

Change

This section has been revised to provide that the Department will require an ambulance service to maintain a duty roster if it issues the ambulance service a temporary license. As in § 1005.8, this change was recommended by PEHSC after it reviewed the Depart-

ment's change to proposed rulemaking to allow ambulance services to maintain a staff availability schedule instead of a duty roster.

Section 1005.10 is the section that enumerates most of the standards an ambulance service needs to meet to become licensed and to continue operations.

Comment

Proposed subsection (a)(1) would require the ambulance service to document its process for scheduling staff to ensure that the minimum staffing requirements proposed in subsection (d) are met. Proposed subsection (d)(1)(iii) would specify that minimum staffing standards are satisfied when an ambulance service has a duty roster that identifies staff who meet the minimum staffing criteria who have committed themselves to be available at the specified times, and when the required staff are present during the emergency medical treatment and transport of a patient. Volunteer services may not be able to meet a "duty roster" requirement that requires staff to "commit" to being available at specified times. If adequate service is being provided, the Department should either use an outcome or performance standard, or explain why volunteers should be required to make specific commitments.

Response

The Department will not rely solely on performance, but has revised the proposed requirement for a duty roster to permit the ambulance service to have a staff availability schedule instead of a duty roster.

The types and number of prehospital personnel who must be present during the emergency medical treatment and transport of a patient are specified by statute. See 35 P. S. § 6932(e)(4) and (g)(1)(i)—(iv) and (2)(ii). Ambulance services are required to be able to meet these requirements whenever they are in operation. ALS ambulance services are expressly required to operate 24 hours-a-day, 7 days-a-week. See 35 P. S. § 6932(n).

In addition to monitoring ambulance service operations to ensure that they are meeting staffing requirements, the Department is required to determine whether an ambulance service will be able to meet staffing requirements before it issues or renews an ambulance service license. See 35 P. S. § 6932(h)(3). If the Department were to rely solely on performance, it would not be satisfying its responsibility to reasonably assure itself, before it issues a license, that staffing standards will be met.

In determining whether an applicant for licensure will meet staffing standards, the Department can look at the roster of personnel included with the application, but to conclude that staffing standards will be met during operation of the ambulance service the Department needs to ensure that the ambulance service has a mechanism in place to identify occasions when it will clearly not be able to meet staffing standards. This is particularly important, so that PSAPs may be properly alerted.

Requiring an ambulance service to maintain a duty roster was the Department's proposed solution, but the Department has been convinced by the comments it has received that prehospital personnel, particularly volunteers, will have a discomfort in making duty commitments for fear of liability should they not be able to honor their commitments. Consequently, the Department has included, as an alternative to the proposed duty roster requirement, a requirement that the ambulance service keep a listing of prehospital personnel who have been assigned to work by the ambulance service, if that has occurred, augmented by a listing of prehospital personnel who believe they will be available to respond if called. In essence, this will result in the exclusion of names of only those persons who know they are not available. If the ambulance service maintains a duty roster or a staff availability schedule it will know, or at least have a reason to believe, when it will not able to fill a time slot with appropriate crew. It can then provide advance notice to the dispatcher. Notwithstanding this change, the Department encourages ambulance services to maintain duty rosters if feasible. The Department expects that most large ambulance services will maintain a duty roster.

If the Department relies solely on outcomes and performances, not only will it not be satisfying its statutory duty to ensure that ambulances will be staffed as required, it also will not be dealing with a staffing problem prospectively. The two most frequent problems presented by ambulance services are failure to respond to an emergency call because they cannot secure a sufficient number of appropriate staff to respond to a call, and treating and transporting a patient without a proper crew. The ambulance services that most often experience these problems are small nonprofit ambulance services whose members are all or mostly volunteers. Maintaining a staff availability schedule or a duty roster will help these services, in particular, to identify staffing inadequacies. When an ambulance service identifies inadequate staff through one of these tools, it will be responsible for notifying a PSAP. While PSAPs have procedures for contacting backup ambulance services or QRSs when the first ambulance service they call cannot respond, precious time is lost if dispatchers need to resort to a backup after making an unfruitful call.

If the Department or a regional EMS council sees that an ambulance service is not able to assign or otherwise have crew available for certain times, it can work with the ambulance service on a timely basis to help it improve its capacity to respond as required by statute. As made clear in section 12(m)—(o) of the EMS act, the legislative preference is that the Department work with ambulance services to resolve staffing and manpower problems before resorting to imposing sanctions, including the possible revocation of a license due to the ambulance service not satisfying staffing requirements. Subsections (a)(1) and (d)(1)(iii) provide ambulance services and the Department with tools to help them identify and address manpower and staffing problems when those problems are in their infancy.

Comment

When issuing a license what formula will the Department use to determine whether the ambulance service will meet minimum staffing requirements?

Response

There is no formula. The ambulance service needs to have commitments from several prehospital personnel to ensure that it has an adequate number of personnel to respond. For BLS ambulance services, a number of those personnel must be certified at least at the level of EMT, and for ALS ambulance services a number of those personnel must be certified at least at the level of EMT-paramedic. If the number is so small that there is a question of whether there will be sufficient numbers and types of personnel to fill all time slots, inquiries may be made regarding the flexibility of work hours of those persons who have been identified, and the applicant may be requested to develop a model staffing schedule after consulting with personnel who have made commitments

to it. Inquiries may also be made about current recruiting efforts. If the Department is not convinced that staffing standards will be satisfied, it may offer to issue the applicant a provisional or temporary license. If the applicant refuses that offer, and elects to pursue its license application, it would be entitled to a hearing on whether it will meet the staffing requirements for licensure. The applicant would have the burden of proof.

Comment

If an ambulance service is required to have personnel "committed" to be available to respond to calls at certain times, this may trigger the minimum wage and overtime provisions of the Fair Labor Standards Act (29 U.S.C.A. §§ 201—219). This would impose a significant expense to many licensees.

Response

This issue has become moot due to the Department revising the regulation to provide an ambulance service with the alternatives of maintaining a duty roster or a staff availability schedule.

Comment

If an ambulance service operates more than one ambulance, it should not be required to meet the minimum staffing standards for each ambulance it maintains.

Response

An ambulance service is not required to have a separate staff availability schedule for different ambulances it operates in the same service area. An ALS ambulance service, for example, need only operate one ambulance in a service area to meet the express statutory requirement that it operate 24 hours-a-day, 7 days-a-week. However, an ALS ambulance service needs to be able to operate at least one ambulance at all times in each service area where it conducts business. Moreover, each ambulance an ambulance service operates needs to be properly staffed, as prescribed by the EMS act, when it being used.

Comment

Remove from proposed subsection (a)(3) the requirement that an ambulance service shall maintain a record of each call it received to which it was unable to respond, and the reason it was unable to respond. A record of the ambulance service's failure to respond should be maintained by the dispatching communications center.

Response

The Department does not regulate PSAPs and, therefore, cannot impose requirements on them. Also, while PSAPs may maintain records of when an ambulance service is unable to respond, it may not receive or maintain a record of the reason for each lack of response. By the ambulance service maintaining this record, the Department and regional EMS councils will be able to identify problems in the EMS system and work with ambulance services to address those problems.

Comment

The proposed deletion in subsection (e) of provisions relating to mutual aid agreements seems to grant PSAPs the authority to dispatch whichever ambulance services they choose. This section should be amended to provide that control over which ambulance services are to be dispatched rests with local government and that the role of the dispatching office is to dispatch in accordance with the plan of a municipality.

Response

The repeal of the prior text of subsection (e) confers no power on PSAPs. The Department neither regulates nor empowers PSAPs. But the Department does recognize that PSAPs are the bodies that dispatch ambulance services, regardless of whether PSAPs have the authority to make dispatch decisions or to merely implement dispatch protocols that have been prescribed by some other entity. The repeal of the previous provisions in subsection (e) does not preclude ambulance services from entering into mutual aid agreements. Ambulance services may continue to have mutual aid agreements with other ambulance services, but they may not use those agreements in an attempt to dictate to PSAPs which ambulance service to dispatch on a second call basis when a party to the agreement is dispatched first but is unable to respond to the call. As stated previously, the Department anticipates that ambulance service dispatch legislation will soon be enacted. The Department expects that particular legislation will establish a statutory scheme for the development and implementation of ambulance service dispatch protocols.

Comment

Proposed subsection (e)(2) requires an ambulance service to apprise the PSAP, as soon as practical after receiving a dispatch call, if it is not able to have an ambulance and required staff immediately en route to an emergency. What does the term "immediately" mean? A fail time of 5 minutes should be used.

Response

The Department agrees that the term "immediately" is not appropriate. PSAPs in different parts of this Commonwealth will have different preferences as to how much time should elapse after dispatch before an ambulance service does not have an ambulance en route to an emergency, such that an ambulance service's knowledge that it can not satisfy that standard triggers a duty to report to the PSAP. In a metropolitan area with a large number of ambulance services in a concentrated area, the PSAP may have viable dispatch alternatives if the delay is more than a few minutes. In a sparsely populated rural area viable alternatives may not exist unless the delay is substantial. Consequently, the Department has revised subsection (e)(2) to provide that the duty to apprise the PSAP about not having an ambulance en route to an emergency after dispatch is triggered when an ambulance service realizes it will not have an ambulance en route to an emergency within the time prescribed by the PSAP to require a notification to the PSAP.

Comment

Proposed subsection (e)(4) would require an ambulance service to respond to an emergency when dispatched by a PSAP. An ambulance service should not have its license jeopardized if it is occupied with another call or if it intends to function solely as an interfacility transport service.

Response

The Department agrees that an ambulance service should not be subject to disciplinary action if it fails to respond to an emergency call because it is occupied with another call. The focus of the Department when proposing this paragraph was to establish a procedure to resolve conflicts between two competing ambulance services when both believe it is the most appropriate service to respond to a call. Over the last few years, physical conflicts between prehospital personnel from different ambulance

services have actually erupted on occasion around which ambulance service should be transporting a patient to a receiving facility. In an EMS system, the PSAP needs to direct ambulance service response when there is a dispute. If the proposed ambulance service dispatch legislation is enacted, in making the decision as to which ambulance service shall handle the emergency, the PSAP will simply be following a dispatch protocol that has been developed under statutorily prescribed procedures.

As to ambulance services that choose to confine their activities to interfacility transports, the Department believes that there is no likelihood that any dispatch protocol will be developed that designates these services as primary emergency responders. However, these services are part of the EMS system and must be prepared to respond to emergencies when needed. In mass casualty situations they may very well be dispatched to emergency calls. Nevertheless, to clarify the intent of this provision as it applies to both ambulance services that generally respond to emergency calls and ambulance services that generally confine their business to interfacility transports, the Department has revised the proposal to state that the duty to follow the direction of the dispatcher applies only when the ambulance service is able to respond (that is, it has resources available, such as an ambulance, crew, equipment and supplies, that enable it to respond.)

Comment

While the effort made in proposed subsection (g) to tighten the requirements for the use of lights and sirens should be applauded, a better approach would be to prohibit the use of lights and sirens unless the circumstances result in a need for immediate medical intervention that exceeds the capabilities of the ambulance crew.

Response

The Department accepts the recommendation and has revised this subsection accordingly.

Comment

Subsection (g) should be revised to include PEHSC recommendations regarding the use of lights and sirens by ambulance services.

Response

The regulation is consistent with the PEHSC recommendation. Both provide that lights and sirens are to be used only when responding to or transporting a patient with a life-threatening or potentially life-threatening condition.

Comment

Proposed subsection (i) should be clarified whether it requires reporting of only those accidents and injuries to individuals that result from or are associated with an ambulance vehicle accident.

Response

Subsection (i) requires that ambulance services report ambulance vehicle accidents that are reportable under 75 Pa.C.S. (relating to Vehicle Code) and all line of duty fatalities and injuries that required treatment at a hospital, whether from ambulance crashes or other incidents.

Comment

Injury reporting under proposed subsection (i) could become very cumbersome. The proposed reporting requirement should be revised to require the report of severe injuries only, and define what a severe injury is.

Response

The recommendation is rejected. By requiring the reporting of only those injuries that are treated in a hospital, the burden to ambulance services should be minimal. These reports will enable the Department to gather data regarding the incidence, type and severity of injuries sustained in providing EMS. The Department, with the assistance of PEHSC and the regional EMS councils, will be able to use this information to alert ambulance services to potential hazards, and to develop prevention and risk management guidelines to disseminate to providers of EMS and EMS training institutes.

Comment

Requiring all ALS ambulances to have guaranteed staffing 24 hours-a-day, 7 days-a-week would require all volunteer ALS ambulance services to convert to paying prehospital practitioners and eliminating the volunteer system. There should be no strict Statewide standards on staffing. Let municipalities, working with the appropriate regional EMS council, establish the staffing standards within their borders.

Response

This recommendation is rejected. Statewide standards are imposed by the EMS act. The Department has no authority to promulgate regulations providing otherwise. Section 12(g) of the EMS act prescribes minimum staffing standards for ALS ambulance services on a Statewide basis. Section 12(n) of the EMS act requires an ALS to provide service 24 hours-a-day, 7 days-a-week to maintain full licensure.

Other Changes

One of the criteria an entity needs to meet to be licensed as an ambulance service is that it be staffed by responsible persons. See 35 P. S. § 6932(h)(1). Neither the EMS act nor Part VII have heretofore identified the persons to whom the "responsible" standard applies. The Department has revised subsection (d) by adding paragraph (3) to address this matter. Subsection (d)(3) clarifies that the "responsible" standard applies to the management team, prehospital personnel and ambulance drivers. It requires the ambulance service to ensure that it is staffed by responsible persons, and directs the ambulance service to collect and consider the criminal and disciplinary records of its staff in making that determination. It also requires the ambulance service to provide the Department with 30 days advance notice, if possible, if it makes a change in its management team that includes the addition of a person who has a criminal or disciplinary record. This last provision will enable the Department to monitor management changes and to take appropriate action if a licensed ambulance service seeks to employ management personnel who present the greatest potential for being determined by the Department not to be responsible persons.

Subsection (a)(1) is revised to require the ambulance service to maintain a record of persons who function as its management team, and to maintain the disciplinary and criminal history record of all persons who staff the ambulance service. Subsection (k), which pertains to the ambulance service's monitoring responsibilities, requires the ambulance service to apprise the Department if it determines that a prehospital practitioner who is part of its staff has engaged in conduct for which the Department may impose discipline.

Section 12(i) of the EMS act prohibits the transfer of an ambulance service license. Section 12(l)(6) of the

EMS act makes the lending, borrowing or using of another's license a basis for disciplinary action against an ambulance service. Over the last few years there has been an increasing use of management services by ambulance services to help them manage their operations. This is acceptable, provided that the management service does not make fundamental operating decisions for the ambulance service. The Department needs to be able to review management agreements and ask questions of the ambulance service to ensure that the arrangement is not a de facto lending or permitting use of an ambulance service license by an entity not licensed as an ambulance service. Consequently, the Department has added subsection (a)(6) to require an ambulance service to maintain in its records a copy of any management agreement it has entered into to either manage an ambulance service or be managed by another entity.

There have been questions about acceptable and required identifications on ambulance services. Subsection (b) pertains to ambulance standards. The Federal KKK standards address, among other matters, star of life markings on ambulances that operate as mobile ALS care units. Those standards do not apply to ambulances that operate as squad units. The Department has redesignated the text of proposed subsection (b) as paragraph (1) and has added a paragraph (2) to address the placement of names on ambulances and the placement of star of life markings on squad units.

Proposed subsection (c)(3) has been revised to provide improved clarity.

Subsection (d)(1)(i) has been revised to incorporate the statutory standard regarding when a BLS ambulance needs to meet minimum staffing standards.

Subsection (d)(1)(iii) has been revised to include the proposed text in clause (A) and to include in clause (B) language requiring an ambulance service to comply with child labor law statutes and regulations when using persons 18 years of age or younger to staff the service.

In subsection (d)(2) the term "ALS medical director" has been corrected to read "ALS service medical director."

Subsection (g), which pertains to the use of lights and other warning devices, is revised to clarify that compliance with the standards in that subsection does not excuse noncompliance with standards imposed by the Vehicle Code.

Subsection (l) is amended to add a policy on substance abuse in the workplace as one of the policies that an ambulance service must have.

Section 1005.11 (relating to drug use, control and security) addresses the circumstances under which ambulance services may stock and carry drugs, drugs that may be used, requirements for securing and maintaining those drugs, and who may administer such drugs.

Comment

Proposed subsection (a)(3) mentions drugs being carried on board an ambulance by a physician assistant. The status of the physician assistant in the EMS system should be clarified.

Response

Physician assistants are not regulated under the EMS act. They do not function as prehospital personnel for ambulance services. However, the Department recognizes that nurses and physician assistants with special training may be attending to a patient in a hospital setting and that the hospital may want them to accompany the patient and continue to address certain patient care needs during an interfacility transport. Subsection (a)(3) provides for a physician assistant to bring drugs on board an ambulance only when the ambulance is engaged in an interfacility transport, the physician assistant has special training for the continuation of treatment that had been provided to the patient at the facility from which the patient is being transferred, and the physician assistant does not substitute for staff required by the EMS act.

Comment

Proposed subsection (d)(2) permits a health professional to administer drugs in addition to those permitted by the applicable regional and Statewide medical treatment protocols. Does this open the door for prehospital registered nurses to operate in the EMS system on an unregulated basis?

Response

There are sufficient controls to ensure that the prehospital registered nurse functions within the parameters of the EMS system. This paragraph requires that the health professional's use of additional drugs be approved by the ALS service medical director for the ambulance service and then specifically ordered by a medical command physician.

Comment

Current subsections (j) and (k) are not consistent with current practice when drugs that are used are replaced through medication orders rather than prescriptions. These subsections should be revised to reflect current acceptable practices.

Response

The person who made this comment was apparently confused by the proposed amendments to this section. The Department proposed to remove subsections (j) and (k), and to address the subject matter previously addressed in those subsections in new subsection (e). Subsection (e)(5) requires the ambulance service that seeks to replace a drug to provide the dispensing hospital, physician or pharmacy with a written record of the use, loss or other disposition of the drug. When a drug's disposition occurs through administration of the drug to the patient, as opposed to another disposition, such as breakage or theft, the EMS patient care report will suffice as the requisite written record.

Changes

The language in subsection (b) is revised to improve clarity.

A new paragraph (7) is added to subsection (d) to require an ambulance service to ensure that the disposal of drugs occurs in compliance with the requirements of The Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. §§ 780-101—780-149), and proposed subsection (d)(7) is now subsection (d)(8).

Section 1005.12 (relating to disciplinary and corrective actions) pertains to the disciplinary process applicable to ambulance services. The title of this section is changed from "Grounds for suspension, revocation or refusal of an ambulance service license" because the scope of this section exceeds the enumeration of grounds for discipline.

Comment

Proposed subsection (a)(9) would establish that failure of an ALS ambulance service to have staff sufficient to operate an ambulance 24 hours-a-day, 7 days-a-week, is a ground for discipline against an ALS ambulance service. This ground should be revised so that it applies to BLS ambulance services also.

Response

This recommendation is rejected. Following the recommendation would require the Department to exceed the scope of its rulemaking authority. The criteria for licensure of an ambulance service under section 12(h) of the EMS act does not include operation of an ambulance around-the-clock. That requirement is made applicable to ALS ambulance services under section 12(n) of the EMS act, which provides that an ALS ambulance service could operate under a temporary license if it fails to meet that standard. No similar provision links a BLS ambulance service to an around-the-clock operational standard. Nevertheless, under § 1005.10(e) a BLS ambulance service that provides emergency response is required to apprise a PSAP when it will not be in operation.

Other Changes

A new paragraph (19) is added in subsection (a) to include as a basis for discipline the failure of an ambulance service to continue to meet the standards it was required to satisfy when it secured a license.

Section 1005.13 (relating to removal of ambulances from operation) pertains to the removal of an ambulance from operation when there is a mechanical or equipment deficiency that poses a significant threat to the safety of patients or crew. No comments on this section were received, however the Department has revised the language to provide greater clarity.

Section 1005.14 (relating to invalid coaches) pertains to a statutory exemption from ambulance requirements for vehicles that are used to transport individuals who require assistance, but who are not anticipated to require emergency medical care during transport. No comments on this section were received. This section is revised to eliminate reference to § 1001.2 for the definition of "invalid coach," as no similar reference is made in other regulations for terms defined in § 1001.2.

Section 1005.15 is new. It addresses and clarifies the duty imposed upon an ambulance service, by section 12(q) of the EMS act, to not discontinue its operations prior to giving the public, the Department and political subdivisions in its service area at least 90 days advance notice. The regulation also requires the ambulance service to provide similar notice to emergency communications centers in the EMS region in which it would be ceasing operations.

Comment

Although the proposed section is consistent with section 12(q) of the EMS act, the statutory provision is probably unconstitutional in that it forces an entity to stay in business without just compensation.

Response

The Department must assume that the referenced statutory provision is constitutional. The regulation is adopted as proposed.

Chapter 1007. Licensing of Air Ambulance Services-Rotorcraft

This chapter specifies the licensure and operating criteria for air ambulance services. Several provisions in Chapter 1005 that are applicable to ground ambulance services are equally applicable to air ambulance services. Express provision is made in this chapter to incorporate applicable provisions in Chapter 1005. Consequently, some of the prior sections in this chapter are not needed. They have been repealed.

Section 1007.1 (relating to general provisions) specifies general standards applicable to air ambulance services. The most significant amendment of this regulation is the addition of subsection (e). This subsection specifies sections in Chapter 1005 that apply to air ambulance services as well as ground ALS ambulance services.

All air ambulance services are licensed to provide ALS care. Some of the sections that are referenced in subsection (e) impose different requirements upon a ground ambulance service depending upon whether the service is licensed to provide ALS care or only BLS care. This subsection clarifies that the provisions of those sections that apply to air ambulance services are those which also apply to ground ALS ambulance services.

Comment

Air ambulance services are not addressed by the EMS act. This chapter should be deleted.

Response

The recommendation is rejected. The EMS act requires the Department to license and regulate entities that use ambulances to provide EMS to patients. The statutory definition of "ambulance" does not confine the described vehicle to a ground vehicle.

Changes

The proposed language the Department submitted to the LRB for subsection (e) was different than the actual language published. The Department's proposal related that only those provisions in the Chapter 1005 sections referenced in subsection (e), that apply to ground ALS ambulance services, are applicable to air ambulance services. The LRB exercised its editorial prerogative to revise the proposed language in a nonsubstantive manner. However, the LRB or its contract printer made errors in printing the revised language, causing it to read that all provisions in the referenced sections would be applicable to air ambulance services. The Department has corrected the error. The Department has also added § 1005.2a (relating to change in ambulance fleet) to the list of sections in Chapter 1005 that apply to air ambulance services.

Section 1007.2 (relating to applications) specifies the information solicited by applications for air ambulance service licenses. No comments on this section were received.

Changes

Consistent with its addition of § 1005.2(a)(10), to provide that the license application for a ground ambulance service will solicit specified information regarding the management team, the Department has added a similar provision in subsection (a)(10) and has renumbered proposed subsection (a)(10) as subsection (a)(11).

Procedures for an entity to apply for a license as an air ambulance service, for an air ambulance service to apply for an amendment of its license, and for regional EMS councils to process those applications are the same as those that are applicable to ground ambulance services. The Department had proposed new subsections (b)—(d) to cover this subject matter. However, it has elected to replace the proposed text of these subsections with a revised subsection (b). That subsection states that the procedures for making the applications and for regional EMS councils to process the applications are the same as those that are applicable to ground ambulance services.

As proposed, §§ 1007.3—1007.6 are repealed. Most of the subject matter that was addressed in these sections

duplicated provisions in Chapter 1005. Section 1007.1(e) makes those provisions applicable to air ambulance services.

Section 1007.7 (relating to licensure and general operating requirements) enumerates most of the standards an entity needs to meet to become licensed as an air ambulance service and to continue operations. No comments addressing this section were received.

Changes

Subsection (a) is revised to require the air ambulance service to maintain the same type of information on medical command authorization and persons managing the air ambulance service that is required of a ground ambulance service under § 1005.10(a)(1). Subsection (a)(2) is revised by replacing "ambulance call report" with "EMS patient care report."

Subsection (b)(7) is revised to reflect that survival gear carried on an air ambulance shall be determined on a flight-by-flight basis.

Subsection (d)(3)(iii) is revised to require the air ambulance service to maintain a duty roster. No provision for a "staff availability schedule," as an alternative to a duty roster, is required for an air ambulance service.

Subsection (d)(4) is added to require an air ambulance service to collect the same type of information regarding its staff as a ground ambulance service and to consider that information in making determinations as to whether its staff is comprised of responsible persons.

Subsection (f)(2) is revised to insert the word "service's" before "service area."

Subsection (g)(1) is revised to include air ambulance availability as an additional criterion in making a decision regarding whether to respond to a call.

Subsection (h) is revised by adding to the medical service requirements of an air ambulance service the requirement that the air ambulance service shall ensure that the patient is transported to the nearest appropriate receiving facility. Air ambulances may travel great distances to pick up an emergency patient. An equally long return trip is not in the best interest of the patient if appropriate care for the patient can be achieved by the air ambulance making a shorter patient transport trip. The Department does not consider it appropriate for an air ambulance to transport a patient to a trauma center affiliated with the entity that operates the air ambulance service if a trauma center appropriate for the care of the patient is located much closer to the location where the patient is retrieved. Considerations such as weather conditions, and patient choice when additional travel time will not impact the patient's condition, may justify bypassing a closer trauma center but, in most instances, these considerations do not come in to play.

Subsection (k)(1) is revised to substitute the words "air medical" for "aeromedical."

Subsection (m) is revised to add, to an air ambulance service's monitoring duties, responsibilities similar to those that are being imposed upon ground ambulance services.

Subsection (n) is revised to include a policy on substance abuse in the workplace as a policy an air ambulance service is required to maintain.

Section 1007.8 (relating to disciplinary and corrective actions) deals with the disciplinary process applicable to air ambulance services. No comments addressing this section were received.

Changes

A new paragraph (22) is added in subsection (a) to include as a basis for discipline the failure of an air ambulance service to continue to meet the standards it was required to satisfy when it secured a license.

As proposed, § 1007.9 (relating to voluntary discontinuation of service) is repealed. This section addressed the duty imposed upon an air ambulance service, under section 12(q) of the EMS act, to not discontinue its operations prior to giving advance notice to the Department, political subdivisions in its service area, and the public. This subject matter is addressed in § 1005.15 (relating to discontinuance of service). Section 1007.1(e) makes § 1005.15 applicable to air ambulance services.

Chapter 1009. Medical Command Facilities

This chapter deals with the distinct units in hospitals out of which physicians who qualify as medical command physicians provide medical direction to prehospital personnel. Medical direction is provided when prehospital personnel are providing emergency medical care in prehospital settings and during the interfacility transport of patients.

Section 1009.1 (relating to operational criteria) sets forth the requirements that must be met for a distinct unit in a hospital to function as a medical command facility.

Comment

Proposed paragraph (12) should be revised to prescribe a standard length of time a medical command facility needs to keep communication records and tapes.

Response

The Department agrees with this comment. It has revised paragraph (12) to require a medical command facility to maintain medical command tapes for 180 days. This should assure the availability of these tapes for a period of time adequate to enable their use in quality improvement reviews and disciplinary investigations.

Comment

Contrary to proposed paragraph (15), medical command facilities should not be required to provide medical command to a prehospital practitioner with whom the facility is not familiar.

Response

This recommendation was previously discussed under § 1003.4. It is rejected for the reasons explained in responding to the recommendation under that section.

Section 1009.2 (relating to recognition process) describes the procedure to be followed if a facility chooses to be recognized as a medical command facility by the Department.

