



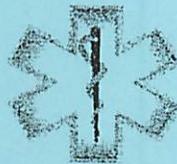
New York State Department of Health

Bureau of Emergency Medical Services

Pre-Hospital Care Provider

Student Reference Guide

**New York State's
Emergency Medical Services**



People Who Care

Table of Contents

Section One

- Introduction
- Bureau of Emergency Medical Services
- State Emergency Medical Services Council (SEMSCO)
- State Emergency Medical Advisory Committee (SEMAC)
- Regional Emergency Medical Services Council (REMSCO)
- Regional Emergency Medical Advisory Committee (REMAC)
- Emergency Medical Services Program Agencies
- Role of the EMS Course Sponsor in the EMS System
- Description of the EMS Course Sponsor
- Role of the Certified First Responder (CFR)
- Role of the Emergency Medical Technician-Basic (EMT-B)

Section Two

- Functional Job Description for CFR
- Functional Job Description for EMT-B
- NYS DOH Policy Statement 00-09
- NYS DOH Policy Statement 00-10

Section Three

- General Requirements for Certification
- Requirements for CFR Certification
- Requirements for EMT-B Certification
- NYS DOH Policy Statement 00-12

Section Four

- Guide for the New York State Written Certification Examination

Section Five

- Curriculum Objectives for CFR
- Curriculum Objectives for EMT-B

Section Six

- Practical Skills Practice Guides
- Clinical Rotation Guide

Section Seven

- New York State Pre-Hospital Care Report (PCR)

Section Eight

- Continuing Quality Improvement

Section Nine

Recommendations for Decontamination and Cleaning of Emergency Service Vehicles
Recommendations for Body Substance Isolation (BSI)
Recommendations for Prevention of Latex Allergy
10 NYCRR Part 63 – HIV/Aids Testing, Reporting and Confidentiality of HIV-Related Information
OSHA Standard 29 CFR 1910.1030 – Bloodborne Pathogens

Section 10

Governor’s Executive Order Number 26
Introduction to the Incident Command System (ICS)

Section 11

Public Health Law Article 30 and 30A

Section 12

10 NYCRR Part 800 – Emergency Medical Services Code

Section 13

NYS DOH Policy Statement 00-13
Section of NYS Vehicle and Traffic Law Pertaining to Emergency Vehicle Operation

Section 14

Department of Health Memorandum 92-32 – Regarding Orders Not to Resuscitate (DNR)
Pertinent Sections from Public Health Law Article 29-B
DOH Policy Statement 99-10

Section 15

Active NYS DOH Bureau of Emergency Medical Services Policy Statements

Section 16

Contact Information
Bureau of Emergency Medical Services
REMSCO’s
EMS Program Agencies
Trauma Centers
Poison Control Centers

Section 17

County EMS Coordinators
County Fire Coordinators
Department of State – Office of Fire Prevention and Control (OFPC)
State Emergency Management Office (SEMO)
Federal Emergency Management Agency (FEMA)
Occupational Safety and Health Administration (OSHA)
U.S. Health and Human Services Administration – Center for Disease Control (CDC)

Section 18

Pediatric Emergency Care Reference Card

Section One

Introduction

Bureau of Emergency Medical Services

State Emergency Medical Services Council (SEMSCO)

State Emergency Medical Advisory Committee (SEMAC)

Regional Emergency Medical Services Council (REMSCO)

Regional Emergency Medical Advisory Committee (REMAC)

Emergency Medical Services Program Agencies

Role of the EMS Course Sponsor in the EMS System

Description of the EMS Course Sponsor

Role of the Certified First Responder (CFR)

Role of the Emergency Medical Technician-Basic (EMT-B)



New York State Department of Health Bureau of Emergency Medical Services

Pre-Hospital Care Provider Student Manual

Welcome to New York State's Emergency Medical Services System. This manual is intended to assist you in the certification process as a Pre-Hospital Care Provider in New York State. The manual is designed in modular form to serve all levels of providers and as a constant reference guide to use throughout your career as a Pre-Hospital Care Provider in New York State.

The first module will address the Certified First Responder (CFR), and the Emergency Medical Technician – Basic (EMT-B). Later publications will include modules for Advanced Emergency Technician (AEMT) levels, and the Emergency Medical Technician – Paramedic (EMT-P). Add these modules to this manual as you progress in your career.

A listing of classroom and practical skill objectives one must reach to become eligible for certification as a CFR or EMT-B are included in the manual. The New York State Practical Skills and Written Certification Examinations are based on these objectives. In your first class you should receive additional material from your Certified Instructor Coordinator (CIC) with regard to policies and procedures specific to your course and the course sponsor. Please use this as a study aid during your training program and as a reference source during your EMS career.

In addition to the course objectives and skill practice sheets the manual includes:

- ◆ Articles 30 and 30a of the Public Health Law
- ◆ Part 800 of Title 10 New York Codes Rules and Regulations the Emergency Medical Services Code
- ◆ Excerpts from the New York State Vehicle and Traffic Law as it applies to Emergency Medical Services operation.

The manual also contains Functional Job Descriptions that provide information about the duties and expectations of the CFR and EMT-B. Included as well is a variety of information that will be helpful to you in the certification process and throughout your career.

You are encouraged to work closely with your CIC to ensure that you understand all of the course objectives and have practiced the required skills. It is important that you record in this manual your Course Number, Student ID Number and Examination Date. This information will be necessary if you need to contact the Bureau of EMS. If you have questions or if we may be of assistance, please contact your New York State EMS Area Office Representative. A listing of the area offices and the representatives is provided in this manual.

We at the Bureau of EMS wish you success in this endeavor and hope you have a rewarding career as a Pre-Hospital Emergency Medical Care Provider.



New York State Department of Health Bureau of Emergency Medical Services

The Bureau of Emergency Medical Services (EMS), part of the New York State Department of Health (DOH) is charged with oversight of the EMS system statewide. The Bureau works closely with various EMS councils and their committees to assure appropriate training and education of EMS providers, as well as quality Pre-Hospital Emergency Medical Care. The Bureau is staff to the State Emergency Medical Services Council (SEMSCO) and the State Emergency Medical Advisory Committee (SEMAC); both committees are charged with making recommendations to the DOH on the design of the New York State EMS system.

State Emergency Medical Services Council

SEMSCO is an advisory body to the Commissioner of Health in areas of concern involving EMS. SEMSCO's charge and statutory authority can be found in Article 30 Section 3002 of the Public Health Law.

The Bureau provides staff and financial assistance to SEMSCO. SEMSCO assists the DOH in providing leadership and developing rules, regulations and general guidelines for operation of the state's EMS system. SEMSCO holds public meetings six times a year. Its membership is comprised of a representative from each of the regional EMS councils, and representatives from various organizations and interests in the EMS community. The Commissioner of Health appoints all council members.

There are several subcommittees of SEMSCO. Each subcommittee has a defined purpose and brings motions to SEMSCO for action. The subcommittees are the structural underpinnings of SEMSCO. The committees research issues in their areas of concern that come before SEMSCO, and make recommendations to SEMSCO on how to proceed. The major subcommittees are as follows:

The ***Finance*** subcommittee prepares budget recommendations for the state EMS system for adoption by SEMSCO and submission to the Commissioner of Health.

The ***Education and Training*** subcommittee addresses issues involving certification and recertification of EMS providers including the certification exam issues. The subcommittee reviews course objectives, curricula, conduct, clinical requirements and scope of practice for all EMS providers.

The ***EMS Systems*** subcommittee addresses the issues of system development throughout the state. This includes need determination through the Certificate of Need (CON) process. This committee also uses the parameters established in Title 10 of the New York Codes, Rules and Regulations (10NYCRR) Part 800 and General Municipal Law to evaluate Mutual Aid agreements, liability for EMS agencies and on-scene coordination and communication between multi-jurisdictional agencies.

The ***Quality Improvement (QI)*** subcommittee reviews the state EMS system and each of its components. This review looks at strengths and weaknesses in each area and makes recommendations for improvement. One example of this process is creating generic QI guidelines for use throughout the state.

The ***Legislative*** subcommittee reviews pending federal and state legislation and evaluates how it may affect EMS in New York State.

The *Public Information, Education and Relations* subcommittee addresses issues of public awareness of EMS. One of the main functions of this subcommittee is to coordinate NYS-EMS awards of excellence presented by SEMSCO at the annual conference. Award recipients are recognized for clinical, educational and administrative excellence. This subcommittee also is charged with presenting concepts for public awareness programs to SEMSCO for action.

State Emergency Medical Advisory Committee (SEMAC)

SEMAC is a committee of SEMSCO. The charge and authority of the SEMAC can be found in Article 30 Section 3002-a of the Public Health Law. SEMAC is comprised of voting physician members from the Regional Emergency Medical Advisory Committees (REMAC) and others with demonstrated knowledge and experience in emergency medical services.

SEMAC is responsible for recommending to SEMSCO minimum statewide standards for medical control, treatment, triage and transportation. This committee also develops statewide standards for use of regulated medical equipment and medications by certified EMS providers. The SEMAC has the authority to issue advisory guidelines relating to any of these mentioned areas with the consent of the Commissioner of Health.

SEMAC has two working subcommittees that assist in accomplishing the SEMAC tasks.

The *Protocol* subcommittee addresses the issues of treatment, triage and transportation standards for protocol development. It reviews regional protocols for compatibility with the established statewide guidelines. This committee also develops and maintains the statewide Basic and Advanced Life Support protocols. The protocol committee works closely with the medical standards committee.

The *Quality Improvement* subcommittee assists SEMSCO and the Bureau of EMS in developing quality improvement evaluation tools for the EMS system. Part of this process includes developing ways to utilize data collected by the DOH from the Pre-Hospital Care Reporting System (PCR) to generate reports used in quality improvement programs.

Regional Emergency Medical Services Council (REMSCO)

The charge and authority of REMSCO can be found in Article 30 Section 3003 of the Public Health Law. Each REMSCO is comprised of representatives from local ambulance services, physicians, nurses, hospitals and other EMS organizations. The county EMS Coordinator serves as an ex-officio member of REMSCO.

The primary function of the REMSCO is to encourage and facilitate regional cooperation and organization of local EMS systems. The REMSCO is the local provider's direct link to SEMSCO and the Bureau of EMS.

Regional Medical Advisory Committee (REMAC)

REMAC charge and authority can be found in Article 30 Section 3004-a of the Public Health Law. REMAC is comprised of five or more physicians, representatives from REMSCO(S) they serve, hospitals, basic and advanced life support providers.

REMAC's role is to facilitate local medical direction, and guide the development of regional EMS systems. REMAC is a committee of REMSCO but may represent more than one REMSCO with a local agreement to do so. REMAC has the authority to develop policies and procedures; develop triage, treatment and transportation protocol, consistent with those of SEMAC; and address specific local issues.

Emergency Medical Service Program Agencies

The role of the EMS program agency can be found in Article 30 Section 3003-a of the Public Health Law. DOH funds these agencies to assist the REMSCOs and the DOH in developing regional EMS systems. These organizations have no statutory authority and were created to provide professional and clerical staff to implement and support the REMSCOs and REMACs and provide day to day continuity to the evolution of the regional EMS systems. A major role of the EMS Program Agency is the collection and review of Prehospital Care Report (PCR) data and use of this data in regional QI programs.

Job Description - Certified First Responder

Responsibilities:

Certified First Responders (CFR) may function in the context of a broader role, i.e., law enforcement, fire rescue or industrial response. With a limited amount of equipment, the CFR answers emergency calls to provide efficient and immediate care to ill and injured patients. After receiving notification of an emergency, the CFR safely responds to the address or location given, using the most expeditious route, depending on traffic and weather conditions. The CFR must observe traffic ordinances and regulations concerning emergency vehicle operation. The CFR:

- ◆ functions in uncommon situations;
- ◆ has a basic understanding of stress response and methods to ensure personal well-being;
- ◆ has an understanding of body substance isolation;
- ◆ understands basic medical-legal principles;
- ◆ functions within the scope of care as defined by state, regional and local regulatory agencies;
- ◆ complies with regulations on the handling of the deceased, protection of property and evidence at the scene, while awaiting additional EMS resources.

Before initiating patient care, the CFR will "size-up" the scene to determine if the scene is safe, to identify the mechanism of injury or nature of illness, the total number of patients and to request additional help, if necessary. In the absence of law enforcement, the CFR creates a safe traffic environment, such as the placement of road flares, removal of debris and redirection of traffic for the protection of the injured and those assisting in the care of injured patients. Using a limited amount of equipment, the CFR renders emergency medical care to adults, children and infants based on assessment findings. Duties include but are not limited to:

- ◆ opening and maintaining an airway;
- ◆ ventilating patients;
- ◆ administering cardiopulmonary resuscitation;
- ◆ providing emergency medical care of simple and multiple system trauma such as:
 - ◆ controlling hemorrhage,
 - ◆ bandaging wounds,
 - ◆ manually stabilizing injured extremities.
- ◆ providing emergency medical care to:
 - ◆ assist in childbirth
 - ◆ manage general medical complaints, altered mental status, seizures, environmental emergencies, behavioral emergencies and psychological crises.
- ◆ searching for medical identification emblems as a guide to appropriate emergency medical care.
- ◆ reassuring patients and bystanders by working in a confident, efficient manner.
- ◆ Avoiding mishandling and undue haste while working expeditiously to accomplish the task.

Where a patient must be extricated from entrapment, the CFR:

- ◆ assesses the extent of injury and assists other EMS providers rendering emergency medical care and protection to the entrapped patient
- ◆ performs emergency moves and assists other EMS providers in the use of prescribed techniques and appliances for safely removing the patient
- ◆ assists other EMS providers, in lifting the stretcher, placing the stretcher in the ambulance, and seeing that the patient and stretcher are secured
- ◆ if needed, radios the dispatcher for additional help or special rescue and/or utility services
- ◆ in case of multiple patients, performs basic triage.
- ◆ reports directly to the responding EMS unit, emergency department or the communications center the nature and extent of injuries, the number of patients, and the condition of each patient.
- ◆ identifies assessment findings that may require communicating with medical control for advice.
- ◆ constantly assesses patient and administers additional care while awaiting additional EMS resources and while enroute to the emergency facility.

For purposes of records and diagnostics the CFR reports verbally and in writing, observations and emergency medical care of the patient at the emergency scene and in transit, to the responding EMS unit or the receiving medical facility staff. Upon request, the CFR provides assistance to the transporting unit staff or the receiving medical facility staff.

After each call, the CFR:

- ◆ restocks and replaces used supplies,
- ◆ cleans all equipment following appropriate disinfecting procedures,
- ◆ carefully checks all equipment to ensure the availability for the next response
- ◆ maintains emergency vehicle in efficient operating condition
- ◆ ensures that the emergency vehicle is clean and washed and kept in a neat orderly condition
- ◆ in accordance with local, state or federal regulations, decontaminates the interior of any vehicle used to transport patients after transport of a patient with contagious infection or hazardous materials exposure.

Additionally the CFR:

- ◆ determines that the emergency vehicle is in proper mechanical condition by checking items required by service management
- ◆ maintains familiarity with specialized equipment used by the service
- ◆ attends continuing education and refresher education programs as required by employers, medical control and licensing or certifying agencies.

Job Description - Emergency Medical Technician - Basic

Responsibilities:

Emergency Medical Technicians-Basic (EMT-B) respond to emergency calls to provide efficient and immediate care to the critically ill and injured, and to transport the patient to a medical facility. After receiving the call from the dispatcher, the EMT-B drives the ambulance to address or location given, using the most expeditious route, depending on traffic and weather conditions. The EMT-B must observe traffic ordinances and regulations concerning emergency vehicle operation.

The EMT-B:

- ◆ functions in uncommon situations;
- ◆ has a basic understanding of stress response and methods to ensure personal well-being;
- ◆ has an understanding of body substance isolation;
- ◆ understands basic medical-legal principles;
- ◆ functions within the scope of care as defined by state, regional and local regulatory agencies;
- ◆ complies with regulations on the handling of the deceased, notifies authorities and arranges for protection of property and evidence at the scene.

Upon arrival at the scene of crash or illness, the EMT-B parks the ambulance in a safe location to avoid additional injury. Prior to initiating patient care, the EMT-B will also "size-up" the scene to determine: that the scene is safe; the mechanism of injury or nature of illness; the total number of patients; and to request additional help, if necessary. In the absence of law enforcement, the EMT-B creates a safe traffic environment, such as the placement of road flares, removal of debris and redirection of traffic for the protection of the injured and those assisting in the care of injured patients. The EMT-B determines the nature and extent of illness or injury and establishes priority for required emergency care. The EMT-B renders emergency medical and or trauma care, to adults, children and infants based on assessment findings. Duties include but are not limited to:

- ◆ opening and maintaining an airway;
- ◆ ventilating patients;
- ◆ administering cardiopulmonary resuscitation, including use of automated external defibrillators;
- ◆ providing prehospital emergency medical care of simple and multiple system trauma such as:
 - controlling hemorrhage,
 - treatment of shock (hypoperfusion),
 - bandaging wounds,
 - immobilization of painful, swollen, or deformed extremities,
 - immobilization of painful, swollen, or deformed neck or spine;
- providing emergency medical care to:
 - assist in emergency childbirth,
 - manage general medical complaints of altered mental status, respiratory, cardiac, diabetic, allergic reaction, seizures, poisoning behavioral emergencies, environmental emergencies, and psychological crises. Additional care is provided based upon assessment of the patient and obtaining historical information.
- searching for medical identification emblems as a guide to appropriate emergency medical care.
- assisting patients with prescribed medications, including sublingual nitroglycerin, epinephrine auto-injectors and hand-held aerosol inhalers.
- administration of oxygen, oral glucose and activated charcoal.
- reassuring patients and bystanders by working in a confident, efficient manner.
- avoiding mishandling and undue haste while working expeditiously to accomplish the task.

Where a patient must be extricated from entrapment, the EMT-B assesses the extent of injury and gives all possible emergency care and protection to the entrapped patient and uses the prescribed techniques and appliances for safely removing the patient. If needed, the EMT-B radios the dispatcher for additional help or special rescue and/or utility services. Provides simple rescue service if the ambulance has not been accompanied by a specialized unit. After extrication, provides additional care in triaging the injured in accordance with standard emergency procedures.

The EMT-B is responsible for:

- ◆ lifting the stretcher (be able to lift and carry 125 pounds),
- ◆ placing it in the ambulance and seeing that the patient and stretcher are secured
- ◆ continuing emergency medical care while enroute to the medical facility.

The EMT-B uses the knowledge of the condition of the patient and the extent of injuries and the relative locations and staffing of emergency hospital facilities to determine the most appropriate facility to which the patient will be transported, unless otherwise directed by medical direction. The EMT-B reports directly to the emergency department or communications center the nature and extent of injuries, the number being transported and the destination to assure prompt medical care on arrival. The EMT-B identifies assessment findings, which may require communications with medical control, for advise and for notification that special professional services and assistance be immediately available upon arrival at the medical facility.

The EMT-B:

- ◆ constantly assesses the patient enroute to the emergency facility, administers additional care as indicated or directed by medical control,
- ◆ assists in lifting and carrying the patient out of the ambulance and into the receiving medical facility
- ◆ reports verbally and in writing, their observation and emergency medical care of the patient at the emergency scene and in transit, to the receiving medical facility staff for purposes of records and diagnostics
- ◆ upon request provides assistance to the receiving medical facility staff.

After each call, the EMT-B:

- ◆ restocks and replaces used linens, blankets and other supplies,
- ◆ cleans all equipment following appropriate disinfecting procedures,
- ◆ makes careful check of all equipment so that the ambulance is ready for the next run
- ◆ maintains ambulance in efficient operating condition
- ◆ ensures that the ambulance is clean and washed and kept in a neat orderly condition
- ◆ in accordance with local, state or federal regulations, decontaminates the interior of the vehicle after transport of patient with contagious infection or hazardous materials exposure.

Additionally the EMT-B:

- ◆ determines that vehicle is in proper mechanical condition by checking items required by service management. Maintains familiarity with specialized equipment used by the service
- ◆ attends continuing education and refresher training programs as required by employers, medical control, licensing or certifying agencies.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: Policy Statement 93-01

No. 00-09

Date: 09/25/00

Re: Certified First Responder

Page 1 of 2

**Functional Position Description
Certified First responder (CFR)**

Purpose:

Provide a guide for anyone who is interested in understanding what qualifications, competencies and tasks are expected of the CFR.

Qualifications:

- Complete the *Application for Emergency Medical Services Certification* (DOH-65), including affirmation regarding criminal convictions
- Successfully complete an approved New York State CFR course
- Achieve a passing score on the practical and written certification examinations
- Must be at least 16 years of age prior to the last day of the month in which they are scheduled to take the written certification examination
- Knowledge and Skills required show a need for high school or equivalent education
- Ability to communicate effectively via telephone and radio equipment
- Ability to lift, carry and balance up to 125 pounds (250 pounds with assistance)
- Ability to interpret oral, written and diagnostic form instructions
- Ability to use good judgement and remain calm in high stress situations
- Ability to be unaffected by loud noises and flashing lights
- Ability to function efficiently without interruption throughout an entire work shift
- Ability to read English language, manuals and road maps
- Ability to accurately discern street signs and addresses
- Ability to interview patients, patient family members and bystanders
- Ability to document, in writing, all relevant information in prescribed format in light of legal ramifications of such
- Ability to converse in English with coworkers and hospital staff with regard to the status of the patient
- Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care
- Ability to bend, stoop and crawl on uneven terrain
- Ability to withstand varied environmental conditions such as extreme heat, cold and moisture
- Ability to work in low light situations and confined spaces
- Ability to work with other providers to make appropriate patient care decisions

Competency Areas:

- Patient Assessment
- Use of Basic Life Support Equipment within the scope of practice for the CFR
- Ability to perform Cardio-Pulmonary Resuscitation (CPR)
- Control Bleeding
- Provide non-invasive treatment for hypoperfusion
- Manage environmental emergencies
- Provide initial care in medical and trauma emergencies, and emergency childbirth

Description of Tasks:

Responds to calls when dispatched. Reads maps, may drive emergency response vehicle to emergency site using most expeditious route permitted by weather and road conditions. Observes all traffic ordinances and regulations.

Uses appropriate body substance isolation procedures. Assesses the safety of the scene, gains access to the patient, assesses extent of injury or illness. Communicates with dispatcher requesting additional assistance or services as necessary. Determines nature of illness or injury. Visually inspects for medical identification emblems to aid in care (medical bracelet, charm, etc.) Uses prescribed techniques and equipment to provide patient care. Provides additional emergency care following established protocols. Assess and monitor vital signs and general appearance of patient for change. Makes determination regarding patient status and priority for emergency care using established criteria. Reassures patient, family members and bystanders. Avoids mishandling patient and undue haste. Reports verbally and in writing, information gathered about patient's emergency and care rendered to EMT or AEMT in charge of ambulance crew on scene. Assists with lifting, carrying and properly loading patient into the ambulance.

Complies with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.

Replaces supplies, properly disposes of medical waste. Properly cleans contaminated equipment according to established guidelines. Checks all equipment for future readiness. Maintains emergency vehicle in operable condition. Ensures cleanliness and organization of emergency response vehicle, its equipment and supplies. Determines vehicle readiness by checking operator maintainable fluids, fuel and air pressure levels. Maintains familiarity with all specialized equipment.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: Policy Statement 92-04

No. 00-10

Date: 09/25/00

Re: EMT-B / AEMT

Page 1 of 3

**Functional Position Description
Emergency Medical Technician – Basic (EMT-B)
Advanced Emergency Medical Technician (AEMT)**

Purpose:

Provide a guide for those who are interested in understanding what qualifications, competencies and tasks are expected of the EMT-B and/or the AEMT.

Qualifications:

- Complete the *Application for Emergency Medical Services Certification* (DOH-65), including affirmation regarding criminal convictions
- Successfully complete an approved New York State EMT-B or AEMT course
- Achieve a passing score on the practical and written certification examinations
- Must be at least 18 years of age prior to the last day of the month in which they are scheduled to take the written certification examination
- Knowledge and Skills required show need for high school or equivalent education
- Ability to communicate effectively via telephone and radio equipment
- Ability to lift, carry and balance up to 125 pounds (250 pounds with assistance)
- Ability to interpret oral, written and diagnostic form instructions
- Ability to use good judgement and remain calm in high stress situations
- Ability to be unaffected by loud noises and flashing lights
- Ability to function efficiently without interruption throughout an entire work shift
- Ability to calculate weight and volume ratios
- Ability to read English language, manuals and road maps
- Ability to accurately discern street signs and addresses
- Ability to interview patients, patient family members and bystanders
- Ability to document, in writing, all relevant information in prescribed format in light of legal ramifications of such
- Ability to converse, in English, with coworkers and hospital staff with regard to the status of the patient
- Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care
- Ability to bend, stoop and crawl on uneven terrain
- Ability to withstand varied environmental conditions such as extreme heat, cold and moisture
- Ability to work in low light situations and confined spaces
- Ability to work with other providers to make appropriate patient care decisions

Competency Areas:

The EMT-B

Must demonstrate competency in assessment of a patient, handling emergencies using Basic Life Support equipment and techniques. Must be able to perform CPR, control bleeding, provide non-invasive treatment of hypoperfusion, stabilize / immobilize injured bones and the spine, manage environmental emergencies and emergency childbirth. Must be able to use a semi-automatic defibrillator. Must be able to assist patients with self-administration or administer emergency medications as described in state and local protocol.

The AEMT-Intermediate

Must demonstrate competency in all EMT-B skills and equipment usage. Must be able to provide Advanced Life Support using intravenous therapy, defibrillator and advanced airway adjuncts to control the airway in cases of respiratory and cardiac arrest.

The AEMT-Critical Care

Must demonstrate competency in all EMT-B skills and equipment usage. Must be able to provide Advanced Life Support using the AEMT-Intermediate skills and equipment. Must be able to administer appropriate medications.

The EMT-Paramedic

Must be capable of utilizing all EMT-B and AEMT-intermediate skills and equipment. Must be able to perform under Advanced cardiac Life Support (ACLS) and Basic Trauma Life Support (BTLS) standards. Must be knowledgeable and competent in the use of a cardiac monitor/defibrillator and intravenous drugs and fluids. The EMT-Paramedic has reached the highest level of pre-hospital care certification.

Description of Tasks:

Responds to calls when dispatched. Reads maps, may drive ambulance to emergency site using most expeditious route permitted by weather and road conditions. Observes all traffic ordinances and regulations.

Uses appropriate body substance isolation procedures. Assesses the safety of the scene, gains access to the patient, assesses extent of injury or illness. Extricates patient from entrapment. Communicates with dispatcher requesting additional assistance or services as necessary. Determines nature of illness or injury. Visually inspects for medical identification emblems to aid in care (medical bracelet, charm, etc.) Uses prescribed techniques and equipment to provide patient care. Provides additional emergency care following established protocols. Assesses and monitors vital signs and general appearance of patient for change. Makes determination regarding patient status and priority for emergency care using established criteria. Reassures patient, family members and bystanders.

Assists with lifting, carrying and properly loading patient into the ambulance. Avoids mishandling patient and undue haste. Determines appropriate medical facility to which patient will be transported. Transports patient to medical facility providing ongoing medical care as necessary enroute. Reports nature of injury or illness to receiving facility. Asks for medical direction from medical control physician and carries

out medical control orders as appropriate. Assists in moving patient from ambulance into medical facility. Reports verbally and in writing observations of the patient's emergency and care provided (including written report(s) and care provided by Certified First Responders prior to EMT-B/AEMT arrival on scene) to emergency department staff and assists staff as required.

Complies with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.

Replaces supplies, properly disposes of medical waste. Properly cleans contaminated equipment according to established guidelines. Checks all equipment for future readiness. Maintains ambulance in operable condition. Ensures cleanliness and organization of ambulance, its equipment and supplies. Determines vehicle readiness by checking operator maintainable fluid, fuel and air pressure levels. Maintains familiarity with all specialized equipment.

General Requirements for Certification

To qualify for certification as a New York State Certified First Responder (CFR) or Emergency Medical Technician-Basic (EMT-B), the applicant must meet the following requirements:

- ◆ enroll in an original CFR or EMT-B course;
- ◆ complete an *Application for Emergency Medical Services Certification (DOH-65)*, with the applicant's original signature in ink;
- ◆ for CFR, be at least 16 years of age prior to the last day of the month in which he/she is scheduled to take the written certification exam; for EMT-B, be at least 18 years of age prior to the last day of the month he/she is scheduled to take the written certification exam;
- ◆ satisfactorily complete all requirements of a New York State approved course in CFR *or* EMT-B given by a New York State approved course sponsor;
- ◆ after successful completion of all course requirements, but within one year after course completion, pass the New York State practical skills examination;
- ◆ within one year of passing the state practical skills examination, pass the New York State written certification examination;
- ◆ have no convictions for a crime or crimes related to murder, manslaughter, assault, sexual abuse, larceny (theft), robbery, drug abuse, sale of drugs or currently be under charges for such a crime, unless the DOH finds that such conviction or charges do not demonstrate a present risk or danger to patients.

What Happens the First Night of Class

- ◆ You will be asked to complete the Application for Emergency Medical Services Certification (DOH-65).
- ◆ You will receive, and the CIC should review, the course policies and procedures which will address at least the following:
 - course goals and objectives
 - attendance requirements and make-up procedure
 - testing requirements (practical and written) and the pass/fail criteria
 - re-test policies
 - requirements regarding personal conduct and ethics
 - class cancellation procedure
 - course termination/expulsion and appeal procedure
 - required textbooks
 - tuition refund schedule (if applicable)
 - for refresher courses, a learning contract between the student and the course sponsor
 - requirements for clinical and/or internship hours
 - statement regarding Americans with Disabilities

You should receive a class schedule listing the time, date and topic for each class session and a schedule for reading assignments.

Requirements for Becoming Certified as a New York State Certified First Responder

Complete General Requirements for Certification.

Complete all course requirements, including but not limited to:

- Acceptable attendance during the course.
- Successfully pass the CPR training portion of the course.
- Maintain the minimum grade average required by the Course Sponsor.
- Successfully pass all skill evaluations.
- Complete all required clinical and/or internship hours prior to the NYS Practical Skills Examination.
- Successfully pass the NYS Practical Skills Examination.
- Successfully pass the NYS Written Examination.

NYS Practical Skills Examination

The purpose of the practical examinations is to assess basic entry level skill competency prior to being admitted to the written certification examination. During the course you will develop proficiency in all of the skills contained in the course learning objectives. The practical examination will test only selected skills.

Prerequisites for Admission - In order to be admitted to the practical examination, students must successfully complete all course requirements to the satisfaction of the course sponsor and as specified in the course policies and procedures.

Certification Examination and re-test sequence - The NYS Practical Skills Examination **must precede the written examination**. The practical examination and scheduled re-test date should precede the NYS Written Examination by at least seven days.

Americans with Disabilities Act (ADA) - For the State Final Practical Skills Examination, the NYS Bureau of EMS does not permit testing accommodations, but will consider the use of certain aids by the candidate. Candidates with an identified disability may be permitted to use certain aids, which they would be responsible to provide and reasonably be able to bring to the patient's side in actual practice. The only types of aids permitted are those that do not alter the essential functions of a CFR or EMT. For example the use of prescription or reading glasses, hearing aids and personal stethoscopes have been permitted since they serve as an aid to the provider. In contrast, a Braille sphygmomanometer would not be permitted since sight is considered an essential function of the certified EMS provider. If you have questions or need further assistance with ADA issues, please contact the NYS Bureau of EMS at (518) 402-0996.

Use of personal equipment - Candidates may use their personal pocket mask and stethoscopes for the practical examination. Candidates may not bring or use equipment for the examination unless it is equipment that has been used during the course or unless special arrangements have been made with the CIC and exam coordinator. This must be done in advance of the exam date.

Required testing stations for CFR - the following skills were identified as being the minimum number of performance items that should be included in every CFR practical examination:

Mandatory Skills

- Station 1 - Patient Assessment Management - Trauma
- Station 2 - Patient Assessment Management - Medical
- Station 3 - Bag-Valve-Mask: Apneic Patient

Random Skills

- Station 4 - Spinal Immobilization – Supine Patient
- Station 5A - Long Bone Injury
- Station 5B - Joint Injury
- Station 5C - Bleeding Control / Management of Hypoperfusion
- Station 5D - Upper Airway Adjuncts and Suction
- Station 5E - Mouth-to-Mask with Supplemental Oxygen
- Station 5F - Supplemental Oxygen Administration

The CFR student must successfully pass four stations -- **mandatory stations #1 through #3 and one random skill station**. The mandatory and random skill stations consist of both skill-based and scenario-based testing. The random skill station is conducted so the student is totally unaware if the skill to be tested until he/she arrives at the test station.

Testing/Re-testing Policies

CFR candidates who fail **two skill stations or less** on the practical exam may be re-tested on those skills. **Three or more failed stations** constitute a failure of the practical examination and the candidate must complete a refresher course prior to being re-tested.

- Those failing two stations or fewer are eligible to take two re-tests. The *first re-test* may occur on the same day as the initial exam. Failure of a same-day re-test entitles the student to a second re-test on those skills failed.
 - The *second re-test* **must** be conducted on **another date** and the candidate must be provided with **remedial instruction**. Failure of the *second re-test* constitutes a failure of the examination and a refresher course must be completed prior to any re-testing.
 - A different examiner should administer re-tests.
 - When a station is failed, the candidate must re-test the same station in its entirety.
- A candidate is allowed to test a single skill station a maximum of three times before he/she must complete a refresher course.

Requirements for becoming certified as a New York State Emergency Medical Technician - Basic

Complete general requirements for certification.

Complete all course requirements, including but not limited to:

- acceptable attendance during the course;
- successfully pass the CPR training portion of the course;
- maintain the minimum grade average required by the Course Sponsor;
- successfully pass all skill evaluations;
- complete all required clinical and/or internship hours prior to the NYS Practical Skills Examination;
- successfully pass the NYS Practical Skills Examination;
- successfully pass the NYS Written Examination.

NYS Practical Skills Examination

The purpose of the practical examinations is to assess basic entry level skill competency prior to being admitted to the written certification examination. During the course you will develop proficiency in all of the skills contained in the course learning objectives. The practical examination will test only selected skills.

Prerequisites for Admission - In order to be admitted to the practical examination, students must successfully complete all course requirements to the satisfaction of the course sponsor and as specified in the course policies and procedures.

Certification examination and re-test sequence - The NYS Practical Skills Examination **must precede the written examination**. The practical examination and scheduled re-test date should precede the NYS Written Examination by at least seven days.

Americans with Disabilities Act (ADA) - For the State Final Practical Skills Examination, the NYS Bureau of EMS does not permit testing accommodations, but will consider the use of certain aids by the candidate. Candidates with an identified disability may be permitted to use certain aids, which they would be responsible to provide and reasonably be able to bring to the patient's side in actual practice. The only types of aids permitted are those that do not alter the essential functions of a CFR or EMT. For example, the use of prescription or reading glasses, hearing aids and personal stethoscopes have been permitted since they serve as an aid to the provider. In contrast, a braille sphygmomanometer would not be permitted since sight is considered an essential function of the certified EMS provider. If you have questions or need further assistance with ADA issues, please contact the NYS Bureau of EMS at (518) 402-0996.

Use of personal equipment - Candidates may use their personal pocket mask and stethoscopes for the practical examination. Candidates may not bring or use equipment for the examination unless it is equipment that has been used during the course or unless special arrangements have been made with the CIC and exam coordinator. This must be done in advance of the exam date.

Required testing stations for EMT-B - The following skills were identified as being the minimum number of performance items that should be included in every EMT-B practical examination:

Mandatory Skills

- Station 1 - Patient Assessment Management - Trauma
- Station 2 - Patient Assessment Management - Medical
- Station 3 - Cardiac Arrest Management/AED
- Station 4 - Bag-Valve-Mask: Apneic Patient
- Station 5A - Spinal Immobilization - Seated Patient

OR

- Station 5B - Spinal Immobilization - Supine Patient

Random Skills

- Station 6A - Long Bone Injury Immobilization
- Station 6B - Joint Injury Immobilization
- Station 6C - Traction Splint Immobilization

- Station 6D - Bleeding Control / Management of Hypoperfusion
- Station 6E - Upper Airway Adjuncts and Suction
- Station 6F - Mouth-to-Mask with Supplemental Oxygen
- Station 6G - Supplemental Oxygen Administration

The EMT student must successfully pass six stations -- **mandatory stations #1 through #5 and one random skill station**. The mandatory and random skill stations consist of both skill-based and scenario-based testing. The random skill station is conducted so the student is totally unaware if the skill to be tested until he/she arrives at the test station.

Testing/Re-testing Policies

EMT candidates who fail **two skill stations or less** on the practical exam may be re-tested on those skills. **Three or more failed stations** constitute a failure of the practical examination and the candidate must complete a refresher course prior to being re-tested.

- Those failing two stations or fewer are eligible to take two re-tests. The *first re-test* may occur on the same day as the initial exam. Failure of a same-day re-test entitles the student to a second re-test on those skills failed.
- The *second re-test* **must** be conducted on **another date** and the candidate must be provided with **remedial instruction**. Failure of the *second re-test* constitutes a failure of the examination and a refresher course must be completed prior to any re-testing.
- A different examiner should administer re-tests.
- When a station is failed, the candidate must re-test the same station in its entirety.

A candidate is allowed to test a single skill station a maximum of three times before he/she must complete a refresher course.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: 00-12, 02-02

No. 09-05

Date: August 5, 2009

**Re: Certification for
Individuals with
Criminal Convictions**

Page 1 of 2

Purpose:

This policy describes the process for the review of applicants seeking EMS certification with a history of criminal convictions. This policy also describes the responsibilities for the applicant, the Certified Instructor Coordinator (CIC) and the Department of Health.

Applications for Original EMS Certification or Recertification:

In accordance with the provisions of the State Emergency Medical Services (EMS) Code – 10 NYCRR Part 800; applicants for EMS certification or recertification must not have been convicted of certain misdemeanors or felonies. The Department will review **all** criminal convictions from any federal, military, state and/or local jurisdiction to determine if such convictions fall within the scope of those specified in Part 800, or to determine if the applicant for certification represents a potential risk or danger to patients or the public at large.

The regulation does not prevent an applicant with a criminal conviction from attending and completing all of the requirements of an EMS course. However, it may prevent the applicant from becoming certified in New York State until the Department has conducted a review and investigation of the circumstances of the conviction(s) and made a determination that the applicant does not demonstrate a risk or danger to patients. If the Department makes a determination allowing certification, the applicant will be eligible to take the NYS practical and written certification examinations, if otherwise qualified. **All applicants should be fully informed of these requirements by the CIC at the beginning of the course.**

Applicants will not be permitted to take the NYS practical or written certification examination until the background review and investigation is completed and a written determination is received by the applicant..

The Certification Application:

All applicants applying for NYS EMS certification at any level must complete the Application for Emergency Medical Services Certification (DOH-65). The bottom of the application contains an affirmation that states “do not sign this if you have any convictions”. ***Under no circumstances should an applicant sign this application if he or she has a criminal conviction of any type.***

The CIC must identify all unsigned applications and send them with the course memorandum and all other applications to the Department immediately after the second class session. The CIC should include a separate memorandum or note identifying each unsigned application. The applicant(s) will be listed on the class list but **will not** be issued an examination ticket until cleared in writing by Department. It is the responsibility of the applicant to understand this policy, gather the required documentation and provide it to the Department. An EMS representative from the Department will conduct an interview. This may take the form of a personal meeting or telephone interview. In an effort to permit a timely review and determination, the applicant must provide all the required documentation within 30 days of the initial Department contact. ***If the applicant does not provide the documentation, the investigatory review will be closed and the applicant will not be able to seek EMS certification.***

There is no need for the applicant to contact the Bureau of EMS (BEMS) directly. Upon the receipt and processing of the unsigned DOH-65 application form, the applicant will be sent a package of information outlining the investigative process, the required information to be supplied and the contact name and telephone number of the EMS representative.

The Department will only discuss issues related to criminal convictions with the applicant or their legal representative. **There is no requirement or need for the applicant to divulge or discuss the circumstances of any conviction(s) with the CIC.**

The Review Process:

All applicants entered in the review process will need to provide the following written documentation concerning **all convictions**. This information must be sent directly to the Department regional office as detailed in the letter sent to the applicant.