Comment

While it is true that section 11(j)(4) of the EMS act (35 P. S. § 6931(j)(4)) provides that a medical command facility will enjoy certain civil liability protection under that provision if it is recognized by the Department, the Department should remove reference to that fact to give some leeway to assert statutory immunity by a hospital that may substantially comply with the regulation but has not gone through the recognition process.

Response

This recommendation is rejected. The EMS act requires that a facility be recognized as a medical command

facility by the Department for a facility to secure the civil immunity protection afforded by section 11(j)(4) of the EMS act. The Department is not aware of any hospital that has operated in this Commonwealth as a medical command facility without completing the Department's recognition program. Nevertheless, the Department believes that including language in this regulation which apprises a hospital that Department recognition of its medical command operations as a medical command facility affords it some civil immunity protection, serves as a helpful reminder to hospitals regarding what they need to do to limit their exposure to liability. It is the Department's experience that some facilities are more familiar with the Department's regulations than they are with the EMS act. Moreover, the questioned provision explains the statutory basis for the Department to operate a medical command facility recognition program.

No other comments addressing this section were received, other than mention of a typographical error in subsection (a) that appeared in the *Pennsylvania Bulletin* when the proposed regulations were published. This section is adopted as proposed. The typographical error has been corrected.

Section 1009.3 (relating to continuity of medical command) is repealed. This regulation grandfathered medical command facilities recognized by regional EMS councils prior to July 1, 1989, the date this former regulation was promulgated. The regulation is no longer required.

Section 1009.4 (relating to withdrawal of medical command facility recognition) identifies the procedures for conducting inspections and investigating complaints against medical command facilities, the grounds for withdrawal of recognition and procedures for dealing with deficiencies in lieu of withdrawing recognition. No comments addressing this section were received. This section is adopted as proposed.

Section 1009.5 (relating to review of medical command facilities) provides for regional EMS councils to conduct reviews of medical command facilities.

Comment

The proposal to have a regional EMS council conduct reviews of medical command facilities as requested by the Department, instead of biennially, as required previously, causes confusion, especially in light of proposed § 1009.2(h), which would make recognition of a medical command facility valid for 3 years.

Response

No changes are made based upon this comment. As explained in the preamble to the proposed rulemaking, the biennial review provision of this section has been deleted to permit the Department more flexibility in determining the frequency of reviews. Comprehensive reviews conducted biennially could impose an excessive work burden on some regional EMS councils, while other regional EMS councils could conduct the reviews more frequently. This is because there are many medical command facilities in some EMS regions, and very few in others. The Department anticipates requesting reviews more frequently than once every 2 years, but will modify the scope of some reviews so that they will not involve a comprehensive assessment of compliance with all recognition criteria.

Section 1009.6 (relating to discontinuance of service) is new. This section requires a medical command facility to provide 90 days notice to the Department, the appropriate regional EMS council and providers of EMS for which they routinely give medical command, prior to discontinuing medical command operations.

Comment

The proposed rulemaking are inconsistent with respect to the number of days various entities need to provide prior notice to the Department and other entities. The time periods should be consistent.

Response

Certain advance notice requirements need to be longer or shorter than others based upon the type of activity involved, and the potential harm to the public due to the commencement or termination of an activity. Nevertheless, the Department agrees that notices regarding the discontinuation of service should be consistent throughout the regulations. Therefore, the Department has revised the proposed 60 days advance notice for discontinuation of medical command facility operations to 90 days advance notice. This makes the advance notice requirement for discontinuation of a medical command facility the same as that imposed prior to the discontinuation of an ambulance service.

Chapter 1011. Accreditation of EMS Training Institutes

This chapter pertains to the Department's accreditation of teaching institutes that provide persons with the training required by the Department's regulations to become certified as a first responder, an EMT or an EMT-paramedic, or recognized as a prehospital registered nurse. Matters addressed are the criteria for accreditation, the process to secure accreditation, and the process for denying, withdrawing or conditioning accreditation.

Section 1011.1 (relating to EMS training institutes) identifies the criteria to operate as a BLS training institute to provide training leading to certification as a first responder or an EMT, and as an ALS training institute to provide training leading to certification as an EMT-paramedic or recognition as a prehospital registered nurse.

Comment

Section 1001.2 deletes the definition of "BLS training institute" and adds the definition of "EMS training institute." Chapter 1011 repeatedly refers to ALS and BLS training institutes, not EMS training institutes. The term "EMS training institute" should be used consistently.

Response

The Department agrees with this observation and recommendation. It has changed the title of Chapter 1011 to "Accreditation of EMS Training Institutes" from "Accreditation of Training Institutes," and the title of § 1011.1 to "EMS training institutes" instead of the proposed title of "BLS and ALS training institutes." Additionally, the Department uses the term "EMS training institute" throughout the chapter to replace proposed references to ALS and BLS training institutes, except where the context requires that the Department make a distinction between an EMS institute that provides BLS training and one that provides ALS training.

Comment

The second subparagraph under subsection (b)(1) should be (ii) rather than (iii).

Response

The Department agrees. The Department has corrected the typographical error.

Comment

Subsection (f) should explain what a qualified instructor is.

Response

This subsection does state that an instructor shall be at least 18 years of age and possess a high school diploma or GED equivalent. It also states that the instructor shall either meet very specific requirements in paragraph (3) or be determined by the EMS training institute, after the EMS training institute has consulted specified resources, to be qualified to provide the instructional services that would be provided by the individual if that person is accepted as an instructor. The Department believes that no more definitive explanation is needed.

Comment

Proposed subsection (f)(4) references a "Prehospital Practitioner Manual," while § 1001.2 defines "Prehospital Personnel Training Manual." The Department should revise the reference in subsection (f)(4) or clarify the paragraph if a different manual is involved.

Response

As discussed under § 1001.2, the Department has removed "prehospital personnel training manual" from the terms defined in that section. The deletion of that term affords the Department greater flexibility in developing various guidance manuals, more properly titled, to address different prehospital personnel subjects. Consequently, the Department has substituted for the name of a manual in this paragraph, a reference to the manual the Department develops to provide guidance regarding course administration. The same substitution is made in subsection (i)(2).

Comment

Proposed subsections (g) and (h) require an ALS training institute to ensure the availability of clinical and field preceptors for each training course. The same requirements should be imposed for BLS training institutes.

Response

The same requirements are not needed for BLS training institutes, for each training course it offers, because the courses these institutes offer rarely include a field internship or clinical activities outside of the classroom. However, there may be occasion when a BLS training course does include these activities. Consequently, the Department has revised subsections (g) and (h) to require a BLS training institute to ensure the availability of clinical and field preceptors whenever it offers a BLS training course that has field and clinical components.

Other Changes

Nonsubstantive revisions have been made to subsections (a), (b)(1) and (2), (c)(1), (d)(3)(i) and (iii), (e)(3), (f)(1) and (3) and (i)(1) to improve clarity.

The Department has revised subsection (j)(4) to add the requirements that an EMS training institute shall provide its students with the Department's testing policies, and the EMS training institute's policy for the prevention of sexual harassment.

The Department has added subsection (j)(7)—(9) to require an EMS training institute to collect from each student an application for enrollment and a completed criminal history disclosure form and to then forward those forms to the appropriate regional EMS council; to complete a course completion form for each student who successfully completes an EMS training course and to then forward the form to the appropriate regional EMS council; and to participate in EMS training institute evaluation activities as requested by the Department.

As proposed, § 1011.2 is rescinded. The subject matter that had been addressed in that section is now incorporated in § 1011.1.

Section 1011.3 (relating to accreditation process) identifies the process for an entity to become accredited as an EMS training institute. No comments addressing this section were received.

Changes

The term "EMS training institute" is substituted for "ALS or BLS institutes" or similar terminology where appropriate.

Paragraphs (1), (5)(ii) and (8) are revised to improve clarity.

Paragraph (9) is added to address procedures for an EMS training institute to be able to offer an EMS training course for initial certification or recognition in an EMS region other than that through which it processed its application for accreditation.

Section 1011.4 (relating to denial, restriction or withdrawal of accreditation) identifies the procedures for investigating complaints against EMS training institutes, for denying, withdrawing or conditioning accreditation, and for appealing those decisions. No comments on this section were received. One person did ask to whom the term "agency head" refers. As stated in the proposed regulation, "agency head" is defined in 1 Pa. Code § 31.3 (relating to definitions). In the Department the "agency head" is the Secretary of Health or a deputy secretary designated by the Secretary.

Changes

The term "EMS training institute" is substituted for other terms where appropriate.

Chapter 1013. Special Event EMS

This chapter enables entities that are responsible for the management and administration of a special event to have a Department determination as to whether EMS arrangements are adequate. A special event is a planned activity that places attendees or participants in a defined geographic area where access by emergency vehicles and personnel might be delayed due to people or traffic congestion at or near the event, or perhaps due to the inadequacy of EMS resources at that location.

Section 1013.1 (relating to special event EMS planning requirements) explains the process for securing Department endorsement of an EMS plan for a special event and prescribes the contents that a plan needs to include to secure the Department's endorsement.

Comment

The regulation should not be revised, as proposed, to provide that the person who is responsible for the management and administration of a special event "may," rather than "shall," secure Department approval of an EMS plan for the event. What happens if a sponsor does not submit an EMS plan for a special event?

Response

This recommendation is rejected. As explained in the preamble to the proposed regulations, submitting a special event EMS plan to the Department for its approval is not mandated under the EMS act. Rather, as the Commonwealth's lead agency for EMS, the Department be-

lieves that approval of EMS plans for special events is a public service it should make available to entities desiring such a review. It encourages sponsors of special events to pursue EMS plan approval. There is nothing the Department can do if an entity sponsoring a special event does not submit a special event EMS plan. The Department believes that municipalities may choose to mandate such a review for special events held within their borders.

Comment

The Department should explain how it intends to coordinate the requirements of this chapter with other Commonwealth emergency operations plans, such as the Commonwealth Emergency Operations Plan, the Special Event Emergency Action Plan Guide and the Planning Guidance for Mass Fatalities Incidents.

Response

The Department has discussed its implementation of this chapter with representatives of the Pennsylvania Emergency Management Agency (PEMA). Population numbers PEMA has used in its policies dealing with the same subject matter have been based on the numbers specified in this chapter. PEMA has advised that it will revise population numbers in the above-referenced plans to be consistent with the changes made in this chapter.

No other comment addressing this section was received. This section is adopted as proposed, except minor revisions are made to subsection (a) to improve clarity, and references to the definition section, which is unnecessary surplusage, are removed.

Section 1013.2 (relating to administration, management and medical direction requirements) prescribes the qualifications and responsibilities for a special event EMS director and emergency supervisory physician. A special event EMS plan needs to show that these standards are met if the plan is to secure Department approval. No comments addressing this section were received. This section is adopted as proposed.

Sections 1013.3—1013.7 are not amended, except that population figures triggering the application of certain standards in §§ 1013.3 and 1013.5 (relating to special event EMS personnel and capability requirements; and onsite facility requirements) are adjusted downward by 5,000, equipment requirements in § 1013.5 are not confined to BLS equipment; and the term "PSAPs" is substituted for "emergency communications centers" in § 1013.6 (relating to communications system requirements).

Comment

Section 1013.5 should be amended to require a special event physician to be onsite at treatment facilities.

Response

The Department rejects this recommendation. The onsite presence of a physician should not normally be required, since prehospital personnel, when operating within the Statewide EMS system, are required to have the capability to immediately access a medical command physician as needed. If the Department believes that the peculiarities of a particular special event warrant the physical presence of a physician onsite, it will impose that requirement as a condition for its approval of the EMS plan for that special event.

Section 1013.8 (relating to special event report) is new. It requires an entity that secures Department approval of a special event EMS plan to file with the appropriate regional EMS council, after concluding a special event, a special event report containing information solicited by the Department in the report form.

Comment

The Department should explain the need for this report and should consider requiring a report only if EMS is provided at the special event.

Response

No change is made to the regulation based on this comment. Capturing information on the EMS outcomes of all events for which the Department approves a special event EMS plan will be helpful for continued quality improvement. Also, if no report is filed, the Department or a regional EMS council would need to follow-up with a special event sponsor to ensure that the failure to report was not merely an oversight. Another concern is that if the after-event reporting is not universally required, sponsors may be tempted not to file a report if the EMS incidents are few and minor. However, even that information is important to EMS planning. The Department will develop a reporting form to facilitate the quick and easy completion of the report when the special event does not give rise to the delivery of EMS.

Chapter 1015. Quick Response Service Recognition Program

This chapter addresses the mobilization of prehospital personnel to arrive at the scene of an emergency and provide EMS in advance of the arrival of an ambulance and its crew. While most areas of this Commonwealth can be reached by an ambulance within a few minutes, there are a few areas, generally rural or remote wilderness areas, where this is not the case. In those areas, the Department approves units of prehospital personnel to respond to emergencies prior to the arrival of an ambulance. The label the Department has given to an early EMS response team is "quick response service (QRS)."

Section 1015.1 (relating to quick response service) is new. It establishes criteria for recognition as a QRS. It also establishes a process for securing that recognition and for renewal of that recognition.

Comment

Many small ambulance services in rural Pennsylvania encounter serious problems in meeting statutory staffing requirements. Greater staffing flexibility should be afforded to those services.

Response

The Department is not authorized to waive statutory staffing requirements for ambulance services other than through procedures associated with issuing provisional and temporary licenses. However, such licenses provide only short-term solutions. The EMS act does not provide for the perpetual renewal of those licenses. The Department has encouraged some small rural ambulance services to terminate their operations as an ambulance service and convert their operations to those of a QRS with AED capability. The regulatory requirements for QRS operation are less stringent than the statutory requirements for ambulance service operation. Several former small rural ambulance services have successfully made the transition. Under the EMS act and this part, QRSs are eligible for EMSOF funding.

Changes

Minor language changes have been made to this section to improve clarity.

Section 1015.2 (relating to discontinuation of service) is also new. It requires a QRS to provide advance notice to the Department, the appropriate regional EMS council, and each political subdivision within its service area before discontinuing services. No comments addressing this section were received, and the Department has made no revisions to the proposal

Fiscal Impact

The cost to the Department to administer and monitor the continuing education program will increase. The Department will incur costs in developing review processes to incorporate alternative methods of course presentation that are permitted by the amendments. All currently approved continuing education courses (approximately 1,400) will need to be reevaluated and assigned new course numbers to reflect trauma and medical continuing education credit hours for which the course qualifies. The Department will need to revise the reporting and recordkeeping procedures for it to process continuing education information. Revision of forms and printing will also result in associated costs.

The Department will also incur additional costs for the continuing education program to update computer software to maintain a registry of continuing education courses. Also, costs will be incurred in updating continuing education data processing capabilities. The total estimated costs for these expenditures are $33,500 for FY 2001-02.

Costs to patients and insurers associated with the routine transport of BLS patients requiring intravenous maintenance medications should decrease. BLS ambulance services, as well as ALS ambulance services, will now be able to transport these patients. Although it is difficult to quantify the savings at this time, it should be sizeable, both in dollars and time saved. ALS ambulance services, freed from the sole responsibility for these transports, should be able to have ambulances increasingly available to respond to emergencies requiring an ALS response. However, services that provide these transports will incur some additional costs in ensuring EMTs are trained to appropriately address patient needs when transporting patients with intravenous medications running.

Individuals who choose to participate in the EMS instructors program will need to attend an update program every 2 years. The update course will probably last 2 days. Persons who attend may incur travel and subsistence costs.

Specified record retention requirements for ambulance services and medical command facilities may create some additional costs for those entities based upon the dedication of additional storage space for that purpose. Those costs may be less for entities that store the records electronically.

Currently, an entity must secure a separate license from the Department for each EMS region in which it stations and operates ambulances. As amended, the regulations provide for a single license, augmented by a process for amending the license if an entity chooses to conduct operations out of a region not identified in the license application. The Department and regional EMS councils may experience some cost-savings from reduced inspection and paperwork processing requirements.

Paper Requirements

The Department intends to employ all reasonable opportunity afforded by technology to reduce paperwork and costs. Websites and e-commerce initiatives will be used, where possible, to reduce paperwork and to support data transmission required by the regulations.

Forms associated with the approval of medical command physicians and the recognition of medical command facilities will need to be revised to accommodate revised qualifying criteria. The Department's records pertaining to continuing education courses will need to be modified. For example, they will need to be revised to reflect trauma and medical continuing education credit assigned to each course. Course forms will need to be revised by continuing education sponsors. Sponsors of continuing education courses will also incur revised reporting and recordkeeping responsibilities.

The Department will also need to revise existing guidance manuals to assist regional EMS councils and regulated entities to meet new requirements imposed upon them.

Ambulance services will be required to maintain additional documentation regarding staff, policies and responsiveness to calls for emergency assistance. They will also be required to develop and maintain additional written policy records and duty rosters or staff availability schedules. They will be required to secure criminal and disciplinary histories from their personnel and to maintain a written record of that information. Additionally, they will also be required to report ambulance accidents resulting in injuries to personnel and patients that result in hospital care. Ambulance services will also need to complete modification of fleet or temporary change of vehicle forms when they add, replace or temporarily use an ambulance not previously inspected and approved by the Department.

QRSs will need to complete part of the EMS patient care report.

Special event sponsors that submit EMS plans for special events will also need to submit a special event report following conclusion of the event.

EMS training institutes that intend to conduct courses leading to the certification of prehospital personnel, in an EMS region other than that through which their applications for accreditation were processed, will need to file an application for amendment to the accreditation. EMS training institutes will also be required to develop and maintain additional written policy records.

Effective Date/Sunset Date

The regulations are effective upon publication in the *Pennsylvania Bulletin* as final-form regulations. No sunset date is imposed. The Department will monitor the regulations to ensure that they meet EMS needs within the scope of the Department's authority to address through regulations.

Statutory Authority

Section 17.1 of the EMS act (35 P. S. § 6937.1) provides that the Department, in consultation with PEHSC, may promulgate regulations as may be necessary to carry out the provisions of the EMS act. Other sections of the EMS act contain more narrow grants of authority to the Department to promulgate regulations.

In section 3 of the EMS act, the definitions of "advanced life support service medical director" and "Commonwealth Emergency Medical Director" provide that to qualify as either, one must be a medical command physician or meet equivalent qualifications as established by the Department through regulation. In the same

section, the definitions of "emergency medical technician" and "emergency medical technician-paramedic" provide that both are to be certified in accordance with the current National standard curriculum as set forth in the regulations of the Department. See, also, section 11(b)(1)(i) and (d)(1)(i) of the EMS act. The definition of "medical command" in section 3 of the EMS act provides that medical command physicians are to meet qualifications prescribed by the Department.

Section 5(2) of the EMS act authorizes the Department to employ regulations to establish standards and criteria governing the award and administration of contracts under the EMS act. Section 5(11) of the EMS act authorizes the Department to adopt regulations to establish standards and criteria for EMS systems.

Section 11(a)(1) of the EMS act provides that the Department shall employ regulations to develop standards for the accreditation of educational institutes for EMS personnel. Section 11(a)(4), (d)(3) and (e) of the EMS act provide that EMTs and EMT-paramedics may, in the case of an emergency, perform duties deemed appropriate by the Department in accordance with the Department's regulations. Section 11(d)(2)(ii)(A) and (B), and (e.1)(3)(i) and (ii)) of the EMS act provide that ALS service medical directors shall base a decision on whether to grant medical command authorization to an EMT-paramedic or prehospital registered nurse upon the individual's demonstrated competency in knowledge and skills as defined by Department regulation and the individual's completion of continuing education requirements adopted by regulation. Section 11(d)(2)(vi) and (e.1)(5) of the EMS act provide that when an EMT-paramedic or prehospital registered nurse chooses to not seek or maintain medical command authorization, and to function exclusively as an EMT, that person is to apply to the Department for recognition as an EMT under Department regulations. Section 11(f) of the EMS act provides that physicians approved by regional EMS councils as medical command physicians may give medical commands subject to Department regulatory requirements. Section 11(h) and (i) of the EMS act provide that regional EMS council transfer and medical treatment protocols are to be established under Department regulation. Section 11(j)(2) of the EMS act grants immunity, for specified conduct, to EMS students enrolled in approved courses and supervised under Department regulations.

Section 12(b) of the EMS act provides that applications for renewal of ambulance service licenses shall be made on forms prescribed by the Department in accordance with its regulations. Section 12(d) of the EMS act provides that the Department shall promulgate regulations setting forth minimum essential equipment for BLS and ALS ambulances, as well as design criteria for ambulances.

Section 14(d) of the EMS act provides that the standards the Department employs to disburse monies from EMSOF to providers of EMS shall be under the regulations.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (act) (71 P. S. § 745.5(a)), on January 29, 1999, the Department submitted a copy of proposed rulemaking, published at 29 Pa.B. 903, to the Independent Regulatory Review Commission (IRRC) and the Chairpersons of the House Health and Human Services Committee and the Senate Public Health and Welfare Committee for review and comment. In compliance with section 5(c) of the act, the Department also provided IRRC and the Committees with copies of all comments received, as well as other documentation.

In compliance with section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)) the Department submitted a copy of the final-form regulations to IRRC and the Committees on August 7, 2000. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

In preparing these final-form regulations the Department considered all comments received from IRRC, the Committees and the public.

These final-form regulations were deemed approved by the House Health and Human Services Committee and the Senate Public Health and Welfare Committee on August 28, 2000. IRRC met on September 7, 2000, and approved the regulations in accordance with section 5.1(e) of the Regulatory Review Act. The Office of Attorney General approved the regulations on September 27, 2000.

Contact Person

Questions regarding these final-form regulations may be submitted to Margaret E. Trimble, Director, Emergency Medical Services Office, Department of Health, 912 Health and Welfare Building, P. O. Box 90, Harrisburg, PA 17108-0090, (717) 787-8740. Persons with disabilities may submit questions in alternative formats, such as by audio tape or Braille. Speech or hearing impaired persons may use V/TT (717) 783-6514, or the Pennsylvania AT&T Relay Services at (800) 654-5984 [TT].

Persons with disabilities who would like to obtain this document in an alternative format (that is, large print, audiotape or Braille) should contact Margaret Trimble so that necessary arrangements may be made.

Findings

The Department finds:

(1) Public notice of intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202), and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered and forwarded to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare.

(3) The adoption of the final-form regulations is necessary and appropriate for the administration of the authorizing statutes.

Order

The Department, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 28 Pa. Code Part VII, are amended by adding §§ 1001.7, 1001.28, 1001.65, 1003.23a, 1003.31—1003.34, 1005.2a, 1005.7a, 1005.15, 1009.6, 1013.8 and 1015.1—1015.2; by amending §§ 1001.1—1001.6, 1001.21—1001.27, 1001.41, 1001.42, 1001.61, 1001.62, 1001.81, 1001.82, 1001.101, 1001.121, 1001.123—1001.125, 1001.141, 1001.161, 1003.1—1003.5, 1003.21—1003.24, 1003.25a—1003.30, 1005.1, 1005.2, 1005.3—1005.7, 1005.8—1005.14, 1007.1, 1007.2, 1007.7,

1007.8, 1009.1, 1009.2, 1009.4, 1009.5, 1011.1, 1011.3, 1011.4, 1013.1—1013.3, 1013.5 and 1013.6; and by repealing 1001.63, 1001.64, 1001.102, 1001.103, 1003.41—1003.44, 1007.3—1007.6, 1007.9, 1009.3 and 1011.2 as set forth in Annex A.

(b) The Secretary of Health shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as required by law.

(c) The Secretary of Health shall submit this order, Annex A and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law.

(d) The Secretary of Health shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(e) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

ROBERT S. ZIMMERMAN, Jr.,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 30 Pa.B. 4989 (September 23, 2000).)

Fiscal Note: Fiscal Note 10-143 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 28. HEALTH AND SAFETY

PART VII. EMERGENCY MEDICAL SERVICES

CHAPTER 1001. ADMINISTRATION OF THE EMS SYSTEM

Subchapter A. GENERAL PROVISIONS

GENERAL INFORMATION

§ 1001.1. Purpose.

The purpose of this part is to plan, guide, assist and coordinate the development of regional EMS systems into a unified Statewide system and to coordinate the system with similar systems in neighboring states, and to otherwise implement the Department's responsibilities under the act consistent with the Department's rulemaking authority.

§ 1001.2. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

ACLS course—Advanced cardiac life support course—A course in advanced cardiac life support sanctioned by the American Heart Association.

ALS ambulance service—Advanced life support ambulance service—An entity licensed by the Department to provide ALS services by ambulance to seriously ill or injured patients. The term includes mobile ALS ambulance services that may or may not transport patients.

ALS service medical director—Advanced life support service medical director—A medical command physician or a physician meeting the equivalent qualifications in § 1003.5 (relating to ALS service medical director) who is employed by, contracts with or volunteers with, either directly, or through an intermediary, an ALS ambulance service to make medical command authorization decisions, provide medical guidance and advice to the ALS ambulance service, and evaluate the quality of patient care provided by the prehospital personnel utilized by the ALS ambulance service.

ALS services—Advanced life support services—The advanced prehospital and interhospital emergency medical care of serious illness or injury by appropriately trained health professionals and EMT-paramedics.

APLS course—Advanced pediatric life support course—A course in advanced pediatric life support sanctioned by the American Academy of Pediatrics and the American College of Emergency Physicians.

ATLS course—Advanced trauma life support course—A course in advanced trauma life support sanctioned by the American College of Surgeons Committee on Trauma.

Act—The Emergency Medical Services Act (35 P. S. §§ 6921—6938).

Air ambulance—A rotorcraft specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to, and air transportation of, patients.

Air ambulance medical director—A medical command physician or a physician meeting the minimum qualifications in § 1003.5 who is employed by, or contracts with, or volunteers with, either directly, or through an intermediary, an air ambulance service to make medical command authorization decisions, provide medical guidance and advice to the air ambulance service, and evaluate the quality of patient care provided by the prehospital personnel utilized by the air ambulance service.

Air ambulance service—An agency or entity licensed by the Department to provide transportation and ALS care of patients by air ambulance.

Aircraft operator—The person, company or agency, certified by the FAA, under 14 CFR Part 135 (relating to air taxi operators and commercial operators), to conduct air taxi operations.

Ambulance—A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients, and the transportation of patients if used for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients.

Ambulance attendant—An individual who possesses the qualifications in § 1003.21(b) (relating to ambulance attendant).

Ambulance identification number—A number issued by the Department to each ambulance operated by an ambulance service.

Ambulance service—An entity which regularly engages in the business or service of providing emergency medical care and transportation of patients in this Commonwealth. The term includes ALS ambulance services that may or may not transport patients.

Ambulance service affiliate number—A unique number assigned by the Department to an ambulance service, the first two digits of which designate the county in which the ambulance service maintains its primary headquarters.

BLS ambulance service—Basic life support ambulance service—An entity licensed by the Department to provide BLS services and transportation by ambulance to patients.

BLS services—Basic life support services—The basic prehospital or interhospital emergency medical care and management of illness or injury performed by specially trained, certified or licensed personnel.

Basic rescue practices technician—An individual who is certified by the Department to possess the training and skills to perform a rescue operation as taught in a basic rescue practices technician program approved by the Department.

Basic vehicle rescue technician—An individual who is certified by the Department to possess the training and skills to perform a rescue from a vehicle as taught in a basic vehicle rescue technician program approved by the Department.

Board certification—Current certification in a medical specialty or subspecialty recognized by either the American Board of Medical Specialties or the American Osteopathic Association.

CPR—Cardiopulmonary resuscitation—The combination of artificial respiration and circulation which is started immediately as an emergency procedure when cardiac arrest or respiratory arrest occurs.