1. A notarized sworn affidavit stating that the applicant has not had any conviction (s) for a crime or crimes other than those currently identified.
2. If the applicant is recertifying and has signed previous certification applications, he/she must provide an explanation as to why these applications were signed.
3. A signed and dated statement describing the reason that they are seeking EMS certification.
4. A signed and dated written narrative description of the circumstances leading to and surrounding each conviction.
5. **An original or certified copy of the plea and sentence minutes, certificate of disposition** and the presentencing report (if available) from the court. A Certificate of Relief from Disabilities does not fulfill this documentation requirement. If any of these items are not available, an original letter from the court must be supplied attesting that the documentation does not exist or is no longer available. Please note that the applicant may be responsible for the cost of obtaining these documents.
6. A letter from the applicant's probation/parole officer (if applicable) documenting compliance with their probation/parole. A copy of the final probation/parole report must also be included.
7. If the applicant's conviction resulted in any court ordered therapy, clinical evaluations or counseling, a letter or report from the organization or individual who provided the evaluation, counseling or therapy is required. The letter or report should indicate if treatment is ongoing or if it has been completed and whether or not it was considered to have been successful. The letter should also indicate that the counselor/therapist believes that the applicant is suitable to perform patient care in a prehospital setting.
8. The applicant is required to submit letters from the administration of each EMS agency with whom they are affiliated. These letters must be on official letterhead and presented to the Department EMS representative in a **sealed and signed** envelope. These letters must describe any involvement in EMS or other health care settings, the length of the affiliation with the agency, **an awareness of the specific conviction(s), the circumstances and the agency's willingness to monitor the individual during the performance of his/her EMS duties.**
9. The applicant must submit other letters of recommendation. These letters must also be presented to the EMS investigator in a **sealed and signed** envelope. These recommendations must include a description of the relationship with the applicant, have knowledge of the conviction, an understanding of the EMS environment, and can attest to the applicant's good character. The letters may include, but not be limited to:
 - a. current employers;
 - b. health care professionals;
 - c. community leaders (ie clergy, law enforcement or educators)
10. Each applicant will have a personal interview with a Department EMS representative **after all the documentation requirements have been met**. A telephone interview may be conducted in the place of a personal meeting. Upon completion of the investigation and review, the applicant will be notified in writing of the Department's decision.

While the investigation and review is ongoing, an applicant may attend all classes. However, the applicant will be prevented from taking any NYS certifying examination, including the challenge practical skills examination at the beginning of the refresher program, the practical examination at the conclusion of the training program and the final written certification examination, until all course requirements are completed and a favorable determination is made in writing by the Department.

Applicants possessing current NYS EMS certification will be afforded a hearing in accordance with the provisions of Section 12-a of the Public Health Law if the Department seeks suspension, revocation or any other legal action.

Summary and Historical Prospective of the New York State Written Certification Examinations

Article 30 of the Public Health Law provides the statutory authority and framework for Emergency Medical Services in New York State. Approximately ten years ago, Article 30-A, the “EMS Personnel Training Act of 1986,” was signed into law to expand and improve training opportunities for EMS personnel.

To implement the mandate of Article 30 and 30A, a number of rules and regulations were established and published as the State EMS Code. The State EMS Code is frequently called “Part 800” because its official title is Part 800 of Chapter VI of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations (10NYCCR-800).

The Certified First Responder (CFR), Emergency Medical Technician (EMT) or Advanced EMT examination you will be taking is required for initial certification and recertification under the State EMS Code.

The Examination Development Process

The New York State EMS written examinations are based on curricula adopted by the State EMS Council and approved by the Commissioner of Health. The state-approved curricula meets or exceeds similar USDOT national standard curricula. To determine how many questions to ask in each of the content areas, an examination blueprint is developed. Data collected from certified EMS providers, educators, and medical directors as to the importance of each area to practice and the amount of time spent in each area, combined with the number of course hours spent in these areas were used to determine the examination blueprint for all the examinations.

To develop the examinations, items (questions) based on curriculum objectives are written, reviewed, and validated for relevance and importance to EMS practice by content experts. The content experts are made up of active EMS providers and educators through the state. Items that survive the review and validation process are included in the item bank and available for use on the certification examinations. The next step in the examination development process is for a representative committee of EMS content experts to meet with Professional Examination Service (PES) staff to select the required number of items that reflect the test blueprint from the item bank. The selected items are reviewed by PES program and editorial staff and a draft examination is prepared. The draft is sent to various EMS providers, including EMS physicians and educators, for review and comment. All comments are reconciled by the State EMS Office and sent to PES for finalization. Finalized examinations are then printed and shipped to the test sites as needed.

When a new examination is administered for the first time, a comprehensive item analysis is generated. The item analysis provides information on how many candidates selected the correct answer to each question and how many candidates selected the other choices. On rare occasions, the item analysis will identify problems with an item or some unexpected results. PES reviews this information with the State EMS Office and if warranted, changes are made to the answer key (e.g., more than one answer is scored as correct). If key changes are made, candidates who received on-site scoring might find that their final official results are slightly higher than the results they received on-site.

Examination Content

All the State EMS written examinations consist of four-choice multiple choice type questions. All exams except for the CFR exams contain 10 pilot items (questions that have never been used on an exam). The pilot questions are placed randomly throughout the test and are not included in the candidate’s score. For example, the Paramedic exam contains a total of 235 items; however, the candidates score is based on 225 items (the 10 pilot items are excluded from the scoring).

Testing Time

The total amount of testing time allotted for each examination is presented in the following table:

Exam Level	Total Testing Time
CFR	1½ hours
EMT	2½ hours
EMT-I	3 hours
EMT-CC	4 hours
EMT-P	4 hours

Passing Points

At the CFR and EMT level, candidates must achieve a score of 70% or higher in order to pass the examination. At the advanced EMT levels (EMT-Intermediate, EMT-Critical Care, and EMT-Paramedic), candidates must achieve a score of 70% on the basic portion of the examination and a score of 70% on the advanced portion of the examination in order to pass. The following table presents both the percent and raw score (the number of items that must be answered correctly) passing points for the State written examinations.

Exam Level	Percent Score	Raw Score
CFR	70%	35
EMT	70%	70
EMT-I:		
Basic Portion	70%	53
Advanced Portion	70%	39
EMT-CC:		
Basic Portion	70%	53
Advanced Portion	70%	88
EMT-P:		
Basic Portion	70%	53
Advanced Portion	70%	105

Passing Policy for Advanced EMT Exams

To be certified at the Advanced EMT (AEMT) level, candidates must score 70% or higher on both the basic portion and the advanced portion of the examination. Candidates who pass the basic portion (scoring 70% or higher) and fail the advanced portion (scoring less than 70%) will receive an EMT-D certification card and a failure letter for the AEMT examination. Candidates must retake the entire examination within one year if they wish to be certified at the advanced level.

Candidates who fail (score less than 70%) the basic examination will receive a failure letter for the entire examination, even if they pass (score 70% or higher) the advanced portion of the examination. Candidates must retake the entire examination within one year if they want to obtain certification.

Receipt of Examination Results

Examination results are generally mailed to candidates within four to six weeks from the test date. Results are mailed to the address provided on the student application that candidates complete at the beginning of the course.

Incorrect information on the student application and/or on the answer sheet (e.g., accidentally recording '97 for year of birth) will delay the receipt of examination results.

Examination results cannot be given over the phone. **Please do not call the State EMS Office or PES for this information.**

Policies and Procedures

- **If you are unable to test on the assigned test date:**

If you are unable to take the certification examination with your class, you will need to contact the State EMS Office testing hotline at 1-800-628-0193. Be prepared to provide the following information:

- Name
- Telephone Number
- Course Number
- CFR/EMT/AEMT Number

After your eligibility has been verified, you will be assigned a new examination date at the regional test site nearest your address. Registration for regional test sites are usually closed six weeks prior to the examination, so do not expect to take the examination any earlier than six weeks after you call.

You will receive a confirmation letter, with directions to the regional test site, approximately three weeks prior to the test date.

- **If you didn't receive your Student Examination Ticket or have lost it:**

A Student Examination Ticket will be provided by your course instructor after you have successfully completed all the course requirements. If you fail the examination on your first attempt, you will receive a new Student Examination Ticket with your examination results.

If you lose your Student Examination Ticket, report the loss to the State EMS Office Certification Unit at 1-518-402-0996.

- **If you fail the examination on your second attempt:**

If you fail the examination on your second attempt, you must successfully complete a refresher (or another original) course prior to being admitted to another state written certification examination.

- **If you need to request special accommodations:**

In accordance with the American Disabilities Act of 1990, the Bureau of Emergency Medical Services will provide reasonable and appropriate accommodations for the state written certification examinations for those persons with documented disabilities.

- **All requests for special accommodations must be made in writing to the:**

Bureau of Emergency Medical Services
New York State Department of Health
433 River Street, Suite 303
Troy, New York 12180-2299

The written request must come directly from the candidate and should indicate the disability and the special accommodation(s) required. This request should be accompanied by recent documentation from a licensed professional or certified specialist appropriate for the disability verifying both the disability and the need for the accommodation.

- **If you have additional questions about the State certification examinations:**

Your instructor is the best resource for questions about the State certification examination. If the instructor cannot answer the question, he/she may contact the State EMS Office at 518-402-0996.

How to Prepare For and Take the Test

The first step in preparing for the test is to decide what you need to study. Although you should review all areas that will be covered on the exam, focus your study on those areas in which you are weak or in which you have had little training or experience. In addition to mentally preparing yourself for the test, it is also important to prepare yourself physically. To prepare yourself physically, keep the following points in mind prior to taking any test:

Get good nights sleep. Don't stay up all night cramming. Avoid both stimulants and tranquilizers. Don't drink a lot of liquids or eat a big meal before the test. If you have to go to the restroom several times during the test, it could disrupt your train of thought. Eating a big meal before the test could make you feel sleepy and lethargic. If you do feel that you need to eat something before the test, have a snack rather than a big meal. Wear clothing that is comfortable and appropriate for the time of year. Wearing layered clothing is recommended, so that you can add or remove a layer as necessary. Wear a watch so that you can monitor your time during the test.

One of the most important rules to follow when you are taking any test is to give the test and the examination proctor your undivided attention. It is extremely important to listen carefully to the directions for the test, especially the directions for filling out the answer sheet. You will be required to mark your responses to the questions, as well as other identifying information (e.g., your name, identification number, test code, etc.) on a special answer sheet that is read by an optical scanner. During the actual test, if you still do not understand how to code your name or the other required information, raise your hand and ask the examination proctor for assistance.

When the test begins, note the starting time. Read the first question and all four choices before responding to the question. Even if you believe the first or second choice is the answer to the question, read all the choices before selecting one. One of the later responses could be a more precise answer to the question. Make sure that you record your answers on the answer sheet and not in the examination booklet. Answers in the booklet will not be scored. When recording information on your answer sheet, you must follow the instructions listed below in order to assure proper scoring of the examination:

1. Use only a number 2 pencil. If you use any other marking instrument, your answers cannot be scored.
2. Your answers must be dark pencil marks completely filling in the circles.
3. Completely erase any marks you wish to change.
4. Do not leave smudges on the answer sheet.
5. Do not make marks in the column of black lines on the bottom of the answer sheet.
6. Do not bend or fold any part of your answer sheet.

If you need to mark your answers in the booklet, don't wait until the end of the test to transfer your answers onto the answer sheet. If you are having difficulty answering a specific question, skip it and go on to the next question. Make sure that you also skip the corresponding answer space for that question on your answer sheet. If you forget to skip a space on your answer sheet, all of your subsequent answers will be in the wrong place and could result in a failing score on the examination.

After you have answered all questions of which you are certain, go through the test again and try to answer the questions you couldn't easily answer the first time. As you reread these questions, try to eliminate the responses you feel are incorrect. The more responses you can eliminate, the better the chance you have at selecting the correct answer. There is no penalty for guessing, so if you can't eliminate any of the responses, it is better to guess at the answer rather than to leave it blank. Therefore, if time permits, you should try to answer all the questions on the examination.

The time allotted for each examination allows approximately one and one-half minutes per question. You should monitor your progress at various intervals throughout the examination to ensure that you will have enough time to complete the examination. For example, if you are taking the EMT Basic examination, you should be at or beyond question 55 after one hour and fifteen minutes into the test. If you are taking the EMT-Paramedic examination, you should be at or beyond question 120 after 2 hours of testing time. If you finish the examination before time is called, you should review the answers you have selected.

The following list summarizes the points you should keep in mind when you are taking a test:

- Listen carefully to all instructions and give the test and the examination proctor your undivided attention.
- Ask for help if you do not understand the instructions or how to fill out your answer sheet.
- Carefully read each question and all choices before selecting your response.
- Answer all questions that you are sure of first, then go back to the more difficult questions, if time permits.
- Try to answer all questions, even if you have to guess at the answer.
- Make sure you record your answers on the answer sheet and not in the examination booklet.
- If you skip a question, make sure you skip the corresponding space for that question on your answer sheet.
- Do not make any stray marks on your answer sheet. Use the margins of your test booklet for scrap paper, if necessary.
- Monitor your time throughout the examination so that you do not fall behind.
- If you finish the examination before time is called, go back and check your work.

Test Day

On the day of the test, you should report to the test site at least 15 minutes prior to the scheduled starting time. You should bring your Student Examination Ticket and several well sharpened number 2 pencils with erasers with you to the test site. Your course instructor should provide you with this ticket prior to the test date. If you did not receive or lost this ticket, follow the instructions listed under the section entitled Policies and Procedures.

Your Student Examination Ticket is the only material you will need to take the test. Books, papers, and calculators are not allowed into the testing room. No scratch paper is provided, however, you may write in the test booklet if necessary. Note taking during the examination is prohibited and no one is allowed to duplicate or retain any portion of the examination. Only one person may be excused from the room at a time. If you wish to leave the room, you must leave all your test materials with the proctor.

CFR Curriculum Objectives

Objectives Legend

C= Cognitive; P= Psychomotor; A= Affective

1 = Knowledge level; 2 = Application level; 3 = Problem-solving level

At the completion of each module the CFR should be able to demonstrate the skills related to that module.

Module 1

- 1-1 Define the components of Emergency Medical Services (EMS) systems. (C-1)
- 1-1.2 Differentiate the roles and responsibilities of the CFR from other out-of-hospital care providers. (C-3)
- 1-1.3 Define medical oversight and discuss the CFR S role in the process. (C-1)
- 1-1.4 Discuss the types of medical oversight that may affect the medical care of a CFR. (C-1)
- 1-1.5 State the specific statutes and regulations in your state regarding the EMS system. (C-1)
- 1-1.6 Accept and uphold the responsibilities of a CFR in accordance with the standards of an EMS professional. (A-3)
- 1-1.7 Explain the rationale for maintaining a professional appearance when on duty or when responding to calls. (A-3)
- 1-1.8 Describe why it is inappropriate to judge a patient based on a cultural, gender, age, or socioeconomic mode and to vary the standard of care rendered as a result of that judgement. (A-3)
- 1-2.1 List possible emotional reactions that the CFR may experience when faced with trauma, illness, death, and dying. (C-1)
- 1-2.2 Discuss the possible reactions that a family member may exhibit when confronted with death and dying. (C-1)
- 1-2.3 State the steps in the CFRs approach to the family confronted with death and dying. (C-1)
- 1-2.4 State the possible reactions that the family of the CFR may exhibit. (C-1)
- 1-2.5 Recognize the signs and symptoms of critical incident stress. (C-1)
- 1-2.6 State possible steps that the CFR may take to help reduce/alleviate stress. (C-1)
- 1-2.7 Explain the need to determine scene safety. (C-2)
- 1-2.8 Discuss the importance of body substance isolation (BSI). (C-1)
- 1-2.9 Describe the steps the CFR should take for personal protection from airborne and bloodborne pathogens. (C-1)
- 1-2.10 List the personal protective equipment necessary for each of the following situations: (C-1)
 - Hazardous materials
 - Rescue operations
 - Violent scenes
 - Crime scenes
 - Electricity
 - Water and ice
 - Exposure to bloodborne pathogens
 - Exposure to airborne pathogens
- 1-2.11 Explain the importance for serving as an advocate for the use of appropriate protective equipment. (A-3)
- 1-2.12 Explain the importance of understanding the response to death and dying and communicating effectively with the patient's family.
- 1-2.13 Demonstrate a caring attitude towards any patient with illness or injury who requests emergency medical services. (A-3)
- 1-2.14 Show compassion when caring for the physical and mental needs of patients. (A-3)
- 1-2.15 Participate willingly in the care of all patients. (A-3)
- 1-2.16 Communicate with empathy to patients being cared for, as well as with family members, and friends of the patient. (A-3)
- 1-2.17 Given a scenario with potential infectious exposure, the CFR will use appropriate personal protective equipment. At the completion of the scenario, the CFR will properly remove and discard the protective garments. (P-1, 2)
- 1-2.18 Given the above scenario, the CFR will complete disinfection/cleaning and all reporting documentation. (P-1, 2)
- 1-3.1 Define the CFR scope of practice. (C-1)
- 1-3.2 Discuss the importance of Do Not Resuscitate [DNR] (advance directives) and local or state provisions regarding EMS application. (C-1)
- 1-3.3 Define consent and discuss the methods of obtaining consent. (C-1)
- 1-3.4 Differentiate between informed and implied consent. (C-3)
- 1-3.5 Explain the role of consent of minors, emancipated minors and mentally incompetent adults in providing care. (C-1)
- 1-3.6 Discuss the implications for the CFR of patient refusal of transport and/or treatment. (C-1)

- 1-3.7 Define abandonment, negligence, and battery as they relate to the CFR.
- 1-3.8 State the conditions necessary for the CFR to have a duty to act. (C-1)
- 1-3.9 Explain the importance, necessity and legality of patient confidentiality.
- 1-3.10 Discuss the role that a CFR should take in the preservation of a crime scene. (C-3)
- 1-3.11 Explain the rationale for the needs, benefits and usage of advance directives. (A-3)
- 1-3.12 Explain the rationale for the concept of varying degrees of DNR. (A-3)
- 1-4.1 Describe the anatomy and function of the respiratory system. (C-1)
- 1-4.2 Describe the anatomy and function of the circulatory system. (C-1)
- 1-4.3 Describe the anatomy and function of the musculoskeletal system. (C-1)
- 1-4.4 Describe the components and function of the nervous system. (C-1)
- 1-4.5 Describe the function of the skin. (C-1)
- 1-5.1 Define body mechanics. (C-1)
- 1-5.2 Discuss the guidelines and safety precautions that need to be followed when lifting a patient. (C-1)
- 1-5.3 Describe the indications for an emergency move. (C-1)
- 1-5.4 Describe the indications for assisting in non-emergency moves. (C-1)
- 1-5.5 Discuss the various devices associated with moving a patient in the out-of-hospital arena. (C-1)
- 1-5.6 Explain the rationale for properly lifting and moving patients. (A-3)
- 1-5.7 Explain the rationale for an emergency move. (A-3)
- 1-5.8 Demonstrate an emergency move. (P-1, 2)
- 1-5.9 Demonstrate a non-emergency move. (P-1, 2)
- 1-5.10 Demonstrate the use of equipment utilized to move patient's in the out-of-hospital arena. (P-1, 2)

Module 2

- 2-1.1 Name and label the major structures of the respiratory system on a diagram. (C-1)
- 2-1.2 List the signs of adequate breathing (C-1)
- 2-1.3 List the signs of inadequate breathing. (C-1)
- 2-1.4 Describe the steps in the head-tilt chin-lift. (C-1)
- 2-1.5 Relate mechanism of injury to opening the airway. (C-3)
- 2-1.6 Describe the steps in the jaw thrust. (C-1)
- 2-1.7 State the importance of having a suction unit ready for immediate use when providing emergency medical care. (C-1)
- 2-1.8 Describe the techniques of suctioning. (C-1)
- 2-1.9 Describe how to ventilate a patient with a pocket mask or barrier device.
- 2-1.10 Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust. (C-1)
- 2-1.11 List the parts of a bag-valve-mask system. (C-1)
- 2-1.12 Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers. (C-1)
- 2-1.13 Describe the signs of adequate artificial ventilation using the bag-valve-mask. (C-1)
- 2-1.14 Describe the signs of inadequate artificial ventilation using the bag-valve-mask. (C-1)
- 2-1.15 Describe the steps in artificially ventilating a patient with a flow restricted, oxygen-powered ventilation device. (C-1)
- 2-1.16 Describe how ventilating an infant or child is different from an adult. (C-1)
- 2-1.17 List the steps in providing mouth-to-mouth and mouth-to-stoma ventilation. (C-1)
- 2-1.18 Describe how to measure and insert an oropharyngeal (oral) airway.
- 2-1.19 Describe how to measure and insert a nasopharyngeal (nasal) airway.
- 2-1.20 Define the components of an oxygen delivery system. (C-1)
- 2-1.21 Identify a non-rebreathing facemask and state the oxygen flow requirements needed for its use. (C-1)
- 2-1.22 Identify a nasal cannula and state the flow requirements needed for its use. (C-1)
- 2-1.23 Describe the indications for using a nasal cannula versus a nonrebreather facemask. (C-1)
- 2-1.24 Describe how to clear a foreign body airway obstruction in a responsive adult. (C-1)
- 2-1.25 Describe how to clear a foreign body airway obstruction in a responsive child with complete obstruction or partial airway obstruction and poor air exchange. (C-1)
- 2-1.26 Describe how to clear a foreign body airway obstruction in a responsive infant with complete obstruction or partial airway obstruction and poor air exchange. (C-1)
- 2-1.27 Describe how to clear a foreign body airway obstruction in a unresponsive adult. (C-1)
- 2-1.28 Describe how to clear a foreign body airway obstruction in a unresponsive child. (C-1)
- 2-1.29 Describe how to clear a foreign body airway obstruction in a unresponsive infant. (C-1)

- 2-1.30 Explain why basic life support ventilation and airway protective skills take priority over most other basic life support skills. (A-3)
- 2-1.31 Demonstrate a caring attitude towards patients with airway problems who request emergency medical services. (A-3)
- 2-1.32 Place the interests of the patient with airway problems as the foremost consideration when making any and all patient care decisions. (A-3)
- 2-1.33 Communicate with empathy to patients with airway problems, as well as with family members and friends of the patient. (A-3)
- 2-1.34 Demonstrate the steps in the head-tilt chin-lift. (P-1, 2)
- 2-1.35 Demonstrate the steps in the jaw thrust. (P-1, 2)
- 2-1.36 Demonstrate the techniques of suctioning. (P-1, 2)
- 2-1.37 Demonstrate the steps in mouth-to-mouth ventilation with body substance isolation (barrier shields). (P-1, 2)
- 2-1.38 Demonstrate how to use a pocket mask to ventilate a patient. (P-1, 2)
- 2-1.39 Demonstrate the assembly of a bag-valve-mask unit. (P-1, 2)
- 2-1.40 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers. (P-1, 2)
- 2-1.41 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust. (P-1, 2)
- 2-1.42 Demonstrate artificial ventilation of a patient with a flow restricted, oxygen powered ventilation device. (P-1, 2)
- 2-1.43 Demonstrate how to ventilate a patient with a stoma. (P-1, 2)
- 2-1.44 Demonstrate how to measure and insert an oropharyngeal (oral) airway.
- 2-1.45 Demonstrate how to measure and insert a nasopharyngeal (nasal) airway.
- 2-1.46 Demonstrate how to ventilate infant and child patients. (P-1, 2)
- 2-1.47 Demonstrate how to clear a foreign body airway obstruction in a responsive adult. (C-1)
- 2-1.48 Demonstrate how to clear a foreign body airway obstruction in a responsive child. (C-1)
- 2-1.49 Demonstrate how to clear a foreign body airway obstruction in a responsive infant. (C-1)
- 2-1.50 Demonstrate how to clear a foreign body airway obstruction in an unresponsive adult. (C-1)
- 2-1.51 Demonstrate how to clear a foreign body airway obstruction in an unresponsive child. (C-1)
- 2-1.52 Demonstrate how to clear a foreign body airway obstruction in an unresponsive infant. (C-1)

Module 3

- 3-1.1 Discuss the components of scene size-up. (C-1)
- 3-1.2 Describe common hazards found at the scene of a trauma and a medical patient. (C-1)
- 3-1.3 Determine if the scene is safe to enter. (C-2)
- 3-1.4 Discuss common mechanisms of injury/nature of illness. (C-1)
- 3-1.5 Discuss the reason for identifying the total number of patients at the scene. (C-1)
- 3-1.6 Explain the reason for identifying the need for additional help or assistance. (C-1)
- 3-1.7 Summarize the reasons for forming a general impression of the patient.
- 3-1.8 Describe the steps of the initial assessment.
- 3-1.9 Discuss methods of assessing mental status. (C-1)
- 3-1.10 Differentiate between assessing mental status in the adult, child, and infant patient. (C-3)
- 3-1.11 Identify the components of vital signs. (C-1)
- 3-1.12 Describe the methods to obtain a breathing rate. (C-1)
- 3-1.13 Describe methods used for assessing if a patient is breathing. (C-1)
- 3-1.14 Differentiate between a patient with adequate and inadequate breathing.
- 3-1.15 Differentiate between shallow, labored and noisy breathing. (C-3)
- 3-1.16 Describe the methods used to assess circulation. (C-1)
- 3-1.17 Describe the methods to obtain a pulse rate. (C-1)
- 3-1.18 Differentiate between obtaining a pulse in an adult, child, and infant patient. (C-3)
- 3-1.19 Differentiate between a strong, weak, regular and irregular pulse. (C-3)
- 3-1.20 Describe the methods to assess the skin color, temperature, condition (capillary refill in infants and children). (C-1)
- 3-1.21 Identify the normal and abnormal skin colors. (C-1)
- 3-1.22 Differentiate between pale, blue, red and yellow skin color. (C-3)
- 3-1.23 Identify the normal and abnormal skin temperature. (C-1)
- 3-1.24 Differentiate between hot, cool and cold skin temperatures. (C-3)
- 3-1.25 Identify normal and abnormal skin conditions. (C-1)
- 3-1.26 Identify normal and abnormal capillary refill in infants and children. (C-1)
- 3-1.27 Describe the methods to assess the pupils. (C-1)
- 3-1.28 Identify normal and abnormal pupil sizes. (C-1)

- 3-1.29 Differentiate between dilated (big) and constricted (small) pupil size. (C-3)
- 3-1.30 Differentiate between reactive and non-reactive pupils and equal and unequal pupils. (C-3)
- 3-1.31 Describe the methods to assess blood pressure. (C-1)
- 3-1.32 Define systolic pressure. (C-1)
- 3-1.33 Define diastolic pressure. (C-1)
- 3-1.34 Explain the difference between auscultation and palpation for obtaining a blood pressure. (C-1)
- 3-1.35 Differentiate between a sign and a symptom. (C-3)
- 3-1.36 State the importance of accurately reporting and recording the baseline vital signs. (C-1)
- 3-1.37 Discuss the need to search for additional medical identification. (C-1)
- 3-1.38 Define each letter of AVPU.
- 3-1.39 Describe the patient characteristics for each letter of AVPU.
- 3-1.40 Discuss the need for assessing the patient for external bleeding. (C-1)
- 3-1.41 Explain the reason for prioritizing a patient for care and transport. (C-1)
- 3-1.42 Discuss the components of the physical exam. (C-1)
- 3-1.43 State the areas of the body that are evaluated during the physical exam.
- 3-1.44 Explain what additional questioning may be asked during the physical exam. (C-1)
- 3-1.45 Explain the components of the SAMPLE history. (C-1)
- 3-1.46 Discuss the components of the on-going assessment. (C-1)
- 3-1.47 Describe the information included in the CFR "hand-off" report. (C-1)
- 3-1.48 Explain the rationale for crew members to evaluate scene safety prior to entering. (A-2)
- 3-1.49 Serve as a model for others by explaining how patient situations affect your evaluation of the mechanism of injury or illness. (A-2)
- 3-1.50 Explain the importance of forming a general impression of the patient.
- 3-1.51 Explain the value of an initial assessment. (A-2)
- 3-1.52 Explain the value of questioning the patient and family. (A-2)
- 3-1.53 Explain the value of the physical exam. (A-2)
- 3-1.54 Explain the value of an on-going assessment. (A-2)
- 3-1.55 Explain the value of performing the baseline vital signs. (A-2)
- 3-1.56 Defend the need for obtaining and recording an accurate set of vital signs.
- 3-1.57 Explain the rationale of recording additional sets of vital signs. (A-1)
- 3-1.58 Explain the importance of obtaining a SAMPLE history. (A-1)
- 3-1.59 Recognize and respond to the feelings patients experience during assessment. (A-1)
- 3-1.60 Demonstrate a caring attitude when performing patient assessments.
- 3-1.61 Place the interests of the patient with foremost consideration when making any and all patient care decisions during patient assessment.
- 3-1.62 Communicate with empathy during patient assessment to patients as well as with family members and friends of the patient. (A-3)
- 3-1.63 Demonstrate the ability to differentiate various scenarios and identify potential hazards. (P-1)
- 3-1.64 Demonstrate the techniques for assessing mental status. (P-1, 2)
- 3-1.65 Demonstrate the techniques for assessing the airway. (P-1, 2)
- 3-1.66 Demonstrate the techniques for assessing if the patient is breathing.
- 3-1.67 Demonstrate the skills involved in assessment of breathing. (P-1, 2)
- 3-1.68 Demonstrate the skills associated with obtaining a pulse. (P-1, 2)
- 3-1.69 Demonstrate the skills associated with assessing the skin color, temperature, condition, and capillary refill in infants and children. (P-1, 2)
- 3-1.70 Demonstrate the skills associated with assessing the pupils. (P-1, 2)
- 3-1.71 Demonstrate the skills associated with obtaining blood pressure. (P-1, 2)
- 3-1.72 Demonstrate the skills that should be used to obtain information from the patient, family, or bystanders at the scene. (P-1, 2)
- 3-1.73 Demonstrate the techniques for assessing the patient for external bleeding. (P-1, 2)
- 3-1.74 Demonstrate the techniques for assessing the patient's skin color, temperature, condition, and capillary refill (infants and children only).
- 3-1.75 Demonstrate questioning a patient to obtain a SAMPLE history.
- 3-1.76 Demonstrate the skills involved in performing the physical exam. (P-1, 2)
- 3-1.77 Demonstrate the on-going assessment (P-1, 2)

Module 4

- 4-1.1 Describe the structure of the heart.
- 4-1.2 Describe the function of the heart.

- 4-1.3 Define coronary heart disease.
- 4-1.4 Define clinical manifestations of CHD
- 4-1.5 Identify the risk factors associated with cardiovascular disease.
- 4-1.6 Discuss prudent heart living.
- 4-1.7 Describe the early warning signs of heart attack and stroke.
- 4-1.8 List and discuss causes of sudden death.
- 4-1.9 Define cardiopulmonary arrest.
- 4-1.10 Describe cardiopulmonary anatomy and physiology.
- 4-1.11 Describe the rationale for each of the steps in CPR.
- 4-1.12 List the reasons for the heart to stop beating (C-1)
- 4-1.13 Define the components of cardiopulmonary resuscitation (C-1)
- 4-1.14 Describe each link in the chain of survival and how it relates to the EMS system. (C-2)
- 4-1.15 List the steps of one-rescuer adult CPR (C-1)
- 4-1.16 Describe the technique of external chest compressions on an adult patient. (C-1)
- 4-1.17 Describe the technique of external chest compressions on a child. (C-1)
- 4-1.18 Describe the technique of external chest compressions on an infant. (C-1)
- 4-1.19 Explain when the CFR is able to stop CPR. (C-2)
- 4-1.20 List the steps of two-rescuer adult CPR (C-1)
- 4-1.21 List the steps of child CPR (C-1)
- 4-1.22 List the steps of infant CPR (C-1)
- 4-1.23 Respond to the feelings that the family of a patient may be having during a cardiac event. (A-3)
- 4-1.24 Demonstrate a caring attitude towards patients with cardiac events who request emergency medical services. (A-3)
- 4-1.25 Place the interests of the patient with a cardiac event as the foremost consideration when making any and all patient care decisions. (A-3)
- 4-1.26 Communicate with empathy with family members and friends of the patient with a cardiac event. (A-3)
- 4-1.27 Demonstrate the proper technique of chest compressions on an adult.
- 4-1.28 Demonstrate the proper technique of chest compressions on a child.
- 4-1.29 Demonstrate the proper technique of chest compressions on an infant.
- 4-1.30 Demonstrate the steps of adult one rescuer CPR. (P-1, 2)
- 4-1.31 Demonstrate the steps of adult two rescuer CPR. (P-1, 2)
- 4-1.32 Demonstrate child CPR. (P-1, 2)
- 4-1.33 Demonstrate infant CPR. (P-1, 2)

Module 5

- 5-1.1 Identify the patient who presents with a general medical complaint. (C-1)
- 5-1.2 Explain the steps in providing emergency medical care to a patient with a general medical complaint. (C-1)
- 5-1.3 State the signs and symptoms of a patient with breathing difficulty. (C-1)
- 5-1.4 Describe the emergency medical care of the patient with breathing difficulty. (C-1)
- 5-1.5 Identify the patient who presents with a specific medical complaint of altered mental status. (C-1)
- 5-1.6 Explain the steps in providing emergency medical care to a patient with an altered mental status. (C-1)
- 5-1.7 Identify the patient taking diabetic medications with an altered mental status and a history of diabetes.
- 5-1.8 State the steps in the emergency care of the patient taking diabetic medications with an altered mental status and a history of diabetes
- 5-1.9 State the definition of Cerebrovascular Accident (Stroke).
- 5-1.10 List the signs and symptoms of Cerebrovascular Accident (Stroke).
- 5-1.11 Describe the emergency medical care of the patient with signs and symptoms of a Cerebrovascular Accident (Stroke).
- 5-1.12 Identify the patient who presents with a specific medical complaint of seizures. (C-1)
- 5-1.13 Explain the steps in providing emergency medical care to a patient with seizures. (C-1)
- 5-1.14 Identify the patient who presents with a specific medical complaint of exposure to cold. (C-1)
- 5-1.15 Explain the steps in providing emergency medical care to a patient with an exposure to cold. (C-1)
- 5-1.16 Identify the patient who presents with a specific medical complaint of exposure to heat. (C-1)
- 5-1.17 Explain the steps in providing emergency medical care to a patient with an exposure to heat. (C-1)
- 5-1.18 Identify the patient who presents with a specific medical complaint of behavioral change. (C-1)
- 5-1.19 Explain the steps in providing emergency medical care to a patient with a behavioral change. (C-1)
- 5-1.20 Identify the patient who presents with a specific complaint of a psychological crisis. (C-1)

- 5-1.21 Explain the steps in providing emergency medical care to a patient with a psychological crisis. (C-1)
- 5-1.22 Attend to the feelings of the patient and/or family when dealing with the patient with a general medical complaint. (A-3)
- 5-1.23 Attend to the feelings of the patient and/or family when dealing with the patient with a specific medical complaint. (A-3)
- 5-1.24 Explain the rationale for modifying your behavior toward the patient with a behavioral emergency. (A-3)
- 5-1.25 Demonstrate a caring attitude towards patients with a general medical complaint who request emergency medical services. (A-3)
- 5-1.26 Place the interests of the patient with a general medical complaint as the foremost consideration when making any and all patient care decisions.
- 5-1.27 Communicate with empathy to patients with a general medical complaint, as well as with family members and friends of the patient. (A-3)
- 5-1.28 Demonstrate a caring attitude towards patients with a specific medical complaint who request emergency medical services. (A-3)
- 5-1.29 Place the interests of the patient with a specific medical complaint as the foremost consideration when making any and all patient care decisions.
- 5-1.30 Communicate with empathy to patients with a specific medical complaint, as well as with family members and friends of the patient. (A-3)
- 5-1.31 Demonstrate a caring attitude towards patients with a behavioral problem who request emergency medical services. (A-3)
- 5-1.32 Place the interests of the patient with a behavioral problem as the foremost consideration when making any and all patient care decisions.
- 5-1.33 Communicate with empathy to patients with a behavioral problem, as well as with family members and friends of the patient. (A-3)
- 5-1.34 Demonstrate the steps in providing emergency medical care to a patient with a general medical complaint. (C-1)
- 5-1.35 Demonstrate the steps in providing emergency medical care for a patient with breathing difficulty. (P-2)
- 5-1.36 Demonstrate the steps in providing emergency medical care to a patient with an altered mental status. (C-1)
- 5-1.37 Demonstrate the steps in providing emergency medical care to a patient with altered mental status and a history of diabetes.
- 5-1.38 Demonstrate the steps in providing emergency medical care to a patient with a Cerebrovascular Accident (Stroke).
- 5-1.39 Demonstrate the steps in providing emergency medical care to a patient with seizures. (C-1)
- 5-1.40 Demonstrate the steps in providing emergency medical care to a patient with an exposure to cold. (C-1)
- 5-1.41 Demonstrate the steps in providing emergency medical care to a patient with an exposure to heat. (C-1)
- 5-1.42 Demonstrate the steps in providing emergency medical care to a patient with a behavioral change. (C-1)
- 5-1.43 Demonstrate the steps in providing emergency medical care to a patient with a psychological crisis. (C-1)
- 5-2.1 Differentiate between arterial, venous, and capillary bleeding. (C-3)
- 5-2.2 State the emergency medical care for external bleeding. (C-1)
- 5-2.3 Establish the relationship between body substance isolation and bleeding.
- 5-2.4 List the signs of internal bleeding. (C-1)
- 5-2.5 List the steps in the emergency medical care of the patient with signs and symptoms of internal bleeding. (C-1)
- 5-2.6 Establish the relationship between body substance isolation (BSI) and soft tissue injuries. (C-3)
- 5-2.7 State the types of open soft tissue injuries. (C-1)
- 5-2.8 Describe the emergency medical care of the patient with a soft tissue injury. (C-1)
- 5-2.9 Discuss the emergency medical care considerations for a patient with a penetrating chest injury. (C-1)
- 5-2.10 State the emergency medical care considerations for a patient with an open wound to the abdomen. (C-1)
- 5-2.11 Describe the emergency medical care for an impaled object. (C-1)
- 5-2.12 State the emergency medical care for an amputation. (C-1)
- 5-2.13 Describe the emergency medical care for burns. (C-1)
- 5-2.14 List the functions of dressing and bandaging. (C-1)
- 5-2.15 Explain the rationale for body substance isolation when dealing with bleeding and soft tissue injuries. (A-3)
- 5-2.16 Attend to the feelings of the patient with a soft tissue injury or bleeding.
- 5-2.17 Demonstrate a caring attitude towards patients with a soft tissue injury or bleeding who request emergency medical services. (A-3)
- 5-2.18 Place the interests of the patient with a soft tissue injury or bleeding as the foremost consideration when making any and all patient care decisions. (A-3)
- 5-2.19 Communicate with empathy to patients with a soft tissue injury or bleeding, as well as with family members and friends of the patient. (A-3)
- 5-2.20 Demonstrate direct pressure as a method of emergency medical care for external bleeding. (P-1, 2)
- 5-2.21 Demonstrate the use of diffuse pressure as a method of emergency medical care for external bleeding. (P-1, 2)