CPR course—Cardiopulmonary resuscitation course—A course of instruction in CPR, meeting the Emergency Cardiac Care Committee National Conference on CPR and Emergency Cardiac Care standards. The course shall encompass one and two-rescuer adult, infant and child CPR, and obstructed airway methods.

Commonwealth Emergency Medical Director—A medical command physician or a physician meeting the equivalent qualifications in § 1003.1 (relating to Commonwealth Emergency Medical Director) and approved by the Department to advise, formulate and direct policy on matters pertaining to EMS.

Continuing education—Learning activities intended to build upon the education and experiential basis of prehospital personnel for the enhancement of practice, education, administration, research or theory development, to strengthen the quality of care provided.

Continuing education sponsor—An entity or institution that is accredited by the Department as a sponsor of continuing education courses.

Council—The Board of Directors of the Pennsylvania Emergency Health Services Council.

Critical care specialty receiving facility—A facility identified by its capability of providing specialized emergency and continuing care to patients, including, in one of the following medical areas: poisoning, neonatal, spinal cord injury, behavioral, burns, cardiac and trauma.

Department—The Department of Health of the Commonwealth or a designee.

Department identification number—A number issued by the Department that identifies an individual who participates in the Statewide EMS system and who has been certified, recognized or otherwise assigned an identification number by the Department.

Direct support of EMS systems—Activities, equipment and supplies that are involved in the planning, initiation, maintenance, expansion or improvement of EMS systems.

EMSOF—Emergency Medical Services Operating Fund—Moneys appropriated to the Department under section 14(c) of the act (35 P. S. § 6934(c)) and which are not assigned to the Catastrophic Medical and Rehabilitation Fund.

EMS—Emergency medical services—The services utilized in responding to the needs of an individual for immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury.

EMS patient care report—A report that provides standardized data and information relating to patient assessment and care.

EMS system—The arrangement of personnel, facilities and equipment for the effective and coordinated delivery of EMS required in the prevention and management of incidents which occur either as a result of a medical emergency or of an accident, natural disaster or similar situation.

EMS training institute—Emergency medical services training institute—An institute accredited by the Department to provide a course required for the certification or recognition of a prehospital practitioner.

EMS training manual—Emergency medical services training manual—A manual adopted by the Department and reviewed biennially by the Council to aid ALS service medical directors in determining whether EMT-paramedics and prehospital registered nurses have demonstrated competency in the knowledge and skills necessary to be granted or maintain medical command authorization.

EMT—Emergency medical technician—An individual trained to provide prehospital emergency medical treatment and certified as such by the Department in accordance with the current EMT-NSC, as set forth in this part.

EMT-NSC—Emergency medical technician-National standard curriculum—An outline of knowledge and skills recommended for the education and training of EMTs, as adopted by the United States Department of Transportation.

EMT-paramedic—Emergency medical technician-paramedic—An individual who is trained to provide prehospital emergency medical treatment at an advanced level and certified as such by the Department in accordance with the current EMT-paramedic NSC, as set forth in this part.

EMT-paramedic NSC—Emergency medical technician-paramedic National standard curriculum—An outline of knowledge and skills recommended for the education and training of EMT-paramedics, as adopted by the United States Department of Transportation.

Emergency—A combination of circumstances resulting in a need for immediate medical intervention.

Emergency department—An area of the hospital dedicated to offering emergency medical evaluation and initial treatment to individuals in need of emergency care.

FAA—The Federal Aviation Administration.

FAA certification number—An air taxi/commercial operator operating certificate number assigned by the FAA, authorizing the certificate holder to operate aircraft as required by 14 CFR Part 135.

Facility—A hospital.

Federal KKK standards—The minimum standards and specifications for ambulance vehicles adopted by the United States Department of Transportation.

Federally declared emergency—A state of emergency declared by the President of the United States, upon the request of a governor. Once the President declares the situation a "major disaster," the Federal government supplements State and local efforts to meet the crisis.

First responder—An individual who is certified by the Department as a first responder.

Health professional—A physician who has education and continuing education in ALS services and prehospital care or a prehospital registered nurse.

Hospital—An institution having an organized medical staff which is primarily engaged in providing to inpatients by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services for the care or rehabilitation of injured, disabled, pregnant, diseased, sick or mentally ill persons. The term includes a facility for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not a facility caring exclusively for the mentally ill.

Invalid coach—A vehicle primarily maintained, operated and intended to be used for routine transport of persons who are convalescent or otherwise nonambulatory and do not ordinarily require emergency medical treatment while in transit. The term does not include an ambulance or another EMS vehicle.

Medical advisory committee—An advisory body, composed of a majority of physicians, to advise a regional EMS council or the Council on issues that have potential impact on the delivery of emergency medical care.

Medical audit—A mechanism to evaluate patient care.

Medical command—An order given by a medical command physician to a prehospital practitioner in a prehospital, interfacility, or emergency care setting in a hospital, to provide immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury, or to withdraw or withhold treatment.

Medical command authorization—Permission given by the ALS service medical director, including an air ambulance medical director, to an EMT-paramedic or a prehospital registered nurse under § 1003.28 (relating to medical command authorization) to perform, on behalf of an ALS ambulance service, ALS services under medical command or in accordance with Department approved regional EMS council transfer and medical treatment protocols when medical command cannot be secured, is disrupted or is not required under the approved regional EMS council transfer and medical treatment protocols.

Medical Command Course—The course adopted by the Department for medical command physicians and ALS service medical directors which provides an overview of the medical command system.

Medical command facility—The distinct unit within a facility that contains the necessary equipment and personnel, as prescribed in § 1009.1 (relating to operational criteria) for providing medical command to and control over prehospital personnel when providing medical command.

Medical command facility medical director—A medical command physician who meets the criteria established by the Department to assume responsibility for the direction and control of the equipment and personnel at a medical command facility.

Medical command physician—A physician who is approved by a regional EMS council to provide medical command.

Medical coordination—A system which involves the medical community in all phases of the regional EMS system and consists of the following elements:

(i) Designation of a regional medical director.

(ii) Responsibility for oversight to assure implementation of all medical requirements, with special emphasis on patient triage and medical treatment protocol.

(iii) Effective emergency medical planning and recommendation for Department recognition of online command facilities with medical command physicians who give orders to prehospital patient care providers.

(iv) Transfer and medical treatment protocols.

(v) Technologic innovations which support the training and operations of the physicians giving orders to prehospital patient care providers.

(vi) Technologic innovations which support the training and operations of the EMS program and an effective process for accountability—for example, records, case review and audits.

Medical record—Documentation of the course of a patient's condition and treatment, maintained to provide communication among health care providers for current and future patient care.

Medical treatment protocols—Written prescribed medical procedures.

NSC—National Standard Curriculum.

PALS course—Pediatric advanced life support course—A course in advanced pediatric life support sanctioned by the American Heart Association and the American Academy of Pediatrics.

PSAP—Public safety answering point—A communications center established to serve as the first point at which calls by or on behalf of patients are received requesting emergency medical assistance.

Patient—An individual who is believed to be sick, injured, wounded or otherwise incapacitated and helpless and in need of immediate medical attention.

Pennsylvania Trauma Systems Foundation—A nonprofit Pennsylvania corporation whose function is to accredit trauma centers in this Commonwealth.

Physician—An individual who has a currently registered license to practice medicine or osteopathic medicine in this Commonwealth.

Prehospital personnel—The term includes any of the following prehospital practitioners:

(i) Ambulance attendants.

(ii) First responders.

(iii) EMTs.

(iv) EMT-paramedics.

(v) Prehospital registered nurses.

(vi) Health professional physicians.

Prehospital registered nurse—An individual who is recognized by the Department as such under § 1003.25b (relating to prehospital registered nurse).

Providers of EMS—A facility, BLS ambulance service or ALS ambulance service, or a QRS.

QRS—Quick response service—An entity recognized by the Department to respond to an emergency and to provide EMS to patients pending the arrival of the prehospital personnel of an ambulance service.

Receiving facility—A fixed facility that provides an organized emergency department, with a physician who is trained to manage cardiac, trauma, pediatric, medical and behavioral emergencies, and is present in the facility and

available to the emergency department 24 hours-a-day, 7 days-a-week, and a registered nurse who is present in the emergency department 24 hours-a-day, 7 days-a-week. The facility shall also comply with Chapter 117 (relating to emergency services).

Regional EMS council—A nonprofit incorporated entity or appropriate equivalent whose function is to plan, develop, maintain, expand and improve EMS systems within a specific geographical area of this Commonwealth and which is deemed by the Department as being representative of health professions and major private and public and voluntary agencies, organizations and institutions concerned with providing EMS in the region.

Registered nurse—An individual who has a current original or renewed license to practice nursing in this Commonwealth as a registered nurse.

Rescue vehicle—A vehicle which is designed or modified and equipped for rescue operations to release persons from entrapment and which is not routinely used for emergency medical care or transport of patients.

Residency program—Training approved or recognized by the State Board of Medicine or the State Board of Osteopathic Medicine as a program of graduate medical training for physicians.

Rural area—An area outside urbanized areas as defined by the United States Bureau of the Census.

Scope of practice—Those emergency medical services that an individual who is certified or recognized by the Department is permitted to perform under the certification or recognition, provided the individual has medical command authorization, if required.

Secretary—The Secretary of the Department.

Service area—The area in which an ambulance service routinely provides services.

Special care unit—An appropriately equipped area of the hospital where provision has been made for a concentration of physicians, registered nurses and others who have special skills and experiences to provide medical care for critically ill patients.

Special event—A planned and organized activity or contest, which will place participants or attendees, or both, in a defined geographic area in which the potential need for EMS exceeds local EMS capabilities, or where access by emergency vehicles might be delayed due to crowd or traffic congestion at or near the event.

Special vehicle rescue technician—An individual who is certified by the Department to possess the training and skills to perform special rescue operations as taught in the special vehicle rescue training program approved by the Department.

State declared emergency—An emergency declared by the Governor.

Statewide BLS medical treatment protocols—Written medical treatment protocols adopted by the Department that have Statewide application to the delivery of BLS services by prehospital personnel.

Trauma center—A facility accredited as a trauma center by the Pennsylvania Trauma Systems Foundation.

Volunteer ambulance service—A nonprofit chartered corporation, association or organization located in this Commonwealth and which is regularly engaged in the service of providing emergency medical care and transportation of patients as an ambulance service.

§ 1001.3. Applicability.

This part affects regional EMS councils, the Council, other entities desiring to receive funding from the Department or the regional EMS councils for the provision of EMS, ALS and BLS ambulance services, QRSs, instructors and institutes involved in the training of prehospital personnel including EMTs, EMT-paramedics, first responders, ambulance attendants and health professionals, and trauma centers and local governments involved in the administration and support of EMS.

§ 1001.4. Exceptions.

(a) The Department may grant exceptions to, and departures from, this part when the policy objectives and intentions of this part are otherwise met or when compliance would create an unreasonable hardship, but would not impair the health, safety or welfare of the public. No exceptions or departures from this part will be granted if compliance with the standard is required by statute.

(b) Requests for exceptions to this part shall be made in writing to the Department. The requests, whether approved or not approved, will be documented and retained on file by the Department. Approved requests shall be retained on file by the applicant during the period the exception remains in effect.

(c) A granted request will specify the period during which the exception is operative. Exceptions may be reviewed or extended if the reasons for the original exception continue.

(d) An exception granted may be revoked by the Department for just cause. Just cause includes, but is not limited to, failure to meet the conditions for the exception. Notice of the revocation will be in writing and will include the reason for the action of the Department and a specific date upon which the exception will be terminated.

(e) In revoking an exception, the Department will provide for a reasonable time between the date of the written notice or revocation and the date of termination of an exception for the holder of the exception to come into compliance with this part. Failure to comply after the specified date may result in enforcement proceedings.

(f) The Department may, on its own initiative, grant an exception to this part if the requirements of subsection (a) are satisfied.

§ 1001.5. Investigation.

The Department may investigate any person, entity or activity for compliance with the act and this part.

§ 1001.6. Comprehensive EMS development plan.

(a) The Department, with the advice of the Council, will develop and annually update a Statewide EMS development plan for the coordinated delivery of EMS in this Commonwealth.

(b) The plan will contain, but not be limited to:

(1) An inventory of emergency services resources available in this Commonwealth.

(2) An assessment of the effectiveness of the existing services and a determination of the need for additional services.

(3) A statement of goals and specific measurable objectives for delivery of EMS to persons in need of the services in this Commonwealth.

(4) Methods to be used in achieving the stated objectives.

(5) A schedule for achievement of the stated objectives.

(6) A method for evaluating the stated objectives.

(7) Estimated costs for achieving the stated objectives.

(c) The Department will incorporate regional EMS development plans into the Statewide EMS development plan.

(d) The Department will adopt a Statewide EMS development plan, and updates to the plan, after public notice, an opportunity for comment and its consideration of comments received, and will make the plan available to the General Assembly and all concerned agencies, entities and individuals who request a copy.

§ 1001.7. Comprehensive regional EMS development plan.

(a) A regional EMS council shall develop and annually update a regional EMS development plan for coordinating and improving the delivery of EMS in the region for which it has been assigned responsibility.

(b) The plan shall contain:

(1) An inventory of emergency services resources available in the region.

(2) An assessment of the effectiveness of the existing services and a determination of the need for additional services.

(3) A statement of goals and specific measurable objectives for delivery of EMS to persons in need of EMS in the region.

(4) Identification of interregional problems and recommended measures to resolve those problems.

(5) Methods to be used in achieving stated objectives.

(6) A schedule for achievement of the stated objectives.

(7) A method for evaluating whether the stated objectives have been achieved.

(8) Estimated costs for achieving the stated objectives.

(9) Other information as requested by the Department.

(c) A regional EMS council shall, in the course of preparing a regional EMS development plan, and updates to the plan, provide public notice and an opportunity for comment. It shall consider all comments before submitting a proposed plan to the Department.

(d) A regional EMS development plan shall become final after it is approved by the Department. The regional EMS council shall make the plan available to all concerned agencies, entities and individuals who request a copy.

Subchapter B. AWARD AND ADMINISTRATION OF FUNDING

§ 1001.21. Purpose.

This subchapter implements section 5(b)(2) of the act (35 P. S. § 6925(b)(2)), which authorizes the Department to establish, by regulation, standards and criteria governing the award and administration of contracts under the act, and section 10 of the act (35 P. S. § 6930), which authorizes the Secretary to enter into contracts with regional EMS councils and other appropriate entities for the initiation, expansion, maintenance and improvement of EMS systems which are in accordance with the Statewide EMS development plan, and which further authorizes the Secretary to enter into contracts with organizations other than regional EMS councils to assist the Department in complying with the act.

§ 1001.22. Criteria for funding.

(a) A potential contractor or other recipient of funds from the Department, either directly or through the Department's agent, may receive funding for the following:

(1) Public education, information and prevention regarding EMS, including:

(i) Public education programs, including CPR, first aid, instruction regarding 911 systems and how to access EMS systems.

(ii) Public information programs, including passenger and driver safety specialty services and EMS system awareness programs.

(iii) Prevention programs, including passenger restraint systems, prudent heart living and general health awareness.

(2) Purchasing ambulances, medical equipment and rescue equipment which enables or enhances the delivery of EMS. Equipment will be funded only if approved by the Department.

(i) Ambulances will be considered for funding if the funds will be used for the addition or replacement of existing vehicles or parts, by a licensed ambulance service or an entity submitting an application for licensure as an ambulance service.

(ii) Medical equipment will be considered for funding if the funds will be used to purchase medical equipment for ambulances, QRSs, rescue services and other emergency services approved by the Department, including police and fire departments and recognized medical command facilities.

(iii) Rescue equipment will be considered for funding if the funds will be used to purchase rescue equipment for ambulance services, rescue services, fire departments, QRSs, police agencies and other emergency services approved by the Department.

(3) Costs associated with training programs for prehospital personnel.

(i) Educational costs associated with the conduct of training programs for prehospital personnel, and for other personnel who are involved in managing interfacility patient transports.

(ii) Priority consideration will be given to training programs providing for certification, recertification, recognition and continuing education of individuals actively engaged in providing prehospital or interhospital EMS and rescue services.

(4) Costs associated with ambulance service inspections conducted to assist the Department with ambulance service licensure.

(5) Purchasing communications equipment, including medical command communications equipment, and alerting equipment for EMS purposes, if the purchases are in accordance with regional EMS council and Statewide telecommunications plans.

(6) Purchasing equipment for emergency departments, if the equipment is used or intended to be used in equipment exchange programs with ambulance services. The equipment purchased shall be of a type used by prehospital and interhospital EMS personnel in the care, treatment, stabilization and transportation of patients in a prehospital or interhospital setting. It shall be the type

of equipment that can be easily or safely removed from the patient upon arrival or during treatment at the receiving facility.

(7) Costs associated with the maintenance and operation of regional EMS councils. Items eligible for funding include:

(i) Salaries, wages and benefits of staff.

(ii) Travel.

(iii) Equipment and supplies.

(iv) Leasing of office space.

(v) Other costs incidental to the conduct of business which are found by the Department to be necessary and appropriate.

(8) Costs associated with the collection and analysis of data necessary to evaluate the effectiveness of EMS systems in providing EMS. These costs may include the processing of both prehospital and hospital data and include the following:

(i) Data collection.

(ii) Data entry.

(iii) Data processing of information.

(iv) Analysis and evaluation of data.

(v) Dissemination and interpretation of data.

(9) Emergency allocations.

(i) Costs associated with a State or Federally declared emergency which the Department finds necessary to carry out the purpose of the act. Eligible applicants are those recognized by the regional EMS council as participants in the delivery of emergency medical or rescue services to or in the affected area.

(ii) Other emergency allocations found necessary by the Department to provide immediate resources or equipment to an area where the health and safety of the residents of this Commonwealth are in jeopardy.

(10) Costs associated with the implementation of voluntary certification or recognition programs, such as a voluntary rescue technician certification program.

(11) Other costs determined by the Department to be appropriate and necessary for the implementation of a comprehensive EMS system.

(b) Funds will not be made available for any of the following:

(1) Acquisition, construction or rehabilitation of facilities or buildings, except renovation as may be necessary for the implementation of 911 and EMS communication systems.

(2) The purchase of hospital equipment, unless the equipment is used or intended to be used in an equipment exchange program with ambulance services.

(3) Maintenance of ambulances, medical equipment or rescue equipment.

(4) Other costs found by the Department to be inappropriate.

(5) Costs which are normally borne by patients.

(c) The Department will set forth additional priorities for funding on a yearly basis in notices published in the *Pennsylvania Bulletin*.

(d) The Department, by contract or notice published in the *Pennsylvania Bulletin*, may require a contractor or other applicant for funding to provide matching funds in specified percentages as a condition for receiving funds distributed by the Department or a regional EMS council.

§ 1001.23. Allocation of funds.

The Department and regional EMS councils will consider the following factors in determining who shall receive funding and in what amount:

(1) The total amount of funds available.

(2) Conformity of the proposed application to the Statewide EMS development plan.

(3) Financial need of the applicant.

(4) Funds available to the applicant for the purpose set forth in the application, including non-State contributions, Federal grants or Federal contracts pertaining to EMS. Non-State contributions include cash and in-kind services provided to the contractor or toward the operation of an EMS system by private, public or government entities, including the Federal government.

(5) Economic base of the geographic area served by the applicant.

(6) Population of the geographic area served by the applicant.

(7) Special rural needs of the geographic area served by the applicant.

(8) Potential duplication of services.

(9) Priorities of the Department.

(10) Other factors set forth by the Department in published guidelines or policies.

§ 1001.24. Application for contract.

To be considered for funding by the Department to plan, initiate, maintain, expand or improve an EMS system, a regional EMS council or other appropriate entity shall submit an application on a form prescribed by the Department and shall provide the following information:

(1) The need for planning, initiation, maintenance, expansion or improvement of an EMS system.

(2) Data and information which demonstrate the qualifications of the applicant to plan, initiate, expand or improve an EMS system, and which include organizational structure and provision for representation of appropriate entities.

§ 1001.25. Technical assistance.

(a) Regional EMS councils and other contracting entities may request technical assistance from the Department, if necessary, for the purpose of carrying out their contracts. Special consideration shall be given to contractors in rural areas to assist with matters such as recruitment, retention of prehospital personnel, ambulance service management, and ambulance equipment, in recognition that rural areas may not have sufficient resources of these types.

(b) Technical assistance from the Department may also be available to subcontractors when technical assistance resources are not available from the regional EMS council designated for the applicable area.

(c) Examples of technical assistance resources include, but are not limited to:

(1) Telecommunications specialists.

(2) Public education resources.

(3) Information management sources.

§ 1001.26. Restrictions on contracting.

(a) The Department will not contract, during the same term of contract, with more than one regional EMS council to exercise responsibility for all or a portion of the same geographic area.

(b) A regional EMS council or other contractor does not have the right to have a contract renewed.

§ 1001.27. Subcontracting.

(a) A regional EMS council, which has received a contract from the Department, may receive the Department's written approval to subcontract certain of its contractual duties to other entities as deemed necessary and appropriate for the proper execution of the contract with the Department.

(b) A subcontract may not be executed until the Department determines in writing that the subcontract is necessary and appropriate.

(c) Subcontractors will be paid on a cost reimbursement basis. The costs will be determined by the Department based on documentation submitted to the Department.

§ 1001.28. Contracts with the Council.

Sections 1001.22—1001.27 do not apply to contracts between the Department and the Council. The Department will contract with the Council to provide it funds to perform the services the Council is required to perform under the act, and may contract with the Council for it to assist the Department in complying with other provisions of the act.

Subchapter C. COLLECTION OF DATA AND INFORMATION

§ 1001.41. Data and information requirements for ambulance services.

(a) Ambulance services licensed to operate in this Commonwealth shall collect, maintain and report accurate and reliable patient data and information for calls for assistance in the format prescribed and on paper or electronic forms provided or approved by the Department. An ambulance service shall file the report for any call to which it responds that results in patient care, assessment or refusal of the patient to be assessed. The report shall be made by completing an EMS patient care report and filing it, within 30 days, with the regional EMS council that is assigned responsibilities for the region in which the ambulance is based. It shall contain information specified by the Department. The Department will publish a list of the data elements and the form specifications for the EMS patient care report form in a notice in the *Pennsylvania Bulletin* and on the Department's World Wide Web Site. Paper EMS patient care report forms may be secured from regional EMS councils. Electronic reporting shall conform with the requirements published in the *Pennsylvania Bulletin* notice. The Department will maintain a list of software it has determined to satisfy the requirements for electronic reporting.

(b) The Department will identify data items for the EMS patient care report as either confidential or not confidential.

(c) An ambulance service shall store the information designated as confidential in secured areas to assure that access to unauthorized persons is prevented, and shall take other necessary measures to ensure that the information is maintained in a confidential manner and is not available for public inspection or dissemination, except as authorized by § 1001.42 (relating to dissemination of information).

(d) When an ambulance service transports a patient to a hospital, before its ambulance departs from the hospital, it shall provide to the individual at the hospital assuming responsibility for the patient, either verbally, or in writing or other means by which information is recorded, the patient information designated in the EMS patient care report as essential for immediate transmission for patient care. Within 24 hours following the conclusion of its provision of services to the patient, the ambulance service shall complete the full EMS patient care report and provide a copy or otherwise transmit the data to the receiving facility. The ambulance service may report the data to the receiving facility in any manner acceptable to the receiving facility which ensures the confidentiality of information designated as confidential in the EMS patient care report.

(e) The ambulance service shall have a policy for designating which member of the ambulance crew is responsible for completing the EMS patient care report.

(f) The ambulance service shall retain a copy of the EMS patient care report for a minimum of 7 years.

§ 1001.42. Dissemination of information.

(a) A person who collects, has access to, or knowledge of, confidential information collected under § 1001.41 (relating to data and information requirements for ambulance services), by virtue of that person's participation in the Statewide EMS system, may not provide the EMS patient care report, or disclose the confidential information contained in the report or a report or record thereof, except:

(1) To another person who by virtue of that person's office as an employe of the Department is entitled to obtain the information.

(2) To another person or agency under contract with or licensed by the Department and subject to strict supervision by the Department to insure that the use of the data is limited to specific research, planning, quality improvement and complaint investigation purposes and that appropriate measures are taken to protect patient confidentiality.

(3) To the patient who is the subject of the information released or to a person who is authorized to exercise the rights of the patient with respect to securing the information, such as the patient's duly appointed attorney-in-fact.

(4) Under an order of a court of competent jurisdiction, including a subpoena when it constitutes a court order, except when the information is of a nature that disclosure under a subpoena is not authorized by law.

(5) For the purpose of quality improvement activities, with strict attention to patient confidentiality.

(6) For the purpose of data entry/retrieval and billing, with strict attention to patient confidentiality.

(7) Under § 1001.41 (relating to data and information requirements for ambulance services) and to another health care provider to whom a patient's medical record may be released under the law.

(b) The Department will regularly disseminate nonconfidential, statistical data collected from EMS patient care reports to providers of EMS for improvement of services.

Subchapter D. QUALITY IMPROVEMENT PROGRAM

§ 1001.61. Components.

(a) The Department, in conjunction with the Council, will identify the necessary components for a Statewide EMS quality improvement program for the Commonwealth's EMS system. The Statewide EMS quality improvement program shall be operated to monitor the delivery of EMS through the collection of data pertaining to emergency medical care provided by prehospital personnel and providers of EMS.

(b) The Department will develop, approve and update a Statewide EMS Quality Improvement Plan in which it will establish goals and reporting thresholds.

§ 1001.62. Regional programs.

A regional EMS council, after considering input from participants in and persons served by the regional EMS system, shall develop and implement a regional EMS quality improvement program to monitor the delivery of EMS, which addresses, at a minimum, the quality improvement components identified by the Department. A regional EMS council quality improvement program shall:

(1) Conduct quality improvement audits on the regional EMS system including reviewing the quality improvement activities conducted by the ALS service medical directors and medical command facilities within the region.

(2) Have a regional quality improvement committee that shall recommend to the regional EMS council ways to improve the delivery of prehospital EMS care within the region based upon State and regional goals and reporting requirements.

(3) Develop and implement a regional EMS quality improvement plan to assess the EMS system in the region.

(4) Investigate complaints concerning the quality of care rendered and forward recommendations and findings to the Department.

(5) Submit to the Department reports as prescribed by the Department.

§ 1001.63. (Reserved).

§ 1001.64. (Reserved).

§ 1001.65. Cooperation.

Each individual and entity licensed, certified, recognized, accredited or otherwise authorized by the Department to participate in the Statewide EMS system shall cooperate in the Statewide and regional EMS quality improvement programs. These individuals and entities shall provide information, data, reports and access to records as requested by the Department and regional EMS councils to monitor the delivery of EMS.

Subchapter E. TRAUMA CENTERS

§ 1001.81. Purpose.

The purpose of this subchapter is to integrate trauma centers into the Statewide EMS system, by providing access to trauma centers and by providing for the effective and appropriate utilization of resources.

§ 1001.82. Requirements.

To ensure that trauma centers are integrated into the Statewide EMS system, trauma centers in this Commonwealth shall:

(1) Maintain a dedicated telephone number to allow for access by referring community hospitals to make arrangements for the most appropriate and expeditious mode of transportation to the trauma center, as well as allow for direct consultation between the two facilities prior to transfer and during the course of treatment of the patient.

(2) Develop and implement outreach education programs to be offered to referring hospitals and emergency services dealing with management of major and multiple systems trauma patients and the capabilities of the trauma center.

(3) Develop and institute a system to insure the provision of patient outcome and treatment information to the referring facility on each patient referred by that facility to the trauma center.

(4) Maintain communications capabilities to allow for direct access by a transferring ground ambulance or air ambulance to insure that patient information and condition updates are available and medical consultation is available to the transferring service. The capabilities shall be in accordance with regional and Statewide EMS telecommunications plans.