- 5-2.22 Demonstrate the use of pressure points as a method of emergency medical care for external bleeding. (P-1, 2)
- 5-2.23 Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding. (P-1, 2)
- 5-2.24 Demonstrate the steps in the emergency medical care of open soft tissue injuries. (P-1, 2)
- 5-2.25 Demonstrate the steps in the emergency medical care of a patient with an open chest wound. (P-1, 2)
- 5-2.26 Demonstrate the steps in the emergency medical care of a patient with open abdominal wounds. (P-1, 2)
- 5-2.27 Demonstrate the steps in the emergency medical care of a patient with an impaled object. (P-1, 2)
- 5-2.28 Demonstrate the steps in the emergency medical care of a patient with an amputation. (P-1, 2)
- 5-2.29 Demonstrate the steps in the emergency medical care of an amputated part. (P-1, 2)
- 5-3.1 Describe the function of the musculoskeletal system. (C-1)
- 5-3.2 Differentiate between an open and a closed painful, swollen, deformed extremity. (C-1)
- 5-3.3 State the reasons for splinting. (C-1)
- 5-3.4 List devices used for splinting. (C-1)
- 5-3.5 List the general rules of splinting. (C-1)
- 5-3.6 List the complications of splinting. (C-1)
- 5-3.7 List the emergency medical care for a patient with a painful, swollen, deformed extremity. (C-1)
- 5-3.8 Relate mechanism of injury to potential injuries of the head and spine.
- 5-3.9 State the signs and symptoms of a potential spine injury. (C-1)
- 5-3.10 Describe the method of determining if a responsive patient may have a spine injury. (C-1)
- 5-3.11 Describe the method of determining if an unresponsive patient may have a spine injury. (C-1)
- 5-3.12 Relate the airway emergency medical care techniques to the patient with a suspected spine injury. (C-3)
- 5-3.13 Describe the basic principals of emergency care for a spine injured patient.
- 5-3.14 Describe how to stabilize the cervical spine. (C-1)
- 5-3.15 Discuss indications for using a cervical spine immobilization device. (C-1)
- 5-3.16 Establish the relationship between airway management and the patient with head and spine injuries. (C-1)
- 5-3.17 Describe a method for sizing a cervical spine immobilization device. (C-1)
- 5-3.18 Describe how to log roll a patient with a suspected spine injury. (C-1)
- 5-3.19 Describe how to secure a patient to a long spine board. (C-1)
- 5-3.20 List the signs and symptoms of injury to the head. (C-1)
- 5-3.21 Describe the emergency medical care for injuries to the head. (C-1)
- 5-3.22 Explain the rationale for splinting at the scene versus load and go.
- 5-3.23 Explain the rationale for immobilization of the painful, swollen, deformed extremity.
- 5-3.24 Explain the rationale for the feeling patients who have need for immobilization of the painful, swollen, deformed extremity. (A-3)
- 5-3.25 Demonstrate a caring attitude towards patients with a musculoskeletal injury who request emergency medical services. (A-3)
- 5-3.26 Place the interests of the patient with a musculoskeletal injury as the foremost consideration when making any and all patient care decisions.
- 5-3.27 Communicate with empathy to patients with a musculoskeletal injury, as well as with family members and friends of the patient. (A-3)
- 5-3.28 Explain the rationale for immobilization of the entire spine when a cervical spine injury is suspected. (A-3)
- 5-3.29 Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity. (P-1, 2)
- 5-3.30 Demonstrate opening the airway in a patient with suspected spinal cord injury. (P-1, 2)
- 5-3.31 Demonstrate evaluating a responsive patient with a suspected spinal cord injury. (P-1, 2)
- 5-3.32 Demonstrate stabilizing of the cervical spine. (P-1, 2)
- 5-3.33 Demonstrate how to log roll a patient with a suspected spinal cord injury. (P-1, 2)
- 5-3.34 Demonstrate how to secure a patient to a long spine board. (C-1)

Module 6

- 6-1.1 Identify the following structures: Uterus, vagina, fetus, placenta, umbilical cord, amniotic sac, perineum. (C-1)
- 6-1.2 Identify and explain the use of the contents of an obstetrics kit. (C-1)
- 6-1.3 Identify pre-delivery emergencies. (C-1)
- 6-1.4 State indications of an imminent delivery. (C-1)
- 6-1.5 Differentiate the emergency medical care provided to a patient with pre-delivery emergencies from a normal delivery. (C-3)
- 6-1.6 State the steps in the pre-delivery preparation of the mother. (C-1)
- 6-1.7 Establish the relationship between body substance isolation and childbirth. (C-3)
- 6-1.8 State the steps to assist in the delivery. (C-1)
- 6-1.9 Describe care of the baby as the head appears. (C-1)
- 6-1.10 Describe how and when to cut the umbilical cord. (C-1)

- 6-1-11 Discuss the steps in caring for a newborn. (C-1)
- 6-1.12 Understand the special needs of a newborn in the pre hospital setting
- 6-1.13 Describe the normal respiratory and heart rates for the newborn
- 6-1.14 Understand the need for warming, drying, suctioning and stimulating the newborn.
- 6-1.15 List the steps in newborn resuscitation and the indications for supplemental oxygen, assisted ventilations and chest compressions
- 6-1.16 Discuss the steps in the delivery of the placenta. (C-1)
- 6-1.17 List the steps in the emergency medical care of the mother post-delivery. (C-3)
- 6-1.18 Summarize neonatal resuscitation procedures. (C-1)
- 6-1.19 Describe the procedures for the following abnormal deliveries: Breech birth, prolapsed cord, limb presentation. (C-1)
- 6-1.20 Differentiate the special considerations for multiple births. (C-3)
- 6-1.21 Describe special considerations of meconium. (C-1)
- 6-1.22 Describe special considerations of a premature baby. (C-1)
- 6-1.23 Discuss the emergency medical care of a patient with a gynecological emergency. (C-1)
- 6-1.24 Explain the rationale for understanding the implications of treating two patients (mother and baby). (A-3)
- 6-1.25 Explain the rationale for attending to the feeling of a patient in need of emergency medical care during childbirth. (A-2)
- 6-1.26 Demonstrate a caring attitude towards patients during childbirth who request emergency medical services. (A-3)
- 6-1.27 Place the interests of the patient during childbirth as the foremost consideration when making any and all patient care decisions. (A-3)
- 6-1.28 Communicate with empathy to patients during childbirth, as well as with family members and friends of the patient. (A-3)
- 6-1.29 Demonstrate the steps to assist in the normal cephalic delivery. (P-1, 2)
- 6-1.30 Demonstrate necessary care procedures of the fetus as the head appears. (P-1, 2)
- 6-1.31 Demonstrate infant neonatal procedures. (P-1, 2)
- 6-1.32 Demonstrate post delivery care of infant. (P-1, 2)
- 6-1.33 Demonstrate how and when to cut the umbilical cord. (P-1, 2)
- 6-1.34 Attend to the steps in the delivery of the placenta. (P-1, 2)
- 6-1.35 Demonstrate the post-delivery care of the mother. (P-1, 2)
- 6-1.36 Demonstrate the care of the newborn. (P-1, 2)
- 6-1.37 Demonstrate how to assess a newborn
- 6-1.38 Demonstrate how to warm, dry, suction and stimulate the newborn
- 6-1.39 Demonstrate how to provide blow-by oxygen to the newborn
- 6-1.40 Demonstrate how to provide assisted ventilations to the newborn
- 6-1.41 Demonstrate how to perform chest compressions on the newborn
- 6-1.42 Demonstrate the procedures for the following abnormal deliveries: vaginal bleeding, breech birth, prolapsed cord, limb presentation. (P-1, 2)
- 6-1.43 Demonstrate the steps in the emergency medical care of the mother with excessive bleeding. (P-1, 2)
- 6-1.44 Demonstrate completing a prehospital care report for patients with obstetrical/gynecological emergencies. (P-2)
- 6-2.1 Describe differences in anatomy and physiology of the infant, child, and adult patient. (C-1)
- 6-2.2 Describe assessment of the infant or child. (C-1)
- 6-2.3 Describe the importance of maintaining an open airway.
- 6-2.4 Indicate various causes of respiratory emergencies in infants and children.
- 6-2.5 Differentiate between respiratory distress and respiratory failure. (C-3)
- 6-2.6 Describe the signs and symptoms of respiratory distress and respiratory failure.
- 6-2.7 Describe the techniques of suctioning the infant and child.
- 6-2.8 Summarize emergency medical care strategies for respiratory distress and respiratory failure/arrest in infants and children. (C-1)
- 6-2.9 Describe the techniques of suctioning the infant and child.
- 6-2.10 List common causes of seizures in the infant and child patient. (C-1)
- 6-2.11 Describe management of seizures in the infant and child patient. (C-1)
- 6-2.12 List the common causes for altered mental status in the infant and child patient. (C-1).
- 6-2.13 Describe the emergency care for altered mental status in the infant/child.
- 6-2.14 Describe the emergency care for poisoning in the infant and child.
- 6-2.15 Identify the signs and symptoms of shock (hypoperfusion) in the infant and child patient. (C-1)
- 6-2.16 Compare the signs and symptoms of compensated and decompensated shock.
- 6-2.17 Identify the signs and symptoms of Sudden Infant Death Syndrome (SIDS)
- 6-2.18 Describe the emergency medical care for a victim of SIDS

- 6-2.19 Discuss emergency medical care of the infant and child trauma patient.
- 6-2.20 Explain the modifications for spinal immobilization for the infant and child
- 6-2.21 Summarize the signs and symptoms of possible child abuse and neglect.
- 6-2.22 Describe the medical - legal responsibilities in suspected child abuse.
- 6-2.23 Recognize need for Certified First Responder debriefing following a difficult infant or child transport. (C-1)
- 6-2.24 Attend to the feelings of the family when dealing with an ill or injured infant or child. (A-1)
- 6-2.25 Understand the provider's own emotional response to caring for infants or children. (A-1)
- 6-2.26 Demonstrate a caring attitude towards infants and children with illness or injury who require emergency medical services. (A-3)
- 6-2.27 Place the interests of the infant or child with an illness or injury as the foremost consideration when making any and all patient care decisions.
- 6-2.28 Communicate with empathy to infants and children with an illness or injury, as well as with family members and friends of the patient. (A-3)
- 6-2.29 Demonstrate how to open the airway of the pediatric patient.
- 6-2.30 Demonstrate assessment of the infant and child. (P-1, 2)
- 6-2.31 Demonstrate the sizing technique for the selection of infant and child bag-valve-masks and oxygen delivery devices.
- 6-2.32 Demonstrate oxygen delivery for the infant and child. (P-1, 2)
- 6-2.33 Demonstrate suctioning techniques for the infant and child (P-1, 2)
- 6-2.34 Demonstrate how to provide manual stabilization of the head and cervical spine.
- 6-2.35 Demonstrate how to open the airway of the pediatric patient with suspected spinal injury.
- 6-2.36 Demonstrate how to properly size and apply a cervical collar to the pediatric patient.
- 6-2.37 Demonstrate the modifications for spinal immobilization for the infant and child

Module 7

- 7-1.1 Discuss the medical and non-medical equipment needed to respond to a call. (C-1) - refer to Part 800
- 7-1.2 List the phases of an ambulance call. (C-1)
- 7-1.3 Describe the general provisions of the NYS Motor Vehicle and Traffic laws relating to the operation of the ambulance and privileges in any or all of the following categories:(C-1)
 - Speed
 - Warning lights
 - Sirens
 - Right-of-way
 - Parking
 - Turning
 - Responsibility of vehicle operator for "Due Regard For Safety of All Others" while operating an emergency vehicle
- 7-1.4 List contributing factors to unsafe driving conditions. (C-1)
- 7-1.5 Describe the considerations that should be given to:
 - Request for escorts.
 - Following an escort vehicle
 - Intersections(C-1)
- 7-1.6 State what information is essential in order to respond to a call. (C-1)
- 7-1.7 Discuss various factors that may affect response to a call. (C-1)
- 7-1.8 Describe the methods of preparing the patient for transport
- 7-1.9 Understand the importance of written documentation of patient care rendered.
- 7-1.10 Discuss issues concerning the fundamental components of documentation. (C-1)
- 7-1.11 Explain the components of the written report and list the information that should be included in the written report. (C-1)
- 7-1.12 Identify the various sections of the written report. (C-1)
- 7-1.13 Describe what information is required in each section of the prehospital care report and how it should be entered. (C-1)
- 7-1.14 Define the special considerations concerning patient refusal. (C-1)
- 7-1.15 Describe the legal implications associated with the written report. (C-1)
- 7-1.16 Discuss all state and/or local record and reporting requirements. (C-1)
- 7-1.17 Summarize the importance of preparing the unit for the next response.
- 7-1.18 Identify what is essential for completion of a call. (C-1)
- 7-1.19 Distinguish among the terms cleaning, disinfection, high-level disinfection, and sterilization. (C-3)
- 7-1.20 Describe how to clean or disinfect items following patient care. (C-1)

- 7-1.21 Describe the common situations in which Advanced Life Support should be utilized.
- 7-1.22 Describe the utilization of aeromedical EMS in a given EMS system. (C-1)
- 7-1.23 Describe the local dispatch and local protocols for use of Aeromedical transport.
- 7-1.24 Explain the rationale for patient care documentation. (A-3)
- 7-1.25 Explain the rationale for the EMS system gathering data. (A-3)
- 7-1.26 Explain the rationale for using medical terminology correctly. (A-3)
- 7-1.27 Explain the rationale for using an accurate and synchronous clock so that information can be used in trending. (A-3)
- 7-1.28 Explain the rationale for appropriate report of patient information. (A-3)
- 7-1.29 Explain the rationale for having the unit prepared to respond. (A-3)
- 7-1.30 Complete a prehospital care report. (P-2)

EMT-B Curriculum Objectives

Legend

C= Cognitive; P= Psychomotor; A= Affective

1= Knowledge Level; 2= Application Level; 3= Problem Solving Level

At the completion of each Module the EMT-B should be able to demonstrate the skills related to that module.

Module 1

- 1-1.1 Define Emergency Medical Services (EMS) systems.
- 1-1.2 Differentiate the roles and responsibilities of the EMT-Basic from other prehospital care providers.
- 1-1.3 Describe the roles and responsibilities related to personal safety
- 1-1.4 Discuss the roles and responsibilities of the EMT-Basic towards the safety of the crew, the patient and bystanders
- 1-1.5 Define quality improvement and discuss the EMT-Basic's role in the process.
- 1-1.6 Define medical direction and discuss the EMT-Basic's role in the process
- 1-1.7 State the specific statutes and regulations in your state regarding the EMS system.
- 1-1.8 Assess areas of personal attitude and conduct of the EMT-Basic
- 1-1.9 Characterize the various methods used to access the EMS system in your community.
- 1-2.1 List possible emotional reactions that the EMT-Basic may experience when faced with trauma, illness, death and dying.
- 1-2.2 Discuss the possible reactions that a family member may exhibit when confronted with death and dying.
- 1-2.3 State the steps in the EMT-Basic's approach to the family confronted with death and dying
- 1-2.4 State the possible reactions that the family of the EMT-Basic may exhibit due to their outside involvement in EMS.
- 1-2.5 Recognize the signs and symptoms of critical incident stress.
- 1-2.6 State possible steps that the EMT-Basic may take to help reduce/alleviate stress
- 1-2.7 Explain the need to determine scene safety.
- 1-2.8 Discuss the importance of body substance isolation (BSI)
- 1-2.9 Describe the steps the EMT-Basic should take for personal protection from airborne and bloodborne pathogens
- 1-2.10 List the personal protective equipment necessary for each of the following situations:
 - Hazardous materials
 - Rescue operations
 - Violent scenes
 - Crime scenes
 - Exposure to bloodborne pathogens
 - Exposure to airborne pathogens
- 1-2.11 Explain the rationale for serving as an advocate for the use of appropriate protective equipment.
- 1-3.1 Define the EMT-Basic scope of practice.
- 1-3.2 Discuss the importance of Do Not Resuscitate [DNR] (advance directives) and local or state provisions regarding EMS application.
- 1-3.3 Define consent and discuss the methods of obtaining consent.
- 1-3.4 Differentiate between expressed and implied consent.
- 1-3.5 Explain the role of consent of minors in providing care
- 1-3.6 Discuss the implications for the EMT-Basic in patient refusal of transport
- 1-3.7 Discuss the issues of abandonment, negligence, and battery and their implications to the EMT-Basic
- 1-3.8 State the conditions necessary for the EMT-Basic to have a duty to act.
- 1-3.9 Explain the importance, necessity and legality of patient confidentiality.
- 1-3.10 Discuss the considerations of the EMT-Basic in issues of organ retrieval
- 1-3.11 Differentiate the actions that an EMT-Basic should take to assist in the preservation of a crime scene.
- 1-3.12 State the conditions that require an EMT-Basic to notify local law enforcement officials
- 1-3.13 Explain the role of EMS and the EMT-Basic regarding patients with DNR orders.
- 1-3.14 Explain the rationale for the needs, benefits and usage of advance directives.
- 1-3.15 Explain the rationale for the concept of varying degrees of DNR.
- 1-4.1 Identify the following topographic terms:

- Medial, lateral, proximal, distal, superior, inferior, anterior, posterior, midline, right and left, mid-clavicular, bilateral, mid-axillary.
- 1-4.2 Describe the anatomy and function of the following major body systems:
- Respiratory, circulatory, musculoskeletal, nervous and endocrine.
- 1-5.1 Identify the components of vital signs.
- 1-5.2 Describe the methods to obtain a breathing rate.
- 1-5.3 Identify the attributes that should be obtained when assessing breathing.
- 1-5.4 Differentiate between shallow, labored and noisy breathing.
- 1-5.5 Describe the methods to obtain a pulse rate.
- 1-5.6 Identify the information obtained when assessing a patient's pulse.
- 1-5.7 Differentiate between a strong, weak, regular and irregular pulse
- 1-5.8 Describe the methods to assess the skin color, temperature, condition (capillary refill in infants and children).
- 1-5.9 Identify the normal and abnormal skin colors.
- 1-5.10 Differentiate between pale, blue, red and yellow skin color.
- 1-5.11 Identify the normal and abnormal skin temperature.
- 1-5.12 Differentiate between hot, cool and cold skin temperature.
- 1-5.13 Identify normal and abnormal skin conditions.
- 1-5.14 Identify normal and abnormal capillary refill in infants and children.
- 1-5.15 Describe the methods to assess the pupils.
- 1-5.16 Identify normal and abnormal pupil size.
- 1-5.17 Differentiate between dilated (big) and constricted (small) pupil size.
- 1-5.18 Differentiate between reactive and non-reactive pupils and equal and unequal pupils.
- 1-5.19 Describe the methods to assess blood pressure.
- 1-5.20 Define systolic pressure.
- 1-5.21 Define diastolic pressure.
- 1-5.22 Explain the difference between auscultation and palpation for obtaining a blood pressure.
- 1-5.23 Identify the components of the SAMPLE history
- 1-5.24 Differentiate between a sign and a symptom.
- 1-5.25 State the importance of accurately reporting and recording the baseline vital signs.
- 1-5.26 Discuss the need to search for additional medical identification.
- 1-5.27 Explain the value of performing the baseline vital signs.
- 1-5.28 Recognize and respond to the feelings patients experience during assessment.
- 1-5.29 Defend the need for obtaining and recording an accurate set of vital signs.
- 1-5.30 Explain the rationale of recording additional sets of vital signs.
- 1-5.31 Explain the importance of obtaining a SAMPLE history.
- 1-6.1 Define body mechanics.
- 1-6.2 Discuss the guidelines and safety precautions that need to be followed when lifting a patient.
- 1-6.3 Describe the safe lifting of cots and stretchers.
- 1-6.4 Describe the guidelines and safety precautions for carrying patients and/or equipment
- 1-6.5 Discuss one-handed carrying techniques.
- 1-6.6 Describe correct and safe carrying procedures on stairs.
- 1-6.7 State the guidelines for reaching and their application.
- 1-6.8 Describe correct reaching for log rolls
- 1-6.9 State the guidelines for pushing and pulling.
- 1-6.10 Discuss the general considerations of moving patients
- 1-6.11 State three situations that may require the use of an emergency move
- 1-6.12 Identify the following patient carrying devices:
- Wheeled ambulance stretcher
 - Portable ambulance stretcher
 - Stair chair
 - Scoop stretcher
 - Long spine board
 - Basket stretcher
 - Flexible stretcher

1-6.13 Explain the rationale for properly lifting and moving patients.

Module 2

- 2-1.1 Name and label the major structures of the respiratory system on a diagram.
- 2-1.2 List the signs of adequate breathing.
- 2-1.3 List the signs of inadequate breathing.
- 2-1.4 Describe the steps in performing the head-tilt chin-lift.
- 2-1.5 Relate mechanism of injury to opening the airway.
- 2-1.6 Describe the steps in performing the jaw thrust.
- 2-1.7 State the importance of having a suction unit ready for immediate use when providing emergency care.
- 2-1.8 Describe the techniques of suctioning.
- 2-1.9 Describe how to artificially ventilate a patient with a pocket mask.
- 2-1.10 Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.
- 2-1.11 List the parts of a bag-valve-mask system.
- 2-1.12 Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.
- 2-1.13 Describe the signs of adequate artificial ventilation using the bag-valve-mask
- 2-1.14 Describe the signs of inadequate artificial ventilation using the bag-valve-mask.
- 2-1.15 Describe the steps in artificially ventilating a patient with a flow restricted, oxygen-powered ventilation device.
- 2-1.16 List the steps in performing the actions taken when providing mouth-to-mouth and mouth-to-stoma artificial ventilation.)
- 2-1.17 Describe how to measure and insert an oropharyngeal (oral) airway.
- 2-1.18 Describe how to measure and insert a nasopharyngeal (nasal) airway.
- 2-1.19 Define the components of an oxygen delivery system.
- 2-1.20 Identify a nonbreather facemask and state the oxygen flow requirements needed for its use. (C-1)
- 2-1.21 Describe the indications for using a nasal cannula versus a nonbreather facemask. (C-1)
- 2-1.22 Identify a nasal cannula and state the flow requirements needed for its use. (C-1)
- 2-1.23 Explain the rationale for basic life support artificial ventilation and airway protective skills taking priority over most other basic life support skills. (A-3)
- 2-1.24 Explain the rationale for providing adequate oxygenation through high inspired oxygen concentrations to patients who, in the past, may have received low concentrations. (A-3)
- 2-1.25 Demonstrate the steps in performing the head-tilt chin-lift. (P-1, 2)
- 2-1.26 Demonstrate the steps in performing the jaw thrust. (P-1, 2)
- 2-1.27 Demonstrate the techniques of suctioning. (P-1, 2)
- 2-1.28 Demonstrate the steps in providing mouth-to-mouth artificial ventilation with body substance isolation (barrier shields). (P-1, 2)
- 2-1.29 Demonstrate how to use a pocket mask to artificially ventilate a patient. (P-1, 2)
- 2-1.30 Demonstrate the assembly of a bag-valve-mask unit. (P-1, 2)
- 2-1.31 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers. (P-1, 2)
- 2-1.32 Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust. (P-1, 2)
- 2-1.33 Demonstrate artificial ventilation of a patient with a flow restricted, oxygen-powered ventilation device. (P-1, 2)
- 2-1.34 Demonstrate how to artificially ventilate a patient with a stoma. (P-1, 2)
- 2-1.35 Demonstrate how to insert an oropharyngeal (oral) airway. (P-1, 2)
- 2-1.36 Demonstrate how to insert a nasopharyngeal (nasal) airway. (P-1, 2)
- 2-1.37 Demonstrate the correct operation of oxygen tanks and regulators. (P-1, 2)
- 2-1.38 Demonstrate the use of a nonbreather facemask and state the oxygen flow requirements needed for its use. (P-1, 2)
- 2-1.39 Demonstrate the use of a nasal cannula and state the flow requirements needed for its use. (P-1, 2)
- 2-1.40 Demonstrate how to artificially ventilate the infant and child patient. (P-1, 2)
- 2-1.41 Demonstrate oxygen administration for the infant and child patient. (P-1, 2)

Module 3

- 3-1.1 Recognize hazards/potential hazards. (C-1)
- 3-1.2 Describe common hazards found at the scene of a trauma and a medical patient. (C-1)
- 3-1.3 Determine if the scene is safe to enter. (C-2)

- 3-1.4 Discuss common mechanisms of injury/nature of illness. (C-1)
- 3-1.5 Discuss the reason for identifying the total number of patients at the scene. (C-1)
- 3-1.6 Explain the reason for identifying the need for additional help or assistance. (C-1)
- 3-1.7 Explain the rationale for crewmembers to evaluate scene safety prior to entering. (A-2)
- 3-1.8 Serve as a model for others explaining how patient situations affect your evaluation of mechanism of injury or illness. (A-2)
- 3-1.9 Observe various scenarios and identify potential hazards. (P-1)
- 3-2.1 Summarize the reasons for forming a general impression of the patient. (C-1)
- 3-2.2 Discuss methods of assessing altered mental status. (C-1)
- 3-2.3 Differentiate between assessing the altered mental status in the adult, child and infant patient. (C-3)
- 3-2.4 Discuss methods of assessing the airway in the adult, child and infant patient. (C-1)
- 3-2.5 State reasons for management of the cervical spine once the patient has been determined to be a trauma patient. (C-1)
- 3-2.6 Describe methods used for assessing if a patient is breathing. (C-1)
- 3-2.7 State what care should be provided to the adult, child and infant patient with adequate breathing. (C-1)
- 3-2.8 State what care should be provided to the adult, child and infant patient without adequate breathing. (C-1)
- 3-2.9 Differentiate between a patient with adequate and inadequate breathing. (C-3)
- 3-2.10 Distinguish between methods of assessing breathing in the adult, child and infant patient. (C-3)
- 3-2.11 Compare the methods of providing airway care to the adult, child and infant patient.
- 3-2.12 Describe the methods used to obtain a pulse. (C-1)
- 3-2.13 Differentiate between obtaining a pulse in an adult, child and infant patient. (C-3)
- 3-2.14 Discuss the need for assessing the patient for external bleeding. (C-1)
- 3-2.15 Describe normal and abnormal findings when assessing skin color. (C-1)
- 3-2.16 Describe normal and abnormal findings when assessing skin temperature. (C-1)
- 3-2.17 Describe normal and abnormal findings when assessing skin condition. (C-1)
- 3-2.18 Describe normal and abnormal findings when assessing skin capillary refill in the infant and child patient. (C-1)
- 3-2.19 Explain the reason for prioritizing a patient for care and transport. (C-1)
- 3-2.20 Explain the importance of forming a general impression of the patient. (A-1)
- 3-2.21 Explain the value of performing an initial assessment. (A-2)
- 3-2.22 Demonstrate the techniques for assessing mental status. (P-1, 2)
- 3-2.23 Demonstrate the techniques for assessing the airway. (P-1, 2)
- 3-2.24 Demonstrate the techniques for assessing if the patient is breathing. (P-1, 2)
- 3-2.25 Demonstrate the techniques for assessing if the patient has a pulse. (P-1, 2)
- 3-2.26 Demonstrate the techniques for assessing the patient for external bleeding. (P-1, 2)
- 3-2.27 Demonstrate the techniques for assessing the patient's skin color, temperature, condition and capillary refill (infants and children only). (P-1, 2)
- 3-2.28 Demonstrate the ability to prioritize patients. (P-1, 2)
- 3-3.1 Discuss the reasons for reconsideration concerning the mechanism of injury. (C-1)
- 3-3.2 State the reasons for performing a rapid trauma assessment. (C-1)
- 3-3.3 Recite examples and explain why patients should receive a rapid trauma assessment.
- 3-3.4 Describe the areas included in the rapid trauma assessment and discuss what should be evaluated. (C-1)
- 3-3.5 Differentiate when the rapid assessment may be altered in order to provide patient care.
- 3-3.6 Discuss the reason for performing a focused history and physical exam. (C-1)
- 3-3.7 Recognize and respect the feelings that patients might experience during assessment.
- 3-3.8 Demonstrate the rapid trauma assessment that should be used to assess a patient based on mechanism of injury. (P-1, 2)
- 3-4.1 Describe the unique needs for assessing an individual with a specific chief complaint with no known prior history. (C-1)
- 3-4.2 Differentiate between the history and physical exam that are performed for responsive patients with no known prior history and responsive patients with a known prior history. (C-3)
- 3-4.3 Describe the needs for assessing an individual who is unresponsive. (C-1)
- 3-4.4 Differentiate between the assessment that is performed for a patient who is unresponsive or has an altered mental status and other medical patients requiring assessment. (C-3)
- 3-4.5 Attend to the feelings that these patients might be experiencing. (A-1)
- 3-4.6 Demonstrate the patient assessment skills that should be used to assist a patient who is responsive with no known history. (P-1, 2)
- 3-4.7 Demonstrate the patient assessment skills that should be used to assist a patient who is unresponsive or has an altered mental status. (P-1, 2)
- 3-5.1 Discuss the components of the detailed physical exam. (C-1)

- 3-5.2 State the areas of the body that are evaluated during the detailed physical exam. (C-1)
- 3-5.3 Explain what additional care should be provided while performing the detailed physical exam. (C-1)
- 3-5.4 Distinguish between the detailed physical exam that is performed on a trauma patient and that of the medical patient. (C-3)
- 3-5.5 Explain the rationale for the feelings that these patients might be experiencing. (A-3)
- 3-5.6 Demonstrate the skills involved in performing the detailed physical exam. (P-1, 2)
- 3-6.1 Discuss the reasons for repeating the initial assessment as part of the on-going assessment. (C-1)
- 3-6.2 Describe the components of the on-going assessment. (C-1)
- 3-6.3 Describe trending of assessment components. (C-1)
- 3-6.4 Explain the value of performing an on-going assessment. (A-2)
- 3-6.5 Recognize and respect the feelings that patients might experience during assessment.
- 3-6.6 Explain the value of trending assessment components to other health professionals who assume care of the patient. (A-2)
- 3-6.7 Demonstrate the skills involved in performing the on-going assessment. (P-1, 2)
- 3-7.1 List the proper methods of initiating and terminating a radio call. (C-1)
- 3-7.2 State the proper sequence for delivery of patient information. (C-1)
- 3-7.3 Explain the importance of effective communication of patient information in the verbal report. (C-1)
- 3-7.4 Identify the essential components of the verbal report. (C-1)
- 3-7.5 Describe the attributes for increasing effectiveness and efficiency of verbal communications. (C-1)
- 3-7.6 State legal aspects to consider in verbal communication. (C-1)
- 3-7.7 Discuss the communication skills that should be used to interact with the patient. (C-1)
- 3-7.8 Discuss the communication skills that should be used to interact with the family, bystanders, individuals from other agencies while providing patient care and the difference between skills used to interact with the patient and those used to interact with others. (C-1)
- 3-7.9 List the correct radio procedures in the following phases of a typical call:(C-1)
 - To the scene.
 - At the scene.
 - To the facility.
 - At the facility.
 - To the station.
 - At the station.
- 3-7.10 Explain the rationale for providing efficient and effective radio communications and patient reports. (A-3)
- 3-7.11 Perform a simulated, organized, concise radio transmission. (P-2)
- 3-7.12 Perform an organized, concise patient report that would be given to the staff at a receiving facility. (P-2)
- 3-7.13 Perform a brief, organized report that would be given to an ALS provider arriving at an incident scene at which the EMT-Basic was already providing care. (P-2)
- 3-8.1 Explain the components of the written report and list the information that should be included in the written report. (C-1)
- 3-8.2 Identify the various sections of the written report. (C-1)
- 3-8.3 Describe what information is required in each section of the prehospital care report and how it should be entered. (C-1)
- 3-8.4 Define the special considerations concerning patient refusal. (C-1)
- 3-8.5 Describe the legal implications associated with the written report. (C-1)
- 3-8.6 Discuss all state and/or local record and reporting requirements. (C-1)
- 3-8.7 Explain the rationale for patient care documentation. (A-3)
- 3-8.8 Explain the rationale for the EMS system gathering data. (A-3)
- 3-8.9 Explain the rationale for using medical terminology correctly. (A-3)
- 3-8.10 Explain the rationale for using an accurate and synchronous clock so that information can be used in trending. (A-3)
- 3-8.11 Complete a prehospital care report. (P-2)

Module 4

- 4-1.1 Identify which medications will be carried on the unit. (C-1)
- 4-1.2 State the medications carried on the unit by the generic name. (C-1)
- 4-1.3 Identify the medications with which the EMT-Basic may assist the patient with administering. (C-1)
- 4-1.4 State the medications the EMT-Basic can assist the patient with by the generic name. (C-1)
- 4-1.5 Discuss the forms in which the medications may be found. (C-1)
- 4-1.6 Explain the rationale for the administration of medications. (A-3)
- 4-1.7 Demonstrate general steps for assisting patient with self-administration of medications. (P-2)
- 4-1.8 Read the labels and inspect each type of medication. (P-2)

- 4-2.1 List the structure and function of the respiratory system. (C-1)
- 4-2.2 State the signs and symptoms of a patient with breathing difficulty. (C-1)
- 4-2.3 Describe the emergency medical care of the patient with breathing difficulty. (C-1)
- 4-2.4 Recognize the need for medical direction to assist in the emergency medical care of the patient with breathing difficulty. (C-3)
- 4-2.5 Describe the emergency medical care of the patient with breathing distress. (C-1)
- 4-2.6 Establish the relationship between airway management and the patient with breathing difficulty. (C-3)
- 4-2.7 List signs of adequate air exchange. (C-1)

- 4-2.8 State the generic name, medication forms, dose, administration, action, indications and contraindications for the prescribed inhaler. (C-1)
- 4-2.9 Distinguish between the emergency medical care of the infant, child and adult patient with breathing difficulty. (C-3)
- 4-2.10 Differentiate between upper airway obstruction and lower airway disease in the infant and child patient. (C-3)
- 4-2.11 Defend EMT-Basic treatment regimens for various respiratory emergencies. (A-1)
- 4-2.12 Explain the rationale for administering an inhaler. (A-3)
- 4-2.13 Demonstrate the emergency medical care for breathing difficulty. (P-1, 2)
- 4-2.14 Perform the steps in facilitating the use of an inhaler. (P-2)
- 4-3.1 Describe the structure and function of the cardiovascular system. (C-1)
- 4-3.2 Describe the emergency medical care of the patient experiencing chest pain/discomfort. (C-1)
- 4-3.3 List the indications for automated external defibrillation (AED). (C-1)
- 4-3.4 List the contraindications for automated external defibrillation. (C-1)
- 4-3.5 Define the role of EMT-B in the emergency cardiac care system. (C-1)
- 4-3.6 Explain the impact of age and weight on defibrillation. (C-1)
- 4-3.7 Discuss the position of comfort for patients with various cardiac emergencies. (C-1)
- 4-3.8 Establish the relationship between airway management and the patient with cardiovascular compromise. (C-3)
- 4-3.9 Predict the relationship between the patient experiencing cardiovascular compromise and basic life support. (C-2)
- 4-3.10 Discuss the fundamentals of early defibrillation. (C-1)
- 4-3.11 Explain the rationale for early defibrillation. (C-1)
- 4-3.12 Explain that not all chest pain patients result in cardiac arrest and do not need to be attached to an automated external defibrillator. (C-1)
- 4-3.13 Explain the importance of prehospital ACLS intervention if it is available. (C-1)
- 4-3.14 Explain the importance of urgent transport to a facility with Advanced Cardiac Life Support if it is not available in the prehospital setting. (C-1)
- 4-3.15 Discuss the various types of automated external defibrillators. (C-1)
- 4-3.16 Differentiate between the fully automated and the semiautomatic defibrillator. (C-3)
- 4-3.17 Discuss the procedures that must be taken into consideration for standard operations of the various types of automated external defibrillators. (C-1)
- 4-3.18 State the reasons for assuring that the patient is pulseless and apneic when using the automated external defibrillator. (C-1)
- 4-3.19 Discuss the circumstances which may result in inappropriate shocks. (C-1)
- 4-3.20 Explain the considerations for interruption of CPR, when using the automated external defibrillator. (C-1)
- 4-3.21 Discuss the advantages and disadvantages of automated external defibrillators. (C-1)
- 4-3.22 Summarize the speed of operation of automated external defibrillation. (C-1)
- 4-3.23 Discuss the use of remote defibrillation through adhesive pads. (C-1)
- 4-3.24 Discuss the special considerations for rhythm monitoring. (C-1)
- 4-3.25 List the steps in the operation of the automated external defibrillator. (C-1)
- 4-3.26 Discuss the standard of care that should be used to provide care to a patient with persistent ventricular fibrillation and no available ACLS. (C-1)
- 4-3.27 Discuss the standard of care that should be used to provide care to a patient with recurrent ventricular fibrillation and no available ACLS. (C-1)
- 4-3.28 Differentiate between the single rescuer and multi-rescuer care with an automated external defibrillator. (C-3)
- 4-3.29 Explain the reason for pulses not being checked between shocks with an automated external defibrillator. (C-1)
- 4-3.30 Discuss the importance of coordinating ACLS trained providers with personnel using automated external defibrillators. (C-1)
- 4-3.31 Discuss the importance of post-resuscitation care. (C-1)
- 4-3.32 List the components of post-resuscitation care. (C-1)
- 4-3.33 Explain the importance of frequent practice with the automated external defibrillator. (C-1)
- 4-3.34 Discuss the need to complete the Automated Defibrillator: Operator's Shift Checklist. (C-1)

- 4-3.35 Discuss the role of the American Heart Association (AHA) in the use of automated external defibrillation. (C-1)
- 4-3.36 Explain the role medical direction plays in the use of automated external defibrillation. (C-1)
- 4-3.37 State the reasons why a case review should be completed following the use of the automated external defibrillator. (C-1)
- 4-3.38 Discuss the components that should be included in a case review. (C-1)
- 4-3.39 Discuss the goal of quality improvement in automated external defibrillation. (C-1)
- 4-3.40 Recognize the need for medical direction of protocols to assist in the emergency medical care of the patient with chest pain. (C-3)
- 4-3.41 List the indications for the use of nitroglycerin. (C-1)
- 4-3.42 State the contraindications and side effects for the use of nitroglycerin. (C-1)
- 4-3.43 Define the function of all controls on an automated external defibrillator, and describe event documentation and battery defibrillator maintenance. (C-1)
- 4-3.44 Defend the reasons for obtaining initial training in automated external defibrillation and the importance of continuing education. (A-3)
- 4-3.45 Defend the reason for maintenance of automated external defibrillators. (A-3)
- 4-3.46 Explain the rationale for administering nitroglycerin to a patient with chest pain or discomfort. (A-3)
- 4-3.47 Demonstrate the assessment and emergency medical care of a patient experiencing chest pain/discomfort. (P-1, 2)
- 4-3.48 Demonstrate the application and operation of the automated external defibrillator.
- 4-3.49 Demonstrate the maintenance of an automated external defibrillator. (P-1, 2)
- 4-3.50 Demonstrate the assessment and documentation of patient response to the automated external defibrillator. (P-1, 2)
- 4-3.51 Demonstrate the skills necessary to complete the Automated Defibrillator: Operator's Shift Checklist. (P-1, 2)
- 4-3.52 Perform the steps in facilitating the use of nitroglycerin for chest pain or discomfort.
- 4-3.53 Demonstrate the assessment and documentation of patient response to nitroglycerin.
- 4-3.54 Practice completing a prehospital care report for patients with cardiac emergencies.
- 4-4.1 Identify the patient taking diabetic medications with altered mental status and the implications of a diabetes history. (C-1)
- 4-4.2 State the steps in the emergency medical care of the patient taking diabetic medicine with an altered mental status and a history of diabetes. (C-1)
- 4-4.3 Establish the relationship between airway management and the patient with altered mental status. (C-3)
- 4-4.4 State the generic and trade names, medication forms, dose, administration, action, and contraindications for oral glucose. (C-1)
- 4-4.5 Evaluate the need for medical direction in the emergency medical care of the diabetic patient. (C-3)
- 4-4.6 Explain the rationale for administering oral glucose. (A-3)
- 4-4.7 Demonstrate the steps in the emergency medical care for the patient taking diabetic medicine with an altered mental status and a history of diabetes. (P-1, 2)
- 4-4.8 Demonstrate the steps in the administration of oral glucose. (P-1, 2)
- 4-4.9 Demonstrate the assessment and documentation of patient response to oral glucose.
- 4-4.10 Demonstrate how to complete a prehospital care report for patients with diabetic emergencies. (P-2)
- 4-5.1 Recognize the patient experiencing an allergic reaction. (C-1)
- 4-5.2 Describe the emergency medical care of the patient with an allergic reaction. (C-1)
- 4-5.3 Establish the relationship between the patient with an allergic reaction and airway management. (C-3)
- 4-5.4 Describe the mechanisms of allergic response and the implications for airway management. (C-1)
- 4-5.5 State the generic and trade names, medication forms, dose, administration, action, and contraindications for the epinephrine auto-injector. (C-1)
- 4-5.6 Evaluate the need for medical direction in the emergency medical care of the patient with an allergic reaction. (C-3)
- 4-5.7 Differentiate between the general category of those patients having an allergic reaction and those patients having an allergic reaction and requiring immediate medical care, including immediate use of epinephrine auto-injector. (C-3)
- 4-5.8 Explain the rationale for administering epinephrine using an auto-injector. (A-3)
- 4-5.9 Demonstrate the emergency medical care of the patient experiencing an allergic reaction. (P-1, 2)
- 4-5.10 Demonstrate the use of epinephrine auto-injector. (P-1, 2)
- 4-5.11 Demonstrate the assessment and documentation of patient response to an epinephrine injection. (P-1, 2)
- 4-5.12 Demonstrate proper disposal of equipment. (P-1, 2)
- 4-5.13 Demonstrate completing a prehospital care report for patients with allergic emergencies. (P-2)
- 4-6.1 List various ways that poisons enter the body. (C-1)
- 4-6.2 List signs/symptoms associated with poisoning. (C-1)
- 4-6.3 Discuss the emergency medical care for the patient with possible overdose. (C-1)
- 4-6.4 Describe the steps in the emergency medical care for the patient with suspected poisoning. (C-1)

- 4-6.5 Establish the relationship between the patient suffering from poisoning or overdose and airway management. (C-3)
- 4-6.6 State the generic and trade names, indications, contraindications, medication form, dose, administration, actions, side effects and re-assessment strategies for activated charcoal. (C-1)
- 4-6.7 Recognize the need for medical direction in caring for the patient with poisoning or overdose. (C-3)
- 4-6.8 Explain the rationale for administering activated charcoal. (A-3)
- 4-6.9 Explain the rationale for contacting medical direction early in the prehospital management of the poisoning or overdose patient. (A-3)
- 4-6.10 Demonstrate the steps in the emergency medical care for the patient with possible overdose. (P-1, 2)
- 4-6.11 Demonstrate the steps in the emergency medical care for the patient with suspected poisoning. (P-1, 2)
- 4-6.12 Perform the necessary steps required to provide a patient with activated charcoal. (P-2)
- 4-6.13 Demonstrate the assessment and documentation of patient response. (P-1, 2)
- 4-6.14 Demonstrate proper disposal of the equipment for the administration of activated charcoal. (P-1, 2)
- 4-6.15 Demonstrate completing a prehospital care report for patients with a poisoning/overdose emergency. (P-1, 2)
- 4-7.1 Describe the various ways that the body loses heat. (C-1)
- 4-7.2 List the signs and symptoms of exposure to cold. (C-1)
- 4-7.3 Explain the steps in providing emergency medical care to a patient exposed to cold.
- 4-7.4 List the signs and symptoms of exposure to heat. (C-1)
- 4-7.5 Explain the steps in providing emergency care to a patient exposed to heat. (C-1)
- 4-7.6 Recognize the signs and symptoms of water-related emergencies. (C-1)
- 4-7.7 Describe the complications of near drowning. (C-1)
- 4-7.8 Discuss the emergency medical care of bites and stings. (C-1)
- 4-7.9 Demonstrate the assessment and emergency medical care of a patient with exposure to cold. (P-1, 2)
- 4-7.10 Demonstrate the assessment and emergency medical care of a patient with exposure to heat. (P-1, 2)
- 4-7.11 Demonstrate the assessment and emergency medical care of a near drowning patient.
- 4-7.12 Demonstrate completing a prehospital care report for patients with environmental emergencies. (P-2)
- 4-8.1 Define behavioral emergencies. (C-1)
- 4-8.2 Discuss the general factors that may cause an alteration in a patient's behavior. (C-1)
- 4-8.3 State the various reasons for psychological crises. (C-1)
- 4-8.4 Discuss the characteristics of an individual's behavior which suggests that the patient is at risk for suicide. (C-1)
- 4-8.5 Discuss special medical/legal considerations for managing behavioral emergencies.
- 4-8.6 Discuss the special considerations for assessing a patient with behavioral problems.
- 4-8.7 Discuss the general principles of an individual's behavior which suggests that he is at risk for violence. (C-1)
- 4-8.8 Discuss methods to calm behavioral emergency patients. (C-1)
- 4-8.9 Explain the rationale for learning how to modify your behavior toward the patient with a behavioral emergency. (A-3)
- 4-8.10 Demonstrate the assessment and emergency medical care of the patient experiencing a behavioral emergency. (P-1, 2)
- 4-8.11 Demonstrate various techniques to safely restrain a patient with a behavioral problem. (P-1, 2)
- 4-9.1 Identify the following structures: Uterus, vagina, fetus, placenta, umbilical cord, amniotic sac, and perineum. (C-1)
- 4-9.2 Identify and explain the use of the contents of an obstetrics kit. (C-1)
- 4-9.3 Identify pre-delivery emergencies. (C-1)
- 4-9.4 State indications of an imminent delivery. (C-1)
- 4-9.5 Differentiate the emergency medical care provided to a patient with pre-delivery emergencies from a normal delivery. (C-3)
- 4-9.6 State the steps in the pre-delivery preparation of the mother. (C-1)
- 4-9.7 Establish the relationship between body substance isolation and childbirth. (C-3)
- 4-9.8 State the steps to assist in the delivery. (C-1)
- 4-9.9 Describe care of the baby as the head appears. (C-1)
- 4-9.10 Describe how and when to cut the umbilical cord. (C-1)
- 4-9.11 Discuss the steps in the delivery of the placenta. (C-1)
- 4-9.12 List the steps in the emergency medical care of the mother post-delivery. (C-3)
- 4-9.13 Summarize neonatal resuscitation procedures. (C-1)
- 4-9.14 Describe the procedures for the following abnormal deliveries: Breech birth, prolapsed cord, limb presentation. (C-1)
- 4-9.15 Differentiate the special considerations for multiple births. (C-3)
- 4-9.16 Describe special considerations of meconium. (C-1)
- 4-9.17 Describe special considerations of a premature baby. (C-1)
- 4-9.18 Discuss the emergency medical care of a patient with a gynecological emergency. (C-1)
- 4-9.19 Explain the rationale for understanding the implications of treating two patients (mother and baby). (A-3)

- 4-9.20 Demonstrate the steps to assist in the normal cephalic delivery. (P-1, 2)
- 4-9.21 Demonstrate necessary care procedures of the fetus as the head appears. (P-1, 2)
- 4-9.22 Demonstrate infant neonatal procedures. (P-1, 2)
- 4-9.23 Demonstrate post delivery care of infant. (P-1, 2)
- 4-9.24 Demonstrate how and when to cut the umbilical cord. (P-1, 2)
- 4-9.25 Attend to the steps in the delivery of the placenta. (P-1, 2)
- 4-9.26 Demonstrate the post-delivery care of the mother. (P-1, 2)
- 4-9.27 Demonstrate the procedures for the following abnormal deliveries: vaginal bleeding, breech birth, prolapsed cord, limb presentation. (P-1, 2)
- 4-9.28 Demonstrate the steps in the emergency medical care of the mother with excessive bleeding. (P-1, 2)
- 4-9.29 Demonstrate completing a prehospital care report for patients with obstetrical/gynecological emergencies. (P-2)

Module 5

- 5-1.1 List the structure and function of the circulatory system. (C-1)
- 5-1.2 Differentiate between arterial, venous and capillary bleeding. (C-3)
- 5-1.3 State methods of emergency medical care of external bleeding. (C-1)
- 5-1.4 Establish the relationship between body substance isolation and bleeding. (C-3)
- 5-1.5 Establish the relationship between airway management and the trauma patient. (C-3)
- 5-1.6 Establish the relationship between mechanism of injury and internal bleeding. (C-3)
- 5-1.7 List the signs of internal bleeding. (C-1)
- 5-1.8 List the steps in the emergency medical care of the patient with signs and symptoms of internal bleeding. (C-1)
- 5-1.9 List signs and symptoms of shock (hypoperfusion). (C-1)
- 5-1.10 State the steps in the emergency medical care of the patient with signs and symptoms of shock (hypoperfusion). (C-1)
- 5-1.11 Explain the sense of urgency to transport patients that are bleeding and show signs of shock (hypoperfusion). (A-1)
- 5-1.12 Demonstrate direct pressure as a method of emergency medical care of external bleeding. (P-1, 2)
- 5-1.13 Demonstrate the use of diffuse pressure as a method of emergency medical care of external bleeding. (P-1, 2)
- 5-1.14 Demonstrate the use of pressure points and tourniquets as a method of emergency medical care of external bleeding. (P-1, 2)
- 5-1.15 Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding. (P-1, 2)
- 5-1.16 Demonstrate the care of the patient exhibiting signs and symptoms of shock (hypoperfusion). (P-1, 2)
- 5-1.17 Demonstrate completing a prehospital care report for patient with bleeding and/or shock (hypoperfusion). (P-2)
- 5-2.1 State the major functions of the skin. (C-1)
- 5-2.2 List the layers of the skin. (C-1)
- 5-2.3 Establish the relationship between body substance isolation (BSI) and soft tissue injuries. (C-3)
- 5-2.4 List the types of closed soft tissue injuries. (C-1)
- 5-2.5 Describe the emergency medical care of the patient with a closed soft tissue injury. (C-1)
- 5-2.6 State the types of open soft tissue injuries. (C-1)
- 5-2.7 Describe the emergency medical care of the patient with an open soft tissue injury. (C-1)
- 5-2.8 Discuss the emergency medical care considerations for a patient with a penetrating chest injury. (C-1)
- 5-2.9 State the emergency medical care considerations for a patient with an open wound to the abdomen. (C-1)
- 5-2.10 Differentiate the care of an open wound to the chest from an open wound to the abdomen. (C-3)
- 5-2.11 List the classifications of burns. (C-1)
- 5-2.12 Define superficial burn. (C-1)
- 5-2.13 List the characteristics of a superficial burn. (C-1)
- 5-2.14 Define partial thickness burn. (C-1)
- 5-2.15 List the characteristics of a partial thickness burn. (C-1)
- 5-2.16 Define full thickness burn. (C-1)
- 5-2.17 List the characteristics of a full thickness burn. (C-1)
- 5-2.18 Describe the emergency medical care of the patient with a superficial burn. (C-1)
- 5-2.19 Describe the emergency medical care of the patient with a partial thickness burn. (C-1)
- 5-2.20 Describe the emergency medical care of the patient with a full thickness burn. (C-1)
- 5-2.21 List the functions of dressing and bandaging. (C-1)
- 5-2.22 Describe the purpose of a bandage. (C-1)
- 5-2.23 Describe the steps in applying a pressure dressing. (C-1)

- 5-2.24 Establish the relationship between airway management and the patient with chest injury, burns, blunt and penetrating injuries. (C-1)
- 5-2.25 Describe the effects of improperly applied dressings, splints and tourniquets. (C-1)
- 5-2.26 Describe the emergency medical care of a patient with an impaled object. (C-1)
- 5-2.27 Describe the emergency medical care of a patient with an amputation. (C-1)
- 5-2.28 Describe the emergency care for a chemical burn. (C-1)
- 5-2.29 Describe the emergency care for an electrical burn. (C-1)
- 5-2.30 Demonstrate the steps in the emergency medical care of closed soft tissue injuries. (P-1, 2)
- 5-2.31 Demonstrate the steps in the emergency medical care of open soft tissue injuries. (P-1, 2)
- 5-2.32 Demonstrate the steps in the emergency medical care of a patient with an open chest wound. (P-1, 2)
- 5-2.33 Demonstrate the steps in the emergency medical care of a patient with open abdominal wounds. (P-1, 2)
- 5-2.33 Demonstrate the steps in the emergency medical care of a patient with an impaled object. (P-1, 2)
- 5-2.34 Demonstrate the steps in the emergency medical care of a patient with an amputation. (P-1, 2)
- 5-2.35 Demonstrate the steps in the emergency medical care of an amputated part. (P-1, 2)
- 5-2.36 Demonstrate the steps in the emergency medical care of a patient with superficial burns. (P-1, 2)
- 5-2.37 Demonstrate the steps in the emergency medical care of a patient with partial thickness burns. (P-1, 2)
- 5-2.38 Demonstrate the steps in the emergency medical care of a patient with full thickness burns. (P-1, 2)
- 5-2.39 Demonstrate the steps in the emergency medical care of a patient with a chemical burn. (P-1, 2)
- 5-2.40 Demonstrate completing a prehospital care report for patients with soft tissue injuries. (P-2)
- 5-3.1 Describe the function of the muscular system. (C-1)
- 5-3.2 Describe the function of the skeletal system. (C-1)
- 5-3.3 List the major bones or bone groupings of the spinal column; the thorax; the upper extremities; the lower extremities. (C-1)
- 5-3.4 Differentiate between an open and a closed painful, swollen, deformed extremity. (C-1)
- 5-3.5 State the reasons for splinting. (C-1)
- 5-3.6 List the general rules of splinting. (C-1)
- 5-3.7 List the complications of splinting. (C-1)
- 5-3.8 List the emergency medical care for a patient with a painful, swollen, deformed extremity. (C-1)
- 5-3.9 Explain the rationale for splinting at the scene versus load and go. (A-3)
- 5-3.10 Explain the rationale for immobilization of the painful, swollen, deformed extremity. (A-3)
- 5-3.11 Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity. (P-1, 2)
- 5-3.12 Demonstrate completing a prehospital care report for patients with musculoskeletal injuries. (P-2)
- 5-4.1 State the components of the nervous system. (C-1)
- 5-4.2 List the functions of the central nervous system. (C-1)
- 5-4.3 Define the structure of the skeletal system as it relates to the nervous system. (C-1)
- 5-4.4 Relate mechanism of injury to potential injuries of the head and spine. (C-3)
- 5-4.5 Describe the implications of not properly caring for potential spine injuries. (C-1)
- 5-4.6 State the signs and symptoms of a potential spine injury. (C-1)
- 5-4.7 Describe the method of determining if a responsive patient may have a spine injury.
- 5-4.8 Relate the airway emergency medical care techniques to the patient with a suspected spine injury. (C-3)
- 5-4.9 Describe how to stabilize the cervical spine. (C-1)
- 5-4.10 Discuss indications for sizing and using a cervical spine immobilization device. (C-1)
- 5-4.11 Establish the relationship between airway management and the patient with head and spine injuries. (C-1)
- 5-4.12 Describe a method for sizing a cervical spine immobilization device. (C-1)
- 5-4.13 Describe how to log roll a patient with a suspected spine injury. (C-1)
- 5-4.14 Describe how to secure a patient to a long spine board. (C-1)
- 5-4.15 List instances when a short spine board should be used. (C-1)
- 5-4.16 Describe how to immobilize a patient using a short spine board. (C-1)
- 5-4.17 Describe the indications for the use of rapid extrication. (C-1)
- 5-4.18 List steps in performing rapid extrication. (C-1)
- 5-4.19 State the circumstances when a helmet should be left on the patient. (C-1)
- 5-4.20 Discuss the circumstances when a helmet should be removed. (C-1)
- 5-4.21 Identify different types of helmets. (C-1)
- 5-4.22 Describe the unique characteristics of sports helmets. (C-1)
- 5-4.23 Explain the preferred methods to remove a helmet. (C-1)
- 5-4.24 Discuss alternative methods for removal of a helmet. (C-1)

- 5-4.25 Describe how the patient's head is stabilized to remove the helmet. (C-1)
- 5-4.26 Differentiate how the head is stabilized with a helmet compared to without a helmet.
- 5-4.27 Explain the rationale for immobilization of the entire spine when a cervical spine injury is suspected. (A-3)
- 5-4.28 Explain the rationale for utilizing immobilization methods apart from the straps on the cots. (A-3)
- 5-4.29 Explain the rationale for utilizing a short spine immobilization device when moving a patient from the sitting to the supine position. (A-3)
- 5-4.30 Explain the rationale for utilizing rapid extrication approaches only when they indeed will make the difference between life and death. (A-3)
- 5-4.31 Defend the reasons for leaving a helmet in place for transport of a patient. (A-3)
- 5-4.32 Defend the reasons for removal of a helmet prior to transport of a patient. (A-3)
- 5-4.33 Demonstrate opening the airway in a patient with suspected spinal cord injury. (P-1, 2)
- 5-4.34 Demonstrate evaluating a responsive patient with a suspected spinal cord injury. (P-1, 2)
- 5-4.35 Demonstrate stabilization of the cervical spine. (P-1, 2)
- 5-4.36 Demonstrate the four-person log roll for a patient with a suspected spinal cord injury. (P-1, 2)
- 5-4.37 Demonstrate how to log roll a patient with a suspected spinal cord injury using two people. (P-1, 2)
- 5-4.38 Demonstrate securing a patient to a long spine board. (P-1, 2)
- 5-4.39 Demonstrate using the short board immobilization technique. (P-1, 2)
- 5-4.40 Demonstrate procedure for rapid extrication. (P-1, 2)
- 5-4.41 Demonstrate preferred methods for stabilization of a helmet. (P-1, 2)
- 5-4.42 Demonstrate helmet removal techniques. (P-1, 2)
- 5-4.43 Demonstrate alternative methods for stabilization of a helmet. (P-1, 2)
- 5-4.44 Demonstrate completing a prehospital care report for patients with head and spinal injuries. (P-2)

Module 6

- 6-1.1 Identify the developmental considerations for the following age groups:(C-1)
 - infants
 - toddlers
 - pre-school
 - school age
 - adolescent
- 6-1.2 Describe differences in anatomy and physiology of the infant, child and adult patient. (C-1)
- 6-1.3 Differentiate the response of the ill or injured infant or child (age specific) from that of an adult. (C-3)
- 6-1.4 Indicate various causes of respiratory emergencies. (C-1)
- 6-1.5 Differentiate between respiratory distress and respiratory failure. (C-3)
- 6-1.6 List the steps in the management of foreign body airway obstruction. (C-1)
- 6-1.7 Summarize emergency medical care strategies for respiratory distress and respiratory failure. (C-1)
- 6-1.8 Identify the signs and symptoms of shock (hypoperfusion) in the infant and child patient. (C-1)
- 6-1.9 Describe the methods of determining end organ perfusion in the infant and child patient. (C-1)
- 6-1.10 State the usual cause of cardiac arrest in infants and children versus adults. (C-1)
- 6-1.11 List the common causes of seizures in the infant and child patient. (C-1)
- 6-1.12 Describe the management of seizures in the infant and child patient. (C-1)
- 6-1.13 Differentiate between the injury patterns in adults, infants, and children. (C-3)
- 6-1.14 Discuss the field management of the infant and child trauma patient. (C-1)
- 6-1.15 Summarize the indicators of possible child abuse and neglect. (C-1)
- 6-1.16 Describe the medical legal responsibilities in suspected child abuse. (C-1)
- 6-1.17 Recognize need for EMT-Basic debriefing following a difficult infant or child transport. (C-1)
- 6-1.18 Explain the rationale for having knowledge and skills appropriate for dealing with the infant and child patient. (A-3)
- 6-1.19 Attend to the feelings of the family when dealing with an ill or injured infant or child. (A-1)
- 6-1.20 Understand the provider's own response (emotional) to caring for infants or children. (A-1)
- 6-1.21 Demonstrate the techniques of foreign body airway obstruction removal in the infant. (P-1, 2)
- 6-1.22 Demonstrate the techniques of foreign body airway obstruction removal in the child.
- 6-1.23 Demonstrate the assessment of the infant and child. (P-1, 2)
- 6-1.24 Demonstrate bag-valve-mask artificial ventilations for the infant. (P-1, 2)
- 6-1.25 Demonstrate bag-valve-mask artificial ventilations for the child. (P-1, 2)
- 6-1.26 Demonstrate oxygen delivery for the infant and child. (P-1, 2)

Module 7

- 7-1.1 Discuss the medical and non-medical equipment needed to respond to a call. (C-1)
- 7-1.2 List the phases of an ambulance call. (C-1)
- 7-1.3 Describe the general provisions of state laws relating to the operation of the ambulance and privileges in any or all of the following categories: (C-1)
 - Speed
 - Warning lights
 - Sirens
 - Right-of-way
 - Parking
 - Turning
- 7-1.4 List contributing factors to unsafe driving conditions. (C-1)
- 7-1.5 Describe the considerations that should be given to:
 - Request for escorts.
 - Following an escort vehicle
 - Intersections (C-1)
- 7-1.6 Discuss "Due Regard For Safety of All Others" while operating an emergency vehicle. (C-1)
- 7-1.7 State what information is essential in order to respond to a call. (C-1)
- 7-1.8 Discuss various situations that may affect response to a call. (C-1)
- 7-1.9 Differentiate between the various methods of moving a patient to the unit based upon injury or illness. (C-3)
- 7-1.10 Apply the components of the essential patient information in a written report. (C-2)
- 7-1.11 Summarize the importance of preparing the unit for the next response. (C-1)
- 7-1.12 Identify what is essential for completion of a call. (C-1)
- 7-1.13 Distinguish among the terms cleaning, disinfection, high-level disinfection, and sterilization. (C-3)
- 7-1.14 Describe how to clean or disinfect items following patient care. (C-1)
- 7-1.15 Explain the rationale for appropriate report of patient information. (A-3)
- 7-1.16 Explain the rationale for having the unit prepared to respond. (A-3)
- 7-2.1 Describe the purpose of extrication. (C-1)
- 7-2.2 Discuss the role of the EMT-Basic in extrication. (C-1)
- 7-2.3 Identify what equipment for personal safety is required for the EMT-Basic. (C-1)
- 7-2.4 Define the fundamental components of extrication. (C-1)
- 7-2.5 State the steps that should be taken to protect the patient during extrication. (C-1)
- 7-2.6 Evaluate various methods of gaining access to the patient. (C-3)
- 7-2.7 Distinguish between simple and complex access. (C-3)
- 7-3.1 Explain the EMT-Basic's role during a call involving hazardous materials. (C-1)
- 7-3.2 Describe what the EMT-Basic should do if there is reason to believe that there is a hazard at the scene. (C-1)
- 7-3.3 Describe the actions that an EMT-Basic should take to ensure bystander safety. (C-1)
- 7-3.4 State the role the EMT-Basic should perform until appropriately trained personnel arrive at the scene of a hazardous materials situation. (C-1)
- 7-3.5 Break down the steps to approaching a hazardous situation. (C-1)
- 7-3.6 Discuss the various environmental hazards that affect EMS. (C-1)
- 7-3.7 Describe the criteria for a multiple-casualty situation. (C-1)
- 7-3.8 Evaluate the role of the EMT-Basic in the multiple-casualty situation. (C-3)
- 7-3.9 Summarize the components of basic triage. (C-1)
- 7-3.10 Define the role of the EMT-Basic in a disaster operation. (C-1)
- 7-3.11 Describe basic concepts of incident management. (C-1)
- 7-3.12 Explain the methods for preventing contamination of self, equipment and facilities.
- 7-3.13 Review the local mass casualty incident plan. (C-1)
- 7-3.14 Given a scenario of a mass casualty incident, perform triage. (P-2)

PATIENT ASSESSMENT DEFINITIONS

Scene Size-up	Steps taken by EMS providers when approaching the scene of an emergency call; determining scene safety, taking BSI precautions, noting the mechanism of injury or patient's nature of illness, determining the number of patients, and deciding what, if any additional resources are needed including Advanced Life Support.
Initial Assessment	The process used to identify and treat life-threatening problems, concentrating on Level of Consciousness, Cervical Spinal Stabilization, Airway, Breathing, and Circulation. You will also be forming a General Impression of the patient to determine the priority of care based on your immediate assessment and determining if the patient is a medical or trauma patient. The components of the initial assessment may be altered based on the patient presentation.
Focused History and Physical Exam	In this step you will reconsider the mechanism of injury, determine if a Rapid Trauma Assessment or a Focused Assessment is needed, assess the patient's chief complaint, assess medical patients complaints and signs and symptoms using OPQRST, obtain a baseline set of vital signs, and perform a SAMPLE history. The components of this step may be altered based on the patient's presentation.
Rapid Trauma Assessment	This is performed on patients with significant mechanism of injury to determine potential life threatening injuries. In the conscious patient, symptoms should be sought before and during the Rapid Trauma assessment. You will estimate the severity of the injuries, re-consider your transport decision, reconsider Advanced Life Support, consider the platinum 10 minutes and the Golden Hour, rapidly assess the patient from head to toe using DCAP-BTLS, obtain a baseline set of vital signs, and perform a SAMPLE history.
Rapid Medical Assessment	This is performed on medical patients who are unconscious, confused, or unable to adequately relate their chief complaint. This assessment is used to quickly identify existing or potentially life-threatening conditions. You will perform a head to toe rapid assessment using DACP-BTLS, obtain a baseline set of vital signs, and perform a SAMPLE history.
Focused History and Physical Exam – Trauma	This is used for patients, with no significant mechanism of injury, that have been determined to have no life-threatening injuries. This assessment would be used in place of your Rapid Trauma Assessment. You should focus on the patient's chief complaint. An example of a patient requiring this assessment would be a patient who has sustained a fractured arm with no other injuries and no life threatening conditions.
Focused History and Physical Exam – Medical	This is used for patients with a medical complaint who are conscious, able to adequately relate their chief complaint to you, and have no life-threatening conditions. This assessment would be used in place of your Rapid Medical Assessment. You should focus on the patient's chief complaint using OPQRST, obtain a baseline set of vital signs, and perform a SAMPLE history.

**Detailed
Physical Exam**

This is a more in-depth assessment that builds on the Focused Physical Exam. Many of your patients may not require a Detailed Physical Exam because it is either irrelevant or there is not enough time to complete it. This assessment will only be performed while enroute to the hospital or if there is time on-scene while waiting for an ambulance to arrive. Patients who will have this assessment completed are patients with significant mechanism of injury, unconscious, confused, or unable to adequately relate their chief complaint. In the Detailed Physical Exam you will perform a head to toe assessment using DCAP-BTLS to find isolated and non-life-threatening problems that were not found in the Rapid Assessment and also to further explore what you learned during the Rapid Assessment.

**Ongoing
Assessment**

This assessment is performed during transport on all patients. The Ongoing Assessment will be repeated every 15 minutes for the stable patient and every 5 minutes for the unstable patient. This assessment is used to answer the following questions:

1. *Is the treatment improving the patient's condition?*
2. *Are any known problems getting better or worse?*
3. *What is the nature of any newly identified problems?*

You will continue to reassess mental status, ABCs, re-establish patient priorities, reassess vital signs, repeat the focused assessment, and continually recheck your interventions.

ACRONYMS USED DURING PATIENT ASSESSMENT

MOI – stands for mechanism of injury

AVPU – used to classify the patient’s mental status:

- **A** = awake, alert, and oriented
- **V** = alert to voice, but not oriented
- **P** = alert to painful stimuli only
- **U** = unresponsive to voice or painful stimuli

CUPS – used as an additional tool to prioritize the patient for transport:

- **C** = critical
- **U** = unstable
- **P** = potentially unstable
- **S** = stable

Priority	Illness/Injury Severity	Transport Decision
C ritical	Patients either receiving CPR, in respiratory arrest, or requiring and receiving life-sustaining ventilatory/circulatory support	<u>C – U – P</u> Scene Size-up Initial Assessment Rapid Assessment And Transport
U nstable P otentially unstable	Poor general impression Unresponsive with no gag or cough reflexes Responsive but unable to follow commands Difficulty breathing Pale skin or other signs of poor perfusion (shock) Complicated childbirth Uncontrolled bleeding Severe pain in any area of the body Severe chest pain, especially with a systolic BP of less than 100 mmHg Inability to move any part of the body	
S table	Minor illness, minor isolated injury, uncomplicated extremity injuries, and/or any patient that cannot be categorized as Critical, Unstable, or Potentially unstable.	<u>S</u> Scene Size-up Initial Assessment Focused Assessment And Transport

Priority Using CUPS

Status	Adult	Infant/Child
C	High	High
U	High	High
P	High	High
S	Low	Low

DCAP-BTLS – A mnemonic for EMT assessment in which each area of the body is evaluated for:

- Deformities
- Burns
- Contusions
- Tenderness
- Abrasions
- Lacerations
- Punctures/Penetrations
- Swelling

DOTS – A mnemonic for CFR assessment in which each area of the body is evaluated for:

- Deformities
- Tenderness
- Open Injuries
- Swelling

SAMPLE – A mnemonic for the history of a patient's condition to determine:

- Signs & Symptoms
- Pertinent past history
- Allergies
- Last oral intake
- Medications
- Events leading up to the illness/injury

OPQRST – A mnemonic used to evaluate a patient's chief complaint and signs & symptoms:

- O = onset
- R = radiation
- P = provocation
- S = severity
- Q = quality
- T = time

Significant Mechanism of Injury

(listed below are some examples)

Vehicle-pedestrian collision

Motorcycle crash

Death in the same passenger compartment

High-speed vehicle collision

Medium speed vehicle collision (infants and children)

Roll-over of vehicle

Falls greater than 20 feet (adults)

Ejection from vehicle

Falls greater than 10 feet (infants and children)

Bicycle collision

Penetrations of the head, chest, or abdomen

(infants and children)

PATIENT ASSESSMENT PRACTICE SHEET

SCENE SIZE-UP

Steps taken when approaching the scene

- Ensure BSI (Body Substance Isolation) procedures and & personal protective gear is being used.
- Observe scene for safety of crew, patient, bystanders.
- Identify the mechanism of injury or nature of illness.
- Identify the number of patients involved.
- Determine the need for additional resources including Advanced Life Support.
- Consider C-Spine stabilization

INITIAL ASSESSMENT

Assessment & treatment (life-threats)

GENERAL IMPRESSION

- Mechanism of injury or nature of illness
- Age, sex, race
- Find and treat life threatening conditions (any obvious problems that may kill the patient within seconds). Problems with Airway, Breathing, or Circulation
- Verbalize general impression of patient

MENTAL STATUS

- If the pt. appears to be unconscious, check for responsiveness, (“Hey! Are you OK?”)
- Evaluate mental status using AVPU.
- Obtain a chief complaint, if possible

AIRWAY

- Is the pt. talking or crying?
- Do you hear any noise?
- Will the airway stay open on it’s own?
- Does anything endanger it?
- Open the airway - head-tilt-chin-lift or jaw thrust – as needed
- Clear the airway – as needed
- Suction - as needed
- Insert an OPA/NPA - as needed

BREATHING

- Do you see any signs of inadequate respirations?
- Is the rate and quality of breathing adequate to sustain life?
- Is the patient complaining of difficulty breathing?
- Quickly inspect the chest for impaled objects, open chest wounds, and bruising (trauma)
- Quickly palpate the chest for unstable segments, crepitation (trauma), and equal expansion of the chest
- If the pt. is responsive and breathing < 8 or > 24, administer oxygen using a NRB at 15 LPM.
- If the pt. is unresponsive and breathing is adequate, administer oxygen using a NRB at 15 LPM.
- If the pt. is unresponsive and breathing is inadequate, administer oxygen using a BVM at 15 LPM, with OPA.

CIRCULATION

- If the pt. is unresponsive, assess for presence and quality of the carotid pulse.
- If the pt. is responsive, assess the rate and quality of the radial pulse.
- If radial pulse is weak or absent, compare it to the carotid pulse.
- For patients 1 year old or less, assess the brachial pulse.
- Is there life threatening hemorrhage?
- Control life threatening hemorrhage
- Assess the patient's perfusion by evaluating skin for color, temperature and condition (CTC); can also check the conjunctiva and lips
- Assess capillary refill in infant or child < 6 yrs. old
- Cover with blanket and elevate the legs as needed for shock (hypoperfusion)

IDENTIFY PRIORITY PATIENTS *Is the patient:*

- ✓ Critical
- ✓ Unstable
- ✓ Potentially Unstable
- ✓ Stable

- Consider the need for Advanced Life Support
- If the patient is **CRITICAL**, **UNSTABLE** or **POTENTIALLY UNSTABLE** , begin packaging the patient during the **rapid assessment** while treating life threats and transport as soon as possible.
- In addition, perform the **rapid trauma assessment** for the trauma patient if he/she has significant mechanism of injury and apply spinal immobilization as needed.
- For the unresponsive medical patient perform the **rapid medical assessment**.
- If the patient is or **STABLE**, perform the appropriate focused physical exam (for the medical pt. perform the **focused physical exam**; for trauma patient perform the **focused trauma assessment**.)

FOCUSED HISTORY AND PHYSICAL EXAM - TRAUMA

Re-consider the mechanism of injury. If there is significant mechanism of injury, perform a **Rapid Trauma Assessment** on-scene while preparing for transport and then a Detailed Assessment during transport. If there is no significant mechanism of injury, perform the **Focused Trauma Assessment**. Direct the focused trauma assessment to the patient's chief complaint and the mechanism of injury (perform it instead of the rapid trauma assessment).

RAPID TRAUMA ASSESSMENT

perform on patients with significant MOI

- Continue spinal stabilization
- Re-consider ALS back-up
- Inspect and palpate the body for injuries to the following:

HEAD - inspect and palpate for signs of injury.

- DCAP-BTLS
- Blood & fluids from the head

NECK - inspect and palpate for signs of injury.

- DCAP-BTLS
- JVD (Jugular Vein Distention)
- Crepitation
- Apply CSIC (Cervical Spinal Immobilization Collar) - if not already done

CHEST - inspect and palpate for signs of injury.

- DCAP-BTLS
- Paradoxical movement
- Crepitation
- Breath sounds - bilateral assessment of the apices, mid-clavicular line; mid-axillary at the nipple line; and at the bases

ABDOMEN - inspect and palpate for signs of injury.

- DCAP-BTLS
- Pain
- Firm
- Soft
- Distended

PELVIS - inspect and palpate for signs of injury.

- DCAP-BTLS

If no pain is noted, gently compress the pelvis to determine tenderness or unstable movement.

EXTREMITIES - inspect and palpate the lower and upper extremities for signs of injury.

- DCAP-BTLS
- Crepitation
- Distal pulses
- Sensory function
- Motor function

POSTERIOR - Log roll the patient. Maintain c-spine stabilization.

- Inspect and palpate for injuries or signs of injury.
- DCAP-BTLS

FOCUSED TRAUMA ASSESSMENT

Perform on patients with no significant MOI

Assess the patient's chief complaint

- The specific injury they are complaining about – Why they called EMS
- Assess and treat injuries not found during your Initial Assessment
- Reconsider your transport decision
- Consider ALS intercept

Focused Assessment

- Follow order of the Rapid Assessment
- Focus assessment on the specific area of injury or complaint

Baseline Vital Signs

- Obtain a full set of vital signs including:
 - Respirations
 - Pulse
 - Blood Pressure
 - Level of Consciousness
 - Skin
 - Pupils

Assess SAMPLE History

- Signs & Symptoms
- Allergies
- Medications
- Pertinent Past Medical History
- Last oral intake
- Events leading up to the injury/illness

OBTAIN BASELINE VITAL SIGNS

RESPIRATIONS

RATE

Watch the chest/abdomen and count for no less than 30 seconds.

If abnormal respirations are present count for a full 60 seconds.

QUALITY

- Normal
- Labored?
- Shallow
- Deep
- Any unusual pattern?
- Noisy breathing?

PULSE

RATE

Check the radial pulse. If pulse is regular, count for 30 seconds and multiply x 2. If it is irregular, count for a full 60 seconds.

QUALITY

- Regular
- Irregular
- Strong
- Weak

SKIN (CTC)

Color - Look at the skin

- Normal (unremarkable)
- Cyanotic
- Pale
- Flushed
- Jaundice

Temperature - touch the skin

- Warm
- Hot
- Cool
- Cold

Condition - assess the skin

- Wet
- Dry

BLOOD PRESSURE

Blood pressure should be measured in all patients over the age of 3.

Auscultate the blood pressure. In a high noise environment, palpate (only the systolic reading can be obtained).

PUPILS - use a penlight to check reactivity of the pupils; also assess for size

- equal or unequal
- normal, dilated, or constricted
- reactive - change when exposed to light
- non-reactive - do not change when exposed to light
- Equally or unequally reactive when exposed to light

ASSESS SAMPLE

- What **S**igns and **S**ymptoms is the patient exhibiting?
- Does the patient have any **A**llergies?
- Does the patient take any **M**edications?
- Does the patient have **P**ertinent past medical history?
- When was the patient's **L**ast meal?
What did the patient eat? When did they last eat?
- **E**vents - What happened, how did this incident happen? Events leading up to the injury or illness.

FOCUSED HISTORY AND PHYSICAL EXAM - MEDICAL

During this phase of the patient assessment, the mnemonic **OPQRST** and **SAMPLE** will be used to gather information about the chief complaint and history of the present illness. **Baseline vital signs** and a **focused physical exam** or a **rapid medical assessment** will be performed. The order in which you perform the steps of this focused history and physical exam varies depending on whether the patient is responsive or unresponsive.

RAPID MEDICAL ASSESSMENT – performed on patients who are unconscious, confused, or unable to adequately relate their chief complaint.

- Perform a rapid assessment using DCAP-BTLS following the order of the Rapid Trauma Assessment
 - Assess the head
 - Assess the neck
 - Assess the chest
 - Assess the abdomen
 - Assess the pelvis
 - Assess the extremities
 - Assess the posterior
- Obtain baseline set of vital signs
- Position patient to protect the airway
- Obtain the SAMPLE history from bystander, family, or friends.

Focused Medical Assessment – performed on the conscious alert patient who can adequately relate their chief complaint.

Obtain the history of the present illness

- **Onset** - “What were you doing when the symptoms started?”
- **Provocation** - “Is there anything that makes the symptoms better or worse?”
- **Quality** - “What does the pain/discomfort feel like?”
- **Radiation** - “Where do you feel the pain/discomfort?” “Does the pain/discomfort travel anywhere else?”
- **Severity** - “How bad is the pain?” “How would you rate the pain on a scale of 1-10, with 10 being the worst pain you’ve felt in your life?”
- **Time** - “How long has the problem been going on?”

ASSESS SAMPLE

- What other **S**igns and **S**ymptoms is the patient exhibiting?
- Does the patient have any **A**llergies?
- Does the patient take any **M**edications?
- Does the patient have a **P**ertinent past medical history?
- When was the patient’s **L**ast meal? (last oral intake)
What did the patient eat/drink?
- **E**vents - What happened, how did this incident happen? Events leading up to the injury or illness.

Focused Assessment

- Follow order of the Rapid Assessment
- Focus assessment on the specific area of complaint (chief complaint)

Examples of questions to ask a conscious medical patient and assessment elements according to the patient's chief complaint		
<p>Altered Mental Status</p> <ul style="list-style-type: none"> <input type="checkbox"/> Description of episode <input type="checkbox"/> Duration <input type="checkbox"/> Onset <input type="checkbox"/> Associated symptoms <input type="checkbox"/> Evidence of trauma <input type="checkbox"/> Interventions <input type="checkbox"/> Seizures <input type="checkbox"/> Fever 	<p>Allergic Reaction</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of allergies <input type="checkbox"/> Exposed to what? <input type="checkbox"/> How exposed <input type="checkbox"/> Effects <input type="checkbox"/> Progression <input type="checkbox"/> Interventions 	<p>Cardiac/Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Onset <input type="checkbox"/> Provocation <input type="checkbox"/> Quality <input type="checkbox"/> Radiation <input type="checkbox"/> Severity <input type="checkbox"/> Time <input type="checkbox"/> Interventions
<p>Poisoning & OD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Substance <input type="checkbox"/> When exposed/ingested <input type="checkbox"/> Amount <input type="checkbox"/> Time period <input type="checkbox"/> Interventions <input type="checkbox"/> Estimated weight 	<p>Environmental</p> <ul style="list-style-type: none"> <input type="checkbox"/> Source <input type="checkbox"/> Environment <input type="checkbox"/> Duration <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Effects-general or local 	<p>Behavioral</p> <ul style="list-style-type: none"> <input type="checkbox"/> How do you feel? <input type="checkbox"/> Determine if suicidal <ul style="list-style-type: none"> “Were you trying to hurt yourself?” “Have you been feeling that life is not worth living?” “Have you been feeling like killing yourself?” <input type="checkbox"/> Threat to self or others <input type="checkbox"/> Medical problem <input type="checkbox"/> Interventions
<p>Obstetrics</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> How long have you been pregnant? <input type="checkbox"/> Pain or contraction <input type="checkbox"/> Bleeding or discharge <input type="checkbox"/> Has your water broke? <input type="checkbox"/> Do you want to push? <input type="checkbox"/> Last menstrual period? 	<p>Acute Abdomen</p> <ul style="list-style-type: none"> <input type="checkbox"/> Location of pain <input type="checkbox"/> Any vomiting <ul style="list-style-type: none"> If so, color/substance <input type="checkbox"/> Taking birth control <input type="checkbox"/> Vaginal bleeding or discharge <input type="checkbox"/> Abnormal vital signs 	<p>Loss of Consciousness</p> <ul style="list-style-type: none"> <input type="checkbox"/> Length of time unconscious <input type="checkbox"/> Position <input type="checkbox"/> History <input type="checkbox"/> Blood in vomit or stool <input type="checkbox"/> Trauma <input type="checkbox"/> Incontinence <input type="checkbox"/> Abnormal vital signs

Baseline Vital Signs

- Obtain a full set of vital signs including:
 - Respirations
 - Pulse
 - Blood Pressure
 - Level of Consciousness
 - Skin
 - Pupils

Provide Treatment

- Provide emergency medical care based on signs and symptoms

DETAILED PHYSICAL EXAM

The **Detailed Physical Exam** is used to gather additional information regarding the patient's condition only after you have provided interventions for life threats and serious conditions. Not all patients will require a Detailed Physical Exam. It is performed in a systematic head-to-toe order. You will examine the same body areas that you examined during your rapid assessment. During the detailed physical exam, you will look more closely at each area to search for findings of lesser priority than life threats and/or signs of injury that have worsened. **Do not delay transport to perform a detailed physical exam; it is only performed while enroute to the hospital or while waiting for transport to arrive.**

Detailed Physical Exam – Trauma or Medical

HEAD - inspect and palpate for signs of injury.