Subchapter F. REQUIREMENTS FOR REGIONAL EMS COUNCILS AND THE COUNCIL

§ 1001.101. Governing body.

A regional EMS council and the Council shall have a governing body.

(1) No more than one staff member of the regional EMS council or Council may sit on the governing body at the same time.

(2) If the governing body consists of a board, it shall adopt written policies which include, but are not limited to:

(i) A method of selection for membership.

(ii) Qualifications for membership.

(iii) Criteria for continued membership.

(iv) Frequency of meetings.

(3) The duties of the governing body shall include, but not be limited to:

(i) Selecting a director as the person officially responsible to the governing body.

(ii) Identifying the purpose and philosophy.

(iii) Describing the organizational structure.

(4) The governing body shall make available to the public an annual report which includes, but is not limited to:

(i) Activities and accomplishments of the preceding year.

(ii) A financial statement of income and expenses.

(iii) A statement disclosing the names of officers and directors.

§ 1001.102. (Reserved).

§ 1001.103. (Reserved).

Subchapter G. ADDITIONAL REQUIREMENTS FOR REGIONAL EMS COUNCILS

§ 1001.121. Designation of regional EMS councils.

(a) The Department will designate a regional EMS council that satisfies the representation requirements in § 1001.125 (relating to requirements) for each geographic area of this Commonwealth.

(b) The designation of the geographical area will be based on:

(1) Existing usual patient care flow patterns.

(2) The capability to provide definitive care services to the majority of general, emergent and critical patients.

(3) Financial resources to sustain the EMS system operations.

(4) The capability to establish community-wide and regional care programs.

(c) The Department will evaluate the performance and effectiveness of each regional EMS council on a periodic basis to assure that each council is appropriately meeting the needs of its region in planning, developing, maintaining, expanding, improving and upgrading the EMS system in its region.

§ 1001.123. Responsibilities.

In addition to other responsibilities imposed upon regional EMS councils by this part, regional EMS councils have responsibility for the following:

(1) Organizing, maintaining, implementing, expanding and improving the EMS system within the geographic area for which the regional EMS council has been assigned responsibilities.

(2) Developing and implementing comprehensive EMS plans, as approved by the Department.

(3) Advising PSAPs, and municipal and county governments, as to EMS resources available for dispatching and recommended dispatching criteria that may be developed by the Department, or by the regional EMS council as approved by the Department.

(4) Developing, maintaining, implementing, expanding and improving programs of medical coordination. The programs are subject to approval by the Department.

(5) Assisting hospitals in providing the Department with a comprehensive written plan for emergency care based on community need as provided in § 117.11 (relating to emergency services plan) and in identifying the hospital's scope of services as provided in § 117.13 (relating to scope of services).

(6) Assisting the Department in achieving a unified Statewide EMS system as described in section 4 of the act (35 P. S. § 6924).

(7) Assisting the Department in collection and maintenance of standardized patient data and information.

(8) Providing ambulance services with data summary reports.

(9) Assuring the reasonable availability of training programs, including continuing education programs, for EMS personnel. The programs shall include those that lead to certification or recognition by the Department. Regional EMS councils may also develop and implement additional educational programs.

(10) Monitoring medical command facilities and prehospital personnel compliance with minimum standards established by the Department, and ambulance service medical director and medical command physician medical control of prehospital personnel.

(11) Facilitating the integration of medical command facilities into the regional EMS system in accordance with policies and guidelines established by the Department.

(12) Developing and implementing regional protocols for the triage, treatment, transport and transfer of patients to the most appropriate facility. Protocols shall be developed in consultation with the regional EMS council's medical advisory committee and approved by the Department. Protocols shall, at a minimum:

(i) Include a method of identifying patients requiring specialized medical care, utilizing measurable criteria to identify patient referral.

(ii) Be based upon the specialty care capabilities of the receiving facilities and available providers of EMS, prehospital personnel, local geodemographic considerations and transport time considerations.

(iii) Be distributed to the providers of EMS within the region.

(iv) Be reviewed annually, and revised as necessary in consultation with the regional EMS council's medical advisory committee.

(v) Be consistent with Chapter 1003 (relating to personnel) which governs the scope of practice of EMTs, EMT-paramedics and other prehospital personnel.

(vi) Be based upon accepted standards of emergency medical care.

(vii) Address patient choice regarding receiving facility.

(viii) Set forth a procedure for the efficient transfer of patients. When appropriate, these regional protocols shall be developed in consultation with specialty care facilities in the region.

(13) Assisting Federal, State or local agencies, upon request, in the provision of onsite mitigation, technical assistance, situation assessment, coordination of functions or postincident evaluations, in the event of a potential or actual disaster, mass casualty situation or other substantial threat to public health.

(14) Maintaining an inventory of EMS resources and personnel available on a volunteer basis as conditions and circumstances require and recruiting volunteers as needed.

(15) Designating a regional medical director.

(16) Supervising the regional EMS medical director to assure that the roles and responsibilities in § 1003.2 (relating to regional EMS medical director) are carried out.

(17) Assisting prehospital personnel and ambulance services operating in the regional EMS system to meet the licensure, certification, recertification, recognition, biennial registration and continuing education require-

ments established under the act and this part, and assisting the Department in ensuring that those requirements are met.

(18) Apprising medical command facilities and ALS ambulance services in the region when an EMT-paramedic or prehospital registered nurse has had medical command authorization removed by an ALS service medical director for an ALS ambulance service in the region.

(19) Developing a conflict of interest policy and requiring employes and officials to agree to the policy in writing.

(20) Approving medical command physicians in accordance with § 1003.4(c)(2) (relating to medical command physician).

(21) Performing other duties deemed appropriate by the Department for the initiation, expansion, maintenance and improvement of the regional and Statewide EMS system which are in accordance with the Statewide EMS development plan.

§ 1001.124. Composition.

Regional EMS councils shall be organized by one of the following:

(1) A unit of general local government with an advisory council.

(2) A representative public entity administering a compact or other areawide arrangement or consortium.

(3) A public or private nonprofit entity.

§ 1001.125. Requirements.

(a) If the regional EMS council is a unit of local government, it shall have an advisory council which is deemed by the Department to be representative of health care consumers, the health professions, and major private and public and voluntary agencies, organizations and institutions concerned with providing EMS.

(b) If the regional EMS council is a public or private nonprofit organization, its governing body shall satisfy the representation requirements in subsection (a).

(c) A regional EMS council shall establish and maintain a medical advisory committee and other committees which are necessary to carry out the responsibilities of the regional EMS council.

(d) The regional medical advisory committee shall assist the regional EMS council's medical director in matters of medical coordination.

(e) Meetings of the regional EMS council shall be held under the Sunshine Act (65 P. S. §§ 271—286).

Subchapter H. ADDITIONAL REQUIREMENTS FOR THE COUNCIL

§ 1001.141. Duties and purpose.

The Council shall advise the Department on emergency health services issues that relate to manpower and training, communications, ambulance services, special care units, the content of EMS patient care reports, the content of rules and regulations, standards and policies promulgated by the Department and other subjects as required by the act or deemed appropriate by the Department or the Council. The Council shall also advise the Department on the content of the Statewide EMS development plan, and proposed revisions to it.

Subchapter I. RESEARCH IN PREHOSPITAL CARE

§ 1001.161. Research.

(a) Clinical investigations or studies that relate to direct patient care may not be conducted by providers of EMS unless the investigation or study is proposed to and approved by the Department.

(b) A proposal for clinical investigation or study shall be presented to the Department. If the Department concludes that the proposal may have merit, it shall refer the proposal to the Council, and to the regional EMS council having responsibilities in the region where the investigation or study would be undertaken. The Council and the regional EMS council shall have the proposal reviewed by their medical advisory committees and consider the comments of those committees, and shall forward their recommendations to the Department within 60 days after receiving from the Department a request to review the proposal.

(c) The Department will approve or disapprove the proposal within 30 days after receiving the recommendations of the Council and the regional EMS council. If the proposal is approved, the prehospital personnel identified in the proposal may function in accordance with the proposal and under conditions specified by the Department during the term of the clinical investigation or study.

(d) A proposal shall include and address the following considerations and items in a format specified by the Department:

(1) A specific statement of the hypothesis to be investigated and the clinical significance of the hypothesis.

(2) A specific description of the methodology to be used in the investigations.

(3) An estimated duration of the investigation.

(4) Consideration of complications or side effects that may be encountered and how they shall be treated.

(5) Consideration of how to assure patient confidentiality.

(6) Consideration of obtaining informed consent of the patient.

(7) Institutional review board approval when required by law.

(8) A letter from the researcher who identifies himself as the lead investigator and assumes clinical responsibility for the investigation.

(9) A letter from the physician who assumes clinical responsibility for the investigation.

(10) A plan for providing the Department with progress reports and a final report on the investigation or study.

(e) The Department may direct that the investigation or study be terminated prematurely for its failure to satisfy conditions of approval.

CHAPTER 1003. PERSONNEL

Subchapter A. ADMINISTRATIVE AND SUPERVISORY EMS PERSONNEL

§ 1003.1. Commonwealth Emergency Medical Director.

(a) *Roles and responsibilities.* The Commonwealth Emergency Medical Director is responsible for the following:

(1) Providing medical advice and recommendations to the Department regarding the EMS system.

(2) Assisting in the development and implementation of a Statewide EMS quality improvement program.

(3) Assisting the Department in revising or modifying the scope of practice of ALS and BLS prehospital personnel.

(4) Providing advice and guidance to the Department on investigations and the pursuit of disciplinary actions against prehospital personnel and providers of EMS.

(5) Reviewing, evaluating and making recommendations regarding regional transfer and medical treatment protocols.

(6) Reviewing, evaluating and making recommendations for the Statewide BLS medical treatment protocols.

(7) Reviewing, evaluating and making recommendations for protocols to get acutely ill and injured patients to the most appropriate facility, including criteria for the evaluation, triage, treatment, transport and referral, as well as bypass protocols.

(8) Evaluating regional EMS quality improvement programs.

(9) Providing direction and guidance to the regional EMS medical directors for training and quality improvement monitoring and assistance.

(10) Meeting with representatives and committees of regional EMS councils and the Council as necessary and as directed by the Department to provide guidance and direction.

(11) Reviewing, evaluating and making recommendations to the Department on clinical research proposals.

(12) Providing other services relating to the Department's administration of the act as assigned by the Department.

(b) *Equivalent qualifications.* If the Commonwealth Emergency Medical Director is not a medical command physician, the Commonwealth Emergency Medical Director shall possess the following qualifications:

(1) The minimum qualifications for a medical command physician in § 1003.4(b)(1)—(3) and (5) (relating to medical command physician).

(2) Experience in the prehospital and emergency department care of the acutely ill and injured patient.

(3) Knowledge regarding the medical command direction of prehospital personnel and the operation of emergency dispatch.

(4) Knowledge of the capabilities and limitations of ambulances, including air ambulances and prehospital personnel.

(5) Knowledge of potential medical complications which may arise during transport of a patient by an ambulance service.

(c) *Disclosure.* The Commonwealth Emergency Medical Director shall disclose to the Department all financial or other interest in providers of EMS and in other matters which present a potential conflict of interest.

§ 1003.2. Regional EMS medical director.

(a) *Roles and responsibilities.* Each regional EMS council shall have a regional EMS medical director who shall carry out the following duties:

(1) Assist the regional EMS council to approve or reject applications for medical command physicians received from medical command facility medical directors.

(2) Maintain liaison with the Commonwealth Emergency Medical Director.

(3) Assist the regional EMS council, after consultation with the regional medical advisory committee, to establish and revise transfer and medical treatment protocols for the regional EMS system.

(4) Assist the regional EMS council to establish field treatment protocols for determining when a patient will not be transported to a treatment facility and establish procedures for documenting the reasons for a nontransport decision.

(5) Assist the regional EMS council to establish field protocols to govern situations in which a patient may be transported without consent, in accordance with Pennsylvania law. The protocols shall cover appropriate documentation and review procedures.

(6) Assist the regional EMS council to establish criteria for level of care and type of transportation to be provided in various medical emergencies, such as ALS versus BLS, and ground versus air ambulance, and distribute approved criteria to PSAPs.

(7) Conduct quality improvement audits of the regional EMS system including reviewing the quality improvement activities conducted by the ALS service medical directors within the region.

(8) Serve on the State EMS Quality Improvement Committee.

(9) Serve as chairperson of the regional EMS council medical advisory committee.

(10) Facilitate continuity of patient care during interregional transport.

(11) Recommend to the Department suspension, revocation or restriction of prehospital personnel certifications and recognitions.

(12) Conduct hearings in accordance with § 1003.28 (relating to medical command authorization) upon appeal of an individual whose medical command authorization is denied or restricted by the ALS service medical director and issue written decisions.

(13) Review regional plans, procedures and processes for compliance with State standards of emergency medical care.

(b) *Minimum qualifications.* A regional EMS council medical director shall have the following qualifications:

(1) Licensure as a physician.

(2) Experience in prehospital and emergency department care of the acutely ill or injured patient.

(3) Experience in medical command direction of prehospital personnel.

(4) Experience in emergency department management of the acutely ill or injured patient.

(5) Have completed 3 years in a residency program in emergency medicine or have served as a medical command physician in this Commonwealth prior to October 14, 2000.

(6) Experience in the training of basic and advanced prehospital personnel.

(7) Experience in the medical audit, review and critique of BLS and ALS prehospital personnel.

(c) *Disclosure.* A regional EMS medical director shall disclose to a regional EMS council all financial or other interest in providers of EMS and in other matters which present a potential conflict of interest.

§ 1003.3. Medical command facility medical director.

(a) *Roles and responsibilities.* A medical command facility shall have a medical command facility medical director. A medical command facility medical director is responsible for the following:

(1) Medical command.

(2) Quality improvement.

(3) Liaison with regional EMS council medical director.

(4) Participation in prehospital training activities.

(5) Clinical and continuing education training of prehospital personnel.

(6) Recommendations to the regional EMS medical director regarding medical command physician applications from the medical command facility.

(b) *Minimum qualifications.* To qualify and continue to function as a medical command facility medical director, an individual shall have the following qualifications:

(1) Be currently serving as a medical command physician.

(2) Satisfy one of the following:

(i) Have completed 3 years in a residency program in emergency medicine.

(ii) Have served as a medical command physician in this Commonwealth prior to October 14, 2000.

(iii) Have secured board certification in surgery, internal medicine, family medicine, pediatrics or anesthesiology. If the physician has board certification in one of these medical specialties, the physician shall also have successfully completed or taught the ACLS course within the preceding 2 years and have completed, at least once, the ATLS course, and either an APLS or PALS course, or other programs determined by the Department to meet or exceed the standards of theses programs.

(3) Experience in prehospital and emergency department care of the acutely ill or injured patient.

(4) Experience in providing medical command direction to prehospital personnel.

(5) Experience in the training of BLS and ALS prehospital personnel.

(6) Experience in the medical audit, review and critique of BLS and ALS prehospital personnel.

§ 1003.4. Medical command physician.

(a) *Roles and responsibilities.* A medical command physician shall provide medical command to prehospital personnel. This includes providing online medical command to prehospital personnel whenever they seek direction.

(b) *Minimum qualifications.* To qualify and continue to function as a medical command physician, an individual shall:

(1) Be a physician.

(2) Satisfy one of the following:

(i) Have completed 3 years in a residency program in emergency medicine.

(ii) Have served as a medical command physician in this Commonwealth prior to October 14, 2000.

(iii) Have successfully completed or taught the ACLS course within the preceding 2 years and have completed, at least once, the ATLS course, and either an APLS or PALS course, or other programs determined by the Department to meet or exceed the standards of these programs.

(3) Have completed the continuing medical education credits required for membership in the American Medical Association, or its equivalent, or be serving a graduate year III in a residency program in emergency medicine or a graduate year II in a residency program in emergency medicine, with concurrent online supervision by an approved medical command physician.

(4) Be a full-time emergency physician or practice emergency medicine for at least half-time of a full-time medical practice.

(5) Possess a valid Drug Enforcement Agency (DEA) number.

(6) Have completed the Medical Command Course.

(c) *Approval of medical command physician.*

(1) A physician may function as a medical command physician if approved to do so by a regional EMS council.

(2) A regional EMS council shall approve a physician as a medical command physician if the physician demonstrates that the physician will function under the auspices of a medical command facility and establishes one of the following:

(i) That the physician satisfies the qualifications for a medical command physician in subsection (b).

(ii) That the physician has received certification as a medical command physician from the Department upon successfully completing the voluntary medical command physician certification program administered by the Department.

(3) A regional EMS council shall conclude that the physician will be operating under the auspices of a medical command facility if the physician establishes that the physician has an arrangement with the medical command facility to provide medical command on its behalf while on duty for the medical command facility, under the direction of the medical command facility medical director and under the policies and procedures of the medical command facility, and further establishes one of the following:

(i) That the facility meets the requirements for a medical command facility prescribed in § 1009.1 (relating to operational criteria).

(ii) That the facility has received recognition as a medical command facility from the Department under § 1009.2 (relating to recognition process).

(d) *Notice requirements for medical command facility and regional EMS council.*

(1) A medical command facility shall give notice to each regional EMS council having responsibility for an EMS region in which the medical command facility anticipates medical command physicians functioning under its auspices will be providing medical command, and shall explain the circumstances under which medical command will be given in that region.

(2) A regional EMS council that has approved a physician as a medical command physician shall give notice of the approval to the Department.

(e) *Transfer and medical treatment protocols.* A medical command physician shall provide medical command to prehospital personnel in ground ambulances and QRSs consistent with the transfer and medical treatment protocols which are in effect in either the region in which treatment originates or the region in which the prehospital personnel begin receiving online medical command from the medical command physician.

§ 1003.5. ALS service medical director.

(a) *Roles and responsibilities.* An ALS service medical director is responsible for the following:

(1) Providing medical guidance and advice to the ALS ambulance service, including:

(i) Reviewing the Statewide BLS medical treatment protocols and the regional transfer and medical treatment protocols, and ensuring that the ALS ambulance service's prehospital personnel are familiar with them, and amendments and revisions thereto.

(ii) Providing guidance to the ALS ambulance service with respect to the ordering, stocking and replacement of drugs, and compliance with laws and regulations impacting upon the ALS ambulance service's acquisition, storage and use of those drugs.

(iii) Participating in the regional and Statewide quality improvement plans, including continuous quality improvement reviews of patient care and its interaction with the regional EMS system.

(iv) Recommending to the relevant regional EMS council, when appropriate, specific transfer and medical treatment protocols for inclusion in the regional transfer and medical treatment protocols.

(2) Granting, denying or restricting medical command authorization to members of the ALS ambulance service's prehospital personnel who require this authorization, and participating in appeals from decisions to deny or restrict medical command authorization in accordance with § 1003.28 (relating to medical command authorization).

(3) Performing medical audits of patient care provided by the ALS ambulance service's prehospital personnel.

(b) *Equivalent qualifications.* If the ALS service medical director is not a medical command physician, the ALS service medical director shall:

(1) Possess the minimum qualifications for a medical command physician in § 1003.4(b)(1)—(5) (relating to medical command physician).

(2) Have experience in the medical command direction of prehospital personnel.

(3) Have knowledge of the capabilities and limitations of ambulances, including air ambulances, and prehospital personnel.

(4) Have knowledge of potential medical complications which may arise during transport of the patient by an ambulance service.

(5) Successfully complete the Medical Command Course.

Subchapter B. PREHOSPITAL AND OTHER PERSONNEL

§ 1003.21. Ambulance attendant.

(a) *Roles and responsibilities.* An ambulance attendant, as part of the crew of an ambulance or a QRS, may perform BLS activities within the ambulance attendant's scope of practice, as set forth in subsection (c), at the scene of an emergency or enroute to a facility. This section does not prohibit an ambulance attendant from providing BLS services as a good Samaritan.

(b) *Qualifications.* To qualify as an ambulance attendant an individual shall satisfy the age requirement under the Child Labor Law (43 P. S. §§ 41—71) and one of the following:

(1) Possess a current certificate evidencing successful completion of an advanced first aid course sponsored by the American Red Cross and a certificate issued within the last 2 years evidencing successful completion of a CPR course.

(2) Possess a current certificate evidencing successful completion of a course determined by the Department to be equivalent to the requirements in paragraph (1).

(c) *Scope of practice.* An ambulance attendant shall have the authority to provide the following BLS services if trained to do so:

(1) Patient assessment—including vital signs—and ongoing evaluation.

(2) Pulmonary or cardiopulmonary resuscitation and foreign body airway obstruction management.

(3) Administration of oxygen.

(4) Insertion of oropharyngeal or nasopharyngeal airways.

(5) Oropharyngeal suctioning.

(6) Assessment and management of cardiac, respiratory, diabetic shock, behavioral and heat/cold emergencies, as prescribed within an advanced first aid course meeting the requirements in subsection (b)(1) or (2).

(7) Emergency treatment for bleeding, burns, poisoning, seizures, soft tissue injuries, chest-abdominal-pelvic injuries, muscle and bone injuries, eye injuries and childbirth (including care of the newborn), as prescribed within an advanced first aid course meeting the requirements in subsection (b)(1) or (2).

(8) Application of spinal immobilization devices and splinting materials, including traction splints.

(9) Basic triage and basic maneuvers to gain access to the patient.

(10) Patient lifting and moving techniques.

(11) Use of an automated external defibrillator when approved by a physician who serves as the medical director of the ambulance service with respect to its use of automated external defibrillators.

(12) Assist a prehospital practitioner who is above the level of first responder in the use of Department-approved automatic ventilators and pulse oximetry when approved by the medical director of the ambulance service.

(13) Other BLS skills taught in a course in advanced first aid sponsored by the American Red Cross, provided the ambulance attendant has received training to perform those skills in a course or in an equivalent training program approved by the Department, and is able to document having received the training. The Department will identify these skills as follows:

(i) The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the skills taught in the most recent course in advanced first aid sponsored by the American Red Cross.

(ii) If the course sponsored by the American Red Cross teaches skills in addition to advanced first aid, the Department will exclude those skills from the published list. An ambulance attendant may not perform a skill taught in a course approved under this paragraph if the Department does not include the skill in the list it publishes under subparagraph (i).

§ 1003.22. First responder.

(a) *Roles and responsibilities.* A first responder may perform, at the scene of an emergency, enroute to a facility, or in an emergency setting in a facility, the BLS services in subsection (e) to stabilize and improve a patient's condition until more highly trained personnel arrive. Following the arrival of more highly trained personnel, a first responder may continue to perform the BLS services within a first responder's scope of practice as set forth in subsection (e) under the direction of more highly trained personnel. This section does not prohibit a first responder from providing BLS services as a good Samaritan.

(b) *Certification.*

(1) The Department will certify as a first responder an individual who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 16 years of age or older.

(iii) Has successfully completed a first responder training course approved by the Department. The Department will publish annually in the *Pennsylvania Bulletin* a list of courses leading to first responder certification.

(iv) Has passed a written examination for first responder certification prescribed by the Department, or has passed an examination which the Department has determined to be equivalent in both content and manner of administration.

(v) Has passed a practical test of first responder skills prescribed by the Department, or has passed an examination which the Department has determined to be equivalent in both content and manner of administration.

(2) A first responder's certification is valid for 3 years, subject to disciplinary action under section 11(j.1) of the act (35 P. S. § 6931(j.1)) and § 1003.27 (relating to disciplinary and corrective action).

(c) *Recertification.* A first responder shall apply for recertification between 1 year and 60 days prior to expiration of the first responder's certification from the Department. Failure to apply for recertification in a timely manner may result in the individual not being recertified before the prior certification expires. The Department will recertify as a first responder an individual who meets the following qualifications:

(1) Completes an application on a form prescribed by the Department.

(2) Is or was previously certified as a first responder.

(3) Has successfully completed one of the following:

(i) The first responder practical skills and written knowledge examination prescribed by the Department.

(ii) The continuing education requirements applicable to first responders in § 1003.29(a) (relating to continuing education requirements).

(d) *Certification by endorsement.*

(1) For an individual who is 16 years of age or older and who is currently certified in another state as a first responder or as a person with similar responsibilities, the Department will endorse the following qualifications as equivalent to those in subsection (b):

(i) Successful completion of training curriculum which meets or exceeds the standards for the training course prescribed by the Department in subsection (b)(1)(iii).

(ii) Successful completion of a written examination for first responder certification, or an equivalent certification, which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department under subsection (b)(1)(iv).

(iii) Successful completion of a practical skills examination for first responder certification, or an equivalent certification, which is determined by the Department to meet or exceed the standards of the practical skills examination prescribed by the Department under subsection (b)(1)(v).

(2) An individual whose first responder certification or equivalent certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(i) endorsed as equivalent to the satisfaction of subsection (b)(1)(iii), but will not be considered by the Department for endorsement of qualifications under paragraph (1)(ii) or (iii), and shall successfully complete the first responder practical skills and written knowledge examinations prescribed by the Department after applying for certification through examination.

(3) Certification under this subsection is valid for 3 years. Upon expiration of that certification, the individual shall meet the requirements for recertification in subsection (c).

(e) *Scope of practice.*

(1) A first responder's scope of practice includes the BLS services which may be performed by an ambulance attendant as set forth in § 1003.21(c) (relating to ambulance attendant), if the first responder has been trained to perform those services.

(2) A first responder's scope of practice also includes other BLS services taught in a first responder training course approved by the Department, if the first responder has received training to perform those services, and is able to document having received the training, in one of the following:

(i) A first responder training course approved by the Department.

(ii) A course which is determined by the Department to meet or exceed the standards or a first responder training course preapproved by the Department.

(iii) A course for which the first responder may receive continuing education credit towards recertification.

(3) The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the skills taught in first responder training courses most recently approved by the Department.

(4) If the approved course is not offered by the Department, the Department may exclude from the published list, skills taught which the Department determines are not appropriate services to be performed by a first responder. A first responder may not perform a skill taught in a course under paragraph (2)(ii) or (iii) if the Department does not include the skill in the list it publishes under paragraph (3).

§ 1003.23. EMT.

(a) *Roles and responsibilities.* An EMT may perform, in a prehospital, interhospital or emergency care setting in a hospital, or during the transfer of convalescent or other nonemergency cases, the BLS services set forth in subsection (e), to prevent loss of life or aggravation of physiological or psychological illness or injury. This section does not prohibit an EMT from providing BLS services as a good Samaritan.

(b) *Certification.*

(1) The Department will certify as an EMT an individual who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 16 years of age or older.

(iii) Has successfully completed an EMT training course approved by the Department.

(iv) Has successfully completed a written EMT examination prescribed by the Department.

(v) Has successfully completed an EMT practical skills examination prescribed by the Department.

(2) The Department will also certify as an EMT an individual who completes an application on a form prescribed by the Department and who has one of the following:

(i) Permanent certification as an EMT-paramedic under § 1003.24(b) (relating to EMT-paramedic) but without medical command authorization under § 1003.28 (relating to medical command authorization).

(ii) Permanent recognition as a prehospital registered nurse under § 1003.25b (relating to prehospital registered nurse) but without medical command authorization under § 1003.28.

(3) Certification granted under paragraph (1) or (2) is valid for 3 years, subject to disciplinary action under section 11(j.1) of the act (35 P. S. § 6931(j.1)) and § 1003.27 (relating to disciplinary and corrective action).

(c) *Certification by endorsement.*

(1) For an individual who is 16 years of age or older and currently certified as an EMT in another state, the Department will endorse the following qualifications as equivalent to those in subsection (b):

(i) Successful completion of EMT training curriculum that meets or exceeds the standards of the training course prescribed by the Department under subsection (b)(1)(iii).

(ii) Successful completion of a written examination for EMT certification which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department under subsection (b)(1)(iv).