DCAP-BTLS

Blood & fluids from the head

FACE - inspect and palpate for signs of injury.

DCAP-BTLS

EARS - inspect and palpate for signs of injury.

DCAP-BTLS

Drainage (blood or any other fluid)

EYES - inspect for signs of injury.

DCAP-BTLS

Discoloration

Unequal Pupils

Foreign Bodies

Blood in Anterior Chamber

NOSE - inspect and palpate for signs of injury.

DCAP-BTLS

Drainage

Bleeding

MOUTH - inspect for signs of injury.

DCAP-BTLS

Damaged/Missing Teeth

Obstructions

Swollen or Lacerated Tongue

Discoloration

Unusual Odors

NECK - inspect and palpate for signs of injury.

DCAP-BTLS

JVD

Tracheal deviation

Crepitation

CHEST - inspect and palpate for signs of injury.

DCAP-BTLS

Paradoxical movement

Crepitation

Breath sounds - bilateral assessment of the apices, mid-clavicular line; mid-axillary at the nipple line; and at the bases

- Present
- Absent
- Equal

ABDOMEN - inspect and palpate for signs of injury.

DCAP-BTLS

Pain/Tenderness

Firm

Soft

Distended

PELVIS - inspect and palpate for signs of injury.

DCAP-BTLS

If no pain is noted, gently compress
the pelvis to determine tenderness
or unstable movement.

EXTREMITIES - inspect and palpate the lower and
upper extremities for signs of injury.

DCAP-BTLS

Crepitation

Distal pulses

Sensory function

Motor function

POSTERIOR - Log roll the patient. Maintain c-spine stabilization.

Inspect and palpate for injuries or signs of injury.

DCAP-BTLS

ON-GOING ASSESSMENT

The **On-Going Assessment** will be performed on all patients while the patient is being transported to the hospital. It is designed to reassess the patient for changes that may require new intervention. You will also evaluate the effectiveness of earlier interventions, and reassess earlier significant findings. You should be prepared to modify treatment as appropriate and begin new treatment on the basis of your findings during the On-Going Assessment.

UNSTABLE PATIENTS – repeat On-Going Assessment at least every 5 minutes
STABLE PATIENTS – repeat On-Going Assessment at least every 15 minutes

REPEAT INITIAL ASSESSMENT

- Reassess mental status.
- Maintain an open airway.
- Monitor breathing for rate and quality.
- Reassess pulse for rate and quality.
- Monitor skin color and temperature (CTC)
- Re-establish patient priorities

REASSESS AND RECORD VITAL SIGNS

REPEAT FOCUSED ASSESSMENT

CHECK INTERVENTIONS

- Assure adequacy of oxygen delivery/artificial ventilation
- Assure management of bleeding
- Assure adequacy of other interventions

OROPHARYNGEAL AIRWAY (OPA) INSERTION

- Take Body Substance Isolation precautions
- Measure for correct size
The OPA is sized by measuring from the center of the mouth to the angle of the jaw, or from the corner of the mouth to the earlobe.
- Open the mouth
The mouth is opened using the “crossed or scissors” finger technique.
- Insert the OPA without pushing the tongue back
The OPA is inserted in the patient’s mouth upside down so the tip of the OPA is facing the roof of the patient’s mouth. As the airway is inserted it is rotated 180 degrees until the flange comes to rest on the patient’s lips and/or teeth. The OPA may be inserted with the pharyngeal curvature if a tongue blade is used to depress the tongue.

If patient begins to retch/gag, remove the OPA!

NASOPHARYNGEAL AIRWAY

NOTE: Nasal airways are contraindicated in-patients with severe trauma to the head and/or face.

- Take Body Substance Isolation precautions.
- Select the proper size airway
Select the proper size airway by measuring from the tip of the patient’s earlobe to the tip of the patient’s nose. The diameter of the airway should be the largest that will fit. To determine this, select the size that approximates the diameter of the patient’s little finger.
- Lubricate the airway with a water-soluble lubricant.
- Insert the airway
With the patient’s head in a neutral position, gently pull back the tip of the patient’s nose. Insert the airway; bevel toward the nasal septum, into the *right* nostril following the natural curvature of the nasal passage. The flange should rest against the nasal opening.

NOTE: If an obstruction or resistance is encountered, do not force the airway. The airway should be removed and inserted in the left nostril.

BAG-VALVE-MASK VENTILATION (BVM)

WARNING! All ventilation skills must be practiced on a manikin intended for CPR practice (Resusci-Annie, Recording-Annie etc.). Other manikins such as intubation heads etc. are unacceptable because they may be ventilated regardless of the head/jaw position. CPR manikins realistically simulate the difficulties of airway maintenance and ventilation.

- Take Body Substance Isolation precautions.
- Open the airway, insert an airway adjunct, and select the appropriate size mask.
While positioned at the top of the patient's head, open the airway using the head-tilt/chin-lift maneuver or the jaw-thrust maneuver. Insert the appropriate sized airway adjunct. Choose the appropriate size mask for the patient. The mask should be transparent with an air cushion that rests against the patient's face.
- Hold the mask position.
Place the mask over the patient's face assuring the top of the mask is over the bridge of the nose and the bottom is in the groove between the lower lip and the chin. Using the "OK" hand position, with both hands, manually open the airway and maintain the mask seal.
- Connect the bag to the mask
If you haven't already done so, attach the bag-valve unit to the mask.
- Ventilate the patient
Squeeze the entire bag over 1-2 seconds and then release the bag. Each ventilation must be a minimum of 800cc. Assure appropriate chest rise during ventilations. Continue to ventilate the patient for 30 seconds prior to attaching the oxygen.
- Attach the oxygen
Assemble the oxygen tank and regulator if not already completed. Attach oxygen tubing to the regulator and to the BVM's reservoir. Turn on the oxygen and adjust the regulator to 15 liters per minute. Allow the reservoir to fill with oxygen prior to the first ventilation.
- Reposition patient and begin artificial ventilations.
As completed earlier, open the airway, place mask over the patient's face, continue with proper mask/face seal, and begin ventilations.

VENTILATE THE PATIENT WITH A PARTNER

Each ventilation must be a minimum of 800cc. This procedure must be practiced with a second rescuer. Switch off who controls the airway and mask with the student who ventilates. One student will maintain a mask seal using both hands while maintaining an open airway. The other student will ventilate the patient by collapsing the bag on the BVM fully with both hands.

VENTILATION OF A PATIENT WITH SUSPECTED SPINAL INJURY

This procedure should be used on any patient requiring ventilation with evidence of blunt trauma from the clavicles to the head. If only one rescuer is available for ventilation, the pocket mask must be used. If two rescuers are available for ventilation, a BVM should be used. It is mandatory that two hands be used on the mask and that the jaw-thrust is used.

MOUTH TO MASK VENTILATION WITH SUPPLEMENTAL OXYGEN

WARNING! All ventilation skills must be practiced on a manikin intended for CPR practice (Resusci-Annie, Recording-Annie etc.). Other manikins such as intubation heads etc. are unacceptable because they may be ventilated regardless of the head/jaw position. CPR manikins realistically simulate the difficulties of airway maintenance and ventilation.

- Take appropriate Body Substance Isolation precautions.
- Instruct a helper to manually stabilize the patient's head for in-line immobilization if there is suspected cervical spinal injury.
- Connect the one-way valve to the face mask.
- Kneel beside the patient's head. Open the airway using the head-tilt/chin-lift maneuver or if suspected cervical spinal injury use the jaw-thrust maneuver.
- Insert an OPA or NPA.
- Place the face mask on the patient's face assuring that the top of the mask is over the bridge of the patient's nose and the bottom is in the groove between the lower lip and the chin.
- Maintain an upward and forward pull on the lower jaw with your fingers to keep the airway open. Maintain a proper face to mask seal using the two-handed technique.
- Take a deep breath and exhale through the open port of the on-way valve. Exhale slowly into the mask for 1 ½ to 2 seconds in duration. Watch for the patient's chest to rise accordingly.
- Remove your mouth and watch for the patient's chest to fall during exhalation. You need to allow for adequate exhalation between ventilations.
- Ventilate the patient at the proper rate.
- After 30 seconds of ventilations attach oxygen to the face mask if the mask has an oxygen port.
 - ✓ Connect the oxygen tubing to the oxygen inlet on the face mask
 - ✓ Connect the other end of the oxygen tubing to the oxygen tank/regulator
 - ✓ Turn on the oxygen tank and set the regulator to 15 LPM
- Reposition the face mask on the patient, open the airway, and maintain a proper face to mask seal using the two-handed technique as completed above.
- Continue to ventilate the patient at the proper rate.

NOTE: If oxygen is not immediately available, do not delay mouth-to-mask ventilations.

SUCTIONING

NOTE: If the patient has secretions or emesis that cannot be removed quickly and easily by suctioning, the patient should be log rolled and the oropharynx should be cleared

- Take Body Substance Isolation precautions.
- Assemble and Check the equipment
Assure a tight fit on all of the hoses. Connect a rigid tip catheter to the hose, turn on the machine and check the vacuum.
- Measure the suction catheter
Measure the catheter in the same manner as the OPA. The length of catheter that should be inserted into the patient's mouth is equal to the distance between the corner of the patient's mouth and their earlobe *or* center of the mouth to the angle of the jaw
- Hyperventilate the patient if necessary
If the patient is being artificially ventilated and is producing "frothy" secretions as quickly as you can suction them from the airway you may alternate hyperventilation with suctioning. Alternating suctioning for 15 seconds with 2 minutes of hyperventilation. However, note that hyperventilation and/or artificial ventilations is not appropriate if vomitus or other particles are present in the airway. ***Remember the patient will not be receiving oxygen while you are suctioning.***
- Open the mouth
The mouth should be opened using the "crossed or scissors" finger technique.
- Insert the suction tip
The rigid tip catheter must be inserted following the pharyngeal curvature, with the suction OFF (usually there is a control hole on the tip, if not you will need to crimp the suction hose to initiate suctioning). Insert the catheter only as far as you properly measured it.
- Suction the mouth while retracting
After inserting the catheter the measured distance initiate suctioning as you retract the catheter in a sweeping motion.
- Do not suction too long!
The maximum suction time should only be 15 seconds.
- Oxygenate
After suctioning, re-oxygenate the patient. If the patient is being artificially ventilated and needs to be suctioned again, you should continue to ventilate the patient for two minutes and then suction again, if needed, for up to 15 seconds and continue in this manner.
- Clean the catheter
If necessary, rinse the catheter and tubing with water to prevent obstructions of the tubing and catheter. A thorough cleaning of the equipment should be done as soon as possible after you arrive at the hospital.

SUPPLEMENTAL OXYGEN ADMINISTRATION

- Take Body Substance Isolation precautions.
- Identify contents of cylinder as medical oxygen and assure hydrostat date.
- Assemble the tank & regulator

Crack open the tank to eliminate foreign particles. If your regulator is equipped with a washer insure the washer is in place to prevent leakage . Be sure the regulator pins line up with the holes on the tank stem. The regulator should be “hand tightened” only.
- Check tank pressure

Turn the valve stem one complete turn and check for tank pressure and leaks.
A full tank has 2,000 psi. 1,500 psi. is 3/4 full etc. Tank should be refilled when the tank pressure reaches 500 psi.
- Select appropriate oxygen delivery device

The available devices include the non-rebreather mask, nasal cannula, and the Bag Valve Mask (BVM). The device chosen will depend on the patient requirements you found during your Initial Assessment. Connect the oxygen tubing to the regulator (do not over tighten the tubing to the regulator).
- Adjust the liter flow

Non-rebreather face mask 10 – 15 Liters Per Minute.
Pre-fill the reservoir on the mask prior to placing the mask on the patient. If you initially set the Liters Per Minute (LPM) to 10 and the patient is continually collapsing the reservoir and not allowing the reservoir to totally re-inflate, you will need to increase the LPM to 15. If the reservoir is still not able to adequately re-inflate and the patient is continually collapsing the reservoir, consider assisting respirations with a bag valve mask.
Bag Valve Mask 15 Liters Per Minute.
Allow the reservoir on the BVM to fill prior to using the BVM on the patient.
Nasal Cannula 2 – 6 Liters Per Minute.
- Adjust the device to patient’s face

All patients receiving oxygen therapy must be watched carefully. Beware of a patient previously having difficulty breathing who has a falling level of consciousness! BE PREPARED TO VENTILATE. Continue to reassess the patient. Check the tank pressure often.

NOTE: When removing an oxygen mask from the patient’s face, remember to remove the mask *before* turning off the oxygen.

- Turning off oxygen

After shutting off the regulator, relieve the pressure within the regulator.

BLEEDING CONTROL / SHOCK MANAGEMENT

NOTE: Whenever possible try to determine if the bleeding is arterial, venous, or capillary and approximate the amount of blood the patient has lost.

- Take appropriate Body Substance Isolation precautions.
- Apply direct pressure
With your gloved hand and a sterile dressing, apply direct pressure over the site that is bleeding. Use an appropriately sized dressing that will cover the site.
- Elevate the extremity
Elevation of the bleeding extremity should be done secondary to and in conjunction with applying direct pressure. Elevate the limb above the level of the heart. Consider laying the patient down to help facilitate elevation of the extremity and to prepare for the shock position.
- Apply additional dressings and bandage
If bleeding does not stop or is soaking through the dressings, apply additional pressure dressings over the dressings that have already been applied. Use a bandage to secure the dressings in place. You may also apply a rigid splint to the bleeding extremity to lessen movement of the extremity and thereby reducing bleeding.
- Locate and apply pressure to the appropriate pressure point
Pressure points may be used in the upper and lower extremities if bleeding does not stop and continues to soak through the dressings. Locate the pressure point for the area that is bleeding and apply pressure to that pressure point.

NOTE: A tourniquet is used as a LAST RESORT to control bleeding of an extremity when all other methods of bleeding control have failed.

Application of a tourniquet can cause permanent damage to nerves, muscles, and blood vessels resulting in the loss of the extremity.

- Apply a tourniquet if necessary
Apply a tourniquet slightly above the site that is bleeding, but not over a joint. Use a wide bandage or an inflated blood pressure cuff as a tourniquet. Never use wire, rope, a belt, or any other material that may cut into the patient's skin and underlying tissue. Document the time that the tourniquet was applied and leave the tourniquet visible.
- Assess patient for signs and symptoms of hypoperfusion (shock)
Assess the patient and obtain a full set of vital signs. If necessary, continue with the following steps to treat for hypoperfusion (shock).

- Properly position the patient
If not already completed, place the patient in the supine position with legs elevated approximately 8 – 12 inches. If the patient has serious injuries to the pelvis, lower extremities, head, chest, abdomen, neck, or spine, keep the patient supine. If the patient is secured to a long backboard you may elevate the foot end of the backboard.
- Apply oxygen
Place the patient on supplemental high concentration oxygen. If the patient does not require ventilatory assistance then you should use a non-rebreather face mask at 15 liters per minute.
- Maintain body temperature
Apply blankets over the patient to reduce heat loss.
- Identify need for ALS and/or rapid transport
Determine if the patient will require Advance Life Support modalities and if they may require rapid transport to the hospital.

IMMOBILIZATION OF LONG BONE INJURIES

- Take appropriate Body Substance Isolation precautions.
- Remove clothing from the injured area.
- Assure the patient is stable and *not* a candidate for rapid transport.
If the patient is critical/unstable and/or meets the significant mechanism of injury criteria, routine extremity splinting should not be done. Instead, immobilize the patient using a long backboard and transport.
- Have a helper manually stabilize the fracture.
This is necessary to keep the jagged bone ends still and minimize pain during assessment and splint application. This is done for both open and closed wounds at the injury site. This is best accomplished by holding above and below the fracture and exerting some gentle traction in opposite directions.
- Assess for distal pulses, motor, and sensory function.
Fractures may result in damage to nerves and blood vessels. Ask the patient to wiggle all their fingers or toes (distal to the injured site) and determine if they can sense your touch. Assess the skin color and temperature distal to the injury site. Also assess for pulses distal to the injury site and comparing the strength of the pulse with the corresponding pulse on the opposite side of the body.
- Severe deformity and/or absent distal pulses.
If there is severe deformity or the extremity distal to the injury site is cyanotic or lacking a palpable pulse, align the extremity with gentle traction before splinting. If you encounter resistance to limb alignment, splint the limb in its deformed position. If the injury is involving a hand it should be immobilized in the position of function.
- Cover open wounds.
Cover all open wounds with sterile dressings and control bleeding.
- Select an appropriate immobilization device.
The device chosen must immobilize the bone ends and the joints above and below the injury site. The splint must be appropriately measured to assure the splint is of adequate size.
- Position the splint while maintaining stabilization of the fracture.
The helper must continue to exert some gentle traction while the EMS provider positions the immobilization device. Gentle traction helps to keep the bone ends apart and minimizes pain. Avoid gross movement of the injured extremity.
- Secure the device to the extremity.
The splint must be applied in a manner that will immobilize the bone ends and the adjacent joints. The ties or straps used to secure the splint should be on either side of the injury site and above and below the adjacent joints (whenever possible). If the radius/ulna, wrist and/or hand is involved, ensure the hand is immobilized in the position of function.

- Assess for distal pulses, motor and sensory function.
The pulses, motor, and sensory function must be re-evaluated after the splint is secured. Ask the patient to wiggle all their fingers or toes (distal to the injury site) and see if they can sense your touch. Assess the skin color and temperature distal to the injury site. Also assess for pulses distal to the injury site and compare the strength of the pulse with the corresponding pulse on the opposite side of the body.

SUGGESTED SPLINTS BY SINGLE ISOLATED FRACTURE SITES

HUMERUS

Sling or wrist-sling and swathe (wire ladder; a commercially made appropriate splint or a padded short board splint may be incorporated with sling/swathe).

WARNING! A “full arm” splint is *not* sufficient to splint fractures of the humerus because it does not immobilize the shoulder! It is designed to splint the hand and forearm.

RADIUS/ULNA

Short padded board with sling and swathe or full padded board; air or vacuum splint, or an appropriate commercially made splint.

HAND

Short padded board with the hand immobilized in the position of function. Sling and swathe may also be used for elevation/fixation.

PELVIS

Long backboard immobilization. If hypotension is present (systolic BP below 90 mm Hg) and an unstable pelvic fracture, MAST should be used.

FEMUR

Traction splint (refer to section on Traction Splinting)

WARNING! “Full leg” splints are not sufficient to splint mid-shaft femur fractures; a traction splint is the splint of choice.

TIBIA/FIBULA

Full leg, air splint, vacuum splint, cardboard, or an appropriate commercially made splint.

ANKLE

Pillow splint, full leg, air splint, vacuum splint, cardboard, or an appropriate commercially made splint.

Any splint which immobilizes the injured bone ends and the adjacent joints is acceptable!

IMMOBILIZATION OF JOINT INJURIES

- Take appropriate body substance isolation precautions.
- Remove clothing from the injured area.
- Assure the patient is stable and *not* a candidate for rapid transport.
If the patient is critical/unstable and/or meets the significant mechanism of injury criteria, routine extremity splinting should not be done. Instead, immobilize the patient to a backboard and transport.
- Have a helper manually stabilize the injury site.
This is necessary to keep the jagged bone ends still and minimize pain during assessment and splint application. This is done for both open and closed wounds at the injury site. This is best accomplished by holding above and below the injury site without applying traction in opposite directions.
- Assess for distal pulses, motor, and sensory function.
Fractures or dislocations may result in damage to nerves and blood vessels. Ask the patient to wiggle all their fingers or toes (distal to the injured site) and determine if they can sense your touch. Assess the skin color and temperature distal to the injury site. Also assess for pulses distal to the injury site and compare the strength of the pulse with the corresponding pulse on the opposite side of the body.

If the extremity distal to the injury site is cyanotic or lacking a palpable pulse, make one attempt to establish a distal pulse by slightly repositioning the extremity with gentle traction before splinting and recheck for a distal pulse. After attempting to reposition once and there is still no palpable pulse distal to the injury site, splint the extremity as-is and notify the hospital of the situation as soon as possible. If you encounter resistance to limb alignment, splint the limb in its deformed position. If the radius/ulna, wrist and/or hand is involved, ensure the hand is immobilized in the position of function.
- Select an appropriate immobilization device
The device chosen must immobilize the bones above and below the injury site. The splint must be appropriately measured to assure the splint is of adequate size.
- Position the splint while maintaining stabilization of the injury.
The helper must continue to manually stabilize the extremity while the EMS provider positions the immobilization device. Avoid gross movement of the injured extremity.
- Secure the device to the extremity.
The splint must be applied in a manner that will immobilize the bones adjacent to the injury site. If the radius/ulna, wrist and/or hand is involved, ensure the hand is immobilized in the position of function.
- Assess for distal pulses, motor, and sensory function.
The pulses, motor function, and sensory function must be re-evaluated after the splint is secured. Ask the patient to wiggle all their fingers or toes (distal to the injury site) and determine if they can sense your touch. Assess the skin color and temperature distal to the injury site. Also assess for pulses distal to the injury site and compare the strength of the pulse with the corresponding pulse on the opposite side of the body.

TRACTION SPLINTING

NOTE: A traction splint is the splint of choice and is to be used only for a painful, swollen, deformed mid-thigh injury with NO lower leg injury.

NOTE: The information included below is designed to be used as a guide for an "Ischial" type traction splint. There are several different types of commercially made traction splints available. This information may differ for the device that you use.
As with all equipment, you must follow the manufacturer's guidelines and instructions for proper application of the device you use.

Contraindications for the use of traction splint:

- ✓ Injury is close to the knee
 - ✓ Injury to the knee
 - ✓ Injury to the hip
 - ✓ Injury to the pelvis
 - ✓ Partial amputation or avulsion with bone separation, distal limb is connected only by marginal tissue.
 - ✓ Lower leg or ankle injury
-
- Take appropriate body substance isolation precautions.
 - Apply manual stabilization
Rescuer #1 should apply manual stabilization to the leg above and below the injury site. This is designed to stabilize the bone ends and reduce further injury.
 - Explain the procedure to the patient
The patient may be very anxious about this procedure. You need to properly communicate to the patient what you will be doing.
 - Remove clothing from the area
Rescuer #2 should remove the clothing to expose the entire leg. Rescuer #2 then removes the shoe and sock from the effected extremity.
 - Assess pulse, motor, and sensory
Assess the pulse, motor function, and sensory function distal to the injury and compare to the opposite (non-injured) extremity.
 - Apply the ankle hitch
Rescuer #2 applies the ankle hitch. After the ankle hitch is in place, rescuer #2 takes over manual stabilization via the ankle hitch and elevates the leg while supporting the ankle. ***If the Sager splint or the Kendrick's Traction Device is used, elevation of the leg and manual traction is not necessary.***

- Measure the traction splint

Rescuer #1 adjusts the traction splint to the proper length. The non-injured leg should be used to measure the length of the traction splint. The traction splint should be adjusted to 12 inches longer than the non-injured leg.
- Apply the traction splint

Rescuer #1 slides the traction splint under the patient's injured leg, as rescuer #2 elevates the leg and continues manual traction via the ankle hitch. The ischial ring of the traction splint must be against the bony prominence of the buttocks (ischial tuberosity). If equipped with a kickstand at the end of the traction splint, extend it once the traction splint is in place. Pad the groin and gently, but securely apply the ischial strap. You should be able to fit two fingers between the ischial strap and the patient's thigh to prevent over tightening. *This step may be different for some commercially made traction splint devices.*
- Apply mechanical traction

Rescuer #1 attaches the mechanical traction device to the ankle hitch while rescuer #2 is continuing to maintain manual traction via the ankle hitch. Rescuer #1 begins to apply the mechanical traction. Rescuer #2 may release manual traction when he/she feels the mechanical traction has taken over. Sufficient mechanical traction is used when it equals the amount of manual traction that was maintained. Avoid using too much traction, which may overstretch the leg, but use enough traction to maintain limb alignment. Many patients will have reduced pain and muscle spasms once adequate mechanical traction is applied. *Some commercially made devices use body weight to calculate the amount of traction needed.*
- Secure the leg to the traction splint

Rescuer #2 stabilizes the injured leg by positioning his/her hands on top of the lower leg to prevent movement. Rescuer #1 fastens the support straps. One strap should be just above the ankle hitch, one strap just below the knee, one strap just above the knee, and one strap at the top of the thigh just below the ischial strap. *Do not fasten a strap directly over the injury site.* Excess straps should be secured underneath the splint to provide additional support. *Some commercially made devices allow a strap to be secured directly over the injury site. Some commercially made devices, such as the Sager, allow a strap to be secured over the knee.* Recheck the ischial strap to assure that it has not loosened.
- Reassess distal pulses, motor, and sensory.

Assess the pulse, motor function, and sensory function distal to the injury site and compare to the opposite (non-injured) extremity.
- Prepare the patient for transport

The patient should now be secured to a long backboard to provide further immobilization of the hip. The traction splint should be secured to the long backboard to prevent excessive movement.

IMMOBILIZING A SUPINE PATIENT

NOTE: If the patient is found in a sitting or semi-sitting position, you must use a short backboard device to immobilize the patient's cervical spine prior to using a long backboard.

- Take appropriate body substance isolation precautions.
- Instruct a helper to manually stabilize the patient's head for in-line stabilization.
- Assess each extremity for the presence of distal pulse, motor function and sensory function.
- Size and apply a cervical collar to the patient if this has not already been done and continue to maintain manual in-line stabilization.
- Place the long backboard next to the patient on the opposite side where you will be positioned when performing the log roll. Be sure that the board is positioned so that when the patient is rolled onto it, the patient's head is not hanging off the top end of the board.
- Position yourself next to the patient's torso. Instruct your 2nd helper to position him/herself at the patient's legs. Place one of your hands at the patient's shoulder and the other hand at the patient's pelvis while your helper places his/her hands at the pelvis and legs.
- When all personnel are in position and ready, the helper stabilizing the head will call for the log roll which will be performed in unison. The helper at the head will make sure that the patient's head remains in a neutral position throughout the procedure. You and your other helper will log roll the patient towards you so that the patient is now positioned on his/her side. You can support the patient with your thighs.
- Now, reach behind the patient for the backboard. Tilt the board so that it is positioned against the patient's back. If there is another rescuer available you can have that person position the backboard.
- When all personnel are ready, the helper at the head will call for the log roll onto the board. Continue to hold the board as the log roll is performed.
- When the log roll is complete and the patient is supine, check the patient's position on the board. The patient should be centered on the board with the head close to the top of the board. If adjustments need to be made, perform those with your 2nd helper positioned at the pelvis and you at the patient's chest. All moves should be at the direction of the helper maintaining stabilization of the c-spine and should be performed in unison by moving the body as a single unit. Avoid any twisting of the patient's body.
- With the patient properly positioned on the board, begin securing the patient to the board. Apply padding to voids between the torso and the board as necessary.
- Secure the patient's torso first and remember to secure the bony portions of the body. Run one 9' strap through the hole closest to the patient's underarm and across the chest to the corresponding hole on the other side. Bring the strap back under the patient's arms to meet the buckle, which should be secured and positioned off the center of the chest. Have the patient inhale deeply and hold their breath (if possible) and then tighten

- the strap. This will assure that the strap does not impede the patient's respirations. The patient's arms should not be strapped in at this point.
- Now secure the pelvis by locating a hole closest to the center of the pelvis. Run the strap through the hole, across the pelvis and to the corresponding hole on the opposite side. Bring the strap back across the pelvis to meet the buckle.
- The legs may be secured in a similar way or you may use cravats if necessary.
- Once the torso and legs are secured, you can begin to secure the head. Be sure that whichever head immobilization device you use allows you to secure the patient's head in a neutral position. Do not remove manual in-line stabilization of the head until the head is completely immobilized to the long backboard.
- Place the arms securely under the strap passing across the lower torso or loosely tie the patient's wrists together with a cravat or other soft bandaging.
- After the immobilization has been completed, reassess all four (4) extremities for distal pulse, motor function and sensory function.
- During transport continue to check the straps to assure they have not come loose.
- If the patient is in a prone position, assess for pulse, motor, and sensory function in all four (4) extremities, quickly assess the patient's posterior, and then log roll the patient as a unit to the supine position while maintaining cervical spine stabilization. Position yourself next to the patient's torso. Instruct your 2nd helper to position him/herself at the patient's legs. Place one of your hands at the patient's shoulder and the other hand at the patient's pelvis while your helper places his/her hands at the pelvis and legs. When all personnel are ready, the helper at the head will call for the log roll onto the board. Continue to hold the board as the logroll is performed.

NOTE: There are numerous commercially manufactured strapping devices, such as the Spider Straps, which may be used. Follow the manufacturers guidelines to assure proper application of the device you use.

SPINAL IMMOBILIZATION OF THE SEATED PATIENT

NOTE: A short backboard immobilization device should be used on an patient found in a sitting or semi-sitting position with suspected cervical spinal injuries. Exceptions to this are when a patient needs to be rapidly extricated or moved.
Review the criteria for rapid extrication.

NOTE: Any commercially manufactured short backboard device must be used and applied according to the manufacturer's guidelines. All rescuers should fully understand the guidelines and instructions from the manufacture for the device they are using.

- Take appropriate body substance isolation precautions.
- Instruct the patient not to move their head and to hold still.
Make sure you fully explain the procedure to the patient so they understand what is about to occur.
- Manual inline stabilization
Have a rescuer position themselves behind the patient and maintain inline stabilization of the cervical spine.
- Assess pulse, motor, sensory
Assess pulses, motor function, and sensory function in all extremities.
- Apply the appropriately sized cervical collar
- Prepare the short board device for placement
Assure that the short board device is intact and in working order. Position all strapping so it will not become entangled during application of the device.
- Move patient forward
If necessary, you may need to move the patient forward slightly to position the device behind him/her. One rescuer should place a hand on the patient's chest and the other hand on the patient's back. At the count of the rescuer holding manual inline stabilization, guide the patient forward only enough to adequately position the device behind the patient.
- Position the short backboard behind the patient
With the patient sitting forward slightly, slide the short backboard behind the patient and between the arms of the rescuer holding manual inline stabilization.
- Move the patient back against the short backboard
Once the short backboard is properly positioned behind the patient and all straps are in position move the patient back to the device. This will be completed in the same manner as when you moved the patient forward.

- Secure the patient to the short backboard
Secure the patient's torso and legs to the short backboard. Have the patient inhale deeply and hold their breath as you tighten the torso straps. This will assure that the straps are not too tight to where they will impede the patient's respirations. Secure the patient's head after the torso and legs are secured. ***Maintain manual inline stabilization until the head is properly secured.*** The patient's head should be in the neutral position. (Some patient's, but not all, will require padding placed between their head and the short backboard so their head is secured in the neutral position.)
- After the immobilization has been completed, reassess all four (4) extremities for distal pulse, motor function and sensory function.
- Immobilize the patient on a long backboard for complete spinal immobilization.

NOTE: A short backboard immobilization device is designed to immobilize the cervical spine *only*. A long backboard must be used in conjunction with the short backboard device to completely immobilize the spine of a patient.

STANDING TAKE DOWN

NOTE: A standing take down is only performed on patients who are found standing or walking around a scene and are suspected to have possible cervical spinal injuries. This procedure is not intended for use on patients who are found in a sitting or semi-sitting position. In these cases a short backboard device should be used in conjunction with a long backboard.

The standing take down requires a minimum of three (3) rescuers who are trained in this procedure.

- Take appropriate body substance isolation precautions.
- Instruct the patient not to move their head and to hold still.
- Manual inline stabilization
 - Position the tallest rescuer (rescuer #1) behind the patient to bring the patient's head into a neutral position and begin and maintain manual inline stabilization of the cervical spine throughout the procedure.
- Assess pulse, motor, sensory
 - Assess pulses, motor function, and sensory function in all extremities.
- Apply a cervical collar
 - Have rescuer #2 apply the appropriately sized cervical collar while rescuer #1 continues to maintain manual inline stabilization.
- Position long backboard
 - Have rescuer #2 or #3 position the backboard upright directly behind the patient. Rescuer #1 will still be maintaining manual inline stabilization as the backboard is positioned in-between his arms and placed behind the patient. The backboard should be held against the patient's back by rescuer #2 or #3.
- Prepare to lower the patient
 - Rescuers #2 and #3 position themselves on each side of the patient and facing the patient. Rescuers #2 and #3 each grasp the backboard, with their closest hand to the patient, at a hand hold in the backboard which is directly under the patient's armpit or slightly higher than the patient's armpit. When the backboard is tilted back the patient will be suspended, temporarily, by his/her armpits.
- Slowly lower the backboard
 - Explain the next step of the procedure to the patient. The patient may be anxious about this step, however, you should continue to reassure the patient and let them know what they need to do and not do during this step. Rescuer #1 (at the head) is in charge of coordinating the next move. On rescuer #1s count, slowly begin to lower the patient backwards down to the ground. Rescuer #1 must continue to maintain inline stabilization and keep the patient's head against the backboard. As rescuer #2 and #3 move in to the squatting position to lower the patient to the ground, in unison, rescuer #1 will need to rotate his/her hands while continuing to maintain manual inline stabilization. Continue to lower the backboard until it is securely on the ground.

NOTE: All rescuers should use proper body mechanics during this procedure to avoid injury.

- Secure patient to the backboard

Secure the patient's torso first and remember to secure the bony portions of the body. Run one 9' strap through the hole closest to the patient's underarm and across the chest to the corresponding hole on the other side. Bring the strap back under the patient's arms to meet the buckle, which should be secured and positioned off the center of the chest. Have the patient inhale deeply and hold their breath (if possible) and then tighten the strap. This will assure that the strap does not impede the patient's respirations. The patient's arms should not be strapped in at this point.

Now secure the pelvis by locating a hole closest to the center of the pelvis. Run the strap through the hole, across the pelvis and to the corresponding hole on the opposite side. Bring the strap back across the pelvis to meet the buckle. The legs may be secured in a similar way or you may use cravats if necessary.

Once the torso and legs are secured, you can begin to secure the head. Be sure that whichever head immobilization device you use allows you to secure the patient's head in a neutral position. Do not remove manual in-line stabilization of the head until the head is completely immobilized to the long backboard.

- After the immobilization has been completed, reassess all four (4) extremities for distal pulse, motor function and sensory function.
- During transport continue to check the straps to assure they have not come loose and make the necessary adjustments.

RAPID EXTRICATION

The rapid extrication technique is designed to move a patient in a series of coordinated movements from the sitting position to the supine position on a long backboard while always maintaining stabilization and support for the head/neck, torso, and pelvis.

Indications for the use of rapid extrication:

- The scene is unsafe
- Unstable patient condition warrants immediate movement and transport
- Patient blocks you from accessing another, more serious, patient

NOTE: This procedure is only performed when a patient fits the above criteria. If the patient does not require a rapid extrication a short backboard device must be used.

The Rapid Extrication technique requires a minimum of three (3) rescuers who are trained in this procedure.

- Take appropriate body substance isolation precautions.
- Instruct the patient not to move their head and to hold still.
Make sure you fully explain the procedure to the patient so they understand what is about to occur.
- Manual inline stabilization
Rescuer #1 positions themselves behind the patient, brings the patient's head in to a neutral position, and maintains inline stabilization of the cervical spine.
- Assess pulse, motor, sensory
Assess pulses, motor function, and sensory function in all extremities.
- Rescuer #2 applies the appropriately sized cervical collar
- Position equipment and prepare to move the patient
Rescuer #3 places the long backboard near the door of the vehicle and then moves into the seat next to the patient. Rescuer #2, standing next to the patient, supports the patient's chest and back as rescuer #3 frees the patient's legs.
- Rotating the patient
At the direction of rescuer #1, who is maintaining inline stabilization, all rescuers begin to rotate the patient in several short, coordinated moves until the patient's back is in the open doorway and his/her feet are on the opposite seat. If rescuer #1 is unable to maintain inline stabilization throughout this step (i.e. the "B" post of the vehicle is in the way), then another available rescuer or bystander should take over manual inline stabilization from outside of the vehicle while rescuer #1 exits the vehicle to continue manual inline stabilization.

- Move patient to the long backboard

The end of the long backboard is placed on the seat next to the patient's buttocks while another rescuer or bystanders support the other end of the long backboard. At the direction of the rescuer maintaining inline stabilization, the patient is lowered onto the long backboard in one movement. The rescuers then slide the patient, as one unit, into position on the long backboard in short coordinated moves.

- Secure patient to the backboard

Secure the patient's torso first and remember to secure the bony portions of the body. Run one 9' strap through the hole closest to the patient's underarm and across the chest to the corresponding hole on the other side. Bring the strap back under the patient's arms to meet the buckle, which should be secured and positioned off the center of the chest. Have the patient inhale deeply and hold their breath (if possible) and then tighten the strap. This will assure that the strap does not impede the patient's respirations. The patient's arms should not be strapped in at this point.

Now secure the pelvis by locating a hole closest to the center of the pelvis. Run the strap through the hole, across the pelvis and to the corresponding hole on the opposite side. Bring the strap back across the pelvis to meet the buckle. The legs may be secured in a similar way or you may use cravats if necessary.

Once the torso and legs are secured, you can begin to secure the head. Be sure that whichever head immobilization device you use allows you to secure the patient's head in a neutral position. Do not remove manual in-line stabilization of the head until the head is completely immobilized to the long backboard.

- After the immobilization has been completed, reassess all four (4) extremities for distal pulse, motor function and sensory function.
- During transport continue to check the straps to assure they have not come loose.

NOTE: This procedure cannot be completed properly unless all team members understand their assignments and work as a team with communication at all times.

Several variations of rapid extrication are possible, including using assistance from bystanders. However, whichever technique is used must be used in a way as to not compromise the spine.

SPINAL IMMOBILIZATION OF A CHILD IN A CAR SEAT

NOTE: This procedure is used for children that do not require a rapid extrication from the car seat. If the car seat is damaged or insufficient to use for immobilization then the child should be removed from the car seat as in the Rapid Extrication from a Child Car Seat.

If the child has already been removed from the car seat prior to your arrival, use an appropriately sized immobilization device.