(iii) Successful completion of a practical skills examination for EMT certification which is determined by the Department to meet or exceed the standards of the practical skills examination prescribed by the Department under subsection (b)(1)(v).

(2) An individual whose EMT certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(i) endorsed as equivalent to the satisfaction of subsection (b)(1)(iii), but will not be considered by the Department for endorsement of qualifications under paragraph (1)(ii) or (iii), and shall successfully complete the EMT practical skills and written examinations prescribed by the Department after applying for certification through examination.

(3) Certification under this subsection is valid for 3 years. Upon expiration of that certification the individual shall meet the requirements for recertification in subsection (d).

(d) *Recertification.* An EMT shall apply for recertification between 1 year and 60 days prior to expiration of the EMT's certification from the Department. Failure to apply for recertification in a timely manner may result in the individual not being recertified before the prior certification expires. The Department will recertify as an EMT an individual who meets the following qualifications:

(1) Completes an application on a form prescribed by the Department.

(2) Is or was previously certified as an EMT.

(3) Has successfully completed one of the following:

(i) The written and practical EMT recertification examinations prescribed by the Department.

(ii) The continuing education requirements for EMTs in § 1003.29(b) (relating to continuing education requirements).

(e) *Scope of practice.* An EMT's scope of practice, under medical command direction or utilization of the Statewide BLS medical treatment protocols, includes the BLS services which may be performed by a first responder as set forth in § 1003.22(e) (relating to first responder) and the following:

(1) Administration to a patient or assisting a patient to administer drugs previously prescribed for that patient, as specified in the Statewide BLS medical treatment protocols.

(2) Transportation of a patient with an indwelling intravenous catheter without medication running, unless the medication is part of the patient's normal treatment plan and the transport of the patient with medication running is consistent with the Statewide BLS medical treatment protocols.

(3) Other BLS services taught in a basic training program for EMTs approved by the Department, if the EMT has received training to perform those services, and is able to document having received the training, in one of the following:

(i) A basic training course for EMTS approved by the Department.

(ii) A course which is determined by the Department to meet or exceed the standards of a basic training course for EMTS preapproved by the Department.

(iii) A course for which the EMT may receive continuing education credit towards recertification.

(f) *Publication of approved skills.*

(1) The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the skills taught in the EMT basic training course most recently approved by the Department.

(2) If the course is not offered by the Department, the Department may exclude, from the published list, skills taught which the Department determines are not appropriate skills to be performed by an EMT. An EMT may not perform a skill taught in a course under subsection (e)(3)(ii) or (iii) if the Department does not include the skill in the list it publishes under paragraph (1).

§ 1003.23a. EMS instructor certification.

(a) *Qualifications for certification.* The Department will issue an EMS instructor certification to an individual who meets all of the following requirements:

(1) Has completed an application for EMS instructor certification on a form prescribed by the Department.

(2) Is 18 years of age or older.

(3) Has successfully completed an EMS instructor course approved by the Department, or possesses a bachelor's degree in education or a teacher's certification in education.

(4) Has successfully completed an EMT-Basic transition program or update, or has completed an EMT-Basic course.

(5) Possesses current certification as an EMT or EMT-paramedic, or recognition as a health professional.

(6) Possesses current certification in CPR or current certification as a CPR instructor.

(7) Possesses at least 1 year experience functioning at the EMT, EMT-paramedic or health professional level providing prehospital care.

(b) *Renewal of instructor certification.* An EMS instructor certification is valid for 3 years. The Department will renew an EMS instructor certification for an individual who meets the following requirements:

(1) Has completed an application for renewal of an EMS instructor certification on a form prescribed by the Department.

(2) Has demonstrated competence in teaching the didactic and practical skills portions of the curriculum.

(3) Has provided documentation to the Department to establish that the individual conducted at least 60 hours of teaching EMS or rescue courses during the previous 3 years.

(4) Possesses current certification as an EMT, certification as an EMT-paramedic or recognition as a health professional.

(5) Possess current certification in CPR.

(6) Effective October 14, 2003, has completed an EMS instructor update program within 3 years prior to applying for renewal of certification.

§ 1003.24. EMT-paramedic.

(a) *Roles and responsibilities.*

(1) An EMT-paramedic who has been granted medical command authorization under § 1003.28 (relating to medical command authorization), or an individual who is a student in an approved EMT-paramedic training program under the supervision of an approved preceptor, may provide in a prehospital, interhospital or in an emergency care setting in a facility, or during the transfer of convalescent or other nonemergency cases, BLS services which may be performed by an EMT as set forth in § 1003.23(a) and (e) (relating to EMT), as well as the ALS services in subsection (d) to prevent loss of life or aggravation of physiological or psychological illness or injury. This section does not prohibit an EMT-paramedic from providing EMS as a good Samaritan.

(2) An EMT-paramedic who does not have or chooses not to maintain medical command authorization under § 1003.28 may apply to the Department for certification as an EMT. The rules applicable to certification of an EMT-paramedic as an EMT are in § 1003.23(b)(2). An EMT-paramedic without medical command authorization who is certified as an EMT may provide only the BLS services within an EMT's scope of practice as set forth in § 1003.23(a) and (e) until the EMT-paramedic has regained medical command authorization in accordance with § 1003.28. Following loss of medical command authorization, an EMT-paramedic may function as an EMT for the ALS ambulance service under which the EMT-paramedic has lost medical command authorization, for 30 days without securing EMT certification, if approval to do so is granted by the ALS service medical director for that ALS ambulance service.

(b) *Certification.*

(1) The Department will certify as an EMT-paramedic an individual who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Possesses current certification as an EMT.

(iii) Is 18 years of age or older.

(iv) Has successfully completed a training course for EMT-paramedics approved by the Department.

(v) Has successfully completed a practical examination of EMT-paramedic skills.

(vi) Has successfully completed a written examination for EMT-paramedics administered by the Department.

(2) An individual certified as an EMT-paramedic is permanently certified as an EMT-paramedic, subject to disciplinary action under section 11(j.1) of the act (35 P. S. § 6931(j.1)) and § 1003.27 (relating to disciplinary and corrective action).

(3) An EMT-paramedic shall register biennially with the Department on forms supplied by the Department prior to the biennial anniversary date of the EMT-paramedic's certification and shall supply information requested by the Department on the registration form.

(c) *Certification by endorsement.*

(1) For an individual who is 18 years of age or older and who is currently certified in another state as an EMT-paramedic, the Department will endorse the following qualifications as equivalent to those in subsection (b).

(i) Certification as an EMT-paramedic in the other state instead of current certification as an EMT in this Commonwealth.

(ii) Successful completion of EMT-paramedic training curriculum that meets or exceeds the standards of the training course prescribed by the Department under subsection (b)(1)(iv).

(iii) Successful completion of a written examination for EMT-paramedic certification which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department under subsection (b)(1)(vi).

(iv) Successful completion of a practical skills examination for EMT-paramedic certification which is determined by the Department to meet or exceed the standards of the practical skills examination prescribed by the Department under subsection (b)(1)(v).

(2) An individual whose EMT-paramedic certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(ii) endorsed as equivalent to the satisfaction of subsection (b)(1)(iv), but will not be considered by the Department for endorsement of qualifications under paragraph (1)(i), (iii) or (iv), and shall successfully complete the EMT-paramedic practical skills and written examinations prescribed by the Department after making application for certification through examination.

(d) *Scope of practice.* An EMT-paramedic's scope of practice includes the BLS services which may be performed by an EMT in § 1003.23(a) and (e) and the ALS services set forth in this subsection. An EMT-paramedic, with medical command authorization, following the order of a medical command physician, or use of Department approved transfer and medical treatment protocols as authorized by the ALS service medical director, may:

(1) Perform pulmonary ventilation by the use of oral, nasal, endotracheal or tracheostomy intubation.

(2) Insert, in peripheral veins, intravenous catheters, needles or other cannulae-IV lines.

(3) Obtain venous blood samples for analysis, but only for diagnostic and treatment purposes.

(4) Prepare and administer approved medication and solutions by intravenous, intramuscular, subcutaneous, intraosseous, oral, sublingual, topical, inhalation, rectal or endotracheal routes.

(5) Perform defibrillation and synchronized cardioversion.

(6) Perform gastric suction by nasogastric or orogastric intubation.

(7) Insert nasogastric or orogastric tubes.

(8) Visualize the airway by use of the laryngoscope and remove foreign bodies with forceps.

(9) Apply electrodes and monitor cardiac electrical activity including electrocardiograms.

(10) Perform Valsalva maneuvers.

(11) Use mechanical cardiopulmonary resuscitation devices.

(12) Assess and manage patients in accordance with the EMT-paramedic training curriculum approved by the Department.

(13) Perform thoracic decompression.

(14) Perform cricothyrotomy and pulmonary ventilation.

(15) Perform central venous and intraosseous cannulation.

(16) Perform external transcutaneous pacing.

(17) Perform urinary catheterization.

(18) Access central venous lines and subcutaneous indwelling catheters.

(19) Perform other ALS skills taught in a training course for EMT-paramedics approved by the Department, if the EMT-paramedic has received training to perform those services and is able to document having received the training, in one of the following:

(i) A training course for EMT-paramedics approved by the Department.

(ii) A course which is determined by the Department to meet or exceed the standards of a training course for EMT-paramedics preapproved by the Department.

(iii) A course for which the EMT-paramedic may receive continuing education credit towards qualifying for medical command authorization.

(e) *Publication of approved skills.*

(1) The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the skills taught in the EMT-paramedic training course most recently approved by the Department.

(2) If the approved course is not offered by the Department, the Department may exclude, from the published list, skills taught which the Department determines are not appropriate skills to be performed by an EMT-paramedic. An EMT-paramedic may not perform a skill taught in a course under subsection (d)(19)(ii) or (iii) if the Department does not include the skill in the list it publishes under paragraph (1).

§ 1003.25a. Health professional physician.

Physicians who have education and continuing education in ALS services and prehospital care may function as a member of the crew on an ambulance as a health professional. This section does not prohibit a health professional physician from providing EMS as permitted under 42 Pa.C.S. § 8331 (relating to medical good Samaritan civil immunity).

§ 1003.25b. Prehospital registered nurse.

(a) *Roles and responsibilities.*

(1) A prehospital registered nurse who has medical command authorization under § 1003.28 (relating to medical command authorization) may provide the ALS services in § 1003.24(d) (relating to EMT-paramedic) and those listed in subsection (c) in addition to the BLS services in § 1003.23(a) and (e) (relating to EMT) to respond to the perceived needs of an individual for immediate medical care in an emergency. This section does not prohibit a prehospital registered nurse from providing EMS as permitted under 42 Pa.C.S. § 8331 (relating to medical good Samaritan civil immunity).

(2) A prehospital registered nurse who does not have or chooses not to maintain medical command authorization may apply to the Department for recognition as an EMT. The rules applicable to certification of a prehospital registered nurse as an EMT are set forth in § 1003.23(b)(2). Following loss of medical command authorization, a prehospital registered nurse may function as an EMT for the ALS ambulance service under which the prehospital registered nurse has lost medical command authorization, for 30 days without securing EMT certification, if approval to do so is granted by the ALS service medical director for that ALS ambulance service.

(b) *Recognition of a prehospital registered nurse.*

(1) The Department will recognize as a prehospital registered nurse a registered nurse who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 18 years of age or older.

(iii) Has successfully completed the American Heart Association or American Red Cross basic cardiac life support training program and the ACLS course, or other programs determined by the Department to meet or exceed the standards of the specified programs.

(iv) Has successfully completed one of the following:

(A) The Pennsylvania prehospital registered nurse curriculum adopted by the Department.

(B) A knowledge and skills assessment process adopted by the Department.

(v) Has successfully completed the written ALS examination for prehospital registered nurses approved by the Department.

(vi) Has successfully completed the EMT practical skills examination.

(2) A registered nurse who received recognition as a health professional registered nurse under the voluntary health professional registered nurse recognition program conducted by the Department prior to September 2, 1995, will be deemed to have Department recognition as a prehospital registered nurse.

(3) Department recognition of a prehospital registered nurse under this section is permanent subject to disciplinary action under section 11(j.1) of the act (35 P. S. § 6931(j.1)) and § 1003.27 (relating to disciplinary and corrective action).

(4) A prehospital registered nurse shall register biennially with the Department on forms supplied by the Department prior to the biennial anniversary date of the prehospital registered nurse's recognition and shall supply information requested on the registration form.

(c) *Scope of practice.* A prehospital registered nurse with medical command authorization may perform, in addition to those services within an EMT-paramedic's scope of practice, other services authorized by The Professional Nursing Law (63 P. S. §§ 221—225.5), when authorized by a medical command physician through either on line medical command or standing medical treatment protocols.

(d) *Recognition by endorsement.* The Department will grant recognition as a prehospital registered nurse to an individual who has served in a similar capacity in another state and who meets the following qualifications:

(1) Completes an application on a form prescribed by the Department.

(2) Is 18 years of age or older.

(3) Has successfully completed the American Heart Association or the American Red Cross basic life support training program and the ACLS course, or other programs determined by the Department to meet or exceed the standards of the specified programs.

(4) Is licensed as a registered nurse in both this Commonwealth and another state.

(5) Has successfully completed one of the following:

(i) The written ALS examination for prehospital registered nurses approved by the Department and the EMT practical skills examination.

(ii) Written and practical skills examinations determined by the Department to meet or exceed the examinations approved by the Department.

(6) Has successfully completed one of the following:

(i) The Pennsylvania prehospital registered nurse curriculum adopted by the Department.

(ii) A knowledge and skills assessment process adopted by the Department.

(iii) Curriculum or a knowledge and skills assessment process, which is determined by the Department to meet or exceed the standards adopted by the Department.

§ 1003.26. Rescue personnel.

(a) *Basic rescue practices technician.*

(1) *Roles and responsibilities.* A basic rescue practices technician is an individual certified by the Department as possessing the training and skills to perform rescue skills in accordance with the basic rescue practices course approved by the Department. A basic rescue practices technician utilizes basic tools and equipment of the rescue service to perform a safe and efficient rescue operation.

(2) *Training programs.* Basic rescue practices technician training programs will be approved by the Department.

(3) *Minimum qualifications.* A basic rescue practices technician shall successfully complete a training program for basic rescue practices approved by the Department and shall successfully complete a written basic rescue practices test administered by the Department.

(b) *Basic vehicle rescue technician.*

(1) *Roles and responsibilities.* A basic vehicle rescue technician is an individual certified by the Department as possessing the training and skills to perform rescue skills in accordance with the basic vehicle rescue course approved by the Department. That program provides the student with the knowledge and skills necessary to achieve the rescue of persons involved in automobile accidents.

(2) *Training programs.* Basic vehicle rescue technician training programs will be approved by the Department.

(3) *Minimum qualifications.* A basic vehicle rescue technician shall complete a training program for basic vehicle rescue approved by the Department, and shall successfully complete a written examination for basic vehicle rescue developed by the Department and administered by the Department.

(c) *Special vehicle rescue technician.*

(1) *Roles and responsibilities.* A special vehicle rescue technician is an individual certified by the Department as possessing the training and skills to perform rescues in accordance with the specialized rescue training course approved by the Department.

(2) *Training programs.* Specialized rescue training programs will be approved by the Department.

(3) *Minimum qualifications.* An individual shall complete a training program approved by the Department for a specific level of specialized vehicle rescue performance, and also shall successfully complete a written examination developed by the Department and administered by the Department.

(d) *Rescue instructor.* The Department will develop a program providing for the certification of rescue instructors. Courses that seek Department approval as a rescue training course shall be taught by certified rescue instructors.

(e) *Certificates.* The rescue technician certifications issued by the Department under this section do not constitute a legal prerequisite to performing rescues. The rescue instructor certifications issued by the Department under this section do not constitute a legal prerequisite to serving as a rescue instructor in programs other than rescue training courses approved by the Department. The Department approves the rescue programs and issues the certifications referenced within this section to promote the Statewide EMS system having an adequate number of personnel with sufficient training and skills to perform rescues.

§ 1003.27. Disciplinary and corrective action.

(a) The Department may, upon investigation, hearing and disposition, impose upon prehospital personnel who are certified or recognized by the Department one or more of the disciplinary or corrective measures in subsection (c) for one or more of the following reasons:

(1) Demonstrated incompetence to provide adequate emergency medical services.

(2) Deceptive or fraudulent procurement or misrepresentation of certification or recognition credentials.

(3) Willful or negligent practice beyond the scope of certification or recognition authorization.

(4) Abuse or abandonment of a patient.

(5) The rendering of services while under the influence of alcohol or illegal drugs.

(6) The operation of an emergency vehicle in a reckless manner or while under the influence of illegal drugs or alcohol.

(7) Disclosure of medical or other information if prohibited by Federal or State law.

(8) Willful preparation or filing of false medical reports or records, or the inducement of others to do so.

(9) Destruction of medical records required to be maintained.

(10) Refusal to render emergency medical care because of a patient's race, sex, creed, national origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(11) Failure to comply with Department-approved regional EMS council transfer and medical treatment protocols.

(12) Failure to comply with ambulance response reporting requirements as established by the Department.

(13) Failure to meet recertification requirements.

(14) Conviction of a felony or crime involving moral turpitude. Conviction includes a judgment of guilt, a plea of guilty or a plea of nolo contendere.

(15) Conviction of a misdemeanor which relates to the practice or the profession of the prehospital practitioner. Conviction is a judgment of guilt.

(16) A willful or consistent pattern of failure to complete details on a patient's medical record.

(17) Misuse or misappropriation of drugs or medication.

(18) Having a certification or other authorization to practice a health care profession or occupation revoked, suspended or subjected to disciplinary sanction.

(19) Failure to comply with skill maintenance requirements established by the Department.

(20) Violating a duty imposed by the act, this part or an order of the Department previously entered in a disciplinary proceeding.

(21) Other reasons as determined by the Department which pose a threat to the health and safety of the public.

(b) It is the duty of all prehospital personnel to report to the Department, within 30 days, a misdemeanor or felony conviction, or a revocation, suspension or other disciplinary sanction of a certificate or other authorization to practice a health care profession or occupation.

(c) If disciplinary action is appropriate for one of the reasons listed in subsection (a), the Department may:

(1) Deny an application for certification or recognition.

(2) Administer a written reprimand with or without probation.

(3) Revoke, suspend, limit or otherwise restrict the certification or recognition.

(4) Require the person to take refresher educational courses.

(5) Stay enforcement of a suspension and place the individual on probation with the right to vacate the probationary order for noncompliance.

(d) The Department will conduct all aspects of the disciplinary process and any hearing that may be held in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). A revocation or suspension of certification or recognition may be appealed to the Commonwealth Court under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to Administrative Agency Law).

§ 1003.28. Medical command authorization.

(a) *Authority to grant medical command.* The ALS service medical director has the authority to grant, deny, or restrict as provided in subsection (c)(3), medical command authorization to an EMT-paramedic or prehospital registered nurse who seeks to provide EMS on behalf of the ALS ambulance service. The ALS service medical director shall document the medical command authorization decision and how that decision was made. The decision of the ALS service medical director shall affect the medical command authorization status of the EMT-paramedic or prehospital registered nurse for that ALS ambulance service only.

(b) *Prerequisites to initial determination regarding medical command authorization.*

(1) Prior to making the initial determination whether to grant or deny medical command authorization, the ALS service medical director shall:

(i) Require the individual seeking medical command authorization to complete an application for medical command authorization on a form prescribed by the Department.

(ii) Verify with the Department the individual's certification or recognition status.

(iii) Inquire of the Department whether disciplinary action under section 11(j.1) of the act (35 P. S. § 6931(j.1))

and § 1003.27 (relating to disciplinary and corrective action) has been or is currently being imposed against the individual.

(2) The ALS service medical director shall deny medical command authorization to an individual who is not certified or recognized by the Department, who is currently subject to a disciplinary or corrective measure imposed by the Department which prevents the individual from having medical command authorization, or who has not complied with the applicable continuing education in § 1003.29 (relating to continuing education requirements).

(3) Before the ALS service medical director may grant medical command authorization to an individual, the ALS service medical director shall verify that the individual can competently perform each of the services set forth within the scope of practice authorized by the individual's certification or recognition. The ALS service medical director may only grant medical command authorization to permit practice in accordance with the medical treatment protocols in the region or regions in which ambulances of the ALS ambulance service, out of which the individual will function, are stationed. If the individual had not previously been granted medical command authorization for any ALS ambulance service in this Commonwealth, the ALS service medical director shall determine the individual's competence to perform those services by direct observation. Alternatively, the ALS service medical director may determine the individual's competence by consulting with a physician, EMT-paramedic or prehospital registered nurse who has directly observed the individual's performance of those services, and who the ALS service medical director has determined to be qualified to make the assessment. If the individual had previously been granted medical command authorization, the ALS service medical director shall verify that the individual can competently perform each of those services by either directly observing the individual's performance of those services; or by consulting with a physician, EMT-paramedic or prehospital registered nurse who has directly observed the individual's performance of those services, and who the ALS service medical director has determined to be qualified to make the assessment; or doing the following for services not directly observed:

(i) Consulting with one or more medical command physicians who have given the individual medical command.

(ii) Consulting with emergency department physicians who have received patients to whom the individual has provided prehospital emergency care.

(iii) Performing a medical audit of records of services provided by the individual seeking medical command authorization, for patients attended to by that individual for the ALS ambulance for which the ALS service medical director is making the medical command authorization decision.

(iv) Consulting with one or more ALS service medical directors who has granted, denied or restricted the individual's medical command status.

(4) If the ALS service medical director determines that the individual applying for medical command authorization cannot competently perform one or more of those services, the ALS service medical director shall either deny, or restrict as provided in subsection (c)(3), the individual's medical command authorization in a written document provided to the individual.

(c) *Review of medical command authorization.* At least annually, and more often as circumstances warrant, the ALS service medical director shall review the medical command authorization status of each EMT-paramedic and prehospital registered nurse providing services on behalf of the ALS ambulance service. In reviewing medical command authorization, the ALS service medical director shall ensure that the individual has completed or is completing the applicable continuing education requirements in § 1003.29 and has demonstrated competence, as verified by the ALS service medical director, in performing each of the services that fall within the scope of the individual's medical command authorization. The ALS service medical director, upon review of medical command authorization, may:

(1) Renew medical command authorization.

(2) Renew medical command authorization and require continuing education courses in any field the ALS service medical director deems appropriate. The ALS service medical director may require an individual to secure more continuing education credit than generally required for personnel operating under medical command authorization for the ALS ambulance service, only if the ALS service medical director determines that the following conditions are satisfied:

(i) The individual does not demonstrate sufficient competence in performing a service.

(ii) The continuing education is prescribed to address that deficiency.

(iii) The number of continuing education hours generally required are not sufficient to provide the education the individual needs to remedy the problem.

(3) Restrict medical command authorization, if the restriction does not preclude the individual from performing the services specified within the scope of the individual's certification or recognition as permitted by the medical treatment protocols for the region. This permits imposing a restriction such as requiring on scene supervision when the individual performs a specified service or services, or permitting a specified service or services to be performed only when the individual is receiving online medical command.

(4) Withdraw medical command authorization.

(d) *Appeals to the regional EMS medical director.* An individual whose medical command authorization has been denied by the ALS service medical director may appeal the decision within 14 days to the regional EMS medical director. The individual's appeal shall be in writing and shall specify the reasons the individual disagrees with the decision of the ALS service medical director. The regional EMS medical director shall conduct a hearing. If the regional EMS medical director is unable to conduct a fair hearing due to receiving prejudicial information prior to the hearing, or for any other reason, the regional EMS council shall arrange for the regional EMS medical director of another region to conduct the hearing. At the hearing, the ALS service medical director shall have the burden to proceed and offer testimony and other evidence in support of the ALS service medical director's decision. The individual shall also have an opportunity to present testimony and other evidence in support of the individual's position. Both parties shall have an opportunity to cross-examine opposing witnesses and to submit oral and written position statements. The regional EMS medical director may give the parties up to 5 additional days following the hearing to submit written position statements. The regional EMS medical director

will issue a written decision affirming, reversing or modifying the ALS service medical director's decision within 14 days after the hearing or within 14 days after the submission of post hearing position statements, if they are filed. The regional EMS medical director's written decision shall contain the regional EMS medical director's findings and conclusions. If the ALS service medical director fails to appear at the hearing, the regional EMS medical director shall reverse the ALS service medical director's decision. If the individual fails to appear at the hearing, the regional EMS medical director shall make a determination upon the evidence presented and either affirm, reverse or modify the decision of the ALS service medical director. The burden of proof is a preponderance of the evidence.

(e) *Appeals to the Department.* If either party is dissatisfied with the decision of the regional EMS medical director with regard to medical command authorization, that party shall have the right of immediate appeal to the Department. The party appealing the regional EMS medical director's decision shall submit a written statement to the Department specifying the reasons for the party's objections to the regional EMS medical director's decision within 14 days after that decision. The other party shall have 14 days to respond. The Department will review the record before the regional EMS medical director, and if deemed advisable by the Department will hear argument and additional evidence. As soon as practicable, the Department, will issue a final decision containing findings of fact and conclusions of law which affirms, reverses or modifies the regional EMS medical director's decision.

(f) *Scope of appeals.* Appeals under this section shall be confined to a review and determination of whether, at the time of the assessment conducted by the ALS service medical director, the individual possessed the competence to perform all services within the scope of the individual's medical command authorization for the ambulance service.

(g) *Service; determination of time period.* Each party shall serve the other with any document the party files with a regional EMS medical director or the Department. In determining the time in which a document is to be filed under this section, time begins to run for the parties when the document is mailed, and time begins to run for a regional EMS medical director when the document is received by the regional EMS medical director.

§ 1003.29. Continuing education requirements.

(a) *First responders.* A first responder who elects to qualify for recertification by fulfilling continuing education requirements shall, prior to the expiration of the 3-year certification period, successfully complete the following:

(1) Sixteen hours of instruction in subjects related to the scope of practice of a first responder as set forth in § 1003.22(a) and (e) (relating to first responder) and which have been approved by the Department for continuing education credit. At least eight of those credits shall be in medical and trauma education, commencing with the first full certification period the first responder begins following October 14, 2000:

(2) A CPR course completed or taught biennially.

(b) *EMTs.* An EMT who elects to qualify for recertification by fulfilling continuing education requirements shall, prior to the expiration of the 3-year certification period, successfully complete the following:

(1) Twenty-four hours of instruction in subjects related to the scope of practice of an EMT as set forth in § 1003.23(a) and (e) (relating to EMT) and which have been approved by the Department for continuing education credit. At least 12 of those credits shall be in medical and trauma education, commencing with the first full certification period the EMT begins following October 14, 2000.

(2) A CPR course completed or taught biennially.

(c) *EMT-paramedics.* To be eligible to receive and retain medical command authorization, an EMT-paramedic shall successfully complete in each calendar year, 18 hours of instruction in subjects related to the scope of practice of an EMT-paramedic as set forth in § 1003.24(a) and (d) (relating to EMT-paramedic) and which have been approved by the Department for continuing education credit, and shall biennially attend or teach a CPR course. Beginning in 2002, at least 9 of the 18 hours of instruction shall be in medical and trauma education. In the initial year of certification, the EMT-paramedic's continuing education requirements, to secure renewal of medical command authorization for the following year, shall be prorated based upon the month the certification was secured.

(d) *Prehospital registered nurses.* To be eligible to receive and retain medical command authorization, a prehospital registered nurse shall successfully complete in each calendar year, 18 hours of instruction in subjects related to the scope of practice of a prehospital registered nurse as set forth in § 1003.25b(a) and (c) (relating to prehospital registered nurse) and which have been approved by the Department for continuing education credit, and shall attend or teach biennially a CPR course. Beginning in 2002, at least 9 of the 18 hours of instruction shall be in medical and trauma education. In the initial year of recognition, the prehospital registered nurse's continuing education requirements, to secure renewal of medical command authorization for the following year, shall be prorated based upon the month the recognition was secured.