- Take appropriate body substance isolation precautions.
- Stabilize the child in the car seat
 - A rescuer stabilizes the child's car seat in an upright position while rescuer #1 initiates and maintains manual inline stabilization of the head and neck in the neutral position.
- Assess each extremity for the presence of distal pulse, capillary refill, motor function and sensory function.
- Remove car seat straps and apply collar
 - Rescuer #2 releases or cuts the straps of the car seat. Whenever possible you should avoid cutting the straps unless it is necessary. Apply an appropriately sized cervical collar. If you do not have a collar that will fit the child then you may use a towel roll around the neck.
- Continue to secure the child in the seat
 - Use towels or bath blankets to fill the voids between the child's torso and pelvis and the car seat. If the straps have not been cut and are not damaged replace them into their secured fasteners to secure the child. If you are unable to use the straps then you may use tape to secure the child. After the torso and pelvis are secured you may fill in the voids around the child's head with towels and securely tape the child's head to the seat.
- Assess each extremity for the presence of distal pulse, capillary refill, motor function and sensory function.
- Transporting the child
 - After the child is secured in the car seat, the car seat should be placed on the ambulance stretcher with the head of the stretcher positioned upright at a 90 degree angle. The stretcher straps should be thread through the appropriate areas on the car seat according the manufactures specifications.
 - If you are unable to use the stretcher the car seat may be properly secured, as stated above, on the bench seat.
- During transport continue to check the straps to assure they have not loosened.

NOTE: Do not secure any straps or tape in a manner which may hinder the patient's airway or breathing at any time.

RAPID EXTIRICATION OF A CHILD FROM A CAR SEAT

NOTE: This procedure is used for children that meet the criteria for a rapid extrication or if the child's car seat is inadequate for immobilization.

- Take appropriate body substance isolation precautions.
- Stabilize the child in the car seat
A rescuer stabilizes the child's car seat in an upright position while rescuer #1 initiates and maintains manual inline stabilization of the head and neck in the neutral position.
- Assess each extremity for the presence of distal pulse, capillary refill, motor function and sensory function.
- Remove car seat straps and apply collar
Rescuer #2 releases or cuts the straps of the car seat. Whenever possible you should avoid cutting the straps unless it is necessary. Apply an appropriately sized cervical collar. If you do not have a collar that will fit the child then you may use a towel roll around the neck.

NOTE: If you are using a commercially made pediatric immobilization device in place of a long backboard, make sure you follow the manufactures guidelines and instructions for the devices use and application.

- Place the car seat on a long backboard
While continuing to maintain inline stabilization, lay the car seat on the long backboard so the child is now in the supine position.
- Remove the child from the car seat
Rescuer #2 stabilizes the child's chest and axillary regions with his/her hands. At the direction of rescuer #1, who is continuing to maintain inline stabilization, the child is slid out of the car seat onto the long backboard.
- Fill voids and secure child to the long backboard
In order to maintain an open airway and a neutral position of the child's head, you may need to place padding under the child's shoulders and back regions. Do not over pad and do not cause excessive movement that will compromise the child's spine. Place blanket rolls or other types of padding along side the patient to stabilize the child to the backboard. Use tape or straps to secure the child's torso, pelvis, and legs to the long backboard. Use towels as head blocks and secure the child's head to the backboard.
- During transport continue to check the straps to assure they have not loosened.

NOTE: Do not secure any straps or tape in a manner which may hinder the patient's airway or breathing at any time.

SEMI AUTOMATIC EXTERNAL DEFIBRILLATOR

NOTE: The use of an AED is contraindicated in patients under the age of 9

- Take appropriate body substance isolation precautions.
- Question the rescuers about the arrest details.
- Instruct the rescuers to stop CPR.
- Verify that the patient is in cardiac arrest by checking for the presence of breathing and a carotid pulse.
- Instruct the rescuers to resume CPR.
- Position the defibrillator on the side of the patient opposite the rescuer performing chest compressions.
- Open the defibrillator pads and attach them to the cables.
- Prepare the patient's chest by opening the shirt, shaving off excess hair and/or drying the chest with a towel or dressing if necessary. If the patient has nitroglycerin paste or a nitroglycerin patch on his/her chest, you must remove it assuring not to get any nitroglycerin on you or other rescuers. Dispose of the nitroglycerin along with any material used to remove it from the patient in a biohazard container.
- Apply the sternum pad or white cable pad to the right side of the patient's chest with the top edge of the pad touching the bottom of the clavicle and the side of the pad to the right border of the sternum. Apply the apex pad or red cable pad to the patient's left lateral chest at the anterior axillary line above the lower rib margin. When the pads are properly positioned the heart should be between the two pads.

NOTE: If the patient has a pacemaker or an internal automatic defibrillator/cardioverter where you would normally apply one of the pads, you will need to apply the pad 5" away from this site.

- Turn on the power to the defibrillator. Make sure that the recording device is running (if applicable). If in a moving ambulance stop the ambulance in a safe location.
- Instruct the rescuers to stop CPR and make sure no one is in contact with the patient. Loudly verbalize "Clear the patient" and assure no one is touching the patient.
- Press the analyze button on the AED. Assure no one is touching the patient or performing CPR while the AED is analyzing.

- If the AED determines that the patient is in a “shockable” rhythm, it will charge to the pre-selected energy setting. When ready, it will alert you to “press to shock” button. Insure that no one is touching the patient or touching anything that is in contact with the patient by looking up and down the patient and saying loudly, “clear”. Keep your eyes on the patient while depressing the button. *The first shock should be delivered within 90 seconds of the AED reaching the patient.*
- After the shock has been delivered, reanalyze the patient’s rhythm assuring there is no one touching the patient. If the patient is still in a “shockable” rhythm, repeat the shock sequence. Complete this sequence one more time for a total of three shocks without interruption.
- After the third shock has been delivered, check for the presence of a carotid pulse. If the pulse is absent, perform CPR (2 rescuer) for one minute and verify the effectiveness of CPR (compressions and ventilations). At the end of one minute, check for a pulse. If the pulse is still absent, reanalyze the patient's rhythm.
- If the patient is still in a “shockable” rhythm, repeat the 3 shock sequence again.
- After the second set of three shocks have been delivered, check for a pulse. If the pulse is absent, perform CPR, begin to package and transport the patient to the hospital.
- If there is a short transport time continue to transport the patient to the hospital. If there is a long transport or ALS backup is close, repeat another set of three (3) stacked shocks. If the patient is still in a shockable rhythm after 9 shocks, repeat sets of three (3) stacked shocks with one (1) minute of CPR between each set of shocks until the patient regains a pulse or you receive the message “no shock indicated”.

NOTE: If at any time the defibrillator doesn’t recommend a shock, check for a pulse. If the pulse is absent, perform CPR.

If a pulse is present, reassess the patients’ breathing status and treat accordingly.

Monitor the patient and transport to the hospital.

New York State Department of Health

Emergency Medical Technician Clinical Rotation Guide

This guide has been prepared to help facilitate the supervised clinical experience of the EMT student in the interest of the excellence in patient care.

The clinical experience the EMT student receives plays an important role in the overall educational process of becoming an EMT. In order for the student's clinical rotation to be a rewarding experience, there needs to be an experienced clinical team at each hospital and ambulance service that provides the required clinical rotation. The role and responsibilities of each member of these teams are outlined in this guide.

To promote a systematic and standardized approach to the clinical rotation experience, the skills appropriate to the EMT have been defined and evaluation forms for both the student and the preceptor have been developed. Students should be given every opportunity possible to use as many of their skills as possible during their clinical rotation. Just as important are the observations the EMT student will have during his/her clinical rotations. The student may not have a great deal of opportunities to use the new skills they have learned, but the observations they have can be just as rewarding.

There are two types of clinical rotations available to the EMT student. A student must complete a minimum of 10 hours of clinical rotation to complete the course and to be eligible to take the New York State Practical Exam. This clinical rotation can be done either with a NYS certified ambulance service or at a hospital's Emergency Department or a combination of both. Following is a description of each rotation:

Ambulance Clinical Rotation

The ambulance rotation affords the student the opportunity to experience what it is like to be a member of an ambulance crew. The student, under the direct supervision of an authorized preceptor, will be allowed to use the skills and knowledge he/she has learned in their current course. This clinical rotation will have the student involved in all aspects of an ambulance call from checking of the ambulance at the start of a shift, to providing patient care, and turning over the patient to the Emergency Department staff.

Emergency Department Clinical Rotation

The Emergency Department (ED) rotation affords the student the opportunity to experience how the ED works and how a patient is cared for in the ED once an ambulance turns over the care of their patient to the ED staff. The ED clinical rotation will also afford the student, under the direct supervision of an authorized preceptor, the ability to use the skills and knowledge he/she has learned in their current course.

At the completion of each scheduled clinical rotation, the preceptor should complete the student evaluation form. This form should be reviewed by the course CIC along with the student. The student evaluation form can be an important and useful tool in the educational process.

If there are any questions or concerns during the clinical rotation that need immediate attention, the preceptor should contact the course's Certified Instructor Coordinator for assistance.

Hospital Emergency Department Staff Clinical Guide

This section is provided as a guide for the ED staff to assure they are familiar with what is expected of them and of the EMT student during this important clinical rotation. The ED staff member/preceptor who will be responsible for the EMT student should review these guidelines along with any other materials provided by the EMT student and the course sponsor. Any questions or concerns about the student or the clinical rotation should be directed to the EMT student's Certified Instructor Coordinator.

One staff member should be designated as the staff member/preceptor who is in-charge of the EMT student during this clinical rotation. Many Emergency Departments and EMS course sponsors designate the Charge Nurse or Triage Nurse as the person who the EMT student will advise of their presence. The staff member who is assigned to the EMT student should be knowledgeable and experienced in emergency nursing, as well as pre-hospital emergency medical services, including the current EMT training program. Once the EMT student has been assigned to an ED staff member, the staff member should do the following:

- ✓ Confirm the student's identity through photo identification if available.
- ✓ Initiate any paperwork required to be completed for the clinical rotation.
- ✓ Establish what skills the student is allowed to perform according to the Skills Eligibility form and what will be expected of the student during the clinical rotation.
- ✓ Introduce the student to the on-duty physician(s) in the ED and advise the physician(s) of the level of training the student is currently enrolled in.
- ✓ Assure the student is familiar with the ED and all safety requirements are reviewed.
- ✓ Assure that the student has been exposed to how patients are received, triaged, and cared for within the ED.
- ✓ Monitor all activities related to the student's care of patients within the ED.
- ✓ Review and critique, with the student, the care he/she has provided to patients.
- ✓ Complete any required paperwork and/or evaluation forms for the student.

Ambulance Service Staff Clinical Guide

This section is provided as a guide for the ambulance service staff to assure they are familiar with what is expected of them and of the EMT student. The ambulance staff member/preceptor who will be responsible for the EMT student should review these guidelines along with any other materials provided by the EMT student and the course sponsor. Any questions or concerns about the student or the clinical rotation should be directed to the EMT student's Certified Instructor Coordinator.

One staff member from the ambulance service should be designated as the staff member/preceptor who is in-charge of the EMT student during this clinical rotation. This staff member must be a NYS Certified EMT-B or higher and should be knowledgeable and experienced with the current EMT training program. Once the EMT student has been assigned to the staff member the staff member should do the following:

- ✓ Confirm the student's identity through photo identification if available.
- ✓ Initiate any paperwork required to be completed for the clinical rotation.
- ✓ Establish what skills the student is allowed to perform according to the Skills Eligibility form and what will be expected of the student during the clinical rotation.
- ✓ Introduce the student to the on-duty ambulance service staff.
- ✓ Assure that the student is familiar with the ambulances and where equipment is located.
- ✓ Review the procedures of the agency for receiving emergency calls, communications, response, levels of care in the agency, mutual aid plans, and destination hospitals served by the agency.
- ✓ Complete objectives listed on the Clinical Evaluation form under the section entitled "Ambulance ONLY: Operational Objectives".
- ✓ Complete any required paperwork and/or evaluation forms for the student.

Emergency Medical Technician Student Clinical Guide

This section is provided as a guide for the EMT student to assure he/she is familiar with what is expected of them during the clinical rotations. It is the responsibility of the EMT student to assure that all clinical rotation staff members/preceptors are knowledgeable in what the student is capable of doing during the clinical rotation. The EMT student is also responsible for assuring that all required paperwork is completed for the clinical rotation. If any problems occur during the clinical rotation the EMT student should contact the course Certified Instructor Coordinator as soon as possible. The EMT student should do the following:

- ✓ Be neatly attired and in a physical and mental state conducive to learning.
- ✓ Have proper identification and name tag available to all clinical rotation staff.
- ✓ Report to the appropriate staff member at the ED or ambulance service on the date and time assigned by your Course Instructor Coordinator.
- ✓ Be under direct supervision of an assigned staff member/preceptor from the hospital or ambulance service.
- ✓ Observe all rules pertaining to patient confidentiality.
- ✓ Observe all policies and regulations set by the EMS Course Instructor Coordinator, hospital, and ambulance service.
- ✓ Return all required paperwork to the course CIC.

Emergency Medical Technician Student Skills Eligibility

Student : _____ Hospital/Agency Name: _____
(print)

Course CIC: _____ EMS Course Sponsor: _____
(print)

The student listed above has been educated in the skills, which the course CIC has initialed below. This student may perform these skills under direct supervision of the preceptor. The student is not to perform any skill in which he/she has not been educated.

- _____ Baseline vital signs including respirations, pulse, blood pressure, and lung sounds.
- _____ Lifting and moving patients
- _____ Airway skills including oralpharyngeal and nasopharyngeal airways, oxygen therapy, artificial ventilations using bag valve mask and pocket mask, and suctioning.
- _____ Cardiopulmonary Resuscitation for infant, child, and adult.
- _____ Patient assessment skills and history & physical exams.
- _____ Assisting patient with self-administered medications to include Nitroglycerin and Bronchodilator inhalers.
- _____ Operation of an Automated External Defibrillator (AED).
- _____ Administration of oral glucose.
- _____ Epinephrine auto injectors
- _____ Administration of activated charcoal and Syrup of Ipecac.
- _____ Safe techniques for restraining a patient with a behavioral problem.
- _____ Normal cephalic delivery of an infant including cutting of the umbilical cord, delivery of the placenta, and post-delivery care of the mother and infant.
- _____ Control of external hemorrhaging and care for hypoperfusion (shock).
- _____ Care for soft tissue injuries including burns and amputations.
- _____ Splinting techniques for extremities including traction splinting.
- _____ Immobilization techniques for suspected spinal injuries.
- _____ Care of pediatric patients.
- _____ Removal of patients with suspected spinal injuries from a motor vehicle.
- _____ Mass Casualty Incidents and performing triage.
- _____ Other skills not listed: _____

Course CIC Signature: _____ Date: _____

Clinical Internship Objectives for Emergency Department & Ambulance Rotations

The EMT-B candidate is required to perform clinical skill objectives based on the performance criteria in the NYS EMT-B curriculum and the current standard of care. The Certified Instructor Coordinator will review the course sponsor's clinical internship policy and procedures prior to the EMT-B's clinical assignment.

The Certified Instructor Coordinator shall review the following clinical internship objectives with each candidate and ambulance or emergency department preceptors identifying candidate performance and evaluation criteria. In addition, a clinical evaluation form will be completed by the preceptor and returned to the Certified Instructor Coordinator. Prior to each clinical rotation, both the clinical staff and candidate(s) are encouraged to complete an orientation of expected behavior pertaining to the time before, during and after each clinical and ambulance rotation.

Clinical Internship Objectives

During emergency department or ambulance clinical rotations, the student should be under direct supervision and demonstrate proficiency for each of the following:

Emergency Department/Ambulance Clinical Objectives:

- Perform patient assessment including medical history and conducting a physical examination. Minimum assessment skills should include taking and recording vital signs and auscultation of lung sounds.
- Assists and reviews the treatment of trauma emergencies
- Assists and reviews the treatment of medical emergencies
- Assists in triaging patients.
- Assists in and use appropriate body substance isolation techniques.
- Assists in hemorrhage control.
- Assists in splinting.
- Assists in respiratory and/or cardiac arrest, including the performance of CPR, basic airway management and on-scene defibrillation.
- Assists in administration of Epinephrine Auto Injector
- Assists in use of Bronchodilator.
- Assists in use of Nitroglycerine.
- Assists/observes in obtaining medical control
- Assists/observes in transfer of patient information and referral

Ambulance Operations Objectives:

- Assists with rig-checkout/restock. Locates, inspects and prepares equipment for use
- Assists with safe-scene operations. Locates and is familiar with safety equipment.
- Assists with lifting and carrying. Locates and is familiar with safe operation.
- Assists with communications. Locates and operates equipment.
- Assists with patient care report completion and transfer of information to ED.

The following evaluation form is to be completed by the student's preceptor for the emergency department or ambulance staff. The completed form must be submitted to the Certified Instructor Coordinator for the candidate to be eligible for course completion.

NYS EMERGENCY MEDICAL SERVICES EMT CLINICAL EVALUATION FORM

This form must be completed for each block of clinical rotation time the student attends

EMT-B Student Name: _____ Rotation Type: ED Site Ambulance
 EMS Course Sponsor: _____ Course CIC: _____
 CIC Contact Phone #: _____ Hospital/Agency Name: _____
 Student Arrival Time: _____ Departure Time: _____ Date: _____

Rating Key: 1 = Needs improvement – Student *did not* meet the minimum standard of performance
 2 = Satisfactory – Student met the minimum standard, but required guidance or assistance
 3 = Very Good – Student performed the minimum standard without guidance or assistance
 4 = Excellent – Student shows mastery level and was able to function independently

PLEASE USE THE BACK OF THIS FORM FOR ADDITIONAL COMMENTS IF NEEDED

ED or Ambulance Skill Performed	Amt. of times Performed	Overall Rating	Preceptor's Comments / Recommendations for Student Improvement
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____
_____	_____	1 2 3 4	_____



Ambulance ONLY: Operational Objectives:

Completed

Precall Activities

- Describe procedures of how calls are received by the ambulance service _____ Yes No
- Describe the procedure for crew response to a call _____ Yes No
- Explain and demonstrate the procedure for checking the ambulance and restocking _____ Yes No
- Discuss the infection control procedures of the ambulance service _____ Yes No

During Call Activities

- Observe/participate in the assessment/management of the patient as directed by the preceptor _____ Yes No
- Demonstrate how to don personal protective equipment and supplies for BSI _____ Yes No
- Discuss potential hazards to the EMT and bystanders at an incident and how they are controlled _____ Yes No
- Explain or demonstrate the proper procedure for vehicle/equipment decontamination in accordance with the services exposure control plan _____ Yes No
- Describe communications procedures for ambulance to dispatch and for ambulance to hospital _____ Yes No
- Demonstrate the procedure for making up the stretcher's linen and where hospital supplies are _____ Yes No

General Observation Activities

- Demonstrate proper procedures for loading and unloading the stretcher _____ Yes No
- Demonstrate how to use patient carrying devices (i.e. stair chair, backboard, etc.) _____ Yes No
- Describe mutual aid procedures including ALS intercepts _____ Yes No
- Describe how first responder agencies interface with the ambulance service _____ Yes No
- Describe how the ambulance service interfaces with police, fire, and rescue personnel _____ Yes No
- Explain the ambulance service's procedures for Incident Command and MCI management _____ Yes No

ADDITIONAL COMMENTS: _____

EVALUATOR: (PRINT) _____ Signature: _____ Date: _____

STUDENT: (PRINT) _____ Signature: _____ Date: _____

EMS STUDENT EVALUATION OF CLINICAL ROTATION

A separate form should be completed for each clinical rotation the student completes

Student Name: _____ Date of Rotation: _____

Rotation performed at: _____

Facility

Department

Use the following rating scale, circle the number which best describes your evaluation of the designated rotation with 1 standing for the worst and 5 standing for the best. Use the back of this form for additional space for you positive or negative comments.

1. Appropriate Orientation by the CIC 1 2 3 4 5

Comments: _____

2. Responsibilities clearly defined by the CIC 1 2 3 4 5

Comments: _____

3. Adequate Clinical Supervision at the clinical site 1 2 3 4 5

Comments: _____

4. Availability of preceptor(s) during the clinical session 1 2 3 4 5

Comments: _____

5. Responsiveness to clinical questions by staff at clinical site 1 2 3 4 5

Comments: _____

6. Incorporation as member of service or clinical site 1 2 3 4 5

Comments: _____

7. Educational objectives accomplished 1 2 3 4 5

Comments: _____

8. Overall educational experience 1 2 3 4 5

Comments: _____

Comment on Individual Preceptors with which you have had significant educational interactions.

Preceptor or faculty	Availability	Clinical teaching
----------------------	--------------	-------------------

1. _____	1 2 3 4 5	1 2 3 4 5
----------	-------------------	-------------------

Comments: _____

2. _____	1 2 3 4 5	1 2 3 4 5
----------	-------------------	-------------------

Comments: _____

3. _____	1 2 3 4 5	1 2 3 4 5
----------	-------------------	-------------------

Comments: _____

PCR

INSTRUCTION MANUAL FOR *PREHOSPITAL CARE REPORT

Revised May 2000

Prepared by
STREMS, Inc.

Funded By
New York State Department of Health
Bureau of Emergency Medical Services

GENERAL INSTRUCTIONS

The PCR is a three-part document printed on NCR paper. Each form is bonded at the top. Care must be taken that what is written on one PCR set does not come through on the set below (an aluminum form-holder clipboard is recommended). It is important that **firm pressure with a ballpoint pen** be used. Be as neat, complete and accurate as possible when completing this form. If a section does not apply to a particular call, leave it blank. Do **NOT** write **NA** or draw lines across sections of the form. It is important for the crew members to review the document before it is submitted. If an error is made prior to the PCR being submitted, enter the correct information on a second PCR and destroy all copies of the first form.

DISTRIBUTION OF COPIES

The distribution of the PCR is as follows:

- ◆ **White copy** is retained by the agency.
- ◆ **Yellow copy** is used for data collection, and agencies should follow procedures for collection of these records. This copy is the **only acceptable form** for the data program, because it contains the keypunch codes.
- ◆ **Pink Copy** becomes part of the medical record and therefore must be left at the hospital.

WHEN TO USE A PCR

Complete a PCR for every patient and every call. The PCR is used to substantiate all patient assessment and care provided, and documents all calls including canceled calls, standby calls, refused medical aid calls, walk-ins, etc. The call outcome is recorded in the Disposition section of the form (see Disposition Codes). A PCR should **NOT** be completed when the unit is being used for administrative purposes such as driver training or vehicle maintenance.

A separate PCR should be completed for each patient. When a mother and newborn infant are transported together, or a baby is delivered en route, separate PCRs should be completed for the mother and each infant. A separate PCR should be completed for each patient transport. A PCR should be concluded whenever a patient is delivered to a destination such as a hospital, nursing home, or doctor's office. If the same patient is then transported to another facility/destination or returned to the original call location, a second PCR should be completed. For example, when a patient is taken to and from a hospital for diagnostic tests or for therapeutic purposes, two PCRs should be completed. Or, when a critical patient is taken to one hospital and then transferred to another hospital, a separate PCR should be completed for each leg of the trip.

TIERED RESPONSES

When more than one agency responds to the scene, each service should complete a separate PCR. Each PCR should reflect **only** the actions taken by that crew. When a fly car arrives at the scene prior to an ambulance from the **same agency**, two PCRs should be completed. When patient assessment and/or treatment is provided by a first responder agency, fly car, or other nontransporting service, a PCR should be completed and the Disposition Code 004, "treated by this unit and transported by another," should be entered on the form. The hospital (pink) copy should be given to the transporting ambulance to accompany the patient to the hospital.

DETAILED INSTRUCTIONS

Serial

Located in the upper center of PCR form: this number is to identify each call. Be careful when separating the copies that you do not tear this number off. If this happens you should tape the torn pieces together immediately. The form will not be accepted without this number.

Date of Call

Enter the date the call is received. If a unit is reserved ahead of time for a transport, enter the date the unit responds. Numbers less than 10 are to be listed as two digits. Example: January 2, 2001 (01:02:01). NOTE: The record is dropped from all data reports if the date is omitted.

Run

Enter the number assigned by your dispatcher or agency. Agency Code Enter the number that is assigned to your agency by the Emergency Medical Services Program of the New York State Department of Health or your regional emergency medical services agency.

Vehicle ID

Enter the identification number of the vehicle that responds to the call. This is the number assigned by your agency.

Name

Enter the name of the patient. If the name is unknown, write "unknown" and add important identifiers. Examples:

- ◆ unknown white female
- ◆ unknown black male.

Address

Enter the mailing address of the patient. Be as complete as possible. If the address is unknown, write "unknown."

Ph

Enter the patient's telephone number.

Age

Enter the age of the patient. The patient's age must be entered even if the date of birth is entered. If the patient's age is unknown, enter the approximate age of the patient. If the patient is less than one year of age, enter either H for hours, or D for days, or M for months. Examples:

- ◆ 12 hours entered as 12H,
- ◆ 5 days entered as 5D
- ◆ 7 months entered as 7M.

DOB

Enter the date of the patient's birth. If the date of birth is unknown, leave this section blank. Numbers less than 10 are to be listed as two digits. Example:

- ◆ January 3, 1925 (01:03:25).

Sex

Place an X in the appropriate box to indicate whether the patient is male or female.

Physician

Enter the name of the patient's personal physician.

Care in Progress on Arrival

Place an X in the appropriate box to indicate the type of care, if any, the patient received prior to your arrival. Indicate what was done for the patient in the comment section.

- ◆ **None:** the patient is not receiving any care.
- ◆ **Citizen:** care is being administered by a person who is not certified at any level of EMS.
- ◆ **PD/FD/Other First Responder:** care is being administered by a member of the Police Department, Fire Department, or another certified as a First Responder (may be off-duty).
- ◆ **Other EMS:** patient is being cared for by physician, nurse, EMT or paramedic (may be off-duty).

Agency Name

Enter the official name of your agency or service.

Dispatch Information

Enter any additional dispatch information provided to your agency or service. (Examples: MVA, unconscious patient, gunshot wound).

Call Location

Enter the address of the incident scene to which you were dispatched. Place an X in the appropriate box indicating the location where the patient was initially found. (Check ONLY one box).

- ◆ **Residence:** Private homes, multiple occupancies such as apartments, dormitories, etc. (Note: May not necessarily be the patient's own residence).
- ◆ **Health Facility:** A place where medical care is routinely provided. (Examples include: hospital, nursing home, doctor's office, health clinic, emergicare clinic, infirmary).
- ◆ **Farm:** National Safety Council Definition: A rural place from which \$1,000 or more of agricultural products were sold, or normally would have been sold. (Examples: dairy farms, fields where crops are grown, chicken farms, tree farms; includes barns as well as fields).
- ◆ **Indus.Facility:** A place where a product is manufactured or stored. (Examples: warehouses, manufacturing plants, etc.).
- ◆ **Other Work Location:** A place of work other than an industrial facility. (Example: Offices).
- ◆ **Roadway:** A place that is designated as a thoroughfare for motor vehicles, to include passenger vehicles, trucks and motorcycles. Not a private residence driveway. (Examples: interstates, town or village roads, county roads, streets).
- ◆ **Recreational:** National Safety Council Definition: Recreational places are those organized for recreation or sport but excluding homes and industrial places. (Examples: gymnasium, tennis court, bike or jogging path, basketball courts).
- ◆ **Other:** Any place which has not been defined by any of the other call locations in this section.

Mileage

Enter the mileage information required by your agency. Indicate the mileage on the responding vehicle's odometer at the beginning of the run and at the end of the run. Subtract the "beginning" reading from the "end" reading and enter the "total" mileage.

Location Code

Enter the four-digit municipality code, from the New York State Gazetteer, for the municipality in which the patient is located at the time of your response.

Call Type As Rec'd

Place an X in the box that indicates how the call was received from the dispatcher. Indicate whether the unit responding was dispatched as an emergency, a non-emergency, or a standby. *NOTE: The PCR will automatically be entered as an emergency call if not marked otherwise.*

- ◆ **Emergency:** Place an X in this box when a call is dispatched as an emergency or a potential emergency even though it may not turn out to be an emergency. This box should also include any emergency or critical care transfers.
- ◆ **Non-Emergency:** Place an X in this box for routine calls such as a non-urgent transport from home to hospital, a transport from hospital to home, or a non-urgent call to assist a patient at home. This box should also include any non-urgent transfers.
- ◆ **Stand-by:** Place an X in this box when your unit is dispatched but no patient is treated such as when covering a football game, standing by at a fire, or providing mutual aid at a neighboring station. If an incident occurs during a standby such as an injured football player, a separate PCR should be completed and the appropriate Call Type (emergency, non-emergency) marked.

Interfacility Transfers

Complete this section *ONLY* if the patient is transferred from one medical facility to another.

- ◆ **Transferred from:** Hospital Disposition Code.
- ◆ **No Previous PCR:** Place an X in box if no previous PCR has been filled out.
- ◆ **Unknown if Previous PCR:** Place an X in box if you do not know if a PCR was previously completed for this patient, or if you do not know the PCR number.
- ◆ **Previous PCR Number:** Fill in the serial number of the PCR that was completed when this patient was originally transported for this complaint.

Call Times

Only enter military times in this section. To calculate military time, see General Instructions.

- ◆ **Call Rec'd** Enter the time the service/agency receives the call. If a unit was reserved ahead of time for a transport, record the time when the vehicle responds. In that case, the call received time and the enroute time will be the same.
- ◆ **Enroute** Enter the time the unit starts toward the incident location.
- ◆ **Arrived At Scene** Enter the time the unit arrives at the incident location. If the incident is within a structure, the time the emergency vehicle arrives at the structure should be entered.
- ◆ **From Scene** Enter the time of departure from the scene.
- ◆ **At Destin** Enter the time the unit arrives at the destination. The destination (hospital, nursing home, residence, etc.) is where the patient is unloaded. If the unit does not transport, leave blank.
- ◆ **In Service** Enter the time when the unit is available to receive another call. If your county or region requires the research (yellow) copy to be handed in at the hospital, estimate and enter in-service time.
- ◆ **In Quarters** Enter the time the unit is back in the station where it is regularly housed. If the unit is dispatched to another call before returning to quarters, then this time should be left blank.

Mechanism of Injury

Place an X in the appropriate box. Check all that apply.

- ◆ **MVA (complete seat belt section)** Place an X in this box if the patient was in a motor vehicle at the time of the accident (this includes motorcycles). If in doubt, check to see if the police agency investigating completes an MV-104A form. (If this box is checked, then the "Seatbelt used?" section must be completed).
- ◆ **Struck by Vehicle** Place an X in this box if the patient was struck by a vehicle (including a motorcycle). The patient could be a pedestrian or riding on a non-motorized vehicle such as a bicycle. If in doubt, check to see if the police agency investigating completes an MV-104 form.

- ◆ **Fall of ____ feet** Place an X in this box if the patient fell from some height. (If this box is checked, place a number in the section to indicate the approximate number of feet of the fall).
- ◆ **Unarmed Assault** Place an X in this box if the patient was assaulted (harmed by another person) but no weapon such as gun, knife, etc., was used.
- ◆ **GSW (GunShot Wound)** Place an X in this box if the patient was injured by ballistics from a rifle, handgun or shotgun. This box should be checked whether the wound was intentional or accidental.
- ◆ **Knife** Place an X in this box if the patient was harmed by a knife or knife-like object (i.e., scissors, screwdriver).
- ◆ **Machinery** Place an X in this box if the patient's injury was related to use of any type of machinery (i.e., farm or industrial equipment).
- ◆ Place an X in this box if the mechanism of injury is not among the choices listed on the PCR; fill in the cause of injury.

Extrication required _____ minutes

Place an X in this box if the patient had to be extricated. (Note: this does not just apply to motor vehicles but any situation where extraordinary measures and/or equipment must be used to disentangle a patient for treatment and/or transport). (NOTE: If this box is marked, then the details of the situation that required the patient to be extricated should be placed in the comment section). The number of minutes required to extricate the patient should be placed in the space provided. The number of minutes to extricate a victim is determined from the time "at scene" till the patient is free to be removed from the vehicle and transported.

Seat Belt Used?

Place an X in the appropriate box to indicate if the patient being reported on the PCR was using safety equipment such as a lap belt, shoulder harness, 3 point harness, or child restraint device. This may be determined by observation of the crew, or as reported by the police, or stated by the patient, or reported by other observers. Mark the appropriate box. Do not complete this section for pedestrians, bicycle riders, or motorcycle riders involved in the MVA.

Chief Complaint

Record the most important problem the patient is describing, or state the reason the unit was called. Use the patient's own words. Example: "My chest hurts; I can't breathe."

Subjective Assessment

From your patient interview, record additional information regarding the patient's Chief Complaint in the space provided.

Presenting Problem

Place an X in the box or boxes that describe the patient's current problem(s). Mark all that apply; circle the primary problem. If necessary, describe any presenting problem in the Comment section. Do not record the patient's past medical history in this section.

- ◆ **Airway Obstruction** Complete or partial blockage of the route for the passage of air into the lungs.
- ◆ **Respiratory Arrest** When breathing stops completely.
- ◆ **Respiratory Distress** Difficulty in breathing.
- ◆ **Cardiac Related (Potential)** Signs and symptoms that may relate to, or indicate, a heart condition or disease.
- ◆ **Cardiac Arrest** When the heart stops beating and there is absence (disappearance) of a palpable carotid pulse.
- ◆ **Allergic Reaction** An abnormal or unexpected reaction to a substance such as a drug, an insect sting or bite, a food, dust, pollen, or chemical.
- ◆ **Syncope** A temporary loss of consciousness; fainting.
- ◆ **Stroke/CVA** A condition characterized by a sudden lessening or a loss of consciousness, sensation and/or voluntary movement. Cerebrovascular accident (CVA) is a medical problem and not a trauma-related problem.
- ◆ **General Illness/Malaise** A vague feeling of physical discomfort or uneasiness often occurring before or during an illness.
- ◆ **Gastro-Intestinal Distress** Complaints associated with the stomach and intestines such as nausea, vomiting, diarrhea, stomach pain, indigestion, and passage of blood in the stool.

- ◆ **Diabetic Related (Potential)** Signs and symptoms that are consistent with insulin shock or diabetic coma. Potential Insulin Shock: The patient is hypoglycemic with presenting signs of full, rapid pulse; normal breathing; dizziness; headache; fainting; seizures; disorientation; coma; normal blood pressure. Potential Diabetic Coma: The patient is hyperglycemic with presenting signs of sweet or fruity smelling breath; rapid, weak pulse; rapid, deep breathing; varying degrees of unresponsiveness up to coma; normal or slightly low blood pressure.
- ◆ **Pain** A sensation in which the patient states he is experiencing distress, discomfort, or suffering. Specify the type and location of pain on the line provided.
- ◆ **Unconscious/Unresponsive** When the Patient is comatose and does not react to verbal or painful stimuli.
- ◆ **Seizure** Involuntary contraction and relaxation of voluntary muscles (convulsions). These are signs, for example, that may be seen with a grand mal seizure.
- ◆ **Behavioral Disorder** An inappropriate mood or conduct exhibited by the patient.

Select Substance Abuse or Poisoning. Do not check both categories.

- ◆ **Substance Abuse (Potential)** An injection, ingestion, or inhalation of excessive amounts of any drug including alcohol. Overdose and suicide attempts using drugs and/or alcohol would fall into this category.
- ◆ **Poisoning (Accidental)** The injection, ingestion, exposure, inhalation, or absorption of any substance that will produce a harmful or injurious effect on the body. Substance abuse, overdose, or attempted suicides should not be recorded under this category.
- ◆ **Shock** is defined as:
 - 1. systolic BP is 90mmhg or less
 - 2. systolic BP above 90mmhg and signs of inadequate perfusion, such as:
 - a. altered mental state (restlessness, inattention, confusion, agitation)
 - b. tachycardia (pulse greater than 100)
 - c. delayed capillary refill (greater than 2 seconds)
 - d. pallor
 - e. cold, clammy skin
- ◆ **Head Injury** Any obvious or suspected injury to the skull, brain, or facial structures.
- ◆ **Spinal Injury** Signs and symptoms consistent with injury to the vertebral column including fracture, dislocation, and disc injury (including compression), or suspicion of such injury based on the mechanism of injury.
- ◆ **Fracture/Dislocation** Suspected bone or joint injury such as a fracture or dislocations.
 - ◆ *Fracture:* A break, crack, split, or crumbling of a bone.
 - ◆ *Dislocation:* A temporary displacement of a bone out of its normal position in a joint.
- ◆ **Amputation** The traumatic removal or separation of a body part.
- ◆ **Other** Any presenting problem other than those listed in this section. Note the problem on the line provided and explain in detail in the Comment section.
- ◆ **Major Trauma** is present if the mechanism of injury or patient's physical findings meets any one of the following criteria. By definition, all such patients fall into either the critical or unstable "C.U.P.S." classification.

MECHANISM OF INJURY

1. Fall more than 20 feet.
2. Survivor of motor vehicle crash in which there was a death of an occupant of the same vehicle.
3. Patient struck by a vehicle moving faster than 20 mph.
4. Patient ejected from the vehicle.
5. High speed crash with resulting severe deformity of the vehicle
6. Vehicle rollover.

PHYSICAL FINDINGS

7. Pulse less than 50/min or greater than 120/min.
8. Systolic blood pressure of 90 mm Hg or less.
9. Respiratory rate less than 10/min or greater than 28/min.
10. Glasgow coma scale less than 13.
11. Penetrating injuries of the trunk, head, neck, chest, abdomen or groin.
12. Two or more proximal long bone fractures.
13. Flail chest.
14. Burns that involve 15% or more of the body surface or facial/airway.
15. Combined system trauma that involves two or more body systems.
16. Spinal cord injury or limb paralysis.
17. Amputation (except digits).

- ◆ **Trauma - Blunt** A severe injury caused by a thick or dull-edged object. Since the damage occurs below the skin, there may not be a break in the skin.
- ◆ **Trauma - Penetrating** A severe injury with an entrance and/or exit wound. This includes penetrating wounds, perforating wounds, and impaled objects.
- ◆ **Soft Tissue Injury** An injury that involved skin, muscle, blood vessel, nerve, fatty tissue, or tissues that line or cover an organ. This injury is not severe enough to be classified as blunt trauma. Examples: contusions, abrasions, incisions, lacerations, and avulsions.
- ◆ **Bleeding/Hemorrhage** Blood escaping from arteries or veins. The blood loss may be either internal, external, or both.
- ◆ **OB/GYN**
 - ◆ *Obstetrics (OB)*: Conditions resulting from the state of pregnancy.
 - ◆ *Gynecology (GYN)*: Conditions related to the female reproductive system.
- ◆ **Burns** An injury to the body surface and/or underlying tissue caused by overexposure to heat, chemicals, electricity, or radiation.
- ◆ **Environmental**
 - ◆ *Heat* A condition caused by exposure to excessively high temperatures. It may be characterized by heat cramps, heat exhaustion, or heat stroke.
 - ◆ *Cold* A condition caused by exposure to excessively low temperatures. It may be characterized by frostnip, superficial frostbite, or freezing.
- ◆ **Hazardous Materials** Exposure to or an injury suspected to have been caused by hazardous materials such as solid, liquid or gaseous chemicals, or radioactive materials.
- ◆ **Obvious Death** Conforms to the commissioner of Health's statement of December 1, 1981, relative to CPR by EMTs. Obvious death includes decapitation or other similarly mortal injuries, or where rigor mortis, tissue decomposition or extreme dependent lividity is present (Policy Statement appended).

Past Medical History

Place an X in all appropriate boxes. List allergies and current medications in the spaces provided. If necessary, continue past medical history in the comment section.

Vital Signs

Enter each set of vital signs in the space provided. If more than three sets are taken, record them in the Comment section or on a Continuation Form. (Note: The statistical program uses only complete sets of vital signs-- respiration, pulse, blood pressure-- that are recorded in numbers; vital signs recorded by terms such as "normal" or "stable" are not included.)

- ◆ **Time** Enter the time each set of vitals are taken. Only enter military time in this section. To calculate military time, see General Instructions.
- ◆ **Resp.** Record the number of respirations per minute. Also place an X in the box that best describes the quality of respiration (regular, shallow, labored).
- ◆ **Pulse** Record the pulse rate per minute. Also place an X in the box that best describes the patient's pulse (regular, irregular).
- ◆ **B.P.** Record the blood pressure (B.P.) as systolic over diastolic pressure. If you are unable to take the patient's blood pressure, explain the reason in the Comment section. If the blood pressure is taken by palpation, record the systolic pressure over P. Example: 90/P.

Level of Consciousness

This section denotes level of consciousness, using the acronym AVPU, which stands for:

- A** - Alert--Knows his name (person); knows where he is (place); knows day of week (day).
- V** - Verbally responds--but not able to respond correctly to all three questions above.
- P** - Responds to painful stimulus but not oriented to person, place and/or time.
- U** - Unresponsive to both painful and verbal stimulus.