(e) This section does not prohibit an ambulance service from requiring prehospital personnel to satisfy continuing education requirements it may choose to impose as a condition of employment, provided that the ambulance service may not do the following:

(1) Excuse a prehospital practitioner from meeting continuing education requirements imposed by this section.

(2) Establish individual continuing education requirements for the EMT-paramedics or prehospital registered nurses staffing the ambulance service, except as authorized by § 1003.28(c)(2) (relating to medical command authorization).

§ 1003.30. Accreditation of sponsors of continuing education.

(a) Entities and institutions may apply for accreditation as a continuing education sponsor by submitting to the Department an application in a format prescribed by the Department. The applicant shall supply all information requested in the application. The Department will grant accreditation to an applicant for accreditation as a continuing education sponsor if the applicant satisfies the Department that the courses the applicant will offer will meet the following minimum standards:

(1) The courses shall be of intellectual and practical content.

(2) The courses shall contribute directly to the professional competence, skills and education of prehospital personnel.

(3) The course instructors shall possess the necessary practical and academic skills to conduct the course effectively.

(4) Course materials shall be well written, carefully prepared, readable and distributed to attendees at or before the time the course is offered whenever practical.

(5) The courses shall be presented by a qualified responsible instructor in a suitable setting devoted to the educational purpose of the course.

(b) Accreditation of the continuing education sponsor shall be effective for 3 calendar years.

(c) At least 90 days prior to expiration of the 3-year accreditation period, a continuing education sponsor shall apply to the Department for renewal of the sponsor's accreditation. The Department will renew the sponsor's accreditation if the sponsor meets all of the following requirements:

(1) The sponsor has presented, within the preceding 3 years, at least five separate continuing education courses which met the minimum standards in subsection (a).

(2) The sponsor establishes to the Department's satisfaction that future courses to be offered by the sponsor will meet the minimum standards in subsection (a).

(3) The sponsor has satisfied its responsibilities under § 1003.32 (relating to responsibilities of continuing education sponsors).

(d) If the Department deems that the continuing education sponsor has demonstrated a history of understanding and compliance with the regulatory standards for providing continuing education to prehospital personnel, the Department may apprise the continuing education sponsor that its accreditation constitutes prior approval of continuing education courses offered under this chapter which are presented in a classroom setting, and permit the continuing education sponsor to assign the number of credit hours for such a course, based upon the criteria in § 1003.31(a) (relating to credit for continuing education).

§ 1003.31. Credit for continuing education.

(a) *Credit hour.* A prehospital practitioner shall receive 1 hour credit for each 60 minutes of instruction presented in a classroom setting by a continuing education sponsor. Credit may not be received if attendance or other participation in the course is not adequate to meet the educational objectives of the course as determined by the course sponsor. Credit may not be received for other than 30 or 60-minute units of instruction, however the course shall be at least 60 minutes. For completing a continuing education course that is not presented in a classroom setting, or that is not presented by a continuing education sponsor, the prehospital practitioner shall receive the number of credit hours assigned by the Department to the course.

(b) *Course completion.* A prehospital practitioner may not receive credit for a continuing education course not completed, as evidenced by satisfaction of the check-in/check-out process for a course presented in a classroom setting by a continuing education sponsor, which reflects that the prehospital practitioner met the continuing education attendance requirement for receiving credit, and the continuing education sponsor's report to the Department verifying that the prehospital practitioner has completed the course. The course will also not be considered completed if the prehospital practitioner does not satisfy other course completion requirements imposed by this chapter and the continuing education sponsor.

(c) *Continuing education credit for instruction.* A prehospital practitioner shall receive credit equal to the number of hours served as an instructor in a continuing education course offered by a continuing education sponsor, or in a course that satisfies requirements for initial certification or recognition of a prehospital practitioner conducted by an EMS training institute.

(d) *Continuing education credit through endorsement.* A prehospital practitioner who attends or teaches a course offered by an organization with National or state accreditation to provide education may apply to the Department to receive credit for the course. The prehospital practitioner shall have the burden of demonstrating to the Department that the course meets standards substantially equivalent to the standards imposed in this chapter.

(e) *Continuing education credit assigned to courses not conducted by a continuing education sponsor.* If a course is offered by an organization with National or state accreditation to provide education, which is not a continuing education sponsor, the Department will assign credit to the course, including the possibility of no credit or partial credit, based upon considerations of whether the course bears entirely upon appropriate subject matter and whether the method of presenting the course meets standards substantially equivalent to those prescribed in this chapter.

(f) *Continuing education credit assigned to self-study courses.* Credit may be sought from the Department for a self-study continuing education course. The prehospital practitioner shall submit an application to the Department to approve the self-study course for credit prior to commencing the course and shall supply the Department with the materials the Department requests to conduct the evaluation. The Department will assign credit to the course based upon considerations of whether the course addresses appropriate subject matter and whether the method of completing the course meets standards substantially equivalent to those prescribed in this chapter. The Department may require modifications to the proposed self-study as a precondition to approving it for credit.

(g) *Continuing education credit assigned to courses not presented in a classroom setting.* A prehospital practitioner shall be awarded credit for completing a course without the prehospital practitioner physically attending the course in a classroom setting, provided the course has been approved by the Department for credit when presented in that manner.

(h) *Reporting continuing education credits to prehospital personnel.* A record of the continuing education credits received by prehospital personnel shall be maintained in a Statewide registry. A report of the continuing education accumulated shall be provided annually to first responders and EMTs, and semiannually to EMT-paramedics and prehospital registered nurses at the mailing address on record with the Department.

(i) *Resolution of discrepancies.* It is the responsibility of the prehospital practitioner to review the report of continuing education credits and to notify the appropriate regional EMS council of any discrepancy within 30 days after the report is mailed. The Department will resolve all discrepancies between the number of continuing education credits reported and the number of continuing

education credits a prehospital practitioner alleges to have earned, which are not resolved by the regional EMS council.

§ 1003.32. Responsibilities of continuing education sponsors.

(a) *Course approval.* A continuing education sponsor shall submit, to the regional EMS council that exercises responsibility for the EMS region in which the continuing education sponsor intends to conduct a new continuing education course, an application for approval of that continuing education course. The continuing education sponsor shall submit that application at least 30 days prior to the date the continuing education sponsor expects to conduct the course.

(b) *Record of attendance.* A continuing education sponsor shall maintain a record of attendance for a course presented in a classroom setting by maintaining a check-in/check-out process approved by the Department, and shall assign at least one person to ensure that all individuals attending the course check in when entering and check out when leaving. If an individual enters a course after the starting time, or leaves a course before the finishing time, the assigned person shall ensure that the time of arrival or departure is recorded for the individual.

(c) *Reporting attendance.* A continuing education sponsor shall report to the Department, in the manner and format prescribed by the Department, attendance at each continuing education course presented in a classroom setting within 10 days after the course has been presented.

(d) *Course evaluation.* A continuing education sponsor shall develop and implement methods to evaluate its course offerings to determine their effectiveness. The methods of evaluation shall include providing a course evaluation form to each person who attends a course.

(e) *Record retention.* The continuing education sponsor shall retain for each course it presents, the completed course evaluation forms and the check-in/check-out record for a course presented in a classroom setting. If the continuing education sponsor has received Department approval to assign credit to a course under § 1003.30(d) (relating to accreditation of sponsors of continuing education), the retained records shall also include course materials used, a record of the course instructor's qualifications, the course instructor's lesson plans and examinations if applicable. These records shall be retained for at least 4 years from the presentation of the course.

(f) *Providing records.* A continuing education sponsor shall promptly provide the Department with complete and accurate records relating to the course as requested by the Department.

(g) *Course not presented in a classroom setting.* A continuing education sponsor shall be exempt from the requirements of subsections (a) and (b) for a course which is not presented in a classroom setting, if the course is approved by the Department for credit when presented in that manner. When presenting the course to the Department for approval for credit, the continuing education sponsor shall present a procedure for monitoring, confirming and reporting prehospital practitioner participation in a manner that achieves the purposes of subsections (a) and (b).

(h) *Monitoring responsibilities.* A continuing education sponsor shall ensure that a course was presented in a manner that met all of the educational objectives for the course, and shall determine whether each prehospital practitioner who enrolled in the course met the requirements of this chapter and the continuing education sponsor to receive credit for completing the course.

(i) *Course completion.* A continuing education sponsor shall report to the Department, in a manner and format prescribed by the Department, completion of a course by a prehospital practitioner who completes the course, and shall identify to the Department a prehospital practitioner who seeks credit for a course but who did not meet the requirements of the continuing education sponsor or this chapter to receive continuing education credit. The continuing education sponsor shall also provide a prehospital practitioner who completes a course with a document certifying completion of the course.

§ 1003.33. Advertising.

(a) A continuing education sponsor may advertise a course as a continuing education course in a manner that states or suggests that the course meets the requirements of this chapter only if the course has been approved by the Department or is deemed approved under § 1003.30(d) (relating to accreditation of sponsors of continuing education).

(b) When a course has been approved for continuing education credit, the continuing education sponsor shall announce, in its brochures or registration materials: this course has been approved by the Pennsylvania Department of Health for _____ (the approved number of hours) of continuing education credit for _____ (the type of prehospital practitioner to which the course applies).

(c) If a continuing education sponsor advertises that it has applied to the Department to secure continuing education credit for a course, prior to presenting the course it shall disclose to all enrollees whether the course has been approved or disapproved for credit.

§ 1003.34. Withdrawal of accreditation or course approval.

If the continuing education sponsor fails to satisfy the requirements of this chapter, the Department may:

(1) Withdraw its accreditation.

(2) Downgrade its accreditation status to provisional accreditation, subject to withdrawal if deficiencies are not resolved within a time period prescribed by the Department.

(3) Withdraw approval of a continuing education course applicable to any future presentation of the course.

Subchapter C. (Reserved).

§ 1003.41. (Reserved).

§ 1003.42. (Reserved).

§ 1003.43. (Reserved).

§ 1003.44. (Reserved).

CHAPTER 1005. LICENSING OF BLS AND ALS GROUND AMBULANCE SERVICES

§ 1005.1. General provisions.

(a) This chapter applies to ground ambulance services. A person, or other entity, as an owner, agent or otherwise, may not operate, conduct, maintain, advertise or otherwise engage in or profess to be engaged in providing a BLS or ALS ambulance service upon the highways or in other public places in this Commonwealth, unless that person holds a current valid license as a BLS or ALS

ambulance service issued by the Department or is exempt from these prohibitions under the act.

(b) The Department will license an applicant as a BLS or ALS ambulance service, or both, when it meets the requirements of the act and this part.

(c) An ALS ambulance service may employ either or both of the following types of ambulances:

(1) A mobile ALS care unit vehicle, which is a vehicle that is designed, constructed, equipped and maintained or operated to provide ALS and BLS emergency medical care to and transportation of patients.

(2) An ALS squad unit vehicle, which is a vehicle that is specifically modified and equipped, and is maintained or operated for the purpose of transporting ALS prehospital personnel and equipment to the scene of an emergency.

(d) In addition to the general requirements for exception in § 1001.4 (relating to exceptions), the Department may grant exceptions to regulatory licensure standards for ALS and BLS ambulance services that are licensed in a contiguous state if:

(1) Requiring compliance with both states' licensure standards imposes an undue hardship on the individual or service.

(2) Standards in the contiguous state are comparable.

(3) The exception will not have a negative impact on the quality of care for the population of this Commonwealth.

§ 1005.2. Applications.

(a) An application for an original or renewal ambulance service license shall be submitted on forms prescribed by the Department. The application shall contain the following information as well as any additional information that may be solicited by the application form:

(1) The name and address of the applicant.

(2) The name under which the applicant is doing business.

(3) The type of organization—profit or nonprofit.

(4) The level of service—ALS or BLS.

(5) The emergency service area the applicant plans to serve, or, alternatively, a statement that the applicant intends to engage primarily in interfacility transports.

(6) A personnel roster and staffing plan.

(7) The number and types (BLS, mobile ALS care unit, ALS squad unit) of ambulance vehicles to be operated by the applicant, and identifying information relating to those ambulances.

(8) Communication access and capabilities of the applicant.

(9) The primary physical building location, and other building locations out of which it will operate ambulances or a full description of how its ambulances will be placed and respond to emergency calls if they will not be operated out of other building locations.

(10) The names, titles and summary of responsibilities of persons who will be staffing the ambulance service as officers, directors or other ambulance service officials, and information as to any misdemeanor or felony convictions, or disciplinary sanctions against licenses, certifications, or other authorizations to practice a health care occupation or profession, that have been imposed against them.

(11) A statement attesting to the veracity of the application, which shall be signed by the principal official of the applicant.

(b) The applicant shall submit the application to the regional EMS council exercising responsibility for the EMS region in which the applicant will station its ambulances if licensed. If the applicant seeks a license to station and operate its ambulances in more than one region, it shall choose a primary headquarters, submit an original license application form to the regional EMS council that exercises responsibility for the region in which that primary headquarters is located, and submit a copy of the application to the regional EMS council that exercises responsibility for each additional region in which it seeks to station and operate an ambulance.

(1) The regional EMS council shall review the application for completeness and accuracy.

(2) A regional EMS council shall return an incomplete application to the applicant within 14 days of receipt. Prior to conducting an onsite inspection, a regional EMS council shall return an inaccurate application to the applicant as soon as the regional EMS council determines that any information provided in the application is inaccurate.

(c) Upon receipt of a complete application, and its verification of the accuracy of the information provided in the application which is verifiable without an onsite inspection, the regional EMS council will schedule and conduct an onsite inspection of the applicant's vehicles, equipment, and personnel qualifications, as well as other matters that bear upon whether the applicant satisfies the statutory and regulatory criteria for licensure. The inspection shall be performed within 45 days after receipt by the regional EMS council of the completed application.

(d) An ambulance service shall apply for and secure an amendment of its license prior to substantively altering the location or operation of its ambulances within an EMS region, such as a change in location or operations which would not enable it to timely respond to emergencies in the emergency service area it planned to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

(e) An ambulance service shall apply for and secure an amendment of its license prior to locating and operating an ambulance in a region not identified in its original license application or in a prior amendment thereto. It shall submit its application for amendment to the regional EMS council having responsibility for the region in which it intends to begin locating and operating an ambulance. That regional EMS council shall process the application for amendment as set forth in subsections (b) and (c). The ambulance service shall also file a copy of the application for amendment with the regional EMS council having responsibility for the region in which the ambulance service maintains its primary headquarters.

§ 1005.2a. Change in ambulance fleet.

(a) *Permanent change.* Before placing and operating an additional or permanent replacement ambulance in a region, an ambulance service shall submit a modification of ambulance fleet form to the regional EMS council responsible for that region. The ambulance service may not operate that ambulance unless it is authorized to do so by the Department following an inspection of the ambulance.

(b) *Temporary change.* An ambulance service may operate a temporary replacement ambulance without securing prior approval from the Department. It shall submit a temporary change of vehicle form to the appropriate regional EMS council, by facsimile, electronic or regular mail, no later than 24 hours after placing that ambulance in service. This duty applies even if use of the replacement ambulance has stopped. Upon filing a temporary change of vehicle form, the ambulance service may continue to operate the temporary replacement ambulance unless its authority to do so is disapproved by the Department following an inspection of the ambulance. Upon receiving a temporary change in vehicle form the regional EMS council shall issue a letter and a temporary certificate authorizing the ambulance service to operate the replacement ambulance for 7 days. That time period may be extended by the regional EMS council, by letter.

§ 1005.3. Right to enter, inspect and obtain records.

(a) Upon the request of an employe or agent of the Department during regular and usual business hours, or at other times when that person possesses a reasonable belief that violations of this part may exist, a licensee shall:

(1) Produce for inspection records maintained under § 1001.41 (relating to data and information requirements for ambulance services).

(2) Produce for inspection, permit copying, and provide within a reasonable period of time, records that pertain to personnel and their qualifications, staffing, equipment, supplies, and policies and procedures required under § 1005.10 (relating to licensure and general operating standards).

(3) Permit the person to examine vehicles, required equipment and supplies and security facilities.

(b) The Department's representative shall advise the licensee that the inspection is being conducted under section 12(k) of the act (35 P. S. § 6932(k)) and this chapter.

(c) Failure of a licensee to produce records or to permit an examination as required by this section constitutes misconduct in operating the ambulance service and shall be grounds for disciplinary sanctions or denial of license.

§ 1005.4. Notification of deficiencies to applicants.

(a) Upon completion of an inspection pursuant to an application for a license or an amendment of a license, the inspector shall provide the applicant an inspection report specifying the results of the inspection.

(b) If the inspector determines that deficiencies warrant a reinspection, the inspector shall give the ambulance service written notice of the matters to be reinspected.

(c) If the type of deficiency requires a plan of correction, the applicant shall have 30 days in which to provide the inspector with a plan to correct the deficiency. If the plan is found to be acceptable, the inspector will conduct a reinspection in accordance with the time frame given in the plan of correction.

(d) If the applicant disagrees with any deficiency cited by the inspector following the inspection or reinspection, or the regional EMS council's rejection of a plan of correction, the applicant shall apprise the Department of the matter in dispute, and the Department will resolve the dispute.

(e) The Department will act upon the license application within 30 days after the inspection process has been completed, unless the Department requires additional time to complete an investigation of those qualifications of the applicant which cannot, for just cause, be determined through the inspection process.

§ 1005.5. Licensure.

(a) A license to operate as an ambulance service will be issued by the Department when it has determined that requirements for licensure have been met.

(b) A license certificate will specify the name of the ambulance service, its license number, the address of its primary headquarters, the dates of issuance and expiration, the levels of service the ambulance service is authorized to provide, and the name of the regional EMS council through which the license application was processed. If the ambulance service is an ALS ambulance service, the license certificate will also specify the type or types of ALS ambulance the ambulance service has been authorized to use. The Department will issue a new license certificate if there is a need to change information on an existing license certificate.

(c) The current license certificate shall be displayed in a public and conspicuous place in the ambulance service's primary headquarters.

(d) An ambulance, other than a temporary replacement ambulance, shall be identified by a decal issued by the Department which shall be considered part of its license and which shall be applied to the outside of the ambulance in a conspicuous place. After an ambulance service receives a temporary certificate issued under § 1005.2a(b) (relating to change in ambulance fleet) it shall identify a temporary replacement ambulance by displaying the temporary certificate in a conspicuous place in the ambulance. If the expiration date of a temporary certificate has been extended, the ambulance shall keep in the temporary replacement ambulance a copy of the letter extending the expiration date.

(e) An ambulance decal issued by the Department may not be displayed on a vehicle by an entity not licensed as an ambulance service by the Department.

(f) A license shall be nontransferable and shall remain valid for 3 years unless revoked or suspended by the Department.

(g) The Department will consolidate into one license a person's multiple licenses to operate an ambulance service in this Commonwealth, as of January 12, 2001, unless the person objects and asserts reasons in writing why consolidation of the multiple licenses into a single license is opposed. The person shall file the written objection by December 13, 2000. If an objection is filed, the Department will consider and rule upon the objection prior to consolidating the licenses.

§ 1005.6. Out-of-State providers.

Ambulance services located or headquartered outside of this Commonwealth that engage in the business of providing emergency medical care and transportation of patients from within this Commonwealth, to facilities within or outside this Commonwealth, are required to be inspected and licensed by the Department. Ambulance services located or headquartered outside of this Commonwealth that limit their operations in this Commonwealth to the transportation of patients from outside this Commonwealth to facilities within this Commonwealth are not required to be licensed and inspected by the Department provided they do not engage in these patient transports on a routine basis.

§ 1005.7. Services owned and operated by hospitals.

A hospital licensed under Chapter 8 of the Health Care Facilities Act (35 P. S. §§ 448.801—448.820) is not required to obtain a separate ambulance service license to own and operate an ambulance service. An ambulance service owned and operated by a hospital is subject to the act and this part, and shall be inspected under this part, regardless of whether the hospital secures a license to operate as an ambulance service.

§ 1005.7a. Renewal of ambulance service license.

(a) The Department will notify the ambulance service to renew its license at least 120 days prior to the expiration date of the license.

(b) An ambulance service shall apply for renewal of its license between 120 days and 60 days prior to the expiration of its license. Failure to apply for renewal in a timely manner may result in the applicant not securing a renewal of its license before the prior license expires.

(c) The criteria for license renewal are the same as the requirements that would apply for original licensure at the time the renewal application is made.

§ 1005.8. Provisional license.

(a) If an ambulance service or an applicant for an ambulance service license fails to meet licensure requirements, the Department may issue it a provisional license, valid for a specific time period of not more than 6 months, when the Department deems it is in the public interest to do so.

(b) The Department may renew a provisional license once, for a period not to exceed 6 months except when a longer period of renewal is permitted under subsection (c), if:

(1) The ambulance service has substantially, but not completely, complied with applicable requirements for licensure.

(2) The ambulance service is making a good faith effort to comply with a course of correction approved by the Department.

(3) The Department deems it is in the public interest to do so.

(c) The Department may renew a provisional BLS ambulance service license for 12 months for a volunteer ambulance service, or a volunteer fire department or rescue service that operates an ambulance service, which does not meet the minimum standards for staffing at the BLS level of care, but meets the other requirements of this chapter.

(d) The Department will require an ambulance service to maintain a duty roster if the Department issues that ambulance service a provisional license because the ambulance service is not meeting staffing standards or is not providing PSAPS notice when it is unable to respond as required by § 1005.10(e) (relating to licensure and general operating standards).

§ 1005.9. Temporary license.

When an ALS ambulance service or an applicant for an ALS ambulance service license cannot provide service 24 hours-a-day, 7 days-a-week, the Department may issue a temporary license for operation of the ALS ambulance service when the Department deems it is in the public interest to do so. The temporary license is valid for 1 year and may be renewed once. The Department will require an ALS ambulance service to maintain a duty roster if the Department issues that ambulance service a temporary license.

§ 1005.10. Licensure and general operating standards.

(a) *Documentation requirements.* An applicant for an ambulance service license shall have the following documents available for the inspection by the Department:

(1) A roster of active personnel, including certification and recognition documentation with dates of expiration and identification numbers; documentation of medical command authorization decisions and the medical command status of personnel, if applicable; its process for scheduling staff to ensure that the minimum staffing requirements set forth in subsection (d) are met; identification of persons who are responsible for making operating and policy decisions for the ambulance service, such as officers, directors and other ambulance service officials; and the criminal and disciplinary information for all persons who staff the ambulance service as required by subsections (d)(3) and (4)(vii) and (k).

(2) Copies of EMS patient care reports, or other formats on which those records are kept on patients treated or transported, if applicable.

(3) Call volume records from the previous year's operations, if applicable. These records shall include a record of each call received requesting the ambulance service to respond to an emergency, as well as a notation of whether it responded to the call and the reason if it did not respond.

(4) A record of the time periods for which the ambulance service notified the PSAP, under subsection (e), that it would not be available to respond to a call.

(5) Copies of all written policies required by this section.

(6) Copies of any documents by which it agrees to manage another ambulance service or to be managed by another entity.

(b) *Ambulance standards.*

(1) For ambulance vehicles which transport patients the ambulance service will be required to show evidence that the vehicle has met 75 Pa.C.S. §§ 4571 and 4572 (relating to visual and audible signals on emergency vehicles; and visual signals on authorized vehicles) and 67 Pa. Code Chapter 173 (relating to flashing or revolving lights on emergency and authorized vehicles), and the Federal KKK standards which were in effect at the time of the vehicle's manufacture and which are not inconsistent with the Vehicle Code standards in 75 Pa.C.S. §§ 4571 and 4572. These specifications will be for design types, floor plans, general configuration and exterior markings. An ALS squad unit vehicle is not subject to the Federal KKK standards; however, it is required to meet the standards in 75 Pa.C.S. §§ 4571 and 4572. It is also required to have a minimum of six stars of life at least 3 inches in diameter prominently displayed on its exterior, at least two on both the front and rear and at least one on each side.

(2) The name of the ambulance service, or a fictitious name of the ambulance service duly registered with the Department of State, shall be displayed on both sides of an ambulance in lettering at least 3 inches in height, except these requirements do not apply to a temporary ambulance used for 30 days or less.

(c) *Equipment and supplies.* Required equipment and supplies shall be carried and readily available in working order for use on BLS and ALS vehicles.

(1) BLS and ALS vehicles shall carry medical equipment and supplies as published by the Department in the *Pennsylvania Bulletin* on an annual basis, or more frequently.

(2) An ALS squad unit vehicle is exempt from the requirement of carrying patient litters and equipment which is permanently installed.

(3) A BLS ambulance service may carry ALS equipment and drugs, in addition to those generally prescribed for use by a BLS ambulance service, only if it has a physician who is directly responsible for security, accountability, administration and maintenance of the equipment and drugs, and the arrangement is authorized by the Department upon its determination that the arrangement is in the public interest. The physician shall have education and continuing education in ALS and prehospital care and shall serve as the medical director of the BLS ambulance service.

(d) *Personnel requirements.*

(1) *Minimum staffing requirements.*

(i) *BLS unit.* A BLS ambulance, when transporting a patient, except for when engaging in the routine transfer of convalescent or other nonemergency cases, shall be staffed by at least two persons, one of whom shall be an EMT, EMT-paramedic, or health professional, and one of whom shall, at least, qualify as an ambulance attendant. A BLS ambulance need not meet the staffing requirement in this subparagraph when responding to a call, provided that the minimum staffing requirement is satisfied when transporting a patient. An EMT, EMT-paramedic or a health professional shall accompany the patient in the patient compartment of the ambulance during transport.

(ii) *ALS units.* Minimum staffing standards for an ambulance that is operating at the ALS level of care shall be as follows:

(A) Two persons shall respond to calls for assistance. This staff shall consist of one of the following:

(I) Two health professionals.

(II) One health professional and either one EMT or one EMT-paramedic.

(III) One EMT and one EMT-paramedic.

(IV) Two EMT-paramedics.

(B) An ALS ambulance service may be staffed by one EMT-paramedic or one health professional when responding to calls for assistance, if the minimum ALS staffing requirements in this subsection are met during emergency medical treatment and transport of the patient.

(C) An ALS squad unit meets minimum staffing requirements by transporting an EMT-paramedic or health professional to rendezvous with a BLS ambulance, and having the EMT-paramedic or health professional provide emergency medical treatment to, and accompany on the BLS ambulance during transport, a patient requiring ALS care.

(D) Minimum ALS staffing standards apply to the ALS ambulance service 24 hours-a-day, 7 days-a-week. A mobile ALS care unit, itself, need only satisfy BLS ambulance staffing requirements under subparagraph (i) when responding to a call for BLS assistance exclusively. If the nature of the assistance requested is unknown, the mobile intensive care unit shall respond as if the patient requires ALS care.

(iii) All units.

(A) Minimum staffing standards are satisfied when an ambulance service has a duty roster that identifies staff who meet minimum staff criteria and who have committed themselves or been assigned by the ambulance service to be available at the specified times, or a staff availability schedule that identifies staff who meet minimum staff criteria and have identified themselves to the ambulance service as being available at the specified times, and minimum staff are present at times required by this subsection, the staff being the staff of the ambulance service except as otherwise authorized in this subsection.

(B) The ambulance service shall comply with the Child Labor Law (43 P. S. §§ 41—66.1) and regulations adopted under that law when it is using persons 18 years of age and younger to staff and ambulance.

(2) *ALS service medical director.* An ALS ambulance service shall have an ALS service medical director whose duties include the following:

(i) Providing medical guidance and advice to the ambulance service.