Place an X in the box that most accurately describes the patient's level of consciousness at the time this assessment was performed.

Glasgow Coma Scale (CGS)

The Glasgow Coma Scale (GCS), based upon eye opening, verbal, and motor responses is a practical means of monitoring changes in level of consciousness. If response on the scale is given a number, the responsiveness of the patient can be expressed by summation of the figures. Lowest score is 3; highest is 15. (Refer to GCS guide on back of PCR). Record the numeric total of the highest level of responses to the level of consciousness survey.

Example: GCS
Eye Opening - To Pain 2
Verbal Response - Confused 4
Motor Response - Withdraw (Pain) 4
TOTAL GCS SCORE 10

Pupils

Place an X in the box that best describes each eye's response to light. Record the right pupil under the R column and the left under the L column. These columns are the patient's right and left sides. Indicate in the Comment section if the pupils are normally uneven or if a patient has an artificial eye.

Skin

Place an X only in the boxes that apply. Mark "unremarkable" only if all three assessment categories (temperature, moisture and color) are within normal limits.

Status

Place an X in the box that most accurately describes the patient's status:

C - CPR/arrested patient: cardiac arrest, respiratory arrest, patient being ventilated

U - Unstable patient: severe upper airway difficulties, serious chest trauma, de-compensated shock, rising intracranial pressure, uncontrollable external hemorrhage, penetrating injury to head, neck, chest, abdomen, pelvis

P - Potentially unstable patient: early signs of compensated shock, kinematics or injuries suggest "hidden injury", major isolated injury

S - Stable patient: minor isolated injuries, uncomplicated extremity injuries.

Objective Physical Assessment

Enter in this section a summary of the primary and secondary assessment of the patient.

Comments

Enter in this section information obtained during Primary and Secondary Survey that should be reported, or information that is not described in enough detail in any other part of this form. If there is not sufficient room, use additional PCRs or a Continuation Form if available. Attach additional sheets used to the agency (white), and hospital (pink) copies of the PCR.

Treatment Given

Place an X in the boxes that describe the treatments given by your agency. Mark all that apply.

- ◆ **Moved to Ambulance on Stretcher/Backboard** Place an X in the box if the patient was moved to the ambulance on a stretcher and/or backboard.
- ◆ **Moved to Ambulance on Stair Chair** Place an X in the box if the patient was moved to the ambulance in a stair chair.
- ◆ **Walked to Ambulance** Place an X in the box if the patient walked to the ambulance.
- ◆ **Airway Cleared** Place an X in the box if the patient's airway was cleared.
- ◆ **Oral/Nasal Airway** Place an X in the box if an oropharyngeal or nasal airway was used.
- ◆ **EOA/EGTA** Place an X in the box ONLY if the placement of an esophageal obturator airway or an esophageal gastric tube airway was successful. Circle either EOA or EGTA. If the attempt was unsuccessful, explain in the comment section.
- ◆ **Endotracheal Tube (E/T)** Place an X in the box if the placement of an endotracheal tube was successful. If the attempt was unsuccessful explain in the comment section.

- ◆ **Oxygen Administration** Place an X in the box in oxygen was given. Record the numbers of liters per minute and the appliance(s) used.
- ◆ **Suction Used** Place an X in the box if the patient was suctioned.
- ◆ **Artificial Ventilation** Place an X in the box if the patient was artificially ventilated and record the method.
- ◆ **CPR in progress on arrival** Place an X in the box if cardiopulmonary resuscitation (CPR) was initiated prior to the arrival of responding emergency personnel. (NOTE: if the above is checked, check all of the following that apply) BY:
 - ◆ **Citizen** Place an X in the box if CPR was initiated by a physician, nurse or other EMS personnel (i.e., CFR or EMT who did not respond in an official capacity).
 - ◆ **PD/FD/Other First Responder** Place an X in this box if CPR was initiated by personnel from the Police Department, Fire Department or a Certified First Responder who responded in an official capacity.
 - ◆ **Other** Place an X in the box if CPR was initiated by an individual who was not part of emergency services personnel (EMS, Police, Fire) who responded in an official capacity.
- ◆ **CPR Started** Place an X in this box if the patient was given CPR by anyone (bystander, CFRs, your agency, etc.) @ Time Enter the time that CPR was first started. Only enter this time if you have a reliable source of information regarding the actual time when PCR was started. Use military time. To calculate military time, see General Instructions.
- ◆ **Time From Arrest Until CPR** Enter the best approximation of the patient's down time prior to CPR being administered by anyone. Only enter this time if you have a reliable source of information regarding the patient's down time. If the time is unknown, leave the boxes blank.
- ◆ **EKG Monitored** Place an X in the box if an electrocardiogram (EKG/ECG) was performed and attach section of the tracing to the agency (white) and Hospital (pink) copies of the PCR. Indicated the interpretation of each significant tracing in the space provided.
- ◆ **Defibrillation/Cardioversion** Place an X in the box if the patient was defibrillated or cardioverted. Indicate the number of times and whether the equipment used was manual or semi-automatic.
- ◆ **Medication Administered** Place an X in the box if your crew administered any medication (s). List all medications including time, dosage, and route on a Continuation Form.
- ◆ **IV** Place an X in the box if an intravenous line was established or attempted. Do not mark this section if the IV was started by hospital personnel prior to an Interfacility Transfer (note in Comment section). Indicate the IV fluid (normal saline, D5W, lactated Ringers) administered, and the catheter gauge used. For additional IVs administered, use a Continuation Form.
- ◆ **MAST Inflated** Place an X in the box only if MAST were inflated; enter the time MAST were inflated. (NOTE: Only enter a time if MAST is inflated. Do not enter a time if applied but not inflated.
- ◆ **Bleeding/Hemorrhage** Controlled Place an X in the box and enter the method used to control bleeding/hemorrhage.
- ◆ **Spinal Immobilization** Place an X in the box if spinal column was immobilized. Circle "neck" or "back" or both to indicate the area(s) immobilized.
- ◆ **Limb Immobilized** Place an X in the box if arms or legs were immobilized. Also place an X in the box(es) to indicate the method (fixation and/or traction).
- ◆ **(Heat) or (Cold) Applied** Place an X in the box if either heat or cold applications were used. Circle either "heat" or "cold" to note the appropriate application.
- ◆ **Vomiting Induced** Place an X in the box if vomiting was induced. Note the time and method used. Use military time; to calculate military time, see General Instructions.
- ◆ **Restraints Applied** Place an X in this box if restraint devices or methods were used to prevent the patient from injuring him/herself or others. Indicate the type of restraints used. Restraints applied by other agencies (e.g., police) should be noted in the Comment Section.
- ◆ **Baby Delivered** Place an X in the box if a baby was delivered. Note the time of delivery, the county in which the baby was born, if the baby was born alive or stillborn and whether the baby was male or female. Note the time of birth in military time; to calculate military time, see General Instructions. Complete a separate PCR form for each infant delivered.
- ◆ **Transport**
 - ◆ **Trendelenburg Position** Place an X in the box if the patient was transported in the Trendelenburg position.
 - ◆ **Left Lateral Recumbent Position** Place an X in the box if the patient was transported in the left lateral recumbent position.
 - ◆ **With Head Elevated** Place an X in the box if the patient was transported with their head elevated.
 - ◆ **Other** Place an X in the box if the treatment or care given has not been noted above. Enter the treatment or care given on the line provided. Use the Comment Section if additional space is needed.

Disposition

If your unit transported the patient to a hospital, nursing home, or other medical facility (e.g., doctor's office, clinic, health center), enter the name of the facility. Enter "residence" if the patient was taken home. When these do not apply, enter the phrase from the "Disposition Code" list below that best describes the outcome of the call. Non-hospital disposition codes are listed on the back of the PCR form.

Disposition Code

Enter the code number from the list below that corresponds to the disposition entered. Note that each hospital has an individual code number listed on the PCR Disposition Code List (available from the Department of Health). Nontransporting services should only use codes 004 through 010.

Code Disposition

001 Nursing Home

002 Other Medical Facility

003 Residence

004 Treated by this Unit and Transported by Another

005 Refused Medical Aid or Transport

006 Call Canceled En Route

007 Standby Only

008 Gone on Arrival (Patient removed prior to arrival)

009 Unfounded (False Alarm or no patient found)

010 Other

Continuation Form Used

Place an X over the word YES if a Continuation Form was used on this call.

Crew

Enter the names of the crew members. If there are more than four members on the call, list the additional names in the Comment Section. The crew member in charge of the call should be entered in the first box; the driver's name must be entered in the second box. When the crew member is certified at any level, place an X in the box which indicates his/her highest level of certification and enter the six-digit NYS certification number in the space provided. If the crew member is not New York State certified enter the person's name only, do not enter any numbers.

Continuous Quality Improvement (CQI)

There is an increasing focus on "quality" throughout United States. When talking about "Total Quality Management", "Continuous Quality Improvement", or any other name given to the quality movement, the common thread is meeting the needs of those who pay for and use the services and products provided by an organization. All types of industries, including health care, have lowered costs and improved the quality of their operations and products by working to meet the needs of the people they serve.

EMS leaders must insure that all organizational and system processes focus on the needs of patients and other stakeholders.

Patients and other stakeholders can also be thought of as customers of the EMS system, and, depending on how they relate to the EMS system, as either internal or external customers of the system. External customers include those outside the actual operation of the EMS system, e.g., patients and their families, governmental entities, the community, and insurance companies and other third party payers. Internal customers, i.e., those who are involved in or with the operation of the EMS system, include the system's employees and volunteers, members of the leadership councils or committees that plan and coordinate the system; the variety of agencies that interact to form the ongoing, functioning EMS system; and other health care providers, including hospitals, that together with the EMS service, provide health care to ill and injured patients.

In New York State, the Public Health Law requires all EMS agencies to participate in CQI. This can be accomplished by developing an "in house" review process, or by taking part in a local or regional CQI program.

The common misconception of the CQI review process is that it serves as "the documentation police". CQI is meant to provide an objective review of all facets of EMS care including but not limited to documentation, patient care and operational procedures. CQI should be used to find ways to continuously improve the service we provide to our "customers".

You are encouraged to become involved in the CQI process your agency participates in and take an active role in providing the best service possible.

Resources / References on CQI

National Association of EMS Quality Professionals (NAEMSQP)

3717 South Conway Road
Orlando, Florida 32812-7607

Phone: 407-281-7396

Fax: 407-281-4407

Web: www.mhf.net/naemsqp

A Leadership Guide to Quality Improvement for EMS Systems

Can be downloaded from:

www.nhtsa.dot.gov/people/injury/ems/leadershipguide/index.html

Or write to:

National Highway Traffic Safety Administration

EMS Division

400 7th Street, SW (NTS14)

Washington, DC 20590

National Institute of Standards and Technology
National Quality Program
Route 270 and Quince Orchard Road
Administration Building, Room A635
Gaithersburg, Maryland 20899-0001

Phone: 301-975-2036
Fax: 301-948-3716
E-mail: nqp@nist.gov
Web: www.quality.nist.gov

The Empire State Advantage: Excellence at Work
Barbara Ann Harms, Executive Director
11 Computer Drive West, Suite 212
Albany, NY 12205

Phone: 518-482-1747
Fax: 518-482-2231
Web: www.esaprograms.org

Florida Emergency Medicine Foundation (FEMF)
3717 South Conway Road
Orlando, Florida 32812-6707

Recommendations for Decontamination and Cleanup of Rescue Vehicles

Clean -Up Kit

Household utility gloves

Plastic spray bottle with cleaning agent

Plastic spray bottle with disinfectant solution or bottle with concentrated household bleach diluted with water (1:100 solution approximately ¼ cup bleach per gallon of water)

Disposable toweling

Plastic bags (biohazard red bags, household garbage bags)

Basket carrier to hold cleaning supplies

Clean-Up Procedure for After Each Call

1. Prepare vehicle for cleaning/decontamination
 - a) Always wear utility gloves throughout clean-up procedures.
 - b) Remove used or soiled linen and place in designated bag for laundering. Either leave laundry at hospital or process in the EMS laundry using warm water, detergent and bleach as recommended on the product labels.
 - c) Discard any soiled dressings, bloody materials, and other contaminated non-sharps waste in a red biohazard bag and leave at hospital.
 - d) Place reusable equipment that needs processing in a plastic bag (any color other than red).
 - e) Check the vehicle for needles or other sharps that may have been left, and carefully dispose of them in a sharps container
2. Check for areas soiled with blood or other body substances and clean.
 - a) Clean moist blood and other body substances with disposable toweling and discard in red bag.
 - b) Spray cleaner on affected area and remove any remaining blood or body substance. Dispose of toweling in red bag.
 - c) Spray disinfectant on affected area, wipe over area and allow to air dry. Dispose of toweling in red bag.
3. Spray cleaner on remaining surfaces that the patient came in contact with and surfaces used in providing patient care. Wipe the surfaces with toweling and allow to air dry. Dispose of toweling in normal garbage.

Periodic Cleaning of Rescue Vehicles

On a regular basis (e.g. weekly, monthly), as determined by the frequency of vehicle use and obvious need, the floors, walls, interior and exterior of cabinets and drawers, benches, and other surfaces, should be thoroughly cleaned. The same cleaning agent used after each call can be used for this more extensive cleaning. A supply kit should be kept in a central location for this purpose (e.g. bucket, reusable cleaning towels that are laundered after each use and a supply of cleaning agents). Wipe thoroughly and allow to air dry.

Carpeting and permeable seat covers in the patient compartment of ambulances are more difficult to clean than non-permeable surfaces. Their use is not recommended. Bleach solution should be mixed daily or at the time of use.

**New York State Department of Health
Bureau of Emergency Medical Services
Recommendations for Body Substance Isolation**

Task or Activity	Disposable Gloves	Gown	Mask	Protective Eyewear
Bleeding Control with Spurting Blood	Yes	Yes	Yes	Yes
Bleeding Control with Minimal Blood	Yes	No	No	No
Emergency Childbirth	Yes	Yes	Yes	Yes
Blood Drawing	Yes	No	No	No
Intravenous Line Insertion	Yes	No	No	No
Endotracheal Intubations	Yes	No	Yes	Yes
Oral/Nasal Suctioning, Manually Clearing Airway	Yes	No	No	No
Handling and Cleaning Instruments with Microbial Contamination	Yes	Yes	No	No
Measuring Blood Pressure	No	No	No	No
Measuring Temperature	No	No	No	No
Administering and Injection	No	No	No	No

This chart is intended as a guideline. Appropriate use of Body Substance Isolation (BSI) is recommended any time open skin or mucosa may be exposed to body fluids.

**New York State Department of Health
Bureau of Emergency Medical Services
Recommendations for Body Substance Isolation**



Recommendations for Prevention of Latex Allergy

(Adapted from NIOSH Publication No. 97-135, June 1997)

Latex allergy can be prevented by protecting employees from undue latex exposures. NIOSH recommends the following steps be taken by employees and employers to protect workers from latex exposure and allergy in the workplace:

- Appropriate barrier protection is necessary when handling infectious materials. If latex gloves are chosen, use powder-free gloves with reduced protein content.
- Use non-latex gloves when there is little potential for contact with infectious materials (e.g. food service).
- Ensure that employees use good housekeeping practices to remove latex containing dust from the workplace (frequently clean contaminated areas and change ventilation filters and vacuum bags regularly).
- Provide employees with education programs and training materials about latex allergy.
- Employees should be familiar with procedures for preventing latex allergy and should learn to recognize the symptoms of latex allergy.
- Screen high-risk employees for latex allergy symptoms periodically. Detecting symptoms early and preventing further latex exposure are essential for preventing long-term effects.
- Evaluate current prevention strategies whenever an employee is diagnosed with latex allergy.
- After removing latex gloves, wash hands with a mild soap and dry thoroughly.

Individuals who develop symptoms of latex allergy should avoid direct contact with latex gloves and other latex-containing Products until evaluated by a physician experienced in diagnosing latex allergy.

Efforts to decrease the amount of latex in the environment through the use of other materials (e.g. vinyl gloves), when appropriate, are encouraged. Because the powder in powdered latex gloves increases the dissemination of allergy-causing proteins and sensitization to latex, the use of powder-free gloves is recommended. Please share this communication and the NIOSH Alert with your managers, colleagues and employees. Facilities should develop and implement appropriate policies that address patient and staff exposure.

PART 63

HIV/AIDS TESTING, REPORTING AND CONFIDENTIALITY OF

HIV-RELATED INFORMATION

(Statutory Authority Public Health Law, section 2786 and

Article 21, Title III (section 2139)

SEC.

63.1 Definitions

63.2 Application

63.3 HIV-related testing

63.4 Filing of Reports

63.[4]5 Disclosure pursuant to a release

63.[5]6 Confidentiality and disclosure

63.[6]7 Documentation of HIV-related information and disclosures

63.[7]8 Contact notification

63.[8]9 Health care provider and health facility policy and procedures

63.[9]10 Significant risk

63.[10]11 Approved forms

63.12 Separability

63.1 Definitions:

- a) "HIV-infection" means infection with the human immunodeficiency [virus] viruses that are the cause of AIDS or as the term may be defined from time to time by the Centers for Disease Control and Prevention of the United States Public Health Service [or any other agent identified as a probable cause of AIDS].
- b) "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the Centers for Disease Control and Prevention of the United States Public Health Service.
- c) "HIV-related illness" means any clinical illness that may result from or be associated with HIV infection.
- d) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever, thought to cause or to indicate the presence of HIV infection[.], HIV-related illness or AIDS.

- e) "Capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV-related information, and to make an informed decision concerning the service, treatment, procedure or disclosure.
- f) "Protected individual" means a person who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.
- g) "Confidential HIV-related information" means any information, in the possession of a person who provides health or social services or who obtains the information pursuant to a release of confidential HIV-related information, concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.
- h) "Health or social service" means any care, treatment, laboratory test, counseling or educational service for adults or children, and acute, chronic, custodial, residential, outpatient, home or other health care; public assistance, including disability payments available pursuant to the Social Security Act; employment-related services, housing services, foster care, shelter, protective services, day care, or preventive services; services for the mentally disabled; probation services; parole services; correctional services; detention and rehabilitative services; and the activities of the Health Care Worker HIV/HBV Advisory Panel (see Public Health Law Article 27-DD), all as defined in section 2780(8) of the Public Health Law.
- i) "Health facility" means a hospital as defined in section 2801 of the Public Health Law, blood bank, [blood center, sperm bank, organ or] organ procurement organization, tissue bank, laboratory, or facility providing care or treatment to persons with a mental disability.
- j) "Health care provider" or "provider" means any physician, nurse, licensed or certified provider of diagnostic medical services, including a nurse practitioner, a midwife and physician assistant, provider of services for the mentally disabled or other person involved in providing medical, nursing, counseling, or other health care or mental health service, including those associated with, or under contract to, a health maintenance organization or medical services plan. Diagnostic providers include physicians, nurse practitioners, physician assistants and midwives who are authorized to order diagnostic tests and to make clinical diagnoses.
- k) "Contact" means an identified spouse or sexual contact of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual[.], or a person whom the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as noted in subdivision (m) of section 63.8 of this Part.
- l) "Contact tracing" shall mean the process of notifying known contacts of protected individuals as reported by the physician or as disclosed by the protected individuals themselves, and of seeking the cooperation of protected individuals to name contacts, as described in section 63.8 of this Part. For the purposes of this Part, the terms "contact notification", "partner notification", "partner assistance" and "partner counseling and referral services" shall be synonymous with "contact tracing". In all cases of contact tracing authorized in this Part, the name or other identifying information regarding the protected person shall not be disclosed to contacts and the name of contacts shall not be disclosed to other contacts.
- m) "Person" includes any natural person, partnership, association, joint venture, trust, public or private corporation or state or local government agency.
- n) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual, or if the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual. Such release shall be dated and shall specify to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information shall not be construed as a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general

authorization and an authorization for the release of confidential HIV- related information and complies with this definition.

- o) "Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefits society, agent, broker or other entity in the business of providing health, life and disability coverage including, but not limited to, any health maintenance organization, medical service plan, or hospital plan which:
 - 1) is engaged in the business of insurance;
 - 2) provides health services coverage plans; or
 - 3) provides benefits under, administers, or provides services for, an employee welfare benefit as defined in 29 USC 1002(1).
- p) "Municipal health commissioner" shall mean, for purposes of this Part, a county health commissioner, except, in New York City, the term shall mean the New York City health commissioner. Such county health commissioner and New York City health commissioner shall conduct reporting, counseling and contact notification activities consistent with guidelines acceptable to the commissioner in compliance with Article 21, Title III and Article 27-F of the Public Health Law.
- q) "District health officer" shall mean, for the purposes of this Part, the commissioner or his/her designee.
- r) For the purposes of this Part, "commissioner" shall mean the New York State Commissioner of Health.
- s) For the purposes of this Part, "authorized public health official" shall mean New York State Commissioner of Health, a municipal health commissioner or a district health officer, or their designee.

63.2 Application. These regulations apply to [persons who order an HIV-related test,] physicians and other persons authorized by law to order laboratory tests or to make medical diagnoses, laboratories, blood banks, tissue banks and organ procurement organizations, to persons who receive confidential HIV-related information in the course of providing any health or social service [or] and to persons who receive confidential HIV-related information pursuant to a release. [All disclosures of confidential HIV-related information made on or after February 1, 1989 are subject to such regulations.] These regulations do not apply to information which [is] was received by the commissioner under Subpart 24-1 of this Title and protected from disclosure pursuant to Public Health Law section 206(1)(j).

These regulations do not apply to insurance institutions and insurance support organizations, except as noted in section 63.[5]6(a)(9), (10) and (12). Health care providers associated with or under contract to a health maintenance organization or other medical services plan are subject to these regulations.63.3 HIV-related testing. (a) Except as noted in paragraph (b)(2) below, no physician or other person authorized pursuant to law may order an HIV-related test without first obtaining written informed consent. A physician or other person authorized pursuant to law to order an HIV-related test to be used for patient care shall provide to the laboratory the name and address of the person who is the source of the specimen and other such information as specified by the commissioner.

- (1) Informed consent shall include providing pre-test counseling to the person to be tested or, if such person lacks capacity to consent, to the person lawfully authorized to consent to health care for such person. In situations in which a person other than the test subject consents for the test, pre-test counseling shall also be provided to the test subject to the extent that the person responsible for ordering the test deems that the test subject will benefit from counseling. Pretest counseling shall include:
 - i) explanations regarding the nature of HIV infection and HIV related illness, an explanation of the HIV-related test, including a description of the procedure to be followed, the meaning of the test results, including preliminary positive results obtained prior to confirmation, if applicable, and the benefits of taking the test, including the importance and benefits of early diagnosis and medical intervention;

- ii) an explanation that discrimination problems may result from disclosure of confidential HIV-related information and that legal protections exist which prohibit discrimination (NYC and NYS Human Rights Law) and unauthorized disclosures (PHL Article 27-F and/or Article 21, Title III);
 - iii) information on preventing exposure or transmission of HIV infection, including behavior which poses a risk of HIV transmission;
 - iv) an explanation that the test is voluntary, that consent may be withdrawn at any time, information on the benefits of testing and of early treatment, information that HIV reporting is required by law and that such information must be kept confidential and will be used for the purposes of epidemiologic monitoring of the HIV/AIDS epidemic, that persons who test positive will be requested to cooperate in contact notification efforts, that known contacts will be reported by the physician or other person authorized to order a diagnostic test to the health department for the purposes of contact notification as needed, [and] that anonymous testing is available including the location and telephone numbers of anonymous test sites, and that for the purpose of insurance coverage, confidential, as opposed to anonymous testing is required; and
 - v) information regarding psychological and emotional consequences of receiving the test result.
- b)
- 1) Written informed consent must be executed on a form developed by the department or on another form approved specifically by the department. At the time at which informed consent is obtained, the subject must be offered a copy of the informed consent form or a document that provides all pertinent information contained on the informed consent form.
 - 2) Informed consent is not required in the following situations:
 - i) for court-ordered testing pursuant to Civil Practice Law and Rules Section 3121;
 - ii) when testing without informed consent is otherwise specifically authorized or required by state or federal law;
 - iii) for testing related to procuring, processing, distributing or use of a human body or human body part, including organs, tissues, eyes, bones, arteries, blood, semen or other body fluids for use in medical research or therapy, or for transplantation to persons, provided that if the test results are communicated to the tested person, post-test counseling is required;
 - iv) for research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;[and]
 - v) for testing of a deceased person to determine cause of death or for epidemiological purposes[.]; and
 - vi) for comprehensive newborn testing pursuant to PHL section 2500-f.
- c) A physician or other person authorized pursuant to law to order an HIV-related test shall certify on a laboratory requisition form that informed consent has been obtained, except when not required pursuant to section 63.3(b)(2). In approved anonymous testing sites, authorized employees or agents of the department, may order HIV-related tests and certify that they obtained informed consent in approved anonymous testing sites.
- d) In addition to an explanation of the test result, the person who orders the test shall be responsible for ensuring that post-test counseling or referrals as appropriate with respect to a positive, indeterminate/inconclusive, negative test result and preliminary positive results obtained pursuant to Subpart 58-8, if applicable, shall be provided to the person who consented to the test. Blood banks and tissue banks may report results as specified in sections 58-2.23 and 52-3.6, respectively. In situations in which a person other than the test subject consents for the test, post-test counseling and referrals should also be provided to the test subject, to the extent the person responsible for ordering the test deems that

the test subject will benefit from counseling. Such post-test counseling and referrals [must] shall include specific referral information and [must] shall address:

- 1)
 - i) coping emotionally with the test results;
 - ii) discrimination issues relating to employment, housing, public accommodations, health care and social services;
 - iii) information on the ability to release or revoke the release of confidential HIV-related information; and
 - iv) information on preventing exposure to or transmission of HIV infection and the availability of medical treatment; and
- 2) for persons who test positive, post test counseling shall, in addition, address:
 - i) that HIV reporting is required by law for the purposes of epidemiologic monitoring of the HIV/AIDS epidemic;
 - (5) the need to notify contacts to prevent transmission, including information on State or county assistance in voluntary and non-voluntary contact notification, if appropriate.
 - ii) that contacts should be notified to prevent transmission, and to allow early access of exposed persons to HIV counseling and testing, health care, and prevention services, and a description of notification options and assistance available to the protected individual;
 - iii) an assessment of the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner pursuant to law;
 - iv) that known contacts, including a known spouse, will be reported and that protected persons will also be requested to cooperate in contact notification efforts of known contacts and may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials.
 - v) that the protected individual's name or other information about them is not disclosed to any person during the contact notification process;
 - vi) information on the availability of medical [evaluation and treatment,] services and the location and telephone numbers of treatment sites, information on the [including] use of HIV chemotherapeutics for prophylaxis and treatment and peer group support[.], access to prevention services and assistance, if needed, in obtaining any of these services; and
 - vii) a discussion of perinatal transmission.
- e) A physician or other person authorized pursuant to law to order an HIV-related test shall certify on a laboratory requisition form that informed consent has been obtained. Authorized employees or agents of the department or of the New York City Department of Health may order HIV-related tests and certify, as appropriate, with respect to obtaining informed consent in approved anonymous testing sites.
- f) Nothing in this Part or Part 58 shall be construed to prohibit a person from directly ordering an HIV test on a specimen taken from his/her own body and directly receiving the results of such HIV test. The test must be performed by a [New York State licensed] laboratory using a specimen collection kit which has been approved for home HIV specimen collection by the U.S. Food and Drug Administration and which is available without a prescription.
- g) In situations when HIV-related testing is intended to aid in clinical disease monitoring, e.g., HIV nucleic acid (RNA or DNA) detection tests, pre- and post-test counseling may be tailored to the needs of the patient.

63.4 Filing of reports.

- a)
- 1) All initial determinations or diagnoses of Human Immunodeficiency Virus (HIV) infection, HIV-related illness and Acquired Immune Deficiency Syndrome (AIDS) shall be reported to the commissioner by physicians and other persons authorized to order diagnostic tests or make medical diagnoses or their agents as soon as possible after post-test counseling but no later than 21 days after the provider's receipt of a positive laboratory result or after diagnosis, whichever is sooner.
 - 2) All determinations or diagnoses of HIV, HIV-related illness and AIDS shall be reported to the commissioner by blood banks as defined in Article 5, Title V of the Public Health Law, by tissue banks and organ procurement organizations as defined by Article 43-B of the Public Health Law as soon as possible after post-test counseling but no later than 21 days after receipt of a confirmed positive laboratory result or after diagnosis, whichever is sooner. Such banks and organizations shall report confirmed positive HIV antibody test results.
 - 3) Pathologists, coroners and medical examiners or other persons determining from examination of a corpse or from the history of the events leading to death, that at the time of death the individual was apparently affected with HIV infection, HIV-related illness or AIDS shall also make such report to the commissioner within 21 days after receipt of a test result or determination.
- 4)
- i) Laboratories performing diagnostic tests shall report to the commissioner cases of initial determinations or diagnoses of HIV infection, HIV-related illness and AIDS on a schedule to be specified by the commissioner. Laboratories shall report the following: confirmed positive HIV antibody test results, positive HIV nucleic acid (RNA or DNA) detection test results, CD4 lymphocyte counts less than 500 cells per microliter or less than 29 percent of total lymphocytes unless the test was known to be performed for reasons other than HIV infection or HIV-related illness, and the results of other tests as may be determined by the commissioner to indicate a diagnosis of HIV infection,
 - ii) HIV-related illness or AIDS. For the purposes of laboratory reporting, initial diagnosis shall mean the first such test noted in (i) above which is performed on a specimen submitted after the effective date of these regulations.
- b) Reports, including names and addresses of the protected individual, contact information and other information as may be specified by the commissioner, shall be made in a manner and format as prescribed by the commissioner. Information reported shall also include names and addresses, if available, of contacts, including spouses, known to the physician or other person authorized to order diagnostic tests or make medical diagnoses, or provided to them by the protected person, and the date each contact was notified if contact notification has already been done; and information, in relation to each reported contact, required by an approved domestic violence screening protocol. After receiving the report, the commissioner or his/her authorized representative may request the individual making the report or the person who ordered the diagnostic tests to provide additional information as may be required for the epidemiologic investigation, case finding and analysis of HIV infection, HIV-related illness and Acquired Immune Deficiency Syndrome (AIDS) and to implement Article 21, Title III. Notwithstanding this subdivision, test results from New York State approved anonymous test sites shall not be reported to the commissioner unless the test subject chooses to supply identification and convert the anonymous test result to a confidential test result.
- c) Confidentiality. Such reports and additional information maintained by the commissioner or his/her designated representative, including all information generated by contact notification and domestic violence screening activities, shall be kept confidential as required by Public Health Law, Article 21, Title III, and shall not be disclosed except when in the judgment of the public health official, necessary to other authorized public health officials for conducting accurate and complete epidemiological monitoring of the HIV/AIDS epidemic and for conducting contact notification activities, except that contact names and locating information may be disclosed to public health officials in other jurisdictions when necessary to notify the contact; no information about the protected individual will be released to any person in this process.

63.[4]5 Disclosure pursuant to a release.

- a) No confidential HIV-related information, including such information as related to domestic violence screening, shall be disclosed pursuant to a general release except to insurance companies as noted in section 63.[5]6(a)(9) of this Part. Disclosure is permitted for HIV-related information pursuant to a specific release form for a limited time period which has been developed or approved by the Department. The release must be signed by the protected individual, or if the protected individual lacks capacity to consent, by a person authorized pursuant to law to consent to health care for the individual.
- b) All written disclosures of confidential HIV information must be accompanied by a statement prohibiting re-disclosure. The statement shall include the following language or substantially similar language:

"This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not, except in limited circumstances set forth in this part, sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both."

- c) If oral disclosures are necessary, they must be accompanied or followed as soon as possible, but no later than 10 days, by the statement required by subdivision (b) of this section.
- d) The statement required by subdivisions (b) and (c) of this section is not required for release to the protected person or when a person lacks the capacity to consent, to a person authorized pursuant to law to consent to health care for the person, for releases made by a physician or their agent or public health officer to a contact; or for releases made by a physician or their agent to a person authorized pursuant to law to consent to the health care of the protected person when the person has been counseled and has refused to disclose and the disclosure is medically necessary. For disclosures of confidential HIV-related information from the patient's medical record to persons who are permitted to access this information pursuant to sections 63.[5]6(a)(3), (4), (5), (6), (7), (9) and (10) and 63.[5]6(e) and (f) of this Part, it shall be sufficient for the statement required by subdivisions (b) and (c) of this section to appear as part of the medical record when a medical record is disclosed.

63.[5]6 Confidentiality and disclosure.

- a) No person who obtains confidential HIV-related information in the course of providing any health or social service or pursuant to a release of confidential HIV-related information may disclose or be compelled to disclose such information, except to the following:
 - 1) the protected individual or, when the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual;
 - 2) any person to whom disclosure is authorized pursuant to a release of confidential HIV-related information in accordance with section 63.[4]5(a);
 - 3) an agent or employee of a health facility or health care provider if:
 - i. the agent or employee is authorized to access medical records;
 - ii. the health facility or health care provider itself is authorized to obtain the HIV-related information; and
 - iii. the agent or employee provides health care to the protected individual, or maintains or processes medical records for billing or reimbursement;
 - 4)

- i. a health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual;
 - ii. a health care provider or health facility when knowledge of HIV-related information is necessary to provide appropriate care or treatment to a contact, provided the requirements in subdivision (m) of section 63.8 are followed for disclosures involving exposures in risk situations;
 - iii. in circumstances when consent for health care is necessary, disclosure may also be made to a person authorized to consent to health care for such contact or for such protected individual, provided that if disclosure is to a person authorized to consent to the health care of a contact or to a contact when such contact has been exposed to HIV under circumstances which present a risk of transmission, the requirements in subdivision (m) of section 63.8 must be followed;
- 5) a health facility or health care provider, in relation to the procurement, [processing, distributing] or use of a human body or a human body part, including organs, tissues, [eyes, bones, arteries,] blood, semen, or other body fluids, for use in medical education, research, therapy, or for transplantation to individuals;
 - 6) health facility staff committees, or accreditation or oversight review organizations authorized to access medical records, provided that such committees or organizations may only disclose confidential HIV-related information:
 - i. back to the facility or provider of a health or social service;
 - ii. to carry out the monitoring, evaluation, or service review for which it was obtained; or
 - iii. to a federal, state or local government agency for the purposes of and subject to the conditions provided in paragraph (e) of this section;
 - 7) a federal, state, county or local health officer when such disclosure is mandated by federal or state law[:], including reporting and contact notification processes authorized pursuant to Article 21, Title III, or pursuant to Article 27-F;
 - 8) authorized agencies as defined by Social Services Law, Section 371 and corporations incorporated or organized to receive children for adoption or foster care, in connection with foster care or adoption of a child. Such agency shall be authorized to redisclose such information only pursuant to the provisions of Article 27-F of the Public Health Law or in accordance with the provisions of Social Services Law Section 373-A and regulations promulgated thereunder;
 - 9) third party reimbursers or their agents to the extent necessary to reimburse health care providers, including health facilities, for health services, provided that, an otherwise appropriate authorization for such disclosure has been secured;
 - 10) an insurance institution, for other than the purpose set forth in paragraph (9) of this subdivision, provided the insurance institution secures a dated and written authorization that indicates that health care providers, health facilities, insurance institutions, and other persons are authorized to disclose information about the protected individual, the nature of the information to be disclosed, the purposes for which the information is to be disclosed and which is signed by:
 - i. the protected individual;
 - ii. if the protected individual lacks the capacity to consent, such other person authorized pursuant to law to consent for such individual; or
 - iii. if the protected individual is deceased, the beneficiary or claimant for benefits under an insurance policy, a health services plan, or an employee welfare benefit plan as authorized in Article 27-F of the Public Health Law;

- 11) to a funeral director upon taking charge of the remains of a deceased person when such funeral director has access in the ordinary course of business to HIV-related information on the death certificate of the deceased individual, as authorized by Public Health Law section 4142;
 - 12) any person to whom disclosure is ordered by a court of competent jurisdiction pursuant to Public Health Law section 2785;
 - 13) an employee or agent of the Division of Probation and Correctional Alternatives, Division of Parole, Commission of Correction, or any local probation department, to the extent the employee or agent is authorized to access records containing such information in order to carry out functions, powers and duties with respect to the protected person and in accordance with regulations promulgated pursuant to Public Health Law Article 27-F;
 - 14) a medical director of a local correctional facility in accordance with regulations promulgated pursuant to Article 27-F to the extent the medical director is authorized to access records to carry out his/her functions relating to the protected person. Re-disclosure by the medical director is prohibited except as permitted under Public Health Law Article 27-F, Article 21, Title III and [its] implementing regulations;
 - 15) an employee or agent of the New York City Board of Corrections so that the board may continue to access records of inmates who die while in the custody of the New York City Department of Corrections when necessary for the board to carry out its duties, functions, and powers with respect to the protected individual, pursuant to the New York City charter; or
 - 16) a law guardian, appointed to represent a minor pursuant to the social services law or the family court act, for the purpose of representing that minor. If the minor has the capacity to consent, the law guardian may not redisclose confidential HIV related information without the minor's permission. If the minor lacks capacity to consent, the law guardian may redisclose confidential HIV-related information for the purpose of representing the minor.
- b) A state, county or local health officer may disclose confidential HIV-related information when:
- 1) disclosure is specifically authorized or required by federal or state law including, but not limited to, Public Health Law, Article 21, Title III and Public Health Law, Article 27-F; or
 - 2) disclosure is made pursuant to a release of confidential HIV-related information; or
 - 3) disclosure of information regarding a contact is requested by a physician pursuant to section 63.[7]8 of this Part; or if the contact resides outside the jurisdiction of the authorized public health [officer] official, the [officer may] official shall inform [a] the public health [officer] official in the contact's jurisdiction in order to confidentially inform such [the] contact; or
 - 4) disclosure is authorized by court order pursuant to the provisions of Public Health Law section 2785.
- c) A physician or his/her agent may disclose the confidential HIV-related information to a contact and to a public health officer for the purpose of making a disclosure to the contact. [during contact notification pursuant to section 63.7 of this Part.]
- d) A physician or his/her agent may, upon the consent of a parent or guardian, disclose confidential HIV-related information to a state, county, or local health officer for the purpose of reviewing the medical history of a child to determine the fitness of the child to attend school.
- e) Confidential HIV-related information of a protected person may be disclosed to authorized employees or agents of a governmental agency pursuant to the regulations of the governmental agency when the person providing health or social services is regulated, supervised or monitored by the governmental agency or when the governmental agency administers the health program or a social service program and when such employees or agents have access to records in the ordinary course of business and when access is reasonably necessary for regulation, supervision, monitoring, administration or provision of services. Such authorized employees or agents may include attorneys authorized by a government agency

when access occurs in the ordinary course of providing legal services and is reasonably necessary for supervision, monitoring, administration or provision of services. Such authorized employees or agents may also include public health officers as required for conducting epidemiological or surveillance investigations pursuant to the State Sanitary Code or this Part. Such surveillance or investigational data shall also be disclosed by the public health officer to the State Department of Health as required by the State Sanitary Code or this Part.