(ii) Making medical command authorization determinations for EMT-paramedics and prehospital registered nurses as set forth in § 1003.28 (relating to medical command authorization).

(iii) Reviewing the medical command authorization status of EMT-paramedics and prehospital registered nurses utilized by the ALS ambulance service as set forth in § 1003.28 at least once annually.

(iv) Evaluating the quality of patient care provided by the ALS and BLS prehospital personnel utilized by the ALS ambulance service.

(3) *Responsible staff.* An ambulance service shall ensure that all persons who staff the ambulance service, including its officers, directors and other members of its management team, prehospital personnel, and ambulance drivers, are responsible persons. In making that determination it shall require each person who staffs the ambulance service to provide it with information as to misdemeanor and felony convictions, and disciplinary sanctions against a license, certification or other authorization to practice a health care occupation or profession, that have been imposed against that person, and to update that information if and when additional convictions and disciplinary sanctions occur. The ambulance service shall consider this information in determining whether the person is a responsible person. An ambulance service shall also provide the Department with advance notice, 30 days if possible, of any change in its management personnel to include as a new member of its management team a person who has been convicted of a felony or misdemeanor or has had a disciplinary sanction imposed against a license, certification or other authorization to practice a health care occupation or profession.

(4) *Ambulance drivers.* Notwithstanding other considerations that may bear upon whether a driver of an ambulance is a responsible person, a person who drives an ambulance for an ambulance service will not be considered to be a responsible person unless that individual:

(i) Is at least 18 years of age.

(ii) Has a valid driver's license.

(iii) Observes all traffic laws.

(iv) Is not addicted to, or under the influence of, alcohol or drugs.

(v) Is free from physical or mental defect or disease that may impair the person's ability to drive an ambulance.

(vi) Has successfully completed an emergency vehicle operator's course of instruction approved by the Department.

(vii) Has not been convicted within the last 4 years of driving under the influence of alcohol or drugs, or, within the last 2 years, has not been convicted of reckless driving or had a driver's license suspended. The person will not be considered to be a responsible person until the designated time has elapsed and the individual, after the conviction or suspension of license, repeats an emergency vehicle operator's course of instruction approved by the Department.

(e) *Communicating with PSAPs.*

(1) *Responsibility to communicate unavailability.* An ambulance service shall apprise the PSAP in its area as to when it will not be in operation due to inadequate staffing or for another reason and when its resources are committed in such matter that it will not be able to have an ambulance and required staff respond to a call requesting it to provide emergency assistance.

(2) *Responsibility to communicate delayed response.* An ambulance service shall apprise the PSAP, as soon as practical after receiving a dispatch call, if it is not able to have an ambulance and required staff en route to an emergency within the time as may be prescribed by a PSAP for that type of communication.

(3) *Responsibility to communicate with PSAP generally.* In addition to the communications required by paragraphs (1) and (2), an ambulance service shall provide a PSAP with information, and otherwise communicate with a PSAP, as the PSAP requests to enhance the ability of the PSAP to make dispatch decisions.

(4) *Response to dispatch by PSAP.* An ambulance service shall respond to a call for emergency assistance as communicated by the PSAP, provided it is able to respond as requested.

(f) *Patient management.* All aspects of patient management are to be handled by a prehospital practitioner with the level of EMS certification or recognition necessary to care for the patient based upon the condition of the patient.

(g) *Use of lights and other warning devices.* Ambulances may not use emergency lights or audible warning devices, unless they do so in accordance with standards imposed by 75 Pa.C.S. (relating to Vehicle Code) and are transporting or responding to a call involving a patient who presents or is in good faith perceived to present a combination of circumstances resulting in a need for immediate medical intervention. When transporting the patient, the need for immediate medical intervention must be beyond the capabilities of the ambulance crew using available supplies and equipment.

(h) *Weapons and explosives.* Weapons and explosives may not be worn by ambulance personnel or carried aboard an ambulance. This subsection does not apply to law enforcement officers who are serving in an authorized law enforcement capacity.

(i) *Accident, injury and fatality reporting.* An ambulance service shall report to the appropriate regional EMS council, in a form or manner prescribed by the Department, an ambulance vehicle accident that is reportable under 75 Pa.C.S., and an accident or injury to an individual that occurs in the line of duty of the ambulance service that results in a fatality, or medical treatment at a facility. The report shall be made within 24 hours after the accident or injury. The report of a fatality shall be made within 8 hours after the fatality.

(j) *Medical command notification.* An ALS ambulance service shall identify, to the regional EMS council having responsibility in the region out of which it operates, the prehospital personnel used by it that have medical command authorization in the region for that ALS ambulance service. It shall also notify the regional EMS council when a prehospital practitioner loses medical command authorization for that ALS ambulance service.

(k) *Monitoring compliance.* An ambulance service shall monitor compliance with the requirements that the act and this part impose upon the ambulance service and its staff. An ambulance service shall file a written report with the Department if it determines that a prehospital practitioner who is a member of the ambulance service, or who has recently left the ambulance service, has engaged in conduct not previously reported to the Department, for which the Department may impose disciplinary sanctions under § 1003.27 (relating to disciplinary and corrective action). The duty to report pertains to conduct that occurs during a period of time in which the prehospital practitioner is functioning for the ambulance service.

(l) *Policies and procedures.* An ambulance service shall maintain written policies and procedures addressing each of the requirements imposed by this section, as well as the requirements imposed by §§ 1001.41, 1001.42, 1001.65 and 1005.11 and shall also maintain written policies and procedures addressing infection control, management of personnel safety, substance abuse in the workplace, and the placement and operation of its ambulances.

§ 1005.11. Drug use, control and security.

(a) An ambulance service may stock drugs as approved by the Department, and shall carry drugs in an ambulance in conformance with the transfer and medical treatment protocols applicable in the region in which its ambulance is stationed. Additional drugs may be stocked by an ALS ambulance service as authorized by the ALS service medical director if the ALS ambulance service uses health professionals, and additional drugs may be carried or brought on an ambulance as follows:

(1) Drugs which the applicable regional transfer and medical treatment protocols prescribe for the treatment of an ALS patient may be brought on a BLS ambulance by an EMT-paramedic or health professional when rendezvousing with a BLS ambulance to treat an ALS patient on behalf of an ALS ambulance service.

(2) Drugs other than those authorized by the applicable regional transfer and medical treatment protocols may be carried on an ALS ambulance, or brought on board a BLS ambulance by a health professional, when the requirements of subsection (d)(2) are satisfied.

(3) Drugs other than those authorized by the applicable regional transfer and medical treatment protocols may be carried on an ALS ambulance, or brought on board a BLS ambulance by a registered nurse, physician assistant, or physician when the following standards are met:

(i) The ambulance is engaged in an interfacility transport.

(ii) The physician, registered nurse, or physician assistant has special training required for the continuation of treatment provided to the patient at the facility, and the use of drugs not maintained on the ambulance is or may be required to continue that treatment.

(iii) The physician, registered nurse, or physician assistant does not substitute for required staff.

(4) A BLS ambulance service, if not also licensed as an ALS ambulance service, may not stock drugs which are not prescribed by the Department for use by a BLS ambulance, and a BLS ambulance service may not carry these drugs, except as authorized under this section and § 1005.10(c)(3) (relating to licensure and general operating standards).

(b) The Department will publish at least annually by notice in the *Pennsylvania Bulletin* a list of drugs approved for use by ambulance services when use of those drugs is also permitted by the applicable regional transfer and medical treatment protocols.

(c) An ambulance service may procure and replace drugs, from a hospital, pharmacy or from a participating and supervising physician, if not otherwise prohibited by law.

(d) Administration of drugs by prehospital personnel, other than those approved for use by a BLS ambulance service, shall be restricted to EMT-paramedics and health professionals who have been authorized to administer the drugs by the ALS service medical director, when under orders of a medical command physician or under standing orders in the EMS region's transfer and medical treatment protocols; except all prehospital personnel other than a first responder and an ambulance attendant may administer to a patient, or assist the patient to administer, drugs previously prescribed for that patient, as specified in the Statewide BLS medical treatment protocols.

(1) An EMT-paramedic is restricted to administering drugs permitted by the applicable regional transfer and medical treatment protocols and the Statewide BLS medical treatment protocols.

(2) A health professional may administer drugs in addition to those permitted by the applicable regional transfer and medical treatment protocols and the Statewide BLS medical treatment protocols, provided the health professional has received approval to do so by the ALS service medical director of the ambulance service, and has been ordered to administer the drug by the medical command physician.

(e) The ambulance service shall adequately monitor and direct the use, control and security of drugs provided to the ambulance service. This includes, but is not limited to:

(1) Ensuring proper labeling and preventing adulteration or misbranding of drugs, and ensuring drugs are not used beyond their expiration dates.

(2) Storing drugs as required by The Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. §§ 780-101—780-149), and as otherwise required to maintain the efficacy of drugs and prevent their misappropriation.

(3) Including in the EMS patient care report information as to the administration of drugs by patient name, drug identification, date and time of administration, manner of administration, dosage, name of the medical command physician who gave the order to administer the drug, and name of person administering the drug.

(4) Maintaining records of drugs administered, lost or otherwise disposed of, and records of drugs received and replaced.

(5) Providing the pharmacy, physician or hospital that is requested to replace a drug, with a written record of the use and administration, or loss or other disposition of the drug, which identifies the patient and includes any other information required by law.

(6) Ensuring, in the event of an unexplained loss or theft of a controlled substance, that the dispensing pharmacy, physician or hospital has contacted local or State police and the Department's Drugs, Devices and Cosmetics Office, and has filed a DEA Form 106 with the Federal drug enforcement administration.

(7) Disposing of drugs as required by The Controlled Substance, Drug, Device and Cosmetic Act.

(8) Arranging for the original dispensing pharmacy, physician or hospital, or its ALS service medical director, to provide it consultation and other assistance necessary to ensure that it meets the requirements of this section.

§ 1005.12. Disciplinary and corrective actions.

(a) The Department may, in compliance with proper administrative procedure, reprimand, or suspend, revoke or refuse to issue a license, or issue a provisional or temporary license as permitted by §§ 1005.8 and 1005.9 (relating to provisional license; and temporary license) for the following reasons:

(1) A serious violation of the act or this part. A serious violation is one which poses a continued significant threat to the health and safety of the public.

(2) Failure of the licensee or applicant to submit a reasonable timetable to correct deficiencies and violations cited by the Department.

(3) The existence of a continuing pattern of deficiencies over a period of 3 or more years.

(4) Fraud or deceit in obtaining or attempting to obtain a license.

(5) Lending a license or borrowing or using the license of another, or knowingly aiding or abetting the improper granting of a license.

(6) Incompetence, negligence or misconduct in operating the ambulance service or in providing EMS to patients.

(7) Failure of an ALS ambulance service to secure an ALS service medical director and to ensure that the ALS service medical director meets the roles and responsibilities in § 1003.5(a) (relating to ALS service medical director).

(8) Failure to have appropriate medical equipment and supplies required for licensure as identified in § 1005.10(c) (relating to licensure and general operating standards).

(9) Failure of an ALS ambulance service to staff a sufficient number of qualified EMS personnel to provide service 24 hours-a-day, 7 days-a-week in accordance with required staffing standards.

(10) Failure of the ambulance service licensee to promptly notify the Department of a change of ownership.

(11) Abuse or abandonment of a patient.

(12) Unauthorized disclosure of medical or other confidential information.

(13) Willful preparation or filing of false reports or records, or the inducement of another to do so.

(14) Alteration or inappropriate destruction of medical records.

(15) Refusal to render EMS because of a patient's race, sex, creed, national origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(16) Failure to comply with the regional EMS council transfer and medical treatment protocols which have been approved by the Department.

(17) Misuse or misappropriation of drugs/medication.

(18) Repeated failure by an ambulance service to communicate with the PSAP or comply with the dispatch communication as required by § 1005.10(e).

(19) Failure to continue to meet standards applicable to the issuance of the license.

(b) Upon receipt of a written complaint describing conduct for which the Department may take disciplinary action against an ambulance service, the Department will:

(1) Initiate an investigation of the specific charges.

(2) Provide the ambulance service with a copy of the complaint and request a response unless the Department determines that disclosure to the ambulance service of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the ambulance service if the ambulance service has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed under paragraph (3).

(c) The Department will provide public notification of the sanction it imposes upon an ambulance service license.

§ 1005.13. Removal of ambulances from operation.

(a) When a vehicle manifests evidence of a mechanical or equipment deficiency which poses a significant threat to the health or safety of patients or crew, the ambulance service shall immediately suspend the vehicle from operation. No vehicle, which has been suspended from operation, may be operated as an ambulance until the deficiency has been corrected.

(b) When a vehicle, upon examination by the Department, manifests evidence of a mechanical or equipment deficiency which poses a significant threat to the health or safety of patients or crew, it shall be immediately suspended from operation as directed by the Department. No vehicle, which has been suspended from operation by the Department, may be operated as an ambulance until the Department has confirmed to the ambulance service that the deficiency has been corrected.

§ 1005.14. Invalid coaches.

(a) Invalid coaches are not eligible for licensing as an ambulance.

(b) The terms "ambulance," "emergency" or other similar designations may not be used by invalid coaches. Invalid coaches may not be equipped with emergency warning devices, audible or visible, such as flashing lights, sirens, air horns or other devices except those which are required by 75 Pa.C.S. (relating to Vehicle Code).

§ 1005.15. Discontinuation of service.

An ambulance service may not discontinue service, except upon order of the Department, without providing each regional EMS council, PSAP and the chief executive officer of each political subdivision within its service area, as well as the chief executive officer of a political subdivision outside of its service area that relies upon it for service even if not provided on a routine basis, 90 days advance notice. The ambulance service shall also advertise notice of its intent to discontinue service in a newspaper of general circulation in its service area at least 90 days in advance of discontinuing service, and shall provide the Department with written notice that it has met these responsibilities at least 90 days in advance of discontinuing service.

CHAPTER 1007. LICENSING OF AIR AMBULANCE SERVICES—ROTORCRAFT

§ 1007.1. General provisions.

(a) This chapter applies to air ambulance services. No person, or other entity, as owner, agent or otherwise, may furnish, operate, conduct, maintain, advertise, engage in or profess to engage in providing an air ambulance service in this Commonwealth, unless the agency or person holds a license as an air ambulance service issued by the Department or is exempted from these prohibitions under the act.

(b) The Department will license an applicant as an air ambulance service when it meets the requirements of the act and this part.

(c) A hospital licensed under Chapter 8 of the Health Care Facilities Act (35 P. S. §§ 448.801—448.820) is not required to obtain a separate air ambulance service license to own and operate an air ambulance service. An air ambulance service owned and operated by a hospital is subject to the act and this part, and shall be inspected under this part, regardless of whether the hospital applies for or secures licensure as an air ambulance service.

(d) The Department will issue a certificate acknowledging a hospital's authority to own and operate an air ambulance service if the hospital chooses to operate an air ambulance service without securing a separate license to do so.

(e) Those provisions in §§ 1005.2a, 1005.3—1005.5, 1005.7a, 1005.8, 1005.9, 1005.11, 1005.13 and 1005.15, which apply to ground ALS ambulance services, also apply to air ambulance services.

§ 1007.2. Applications.

(a) An application for an original or renewal license to operate as an air ambulance service shall contain the following information, as well as any additional information that may be solicited by the application form:

(1) The name and address of the applicant and the name, if different, under which the applicant intends to operate.

(2) The FAA certification number of the aircraft operator.

(3) The type of organization—profit or nonprofit.

(4) A description of each aircraft to be used as an air ambulance, including the make, model, year of manufac-

ture, FAA registration number, name, monogram or other distinguishing designation and FAA air worthiness certification.

(5) The intended emergency medical service area and the location and description of the places from which the air ambulance service is to operate.

(6) The name, training and qualifications of the air ambulance medical director.

(7) A personnel roster which includes level of certification, licensure and recognition, and a staffing plan.

(8) A roster of pilots including training and qualifications.

(9) The communications access and capabilities of the applicant.

(10) Names, titles and summary of responsibilities of persons who will be staffing the air ambulance service as officers, directors or other air ambulance service officials, and information as to any misdemeanor or felony convictions, or disciplinary sanctions against licenses, certifications, or other authorizations to practice a health care occupation or profession, that have been imposed against them.

(11) A statement attesting to the veracity of the application, which shall be signed by the chief executive officer.

(b) An entity shall apply for a license as an air ambulance service or an amendment to a license as an air ambulance service, and a regional EMS council shall process those applications, as set forth in § 1005.2(b)—(e) (relating to applications).

§ 1007.3. (Reserved).

§ 1007.4. (Reserved).

§ 1007.5. (Reserved).

§ 1007.6. (Reserved).

§ 1007.7. Licensure and general operating requirements.

(a) *Documentation requirements.* An applicant for an air ambulance service license shall have the following documents available for the inspection by the Department:

(1) A roster of active personnel, including certification and recognition documentation with dates of expiration and identification numbers; documentation of medical command authorization decisions and the medical command status of personnel; identification of persons who are responsible for making operating and policy decisions for the air ambulance service, such as officers, directors and other ambulance service officials; and the criminal and disciplinary information for all persons who staff the ambulance service as required by subsections (d)(4) and (m); and the plan for staffing the air ambulance service.

(2) Copies of EMS patient care reports, or other formats on which those records are kept on patients treated or transported, if applicable.

(3) Call volume records from the previous year's operations if applicable. These records shall include a record of each call received requesting the air ambulance service to respond to an emergency, as well as a notation of whether it responded to the call and the reason if it did not respond.

(4) Copies of the written policies required by this section.

(b) *Air ambulance requirements.* An air ambulance shall meet the following minimum requirements:

(1) The air ambulance shall be configured to carry at least one supine patient with sufficient access to the patient in order to begin and maintain ALS and other treatment modalities.

(2) The air ambulance design may not compromise patient safety in loading, unloading or during flight, and the air ambulance shall be equipped with either a cargo door or an entry that will allow loading and unloading the patient without excessive maneuvering.

(3) The air ambulance shall be climate controlled for the comfort of the patient.

(4) The air ambulance shall have adequate interior lighting so that medical care can be provided and patient status monitored without interfering with the pilot's vision.

(5) The air ambulance shall be configured so that the patient is isolated from the cockpit to minimize in-flight distractions to the pilot and to prevent interference with the pilot's manipulation of the flight controls.

(6) An air ambulance operating from sunset to sunrise shall be equipped with at least one tail rotor illuminating light and a controllable search light.

(7) The air ambulance shall carry, on a flight, survival gear appropriate to the expected terrain and environment.

(8) The air ambulance shall be equipped with appropriate patient restraints.

(9) The air ambulance shall be equipped with 110 V electrical output with appropriate cabin outlets for medical equipment use.

(10) The air ambulance shall be equipped with two-way radios capable of communicating with hospital communications centers, PSAPs and ambulances.

(c) *Equipment and supply requirements.* Required equipment and supplies shall be carried and readily available in working order for use on an air ambulance. The list of required equipment and supplies for an air ambulance will be published by the Department in the *Pennsylvania Bulletin* on an annual basis.

(d) *Personnel requirements.* An air ambulance service shall meet the following requirements related to personnel and staffing:

(1) *Air ambulance medical director.* It shall have an air ambulance medical director who possesses the qualifications specified in § 1003.5(b) (relating to ALS service medical director) and performs the duties specified in § 1003.5(a).

(2) *Pilot and prehospital personnel.* It shall assure that each air ambulance responding to a call for EMS is staffed with at least one pilot and prehospital personnel as set forth in § 1005.10(d)(1)(ii) (relating to licensure and general operating standards). At least one of the responding prehospital personnel shall be specially trained in air-medical transport.

(3) *Other personnel requirements.*

(i) It shall keep a pilot and two prehospital personnel staff as set forth in § 1005.10(d)(ii) available for the air ambulance at all times to assure immediate response to emergency calls.

(ii) It shall require prehospital personnel who staff an air ambulance to undergo annual physical examinations to assure that they are physically able to perform their jobs.

(iii) Minimum staffing standards are satisfied when an air ambulance service has a duty roster that identifies staff who meet minimum staff criteria 24 hours-a-day, 7 days-a-week and who have committed themselves as being available or been assigned by the air ambulance service to be available at the specified times, and when minimum required staff are present during the emergency medical treatment and transport of a patient.

(4) *Responsible staff.* It shall ensure that all persons who staff the air ambulance service, including its officers, directors and other members of its management team, prehospital personnel, and pilots, are responsible persons. In making that determination it shall require each person who staffs the air ambulance service to provide it with information as to misdemeanor and felony convictions, and disciplinary sanctions against a license, certification or other authorization to practice a health care occupation or profession, that have been imposed against the person, and to update that information if additional convictions and disciplinary sanctions occur. It shall consider this information in determining whether the person is a responsible person. It shall also provide the Department with advance notice, 30 days if possible, of any change in its management personnel to include as a new member of its management team a person who has been convicted of a felony or misdemeanor or has had a disciplinary sanction imposed against a license, certification or other authorization to practice a health care occupation or profession.

(e) *Communicating with ground PSAPs.*

(1) If requested by a ground PSAP, an air ambulance service shall apprise the PSAP as to when it will not be in operation, when weather conditions prevent or impede flight, and when its resources are already committed.

(2) An air ambulance service shall apprise the dispatching ground PSAP as soon as practical after receiving a dispatch call, its estimated time of arrival at the scene of the emergency. While its air ambulance is enroute to the scene of an emergency, if an air ambulance service believes that it will not be able to have an air ambulance and required staff arrive at the emergency scene within the estimated time of arrival previously given, the air ambulance service shall contact the ground PSAP and provide its new estimated time of arrival.

(f) *Access to air ambulance service.*

(1) The air ambulance service shall have a policy which addresses the following:

(i) Who, in addition to a PSAP, may request air ambulance service.

(ii) How its air ambulance services should be accessed.

(iii) General and medical guidelines for personnel to consider prior to requesting its air ambulance services.

(iv) To whom the air ambulance service provides its services, including general service area.

(v) What level of EMS is provided by the air ambulance service.

(vi) Patient preparation guidelines.

(vii) Aircraft enplanement and safety requirements.

(2) The air ambulance service shall disseminate this policy to relevant health care providers in the air ambulance service's service area.

(g) *Flight requirements.* The air ambulance service shall ensure that:

(1) A determination to accept the flight is based solely on availability, safety procedures and weather conditions.

(2) The air ambulance proceeds expeditiously and as directly as possible to the flight destination, considering the weather, appropriate safety rules, noise abatement procedures and flight path and altitude clearances.

(3) The air ambulance engages in flight following with an air communications center at intervals not to exceed 15 minutes. If the air ambulance is outside of radio range of the base communications center, adequate flight following shall be planned and executed.

(4) The air ambulance is ready for flight at all times when the air ambulance service has not reported to ground PSAPs that the air ambulance is unavailable to respond to emergencies.

(h) *Medical service requirements.* The air ambulance service shall ensure that:

(1) Equipment and supplies required for an air ambulance flight are on the air ambulance and in working order prior to takeoff for patient transport.

(2) Medical care and intervention is provided according to direct medical command or written protocols/standing orders.

(3) A patient treatment record is maintained, documenting medical care rendered by the medical flight crew and the disposition of the patient at the receiving medical facility. The patient treatment record shall be maintained at the base hospital.

(4) Each patient is evaluated for potential adverse effects from flight operations.

(5) The patient and equipment are secured during flight.

(6) The patient is transported to the nearest appropriate receiving facility. That facility shall be a trauma center when required by Department-approved bypass protocols.

(i) *Air ambulance medical director's operational requirements.* The air ambulance service shall have a policy setting forth the air ambulance medical director's operational procedures which shall include procedures for at least the following:

(1) The performance of responsibilities set forth in § 1003.5(a) (relating to ALS service medical director).

(2) The development of medical treatment protocols for the air ambulance service, submitting them to the regional EMS council medical advisory committee for its review and recommendations, and securing approval of the medical treatment protocols from the Department.

(j) *Communication center arrangements.* The air ambulance service shall ensure that it has access to an air communications center that meets the following standards:

(1) Has a designated person—communications specialist—assigned to receive and dispatch requests for emergency air medical services and charged with the relay of information between the flight crew, requesting agency and receiving hospital.

(2) Is operational 24 hours-a-day, 7 days-a-week and has radio capabilities to transmit to and receive from the air ambulance. At a minimum, 123.05 MHz, radio frequency shall be available.

(3) Has at least one incoming telephone line that is dedicated to the air ambulance service.

(4) Has a system for recording incoming and outgoing telephone and radio transmissions. The system shall have an inherent time recording capability and recordings shall be kept for a minimum of 30 days.

(5) Has the capability of communicating with the flight crew so that the air ambulance may take off within the scheduled takeoff time.

(6) Has a backup emergency power source.

(7) Maintains a status board listing flight crew names and other pertinent operational information.

(8) Has copies of operational protocols and procedures, including emergency operation plans in the event of overdue, missing or downed aircraft.

(9) Has posted or displayed applicable licenses and permits.

(10) Maintains current maps and navigational aids.

(11) Collects and maintains records of the following data:

(i) The time of initial and subsequent air ambulance request calls.

(ii) The name of the party or agency requesting the air ambulance service and a verification phone number.

(iii) Pertinent patient medical information.

(iv) The names of referring and receiving physicians at hospitals.

(v) The landing and destination sites.

(vi) The details of needed ground transportation arrangements at pickup and landing sites.

(vii) The times and reasons for aborted or missed flights.

(viii) The details of coordination with ground personnel for landing and receipt of the aircraft.

(ix) Other data pertinent to the air ambulance service's specific needs for completing activity review reports.

(k) *Community education program requirements.*

(1) An air ambulance service shall develop a professional and community education program that will promote proper air medical service utilization.

(2) The educational program shall include the following:

(i) Communication to the public that the air ambulance service accepts medically necessary calls from authorized personnel and does not discriminate against a person because of race, creed, sex, color, age, religion, national origin, ancestry, medical problem, handicap or ability to pay.

(ii) A safety program covering landing site designation and safe conduct around the air ambulance, which shall be offered to appropriate agencies and individuals.

(iii) Training regarding stabilization and preparation of the patient for airborne transport, which shall be provided to prehospital personnel.

(iv) An active community relations program.

(l) *Medical command notification.* An air ambulance service shall identify, to the regional EMS council having responsibility in the region out of which it operates, the prehospital personnel used by it that have medical command authorization in the region for that air ambulance service. The service shall also notify the regional EMS council when a prehospital practitioner loses medical command authorization for that air ambulance service.

(m) *Monitoring compliance.* An air ambulance service shall monitor compliance with all requirements that the act and this part impose upon the air ambulance service and its staff. An air ambulance service shall file a written report with the Department if it determines that a prehospital practitioner who is a member of the air ambulance service, or who has recently left the air ambulance service, has engaged in conduct not previously reported to the Department, for which the Department may impose disciplinary sanctions under § 1003.27 (relating to disciplinary and corrective action). The duty to report pertains to conduct that occurs during a period of time in which the prehospital practitioner is functioning for the air ambulance service.

(n) *Policies and procedures.* An air ambulance service shall maintain written policies and procedures addressing each of the requirements imposed by this section, as well as the requirements imposed by §§ 1001.41, 1001.42 and 1001.65 (relating to data and information requirements for ambulance services; dissemination of information; and cooperation), and shall also maintain written policies and procedures addressing infection control, management of personnel safety, substance abuse in the workplace and the placement and operation of its air ambulances.

§ 1007.8. Disciplinary and corrective actions.

(a) The Department may, in compliance with proper administrative procedure, reprimand, or suspend, revoke or refuse to issue a license, or issue a provisional or temporary license as permitted by §§ 1005.8 and 1005.9 (relating to provisional license; and temporary license) for the following reasons:

(1) A serious violation of the act or this part. A serious violation is one which poses a continued significant threat to the health and safety of the public.

(2) Failure of the licensee or applicant to submit a reasonable timetable to correct deficiencies and violations cited by the Department.

(3) The existence of a continuing pattern of deficiencies over a period of 3 or more years.

(4) Fraud or deceit in obtaining or attempting to obtain a license.

(5) Lending a license or borrowing or using the license of another, or knowingly aiding or abetting the improper granting of a license.

(6) Incompetence, negligence or misconduct in operating the ambulance service or in providing EMS to patients.

(7) Failure to secure an air ambulance medical director and ensure that the air ambulance medical director exercises the responsibilities in § 1003.5(a) (relating to ALS service medical director).

(8) Failure to have appropriate medical equipment and supplies required for licensure as identified in § 1007.7(b) (relating to licensure and general operating requirements).

(9) Failure of the air ambulance service to have an aircraft equipped in compliance with § 1007.7(a).

(10) Failure of the aircraft operator to maintain required FAA certifications.

(11) Failure to employ a sufficient number of certified, recognized or licensed personnel to provide service 24 hours-a-day, 7 days-a-week.

(12) Failure of the air ambulance service to be available 24 hours-a-day, 7 days-a-week to authorized callers within the service area. Exceptions to this requirement include unsafe weather conditions, commitment to another flight, grounding due to maintenance or other reasons that would prevent response. The air ambulance service shall maintain a record of each failure to respond to a request for service, and make the record available upon request to the Department. Financial inability to pay does not constitute sufficient grounds to deny response for emergency air service.

(13) Failure to notify the Department of the change of ownership or aircraft operation.

(14) Abuse or abandonment of a patient.

(15) Unauthorized disclosure of medical or other confidential information.

(16) Willful preparation or filing of false medical reports or records, or the inducement of another to do so.

(17) Destruction of medical records.

(18) Refusal to render EMS because of a patient's race, sex, creed, national origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(19) Failure to comply with regional EMS council transfer and medical treatment protocols.

(20) Misuse or misappropriation of drugs/medication.

(21) Repeated failure to communicate with a PSAP as required by § 1007.7(e).

(22) Failure to continue to meet standards applicable to the issuance of the license.

(b) Upon receipt of a written complaint describing conduct for which the Department may take disciplinary action against an air ambulance service, the Department will:

(1) Initiate an investigation of the specific charges.

(2) Provide the air ambulance service with a copy of the complaint and request a response unless the Department determines that disclosure to the air ambulance service of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the air ambulance service if the air ambulance service has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed under paragraph (3).

(c) The Department will provide public notification of sanctions it imposes upon an air ambulance service license.

§ 1007.9. (Reserved).

CHAPTER 1009. MEDICAL COMMAND FACILITIES

§ 1009.1. Operational criteria.

To qualify as a medical command facility, an institution shall comply with the following criteria:

(1) Employ a medical command facility medical director who meets the requirements specified in § 1003.3(b) (relating to medical command facility medical director).

(2) Employ sufficient staff to ensure that at least one approved medical command physician, meeting the requirements specified in § 1003.4(b) (relating to medical command physician), is present in the facility 24 hours-a-day, 7 days-a-week.

(3) Satisfy the following communication and record-keeping requirements:

(i) Compatibility with regional telecommunication systems plans, if in place.

(ii) Communication by way of telecommunications equipment/radios with BLS and ALS units within the area in which medical command is exercised.

(iii) Tape recording of medical command communications.

(iv) Maintenance of a medical command record, containing appropriate information on patients for whom medical command is sought.

(v) An appropriate program for training emergency department staff in the effective use of telecommunication equipment.

(vi) Protocols to provide for prompt response to requests from prehospital personnel for radio or telephone medical guidance, assistance or advice.

(4) Accurately and promptly relay information regarding patients to the appropriate receiving facility.

(5) Adhere to transfer and medical treatment protocols established by the regional EMS council, or, when dealing with an air ambulance service, as approved by the Department.

(6) Establish a program of regular case audit conferences involving the medical command facility medical director or the director's designee and prehospital personnel for purposes of problem identification, and a process to correct identified problems.

(7) Obtain a contingency agreement with at least one other medical command facility to assure availability of medical command.

(8) Establish internal procedures that comply with regional EMS transfer and medical treatment protocols.

(9) Notify PSAPs, through which it routinely receives requests for medical command, when it will not have a medical command physician available to provide medical command.

(10) Establish a plan to ensure that medical command is available at all times during mass casualty situations, natural disasters and declared states of emergency.

(11) Participate in the regional EMS council's quality improvement program for monitoring the delivery of EMS.

(12) Adopt procedures for maintaining medical command communication records and tapes under § 117.43 (relating to medical records), and maintain tapes of medical command communications for at least 180 days.

(13) Employ sufficient administrative support staff to enable the institution to carry out its essential duties which include, but are not limited to: audits, equipment maintenance and processing and responding to complaints.

(14) Establish a program of training for medical command physicians, prehospital personnel and emergency department staff.

(15) Provide medical command to prehospital personnel whenever they seek direction.

§ 1009.2. Recognition process.

(a) To qualify for the civil immunity protection afforded by section 11(j)(4) of the act (35 P. S. § 6931(j)(4)), a facility shall secure recognition as a medical command facility from the Department. To secure recognition as a medical command facility, a facility shall submit an application to the Department through a regional EMS council exercising responsibility for an EMS region in which the applicant intends to provide medical command through medical command physicians who function under its auspices. Application for medical command facility recognition shall be made on forms prescribed by the Department.

(b) The regional EMS council will review the application for completeness.

(c) If the application is complete, the regional EMS council shall conduct an onsite inspection of the applying facility to verify information contained within the application and to complete a physical inspection of the medical command area.

(d) After completing its review, the regional EMS council shall forward a copy of its recommendation to the Department and to the applying facility. If the applying facility disagrees with the recommendation of the regional EMS council, it may submit a written rebuttal to the Department.

(e) The Department will review the application, information and recommendation submitted by the regional EMS council, and the rebuttal statement, if any, submitted by the applying facility, and will make a decision within 60 days from the time of its receipt of the regional EMS council's recommendation to grant or deny recognition.

(f) The Department may review and inspect facilities to aid it in making medical command facility recognition decisions.

(g) If the applying facility disagrees with the decision by the Department, it may appeal the decision under 1 Pa. Code § 35.20 (relating to appeals from actions of the staff) if the decision was not issued by the agency head as defined in 1 Pa. Code § 31.3 (relating to definitions) and, if it disagrees with the decision of the agency head, it may file an appeal under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to Administrative Agency Law).

(h) Recognition as a medical command facility shall be valid for 3 years. A facility shall file an application for renewal of its recognition as a medical command facility 60 days prior to expiration of the medical command facility's recognition from the Department. Failure to apply for renewal of recognition in a timely manner may result in the facility having a lapse in the civil immunity protection afforded by section 11(j)(4) of the act.

§ 1009.3. (Reserved).

§ 1009.4. Withdrawal of medical command facility recognition.

(a) The Department may withdraw medical command facility recognition if the facility fails to continue to meet the standards for a medical command facility in § 1009.1 (relating to operational criteria).

(b) The Department will conduct inspections of a medical command facility from time to time, as deemed appropriate and necessary, including when necessary to investigate a complaint or a reasonable belief that violations of this part may exist.

(c) If the facility fails to continue to meet the standards for a medical command facility in § 1009.1, as an alternative to rescinding medical command facility recognition, the Department may request the facility to submit a plan of correction to correct the deficiencies. The procedures are as follows:

(1) The Department will give written notice to the facility and the regional EMS council of the deficiencies.

(2) The facility shall have 30 days in which to respond to the Department with a plan to correct the deficiencies.

(3) The Department will review the plan of correction and, if the plan is found to be acceptable, the Department may make an onsite reinspection in accordance with the time frame given in the plan of correction.

(4) Within 30 days after the review of the plan of correction, as well as 30 days after the reinspection, the Department will give written notice to the facility and the regional EMS council of the results of the Department's review of the plan of correction and reinspection.

(d) Upon receipt of a written complaint describing conduct for which the Department may withdraw medical command facility recognition, the Department will:

(1) Initiate an investigation of the specific charges.

(2) Provide the medical command facility with a copy of the complaint and request a response unless the Department determines that disclosure to the medical command facility of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the medical command facility if the medical command facility has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed under paragraph (3).

§ 1009.5. Review of medical command facilities.

The regional EMS councils shall conduct a review of medical command facilities as requested by the Department, and at other times may inspect medical command facilities. These reviews and inspections shall be conducted to audit for continued compliance with, at a minimum, the criteria in § 1009.1 (relating to operational criteria) as directed by the Department.

§ 1009.6. Discontinuation of service.

A medical command facility may not discontinue medical command operations without providing 90 days advance written notice to the Department, regional EMS councils responsible for regions in which the medical command facility routinely provides medical command and providers of EMS for which it routinely provides medical command.

CHAPTER 1011. ACCREDITATION OF EMS TRAINING INSTITUTES

§ 1011.1. EMS training institutes.

(a) *Eligible entity.* An EMS training institute shall be accredited by the Department. An EMS training institute

shall be a secondary or postsecondary institution, hospital, regional EMS council or another entity which meets the criteria in this part.

(b) *Training programs.*

(1) An EMS training institute that is accredited by the Department to offer BLS training courses (BLS training institute) shall evidence the ability to conduct one or more of the following training programs approved by the Department:

(i) Emergency Medical Technician Course.

(ii) EMS First Responder Course.

(2) An EMS training institute that is accredited by the Department to offer ALS training courses (ALS training institute) shall evidence the ability to conduct one or more of the following training programs approved by the Department:

(i) Emergency Medical Technician-Paramedic Course.

(ii) Prehospital Registered Nurse Course.

(c) *Medical director.*

(1) AN EMS training institute shall have a medical director who is a physician. The medical director shall be experienced in emergency medical care, and shall have demonstrated ability in education and administration.

(2) The responsibilities of the medical director shall include:

(i) Reviewing course content to ensure compliance with this part.

(ii) Reviewing and approving the EMS training institute's criteria for the recruitment, selection and orientation of training institute faculty.

(iii) Providing technical advice and assistance to the EMS training institute faculty and students.

(iv) Reviewing the quality and medical content of the education, and compliance with protocols.

(v) Participating in the review of new technology for training and education.

(3) Additional responsibilities for a medical director of an ALS training institute include:

(i) Approving the content of course written and practical skills examinations.

(ii) Identifying and approving facilities where students are to fulfill clinical and field internship requirements.

(iii) Identifying and approving individuals to serve as field and clinical preceptors to supervise and evaluate student performance when fulfilling clinical and field internship requirements.

(iv) Signing skill verification forms for students who demonstrate the knowledge and skills required for successful completion of the training course and entry level competency for the prehospital practitioner for which the training course is offered.

(d) *Administrative director.*

(1) A BLS training institute shall have an administrative director who has at least 1 year experience in administration and 1 year experience in prehospital care.

(2) An ALS training institute shall have an adminstrative director who has at least 1 year experience in administration and 1 year experience in ALS prehospital care.

(3) Responsibilities of the administrative director include ensuring:

(i) The adequacy of the system for processing student applications and the adequacy of the student selection process.

(ii) The adequacy of the process for the screening and selection of instructors for the EMS training institute.

(iii) The EMS training institute maintains an adequate inventory of necessary training equipment and that the training equipment is properly prepared and maintained.

(iv) The adequate administration of the course and written and practical skills examinations involved in the course.

(v) There is an adequate system for the maintenance of student records and files.

(vi) There is an appropriate mechanism to resolve disputes between students and faculty.

(e) *Course coordinator.*

(1) The EMS training institute shall designate a course coordinator for each training course conducted by the training institute.

(2) A course coordinator shall have:

(i) Reading and language skills commensurate with the resource materials to be utilized in the course.

(ii) Knowledge of the Statewide BLS medical treatment protocols.

(3) A course coordinator for an ALS training course shall also satisfy the following requirements:

(i) One year experience in directly providing ALS prehospital care as an EMT-paramedic or a health professional.

(ii) Have knowledge of the ALS transfer and medical treatment protocols for the region.

(4) A course coordinator is responsible for the management and supervision of each training course offered by the training institute for which that individual serves as a course coordinator.

(5) Specific duties of a course coordinator shall be assigned by the EMS training institute.

(6) One person may serve both as the administrative director and a course coordinator.

(f) *Instructors.*

(1) An EMS training institute shall ensure the availability of qualified and responsible instructors for each training course.

(2) An instructor shall be 18 years of age or older, and possess a high school diploma or GED equivalent.

(3) At least 75% of the instruction provided in training courses shall be provided by instructors who are health professional physicians or prehospital personnel and who have at least 1 year of experience as a health professional physician or a prehospital practitioner above the level of a first responder and at or above the level they are teaching, and have successfully completed an EMS instructor course approved by the Department or possess a bachelor's degree in education or a teacher's certification in education; or be determined by a review body of the training institute to meet or exceed these standards.

(4) An instructor who does not satisfy the requirements in paragraph (3) shall be qualified to provide the instructional services offered as determined by the training

institute after consulting the manual the Department prepares to provide guidance regarding instructor qualifications and with the appropriate regional EMS council.

(5) Instructors are responsible for presenting course materials in accordance with the curriculum established by this part.

(g) *Clinical preceptors.*

(1) An ALS training institute shall ensure the availability of clinical preceptors for each training course.

(2) A clinical preceptor is responsible for the supervision and evaluation of students while fulfilling clinical requirements for a training program.

(3) A BLS training institute shall ensure the availability of clinical preceptors for each training course that includes clinical activities outside of the classroom.

(h) *Field preceptors.*

(1) An ALS training institute shall ensure the availability of field preceptors for each student.

(2) A BLS training institute shall ensure the availability of a field preceptor for each student for whom it provides a field internship.

(3) A field preceptor is responsible for the supervision and evaluation of students while fulfilling a field internship for a training program.

(i) *Facilities and equipment.* An EMS training institute shall:

(1) Maintain educational facilities necessary for the provision of training courses. The facilities shall include classrooms and space for equipment storage, and shall be of sufficient size and quality to conduct didactic and practical skill performance sessions.

(2) Provide and maintain the essential equipment and supplies to administer the course. These shall be identified in the manual the Department develops to provide guidance regarding course administration.

(j) *Operating procedures.* An EMS training institute shall:

(1) Adopt and implement a nondiscrimination policy with respect to student selection and faculty recruitment.

(2) Maintain a file on each enrolled student which includes class performance, practical and written examination results, and reports made concerning the progress of the student during the training program.

(3) Provide a mechanism by which students may grieve decisions made by the institute regarding dismissal or other disciplinary action.

(4) Provide students with Department policies for testing leading to certification or recognition, the EMS training institute's policies for the prevention of sexual harassment, and a clear description of the program and its content, including learning goals, course objectives and competencies to be attained.

(5) Have a policy regarding the transfer of a student into or out of a training program from one EMS training institute to another.

(6) Have a continuing quality improvement process in place for students, instructors, and clinical evaluation.

(7) Require each student applicant to complete an application for enrollment and a criminal history disclosure form provided by the Department and, no later than 14 days after the first class session, forward a copy of both documents to the regional EMS council having responsibility in the EMS region where the EMS training institute operates.

(8) Prepare a course completion form for each student who successfully completes the training course and, no later than 14 days after the training course has concluded, forward that form to the regional EMS council having responsibility in the EMS region where the EMS training institute operates.

(9) Participate in EMS training institute system evaluation activities as requested by the Department.

§ 1011.2. (Reserved).

§ 1011.3. Accreditation process.

For an EMS training institute to be accredited by the Department, the following are required:

(1) The applicant shall submit an application for accreditation on forms developed by the Department to the regional EMS council having responsibility in the EMS region where the EMS training institute intends to conduct its primary operations. An applicant for reaccreditation shall submit the application at least 180 days, but not more than 1 year, prior to expiration of the current accreditation.

(2) The regional EMS council shall review the application for completeness and accuracy.

(3) The regional EMS council shall have 45 days in which to review the application and to conduct an onsite assessment of the institute.

(4) The regional EMS council shall forward to the Department the application for accreditation either with an endorsement or with an explanation as to why the application has not been endorsed.

(5) Within 150 days of receipt, the Department will review the application and make one of the following determinations:

(i) *Full accreditation.* The EMS training institute meets the criteria in § 1011.1 (relating to EMS training institutes) as applicable, and will be accredited to operate for 3 years.

(ii) *Conditional accreditation.* The EMS training institute does not meet criteria in § 1011.1 as applicable, but the deficiencies identified are deemed correctable by the Department. The EMS training institute will be allowed to proceed or continue to provide accredited EMS education with close observation by the Department. Deficiencies which prevent full accreditation shall be enumerated and corrected within a time period specified by the Department. Conditional accreditation may not exceed 1 year, and may not be renewed.

(iii) *Nonaccreditation.* The institute does not meet criteria in § 1011.1 and the deficiencies identified are deemed to be serious enough to preclude any type of accreditation.

(6) EMS training institutes that have received full or conditional accreditation shall submit status reports to the Department as requested.

(7) Prior to and during accreditation, EMS training institutes are subject to review, including inspection of records, facilities and equipment by the Department. An authorized representative of the Department may enter, visit and inspect an accredited EMS training institute or a facility operated by or in connection with the EMS training institute, with or without prior notification. The Department may accept the survey results of another

accrediting body if the Department determines that the accreditation standards of the other accrediting body are equal to or exceed the standards in this chapter, and that the survey process employed by the other accrediting body is adequate to gather the information necessary for the Department to make an accreditation decision.

(8) An EMS training institute shall advise the Department at least 90 days prior to an intended change of ownership, or control of the institute. Accreditation is not transferable to new owners or controlling parties.

(9) An EMS training institute that intends to conduct courses leading to initial certification or recognition, in an EMS region under the jurisdiction of a regional EMS council other than that through which it submitted its application for accreditation, shall file a written application to amend its accreditation with the regional EMS council having responsibility for the region in which it intends to conduct these courses. That application shall be processed by that regional EMS council and acted upon by the Department within 90 days.

§ 1011.4. Denial, restriction or withdrawal of accreditation.

(a) The Department may deny, withdraw or condition the accreditation of an EMS training institute for one or more of the following:

(1) Failure to maintain compliance with the applicable criteria in § 1011.1 (relating to EMS training institutes).

(2) An absence of students in the program for 2 consecutive years.

(b) Before denying or withdrawing accreditation, or granting conditional accreditation, the Department will give written notice to the institute's administrative director and the regional EMS council that the action is contemplated. The notice will identify reasons for the intended decision and will provide sufficient time for response.

(c) If an institute that applies for accreditation, or has its accreditation withdrawn or conditioned, disagrees with the decision of the Department, it may appeal the decision under 1 Pa. Code § 35.20 (relating to appeals from actions of the staff) if the decision was not issued by the agency head as defined in 1 Pa. Code § 31.3 (relating to definitions) and, if it disagrees with the decision of the agency head, it may file an appeal under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to Administrative Agency Law).

(d) Upon receipt of a written complaint describing conduct for which the Department may withdraw EMS training institute accreditation, the Department will:

(1) Initiate an investigation of the specific charges.

(2) Provide the EMS training institute with a copy of the complaint and request a response unless the Department determines that disclosure to the EMS training institute of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the EMS training institute if the training institute has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed under paragraph (3).

CHAPTER 1013. SPECIAL EVENT EMS

§ 1013.1. Special event EMS planning requirements.

(a) *Procedure for obtaining required plan approval.* A person, agency or organization responsible for the management and administration of special events may submit a plan for EMS to the Department, through the regional EMS council assigned responsibility for the region in which the special event is to occur, to secure a determination from the Department as to whether the plan is adequate to address the EMS needs presented by a special event or a series of special events conducted at the same location. The plan shall be submitted prior to the start of the special event or events.

(1) Persons, agencies or organizations, managing facilities or locations which are involved in special events who seek the Department's approval of an EMS plan for a special event or series of special events conducted at the same location, shall submit an annual plan to the appropriate regional EMS council at least 90 days prior to the date of the first scheduled event of each calendar year.

(2) The Department will approve or disapprove a special event EMS plan within 60 days after a complete plan is filed with the regional EMS council.

(b) *Plan content.* The special event EMS plan shall contain information including:

(1) The type and nature of event, location, length and anticipated attendance.

(2) Identification of sponsoring organization.

(3) The name and qualifications of the special event supervisory physician and the special event EMS director.

(4) Identification of the number and qualifications of emergency medical personnel who will be involved.

(5) The type and quantity of emergency medical vehicles, equipment and supplies to be utilized.

(6) A description of the onsite treatment facilities including maps of the special event site.

(7) The level of care to be provided BLS, ALS or both.

(8) Patient transfer protocols and agreements.

(9) A description of the special event emergency medical communications capabilities.

(10) Plans for educating event attendees regarding EMS system access, specific hazards or severe weather.

(11) Measures that have and will be taken to coordinate EMS for the special event or events with local emergency care services and public safety agencies—such as ambulance, police, fire, rescue, and hospital agencies or organizations.

(c) *Plan approval.* To secure Department approval of an EMS plan for a special event, the applicant shall satisfy the requirements of this chapter.

§ 1013.2. Administration, management and medical direction requirements.

(a) *Special event EMS director.* EMS provided at a special event shall be supervised by an individual identified as the special event EMS director.

(1) *Responsibilities.* The responsibilities of the special event EMS director include:

(i) The preparation of a plan under § 1013.1 (relating to special event EMS planning requirements).

(ii) Management of the delivery of special event EMS.

(iii) Ensuring implementation of the EMS coordination measures contained in the special event EMS plan.

(2) *Qualifications.* A special event EMS director shall be experienced in the administration and management of prehospital EMS at the BLS or ALS level, depending on the level of EMS provided at the special event.

(b) *Special event emergency supervisory physician.*

(1) *Requirement.* A special event EMS system shall be directed and supervised by a medical command physician for events involving more than 25,000 actual or anticipated participants or attendees, or both.

(2) *Qualifications.* A special event emergency supervisory physician shall possess the following qualifications:

(i) Experience in the medical direction and supervision of prehospital EMS at the BLS or ALS level, depending on the level of care provided at the special event.

(ii) Be licensed as a physician.

§ 1013.3. Special event EMS personnel and capability requirements.

(a) Special event emergency medical staff shall be certified at appropriate emergency care levels based on the level of EMS provided at the special event; that is, BLS, ALS, or both.

(b) One staffed and Pennsylvania licensed ambulance vehicle shall be stationed onsite of a special event with a known or estimated population of between 5,000 and 25,000 participants or attendees, or both.

(c) Two staffed and Pennsylvania licensed ambulance vehicles shall be stationed onsite of a special event with a known or estimated population greater than 25,000 but less than 55,000 participants or attendees, or both.

(d) Three staffed and Pennsylvania licensed ambulance vehicles shall be stationed onsite of any special event with a known or estimated population greater than 55,000 participants or attendees, or both.

(e) Sufficient personnel shall be available to assure the availability of BLS care to special event spectators or participants within 10 minutes of notification of need for emergency care. EMS personnel shall be currently certified at the ambulance attendant, first responder, EMT, EMT-paramedic or health professional level.

§ 1013.5. Onsite facility requirements.

A special event for which greater than 25,000 participants or spectators, or both, will be involved shall require the use of onsite treatment facilities. The onsite treatment facilities shall provide:

(1) Environmental control, providing protection from weather elements to insure patient safety and comfort.

(2) Sufficient beds, cots and equipment to provide for evaluation and treatment of at least four simultaneous patients.

(3) Adequate lighting and ventilation to allow for patient evaluation and treatment.

§ 1013.6. Communications system requirements.

A special event EMS system shall have onsite communications capabilities to insure:

(1) Uniform access to care for patients in need of EMS.

(2) Onsite coordination of the activities of EMS personnel.

(3) Communication with existing community PSAPs.

(4) Communication interface with other involved public safety agencies.

(5) Communication with receiving facilities.

(6) Communication with ambulances providing emergency transportation.

§ 1013.8. Special event report.

The person or organization that filed the special event EMS plan shall complete a special event report form prepared by the Department and provided to it by the relevant regional EMS council, and shall file the completed report with that regional EMS council within 30 days following a special event.

CHAPTER 1015. QUICK RESPONSE SERVICE RECOGNITION PROGRAM

§ 1015.1. Quick response service.

(a) *Criteria.* An applicant for recognition as a QRS shall file an application in which it shall commit to the following to receive Department recognition as a QRS:

(1) The applicant will maintain essential equipment and supplies for a QRS, as published by the Department at least annually in the *Pennsylvania Bulletin*, for immediate use when dispatched.

(2) The applicant has capabilities to be dispatched and to communicate with a responding ambulance service.

(3) EMS it provides will be performed by prehospital personnel or other persons authorized by law to perform the services.

(4) The applicant shall satisfy the requirements applicable to ambulance services in §§ 1001.41 and 1001.42 (relating to data and information requirements for ambulance services; and dissemination of information), for data elements included in an EMS patient care report which the Department designates for completion by a QRS.

(5) The applicant shall provide EMS in compliance with regional medical treatment protocols and the Statewide BLS medical treatment protocols.

(b) *Recognition process.*

(1) An applicant for Department recognition as a QRS shall submit an application on forms prescribed by the Department to the regional EMS council having jurisdiction over the area in which the applicant intends to locate. The application shall contain the following information:

(i) The name and address of the applicant.

(ii) The physical location of the applicant.

(iii) Service affiliations (police department, fire department, ambulance service, or other).

(iv) The service area.

(v) The types and number of vehicles it will employ, if any.

(vi) Communication access and capabilities of the applicant.

(vii) A roster of persons who have committed to serve as QRS members, and their qualifications.

(viii) A summary of how the QRS will interface with ambulance services.

(ix) Verification that the applicant will satisfy the requirements of subsection (a).

(x) A statement attesting to the veracity of the application, which shall be signed by the principal official of the applicant.

(2) The regional EMS council shall review the application for completeness and accuracy. It shall return an incomplete application to the applicant within 14 days of receipt.

(3) Upon receipt of a complete application, the regional EMS council shall conduct, within 45 days, an onsite inspection of the applicant to determine whether the applicant satisfies the regulatory criteria for QRS recognition. Deficiencies identified during the inspection shall be documented and made known to the applicant. A reinspection shall be scheduled when the applicant notifies the regional EMS council that the deficiencies have been corrected. The results shall be forwarded to the Department.

(c) *Recognition.*

(1) A certificate of recognition as a QRS will be issued by the Department when it has been determined that requirements for recognition have been met.

(2) The certificate of recognition will specify the name of the QRS, the date of issuance, the date of expiration, the regional EMS council through which the application was processed and the recognition number assigned by the Department.

(3) The QRS may identify a vehicle being utilized for response by applying to the outside of the vehicle a QRS decal issued by the Department

(4) The QRS decal issued by the Department may not be displayed on a vehicle not utilized for response by the QRS.

(5) A certificate of recognition is nontransferable and shall remain valid for 3 years unless withdrawn by the Department due to the QRS failing to continue to meet the standards for recognition as a QRS in subsection (a).

(d) *Renewal of recognition.* A QRS may continue to participate in the Quick Response Service Recognition Program by resubmitting an application in a format prescribed by the Department to the appropriate regional EMS council at least 60 days prior to the expiration date of its certificate of recognition.

§ 1015.2. Discontinuation of service.

A QRS may not discontinue service, except upon order of the Department, without providing each regional EMS council and the chief executive officer of each political subdivision within its service area 90 days advance notice. The QRS shall also advertise notice of its intent to discontinue service in a newspaper of general circulation in its service area at least 90 days in advance of discontinuing service, and shall provide the Department with written notice that it has met these responsibilities at least 90 days in advance of discontinuing service.

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