- f) Confidential HIV-related information of a protected person may be disclosed to authorized employees or agents of a provider of health or social services when such provider is either regulated, supervised or monitored by a governmental agency or when a governmental agency administers the provider's health or social service program, and when such employees or agents have access to records in the ordinary course of business and when access is reasonably necessary for regulation, supervision, monitoring, administration or provision of services. Such authorized employees or agents may include attorneys authorized by persons providing health services when access occurs in the ordinary course of providing legal services and is reasonably necessary for supervision, monitoring, administration or provision of services.
- g) A physician or his/her agent may disclose confidential HIV-related information pertaining to a protected individual to a person, known to the physician or his/her agent, authorized pursuant to law to consent to the health care for [a] the protected individual when the physician reasonably believes that:
 - 1) disclosure is medically necessary in order to provide timely care and treatment for the protected individual; and
 - 2) after appropriate counseling as to the need for such disclosure, the protected individual will not inform a person authorized by law to consent to health care; provided, however, that the physician shall not make such disclosure if, in the judgment of the physician:
 - i. the disclosure would not be in the best interest of the protected individual; or
 - ii. the protected individual is authorized pursuant to law to consent to such care and treatment. A physician's decision to disclose pursuant to this paragraph and the basis for that decision shall be recorded in the medical record.
- h) No person to whom confidential HIV information has been disclosed shall disclose the information to another person except as authorized by law, (including, but not limited to, disclosure authorized by PHL Article 21, Title III), except [this Part, provided, however,] that this [the]provision[s of this Part] shall not apply to:
 - 1) the protected individual;
 - 2) a natural person who is authorized pursuant to law to consent to health care for the protected individual;
 - 3) a protected individual's foster parent, subject to Department of Social Services regulations, for the purpose of providing care, treatment or supervision to the protected individual; or
 - 4) a prospective adoptive parent, subject to Department of Social Services regulations, with whom a child has been placed for adoption.
- i) Nothing in this section shall limit a person's or agency's responsibility or authority to report, investigate, or redisclose child protective and adult protective services information in accordance with title six of article six and titles one and two of article nine-b of the Social Services Law, or to provide or monitor the provision of child and adult protective or preventive services.
- j) Confidential HIV-related information shall not be disclosed to a health care provider or health care facility for the sole purpose of implementing infection control precautions when such provider or facility is regulated under the Public Health Law and required to implement such precautions with all individuals pursuant to this Title. This restriction shall not limit access to HIV-related information by a facility's infection control personnel for purposes of fulfilling their designated responsibilities in the facility.

- k) Confidential HIV-related information shall not be released pursuant to a subpoena. A court order pursuant to Public Health Law section 2785 is required for release of confidential HIV-related information.
- l) Confidential HIV related information shall be disclosed upon the request of the Health Care Worker HIV/HBV Advisory Panel (see Public Health Law Article 27-DD) to the Panel or its designee(s) only when the Panel considers the information reasonably necessary for the evaluation and monitoring of a worker who has voluntarily sought the Panel's review.

63.[6]7 Documentation of HIV-related information and disclosures.

- a) Confidential HIV-related information shall be recorded in the medical record such that it is readily accessible to provide proper care and treatment.
- b) All disclosures of confidential HIV-related information must be noted in the record, except:
 - 1) only initial disclosures to insurance institutions must be noted;
 - 2) notation is not required for disclosure to agents or employees of health facilities or health care providers authorized under section 63.[5]6(a)(3);
 - 3) notation is not required for persons engaged in quality assurance, program monitoring or evaluation, nor for governmental payment agents acting pursuant to contract or law.
- c) Confidential HIV-related information shall be noted, as appropriate, in a certificate of death, autopsy report or related documents prepared pursuant to Public Health Law, Article 41 or other laws relating to documentation of cause of death.
- d) The protected person shall be informed of disclosures of HIV information upon request of the protected person.
- e) Confidential HIV-related information shall not be disclosable pursuant to Public Officers Law, Article 6 (the Freedom of Information Law).

63.[7]8 Contact notification.

- a) A physician may disclose HIV-related information, without the protected person's consent, to a contact or to a public health officer for the purpose of notifying a contact when:
 - 1) the physician reasonably believes disclosure is medically appropriate and a significant risk of infection exists to the contact; and;
 - 2) the protected person has been counseled to notify his/her contacts and the physician reasonably believes the protected person will not inform the contacts.
- b) The physician must inform the protected person of the physician's intent to disclose and inform the protected person that he/she may choose whether express a preference whether disclosure shall be made by the physician or health officer will notify the contact. The physician shall honor the protected person's choice. All notification shall be in person, except where circumstances compel otherwise.
- c) The identity of the protected person shall not be disclosed to the contact.
- d) When a public health officer is requested to notify contacts, the officer may, in his/her own discretion, meet with the provider and/or protected person, to counsel and verify information prior to any notification of such person's contacts. Local health units must make provisions for HIV contact notification services.
- e) The person notifying the contact shall provide counseling or make referrals for counseling as appropriate. Such counseling must address coping emotionally with potential exposure to HIV, an explanation regarding the nature of HIV infection and HIV-related illness, availability of anonymous and confidential testing, information on preventing

exposure or transmission of HIV infection, information regarding discrimination problems that might occur as the result of disclosure of HIV-related information, and legal protections against such disclosures.

- f) If a protected person is now deceased and the physician reasonably believes the protected person had not informed his/her contacts and reasonably believes disclosure is medically appropriate and that a significant risk of infection exists, the physician may notify the contact or request the public health officer to notify the contact. All such notifications shall be in person, except where circumstances reasonably prevent doing so, and the identity of the deceased shall not be disclosed. The person notifying the contact shall provide counseling or make referrals for counseling as appropriate.
- g) A physician or public health officer shall have no obligation to identify or locate any contact.]
 - a) When contact notification is conducted based on the mandated reporting of cases of HIV infection, HIV-related illness and AIDS and the reporting of known contacts of such cases, and/or provided by the protected individual, all information collected in the course of these contact notification activities, including screening to assess risk of domestic violence, shall be kept confidential as required by Public Health Law, Article 21, Title III, and shall not be disclosed except when in the judgment of the public health official necessary to other authorized public health officials for conducting accurate and complete epidemiological monitoring of the HIV/AIDS epidemic and for conducting contact notification activities except that contact names and locating information may be disclosed to public health officials in other jurisdictions when necessary to notify the contact; no information about the protected individual will be released to any person in this process. Disclosures and notifications shall be made as follows:
 - 1) Physicians and other persons required to report as provided for in section 63.4 must indicate on the reporting form whether they have conducted post-test counseling and an assessment of the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner, whether they plan to undertake contact notification activities, have completed notification of contacts or are making a referral for partner notification assistance to authorized public health officials. If the physician or other mandated reporter chooses to conduct notification, the results of those activities, including information specified by the commissioner on forms supplied by the commissioner, or their equivalent, must be forwarded to the appropriate authorized public health official within 60 days of the initial report, pursuant to section 63.4.
 - 2) The commissioner shall forward initial reports from physicians and other mandated reporters, including the names and addresses of the reported case and of the known contacts, and/or contacts provided by the protected person, the status of provider initiated contact notification activities and the determination of risk of domestic violence, if any, to the authorized public health official in the county where the reported case resides.
 - 3) Consistent with guidelines acceptable to the commissioner in conformance with Article 21 of the Public Health Law, authorized public health officials, upon determination that the reported case, reported contacts, or any other case merits contact notification in order to protect the public health, shall make a good faith effort to seek the cooperation of the protected individual to name contacts they wish to have notified, to notify the known contacts and to inform the public health official in the jurisdiction where any additional contacts reside, when necessary to notify such contacts. No information about the protected individual will be released to any person in this process.
 - b) Authorized public health officials shall consider the following as important factors in determining the priority for which cases merit contact notification in order to protect the public health:
 - 1) reported contacts, including spouses known to the reporting physician or other diagnostic provider, or who the protected person wishes to have notified, unless the provider certifies that these known contacts have already been notified; and
 - 2) protected persons who are newly diagnosed with HIV infection.

- c) In cases which merit contact notification, if an indication of risk of domestic violence has been identified, pursuant to a protocol acceptable to the commissioner, the authorized public health official, in consultation with the reporting physician, must be satisfied in his/her professional judgment that reasonable arrangements, efforts or referrals to address the safety of affected persons have been made if and when the notification is to proceed. Such consultation shall also consider information, if available, requested from the protected person, or from a domestic violence service provider pursuant to a signed release.
- d) Authorized public health officials shall conduct contact notification activities consistent with guidelines acceptable to the commissioner which will recognize the special needs of adolescents, individuals in residential and institutional settings, and other vulnerable populations.
- e) Authorized public health officials will respond to all requests from HIV infected individuals and their health care providers for assistance in notifying contacts.
- f) When contact notification is conducted by authorized public health officials, such officials shall:
 - 1) confirm that post-test counseling of the protected person is completed;
 - 2) when communication with the protected person is necessary, communicate with the protected person in a confidential, private and safe manner to seek cooperation in contact notification activities, to verify the information about the identity or location of known contacts, to conduct or confirm a screen for domestic violence and if applicable, to make referrals regarding domestic violence, prior to any notification of contacts. If communication cannot be made in a confidential, private and safe manner, it shall be deferred until these requirements can be met; and
 - 3) in circumstances where the protected individual cannot be contacted for post-test counseling or declines to be assessed for risk of domestic violence in relation to known contacts, the authorized public health official shall make the determination of whether to proceed with notification of known contacts, in consultation with the reporting physician.
- g) All persons notifying contacts shall provide counseling or make referrals or appointments for counseling and testing as appropriate. Such counseling must address coping emotionally with potential exposure to HIV, domestic violence issues, an explanation regarding the nature of HIV infection and HIV-related illness, availability of anonymous and confidential testing, information on preventing exposure or transmission of HIV infection, information regarding discrimination problems that might occur as a result of disclosure of HIV-related information, and legal protections against such disclosures. All notifications shall be in person, except where circumstances reasonably prevent doing so, e.g., at the request of the contact.
- h) If a protected person is now deceased, contacts (e.g., spouse) are known to the physician and the physician believes the protected person had not informed such contacts, the physician or his/her agent may notify such contacts or shall request the authorized public health official to notify the contacts, without identifying the protected individual to the contact.
 - i. A physician or authorized public health official shall have no obligation to identify or locate any contact, except as provided pursuant to Public Health Law Article 21, Title III. No criminal sanction or civil liability shall arise against a physician, his/her employer or designated agent, health facility, health care provider or authorized public health official for the disclosure of confidential HIV-related information to a contact or to a person consenting to health care for the contact when in compliance with Article 27-F, or for the failure to disclose such information to a contact or to a person consenting to health care for the contact.

- j) Municipal health commissioners must provide HIV contact notification services and shall forward to the department, summary data and all identifiable information related to notification activities upon completion of such activity unless otherwise determined by the commissioner. Information identifying the contact collected in the course of contact notification activities by authorized public health officials shall not be maintained at the state or local level for more than one year following completion of such activity.
- k) For the purposes of notifying contacts under Public Health Law section 2782(1)(d), blood transfusion and organ and tissue transplantation present a risk of HIV transmission. Notifying contacts potentially exposed to HIV through tissues, organs, or transfused blood under a federally mandated recipient notification program or guidelines acceptable to the commissioner shall be sufficient to meet the notification requirements of Article 21, Title III and Article 27-F. Blood banks, organ procurement organizations, and tissue banks may disclose the HIV status of a donation to a donor's provider for the purposes of notifying known contacts of a donor.
- l) When contact notification is initiated by a physician not related to reporting mandates or Article 21, Title III, but based on authority to notify an identified spouse, sex partner, hypodermic needle and syringe partner under Public Health Law section 2782(4), physicians or their agents and authorized public health officials may conduct contact notification as follows:
 - 1) a physician or his/her agent may, without the protected person's consent, notify such contact or report such contact to the authorized public health official for the purpose of notifying a contact when:
 - i. the physician believes disclosure is medically appropriate and a significant risk of infection may exist to the contact; and
 - ii. the protected person has been counseled to notify his/her contacts or the physician has taken all reasonable efforts to attempt to counsel the person; and
 - iii. domestic violence screening in accordance with the screening protocol has been applied;
 - 2) the physician must inform the protected person of the physician's intent to notify such contacts and of their responsibility to report the case and such contacts to the commissioner, and inform the protected person that he/she may express a preference whether contact notification shall be made by the physician or authorized public health official, and that the protected individual's name or other information about them is not disclosed to any person during the contact notification process;
 - 3) if the protected person's preference is for the authorized public health official to notify contacts or if the protected person's preference is for the physician to notify contacts but the physician chooses not to do so, he/she shall notify the protected person of his/her decision to contact the authorized public health official and shall forward names and addresses of the case and contacts to the authorized public health official, who shall take reasonable measures to notify such contacts. If the protected person's preference is for the physician to notify contacts and the physician elects to do so, the physician or his/her agent may then notify contacts; and
 - 4) the physician must report to the authorized public health official regarding the success or failure of such efforts, including the names and addresses of the cases and contacts. If contacts have not been notified or notification cannot be verified by the physician or his/her agent, public health officers shall take reasonable measures to inform the contact as set forth in subdivisions (b) through (g) of section 63.8.

- m) When the requirements of this section have been met, physicians and other diagnostic providers may disclose HIV-related information to physicians or other diagnostic providers of persons whom the protected individual may have exposed to HIV under the circumstances noted below that present a risk of transmission of HIV, except that disclosures related to exposures of emergency response employees governed by federal law shall continue to be governed by such law:
- 1) the incident must involve exposure to blood, semen, vaginal secretions, tissue or the following body fluids: cerebrospinal, amniotic, peritoneal, synovial, pericardial and pleural; and
 - 2) a person has contact with the body substances, as noted in paragraph (1) above, of another to mucus membranes (e.g., eyes, nose, mouth), non-intact skin (e.g., open wound, skin with a dermatitis condition, abraded areas) or to the vascular system. Examples of such contact may include needle sticks, puncture wound injuries and direct saturation or permeation of non-intact skin by potentially infectious substances. These circumstances shall not include those delineated in subdivision (d) of section 63.10; and
 - 3) the exposure incident occurred to staff, employees or volunteers in the performance of employment or professional duties:
 - i. in a medical or dental office; or
 - ii. in a facility regulated, authorized or supervised by the Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Office of Children and Family Services, Office of Alcoholism and Substance Abuse Services, Department of Correctional Services; or
 - iii. involved an emergency response employee, paid or volunteer, including an emergency medical technician, a firefighter, a law enforcement officer (e.g., police, probation, parole officer) or local correctional officer or medical staff; and
 - 4) an incident report documenting the details of the exposure, including witnesses to the incident, if any, is on record with supervisory staff; and
 - 5) a request for disclosure of HIV status is made to the provider of the source or to the medical officer designated by the facility by the exposed person or by the provider of the exposed person as soon as possible after the alleged exposure if a decision relating to the initiation or continuation of post-exposure prophylactic treatment is being considered; and
 - 6) the medical provider of the exposed person or the medical officer designated by the facility reviews, investigates and evaluates the incident and certifies that:
 - i. the information is necessary for immediate decisions regarding initiation or continuation of post-exposure prophylactic treatment for the exposed person; and
 - ii. the exposed person's status is either HIV negative or unknown and that if the person's status is unknown, the person has consented to an HIV test; and

- iii. if such test result becomes known as positive prior to the receipt of the source's HIV status, no disclosure of the source's HIV status will be made to the person; and
- 7) documentation of the request is placed in the medical record of the exposed person; and
- 8) if the provider of the source or the medical officer designated by the facility determines that a risk of transmission has occurred or is likely to have occurred in the reasonable exercise of his/her professional judgment, the provider or medical officer may release the HIV status of the source, if known. The provider or medical officer may consult with the municipal health commissioner or district health officer to determine whether a risk of transmission exists. If consultation occurs, both the provider and the local health officer must be in agreement if the HIV information is to be disclosed. In the disclosure process the name of the source shall not be provided to the exposed person. Re-disclosure of the HIV status of the source is prohibited except when made in conformance with Public Health Law Article 21, Title III.

63.[8]9 Health care provider and health facility policy and procedures.

Each health care provider and health facility employing persons or contracting with persons to perform any activity related to such provider's or facility's rendering of health services shall develop and implement policies and procedures to maintain the confidentiality of confidential HIV related information. Such policies and procedures shall assure that such information is disclosed to employees or contractors only when appropriate under this Part. Such policies and procedures shall include:

- a) initial employee education and annual in-service education of employees regarding the legal prohibition against unauthorized disclosure in Public Health Law Article 27-F and provisions of Article 21, Title III. A list of all employees who have had such training must be maintained by health care providers and health facilities. Health care providers and health facilities contracting with others for services in which HIV-related information may be disclosed to such contractors, must document evidence that such contractors have been informed of the confidentiality and disclosure requirements of this Part;
- b) maintenance of a list of job titles and the specific employee functions within those titles for which employees are authorized to access such information. This list shall describe the limits of such access to information and must be provided to the employees during employee education sessions;
- c) a requirement that only full-time or part-time employees, contractors and medical, nursing or health-related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall have access to confidential HIV-related information while performing the authorized functions listed under paragraph (2).
- d) protocols for ensuring that records, including records which are stored electronically, are maintained securely and used for the purpose intended;
- e) procedures for handling requests by other parties for confidential HIV-related information;
- f) protocols prohibiting employees/agents/contractors from discriminating against persons having or suspected of having HIV infection; and
- g) review of the policies and procedures on at least an annual basis.

63.[9]10 Significant risk.

- a) The three factors necessary to create a significant risk of contracting or transmitting HIV infection are:
 - 1) the presence of a significant risk body substance;
 - 2) a circumstance which constitutes significant risk for transmitting or contracting HIV infection; and
 - 3) the presence of an infectious source and a non-infected person.
- b) "Significant risk body substances" are blood, semen, vaginal secretions, breast milk, tissue and the following body fluids: cerebrospinal, amniotic, peritoneal, synovial, pericardial, and pleural.
- c) Circumstances which constitute "significant risk of transmitting or contracting HIV infection" are:
 - 1) sexual intercourse (e.g., vaginal, anal, oral) which exposes a non-infected individual to blood, semen or vaginal secretions of an infected individual;
 - 2) sharing of needles and other paraphernalia used for preparing and injecting drugs between infected and non-infected individuals;
 - 3) the gestation, birthing or breast feeding of an infant when the mother is infected with HIV;
 - 4) transfusion or transplantation of blood, organs, or other tissues from an infected individual to an uninfected individual, provided such blood, organs or other tissues have not tested conclusively [negatively] for antibody or antigen and have not been rendered non-infective by heat or chemical treatment;
 - 5) other circumstances not identified in paragraphs (1) through (4) during which a significant risk body substance (other than breast milk) of an infected individual contacts mucous membranes (e.g., eyes, nose, mouth), non-intact skin (e.g., open wound, skin with a dermatitis condition, abraded areas) or the vascular system of a non-infected person. Such circumstances include, but are not limited to needle stick or puncture wound injuries and direct saturation or permeation of these body surfaces by the infectious body substance.
- d) Circumstances that involve "significant risk" shall not include:
 - 1) exposure to urine, feces, sputum, nasal secretions, saliva, sweat, tears or vomitus that does not contain blood that is visible to the naked eye;
 - 2) human bites where there is no direct blood to blood, or blood to mucous membrane contact;
 - 3) exposure of intact skin to blood or any other body substance;
 - 4) occupational settings where individuals use scientifically accepted barrier techniques and preventive practices in circumstances which would otherwise pose a significant risk and such barriers are not breached and remain intact.

Section 63.10 is repealed in its entirety, is hereby renumbered and added as section 63.11 to read as follows:

[63.10]63.11 Approved Forms

- a) The following informed consent form is approved: New York State Department of Health AIDS Institute Informed Consent to Perform an HIV Test The decision to have an HIV test is voluntary. In order to have an HIV test in New York State, you must give your consent in writing on the bottom of this form.

Testing for HIV Infection

Testing Methods:

There are a number of tests that can be done to show if you are infected with HIV, the virus that causes AIDS. Your provider or counselor can provide specific information on these tests. These tests involve collecting and testing blood, urine or oral fluid. The most common test for HIV is the HIV antibody test.

Meaning of HIV Test Results:

- A negative result on the HIV antibody test most likely means that you are not infected with HIV, but it may not show recent infection. If you think you have been exposed to HIV, you should take the test again three months after the last possible exposure.
- A positive result on the test means that you are infected with HIV and can infect others.
- Sometimes the HIV antibody test result is not clearly positive or negative, or may be a preliminary result. Your provider or counselor will explain this result, and may ask that you give your consent for further testing.

Confidential or Anonymous HIV Testing:

When you decide to have an HIV antibody test, you may choose either a confidential or an anonymous test.

- If you want your test result to become part of your medical record so it can be used for your medical care, you can have a confidential test done. A confidential test requires that you provide your name.
- If you do not want anyone to know your test results or that you were tested, you can have an anonymous test at an anonymous test site. You will not be asked your name, address or any other identifying information.
- If you receive an HIV positive test result at an anonymous test site approved by the NYS Department of Health, you will have the option of changing your test result to confidential by attaching your name to the test result. This will allow your test result to become part of your medical record.

Benefits to Testing:

There are many benefits to having an HIV test and knowing if you are infected.

If you receive an HIV negative test result:

- Your provider or counselor will tell you how to protect yourself from getting infected with HIV in the future.

If you receive an HIV positive test result:

- Your provider can give you medical care and treatment that can help you stay healthy and can manage your HIV illness.
- Your provider or counselor can tell you how to prevent passing the virus to your sexual or needle sharing partners.
- You can increase your chances of staying healthy by eating a well-balanced, nutritious diet, getting enough sleep, exercising, avoiding alcohol, tobacco, and recreational drugs, reducing stress and having regular check-ups.

If you are a woman who receives an HIV positive test result:

- If you are pregnant, your doctor can provide the care you need and information about services and options available to you. Your provider can tell you about the risks of passing HIV infection to your baby, about medications given during pregnancy that can significantly reduce the risk of passing HIV to your baby, and the medical care available for babies who may be infected with HIV.
- If you have given birth to or breast fed a child since you were infected, your child will need to be tested for HIV and, if infected, may need additional care and treatment. Your provider can give you information about medical care available for children who may be infected with HIV.

Confidentiality of HIV Information:

If you take the HIV antibody test, your test results are confidential. Under New York State law, confidential HIV information can only be given to people you allow to have it by giving your written approval, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

The law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment.

Reporting Requirements:

Your name will be reported to the health department if you have a confirmed positive HIV antibody test result received through a confidential test, other HIV-related test results, a diagnosis of AIDS, or if you have chosen to attach your name to a positive test result at an anonymous site. The health department will use this information to track the epidemic and to better plan prevention, health care and other services.

Notifying Partners:

If you test HIV positive, your provider will talk with you about the importance and benefits of notifying your partners of their possible exposure to HIV. It is important that your partners know they may have been exposed to HIV so they can find out whether they are infected and benefit from early diagnosis and treatment. Your provider may ask you to provide the names of your partners, and whether it is safe for you if they are notified. If you have been in an abusive relationship with one of these partners, it is important to share information with your provider.

For information regarding services related to domestic violence, call 1-800-942-6906.

- Under state law, your provider is required to report to the health department the names of any of your partners (present and past sexual partners, including spouses, and needle sharing partners) whom they know.
- If you have additional partners whom your provider does not know, you may give their names to your provider so they can be notified.
- Several options are available to assist you and your provider in notifying partners. If you or your provider do not have a plan to notify your partners, the health department may notify them without revealing your identity. If this notification presents a risk of harm to you, the Health Department may defer the notification for a period of time sufficient to allow you to access domestic violence prevention services.
- If you do not name any partners to your provider or if a need exists to confirm information about your partners, the health department may contact you to request your cooperation in this process.

Confidentiality of HIV Test Results and Related Information:

If you feel your confidentiality has been broken, or for more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065. Any health or social service provider who illegally tells anyone about your HIV information may be punished by a fine of up to \$5,000 and a jail term of up to one year. The law also protects you from HIV-related discrimination in housing, employment, health care or other services. For more information, call the New York State Division of Human Rights at 1-800-523-2437.

My questions about the HIV antibody test were answered. I agree to be tested for HIV.

Signature: _____

Date: _____

I provided pre-test counseling in accordance with Article 27-F of the New York State Public Health Law. I answered the above individual's questions about the test and offered him/her an unsigned copy of this form.

Signature: _____ Title: _____

Facility/Provider

Name: _____

b) The following release form is approved. [for purposes of section 63.4(a) of this Part:]

NOTE: A copy of Form DOH-2557 (6/89) (Authorization for Release of Confidential HIV-Related Information) is included in the Official Compilation.

63.12 Separability.

If any section, subsection, clause or provision of this Part shall be deemed by any court of competent jurisdiction to be unconstitutional, ineffective or otherwise legally invalid or unenforceable, in whole or in part, to the extent that it is not unconstitutional, ineffective or otherwise legally invalid or unenforceable, it shall be valid and effective and no other section, subsection, clause or provision shall, on account thereof, be deemed invalid or ineffective.

OSHA Regulations (Standards - 29 CFR) Bloodborne Pathogens. - 1910.1030

OSHA Regulations (Standards - 29 CFR) - Table of Contents

Standard Number: 1910.1030

Standard Title: Bloodborne pathogens.

Subpart Number: Z

Subpart Title: Toxic and Hazardous Substances

(a) Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

(b) Definitions. For purposes of this section, the following shall apply:

"Assistant Secretary" means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

"Blood" means human blood, human blood components, and products made from human blood.

"Bloodborne Pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

"Clinical Laboratory" means a workplace where diagnostic or other screening procedures is performed on blood or other potentially infectious materials.

"Contaminated" means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

"Contaminated Laundry" means laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.

"Contaminated Sharps" means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

"Decontamination" means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

"Director" means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

"Engineering Controls" means controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace.

"Exposure Incident" means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

"Hand washing Facilities" means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

"Licensed Healthcare Professional" is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

"HBV" means hepatitis B virus.

"HIV" means human immunodeficiency virus.

"Occupational Exposure" means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

"Other Potentially Infectious Materials" means

- (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;
- (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

"Parenteral" means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

"Personal Protective Equipment" is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

"Production Facility" means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

"Regulated Waste" means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

"Research Laboratory" means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

"Source Individual" means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

"Sterilize" means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

"Universal Precautions" is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

"Work Practice Controls" means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

(c)
Exposure Control.

(c)(1)
Exposure Control Plan.

(c)(1)(i)
Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

(c)(1)(ii)
The Exposure Control Plan shall contain at least the following elements:

(c)(1)(ii)(A)
The exposure determination required by paragraph (c)(2),

..1910.1030(c)(1)(ii)(B)

(c)(1)(ii)(B)
The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Record keeping, of this standard, and

(c)(1)(ii)(C)
The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph (f)(3)(i) of this standard.

(c)(1)(iii)
Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.1020(e).

(c)(1)(iv)
The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

(c)(1)(v)
The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

(c)(2)
Exposure Determination.

(c)(2)(i)
Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

(c)(2)(i)(A)
A list of all job classifications in which all employees in those job classifications have occupational exposure;

1910.1030(c)(2)(i)(B)

(c)(2)(i)(B)
A list of job classifications in which some employees have occupational exposure, and

(c)(2)(i)(C)

A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph (c)(2)(i)(B) of this standard.

(c)(2)(ii)

This exposure determination shall be made without regard to the use of personal protective equipment.

(d)

Methods of Compliance.

(d)(1)

General. Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

(d)(2)

Engineering and Work Practice Controls.

(d)(2)(i)

Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

..1910.1030(d)(2)(ii)

(d)(2)(ii)

Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(d)(2)(iii)

Employers shall provide hand-washing facilities, which are readily accessible to employees.

(d)(2)(iv)

When provision of hand-washing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(d)(2)(v)

Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

(d)(2)(vi)

Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

(d)(2)(vii)

Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

..1910.1030(d)(2)(vii)(A)

(d)(2)(vii)(A)

Contaminated needles and other contaminated sharps shall not be bent, recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.

(d)(2)(vii)(B)

Such bending, recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

(d)(2)(viii)

Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

(d)(2)(viii)(A)

puncture resistant;

(d)(2)(viii)(B)

labeled or color-coded in accordance with this standard;

(d)(2)(viii)(C)

leak proof on the sides and bottom; and

(d)(2)(viii)(D)

in accordance with the requirements set forth in paragraph

(d)(4)(ii)(E) for reusable sharps.

(d)(2)(ix)

Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

(d)(2)(x)

Food and drink shall not be kept in refrigerators, freezers, shelves, and cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.

..1910.1030(d)(2)(xi)

(d)(2)(xi)

All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(d)(2)(xii)

Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

(d)(2)(xiii)

Specimens of blood or other potentially infectious materials shall be placed in a container, which prevents leakage during collection, handling, processing, storage, transport, or shipping.

(d)(2)(xiii)(A)

The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph (g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph (g)(1)(i) is required when such specimens/containers leave the facility.

(d)(2)(xiii)(B)

If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

..1910.1030(d)(2)(xiii)(C)

(d)(2)(xiii)(C)

If the specimen could puncture the primary container, the primary container shall be placed within a secondary container that is puncture-resistant in addition to the above characteristics.

(d)(2)(xiv)

Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

(d)(2)(xiv)(A)

A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

(d)(2)(xiv)(B)

The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

..1910.1030(d)(3)

(d)(3)

Personal Protective Equipment.

(d)(3)(i)

Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

(d)(3)(ii)

Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

(d)(3)(iii)

Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the work site or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(d)(3)(iv)

Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs (d) and (e) of this standard, at no cost to the employee.

..1910.1030(d)(3)(v)

(d)(3)(v)

Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(d)(3)(vi)

If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

(d)(3)(vii)

All personal protective equipment shall be removed prior to leaving the work area.

(d)(3)(viii)

When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

(d)(3)(ix)

Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin; when performing vascular access procedures except as specified in paragraph (d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

(d)(3)(ix)(A)

Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

..1910.1030(d)(3)(ix)(B)

(d)(3)(ix)(B)

Disposable (single use) gloves shall not be washed or decontaminated for re-use.

(d)(3)(ix)(C)

Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

(d)(3)(ix)(D)

If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

(d)(3)(ix)(D)(1)

Periodically reevaluate this policy;

(d)(3)(ix)(D)(2)

Make gloves available to all employees who wish to use them for phlebotomy;

(d)(3)(ix)(D)(3)

Not discourage the use of gloves for phlebotomy; and

(d)(3)(ix)(D)(4)

Require that gloves be used for phlebotomy in the following circumstances:

[i] When the employee has cuts, scratches, or other breaks in his or her skin;

[ii] When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and

[iii] When the employee is receiving training in phlebotomy.

..1910.1030(d)(3)(x)

(d)(3)(x)

Masks, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(d)(3)(xi)

Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

(d)(3)(xii)

Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopaedic surgery).

(d)(4)

Housekeeping.

(d)(4)(i)

General. Employers shall ensure that the work site is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(d)(4)(ii)

All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

..1910.1030(d)(4)(ii)(A)

(d)(4)(ii)(A)

Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(d)(4)(ii)(B)

Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated during the shift.

(d)(4)(ii)(C)

All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(d)(4)(ii)(D)

Broken glassware, which may be contaminated, shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dustpan, tongs, or forceps.

(d)(4)(ii)(E)

Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

(d)(4)(iii)

Regulated Waste.

..1910.1030(d)(4)(iii)(A)

(d)(4)(iii)(A)

Contaminated Sharps Discarding and Containment.

(d)(4)(iii)(A)(1)

Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

[a] Closeable;

[b] Puncture resistant;

[c] Leak proof on sides and bottom; and

[d] Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

(d)(4)(iii)(A)(2)

During use, containers for contaminated sharps shall be:

[a] Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

[b] Maintained upright throughout use; and

[c] Replaced routinely and not be allowed to overfill.

(d)(4)(iii)(A)(3)

When moving containers of contaminated sharps from the area of use, the containers shall be:

[a] Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

[b] Placed in a secondary container if leakage is possible. The second container shall be:

[i] Closeable;

[ii] Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

[iii] Labeled or color-coded according to paragraph (g)(1)(i) of this standard.

(d)(4)(iii)(A)(4)

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

(d)(4)(iii)(B)

Other Regulated Waste Containment.

(d)(4)(iii)(B)(1)

Regulated waste shall be placed in containers that are:

[a] Closeable;

[b] Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

[c] Labeled or color-coded in accordance with paragraph (g)(1)(i) this standard;
and

[d] Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(d)(4)(iii)(B)(2)

If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be:

[a] Closeable;

[b] Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

[c] Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and

[d] Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(d)(4)(iii)(C)

Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

..1910.1030(d)(4)(iv)

(d)(4)(iv)

Laundry.

(d)(4)(iv)(A)

Contaminated laundry shall be handled as little as possible with a minimum of agitation.

(d)(4)(iv)(A)(1)

Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

(d)(4)(iv)(A)(2)

Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

(d)(4)(iv)(A)(3)

Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers that prevent soak-through and/or leakage of fluids to the exterior.

(d)(4)(iv)(B)

The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

..1910.1030(d)(4)(iv)(C)

(d)(4)(iv)(C)

When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph (g)(1)(i).

(e)

HIV and HBV Research Laboratories and Production Facilities.

(e)(1)

This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs. These requirements apply in addition to the other requirements of the standard.

(e)(2)

Research laboratories and production facilities shall meet the following criteria:

(e)(2)(i)

Standard Microbiological Practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(e)(2)(ii)

Special Practices

(e)(2)(ii)(A)

Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

..1910.1030(e)(2)(ii)(B)

(e)(2)(ii)(B)

Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leak proof, labeled or color-coded container that is closed before being removed from the work area.

(e)(2)(ii)(C)

Access to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

(e)(2)(ii)(D)

When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph (g)(1)(ii) of this standard.

(e)(2)(ii)(E)

All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

(e)(2)(ii)(F)

Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

..1910.1030(e)(2)(ii)(G)

(e)(2)(ii)(G)

Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making hand contact with other potentially infectious materials is unavoidable.

(e)(2)(ii)(H)

Before disposal all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(e)(2)(ii)(I)

Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

(e)(2)(ii)(J)

Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking syringes or disposable syringe-needle units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

(e)(2)(ii)(K)

All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

..1910.1030(e)(2)(ii)(L)

(e)(2)(ii)(L)

A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

(e)(2)(ii)(M)

A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

(e)(2)(iii)

Containment Equipment.

(e)(2)(iii)(A)

Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed

centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

(e)(2)(iii)(B)

Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

(e)(3)

HIV and HBV research laboratories shall meet the following criteria:

..1910.1030(e)(3)(i)

(e)(3)(i)

Each laboratory shall contain a facility for hand washing and an eye wash facility that is readily available within the work area.

(e)(3)(ii)

An autoclave for decontamination of regulated waste shall be available.

(e)(4)

HIV and HBV production facilities shall meet the following criteria:

(e)(4)(i)

The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-door clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

(e)(4)(ii)

The surfaces of doors, walls, floors and ceilings in the work area shall be water-resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

..1910.1030(e)(4)(iii)

(e)(4)(iii)

Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

(e)(4)(iv)

Access doors to the work area or containment module shall be self-closing.

(e)(4)(v)

An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

(e)(4)(vi)

A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be re-circulated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

(e)(5)

Training Requirements. Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph (g)(2)(ix).

(f)
Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

..1910.1030(f)(1)

(f)(1)
General.

(f)(1)(i)

The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident.

(f)(1)(ii)

The employer shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

(f)(1)(ii)(A)

Made available at no cost to the employee;

(f)(1)(ii)(B)

Made available to the employee at a reasonable time and place;

(f)(1)(ii)(C)

Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

(f)(1)(ii)(D)

Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph (f).

(f)(1)(iii)

The employer shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

..1910.1030(f)(2)

(f)(2)
Hepatitis B Vaccination.

(f)(2)(i)

Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(f)(2)(ii)

The employer shall not make participation in a prescreening program a prerequisite for receiving hepatitis B vaccination.

(f)(2)(iii)

If the employee initially declines hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

(f)(2)(iv)

The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in Appendix A.

(f)(2)(v)

If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section (f)(1)(ii).

(f)(3)

Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

(f)(3)(i)

Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

..1910.1030(f)(3)(ii)

(f)(3)(ii)

Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

(f)(3)(ii)(A)

The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

(f)(3)(ii)(B)

When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.

(f)(3)(ii)(C)

Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(f)(3)(iii)

Collection and testing of blood for HBV and HIV serological status;

(f)(3)(iii)(A)

The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

..1910.1030(f)(3)(iii)(B)

(f)(3)(iii)(B)

If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

(f)(3)(iv)

Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

(f)(3)(v)

Counseling; and

(f)(3)(vi)

Evaluation of reported illnesses.

(f)(4)

Information Provided to the Healthcare Professional.

(f)(4)(i)

The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

(f)(4)(ii)

The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

(f)(4)(ii)(A)

A copy of this regulation;

(f)(4)(ii)(B)

A description of the exposed employee's duties as they relate to the exposure incident;

(f)(4)(ii)(C)

Documentation of the route(s) of exposure and circumstances under which exposure occurred;

..1910.1030(f)(4)(ii)(D)

(f)(4)(ii)(D)

Results of the source individual's blood testing, if available; and

(f)(4)(ii)(E)

All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

(f)(5)

Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

(f)(5)(i)

The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

(f)(5)(ii)

The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

(f)(5)(ii)(A)

That the employee has been informed of the results of the evaluation; and

(f)(5)(ii)(B)

That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment.

..1910.1030(f)(5)(iii)

(f)(5)(iii)

All other findings or diagnoses shall remain confidential and shall not be included in the written report.

(f)(6)

Medical Record-keeping. Medical records required by this standard shall be maintained in accordance with paragraph (h)(1) of this section.

(g)

Communication of Hazards to Employees.

(g)(1)

Labels and Signs.

(g)(1)(i)

Labels.

(g)(1)(i)(A)

Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious materials, except as provided in paragraph (g)(1)(i)(E), (F) and (G).

(g)(1)(i)(B)

Labels required by this section shall include the following legend:

(g)(1)(i)(C)

These labels shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in a contrasting color.

(g)(1)(i)(D)

Labels shall be affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

..1910.1030(g)(1)(i)(E)

(g)(1)(i)(E)

Red bags or red containers may be substituted for labels.

(g)(1)(i)(F)

Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

(g)(1)(i)(G)

Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

(g)(1)(i)(H)

Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

(g)(1)(i)(I)

Regulated waste that has been decontaminated need not be labeled or color-coded.

(g)(1)(ii)

Signs.

(g)(1)(ii)(A)

The employer shall post signs at the entrance to work areas specified in paragraph (e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

BIOHAZARD

(Name of the Infectious Agent)
(Special requirements for entering the area)
(Name, telephone number of the laboratory director or other responsible person.)

..1910.1030(g)(1)(ii)(B)

(g)(1)(ii)(B)

These signs shall be fluorescent orange-red or predominantly so, with lettering and symbols in a contrasting color.

(g)(2)

Information and Training.

(g)(2)(i)

Employers shall ensure that all employees with occupational exposure participate in a training program that must be provided at no cost to the employee and during working hours.

(g)(2)(ii)

Training shall be provided as follows:

(g)(2)(ii)(A)

At the time of initial assignment to tasks where occupational exposure may take place;

(g)(2)(ii)(B)

Within 90 days after the effective date of the standard; and

(g)(2)(ii)(C)

At least annually thereafter.

(g)(2)(iii)

For employees who have received training on bloodborne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

(g)(2)(iv)

Annual training for all employees shall be provided within one year of their previous training.

..1910.1030(g)(2)(v)

(g)(2)(v)

Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(g)(2)(vi)

Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

(g)(2)(vii)

The training program shall contain at a minimum the following elements:

(g)(2)(vii)(A)

An accessible copy of the regulatory text of this standard and an explanation of its contents;

(g)(2)(vii)(B)

A general explanation of the epidemiology and symptoms of bloodborne diseases;

(g)(2)(vii)(C)

An explanation of the modes of transmission of bloodborne pathogens;

(g)(2)(vii)(D)

An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

(g)(2)(vii)(E)

An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

..1910.1030(g)(2)(vii)(F)

(g)(2)(vii)(F)

An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

(g)(2)(vii)(G)

Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

(g)(2)(vii)(H)

An explanation of the basis for selection of personal protective equipment;

(g)(2)(vii)(I)

Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

(g)(2)(vii)(J)

Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(g)(2)(vii)(K)

An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

(g)(2)(vii)(L)

Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;

..1910.1030(g)(2)(vii)(M)

(g)(2)(vii)(M)

An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and

(g)(2)(vii)(N)

An opportunity for interactive questions and answers with the person conducting the training session.

(g)(2)(viii)

The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

(g)(2)(ix)

Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

(g)(2)(ix)(A)

The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

(g)(2)(ix)(B)

The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

..1910.1030(g)(2)(ix)(C)

(g)(2)(ix)(C)

The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as techniques are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

(h)

Record-keeping.

(h)(1)

Medical Records.

(h)(1)(i)

The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.1020.

(h)(1)(ii)

This record shall include:

(h)(1)(ii)(A)

The name and social security number of the employee;

(h)(1)(ii)(B)

A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph (f)(2);

(h)(1)(ii)(C)

A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

(h)(1)(ii)(D)

The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

..1910.1030(h)(1)(ii)(E)

(h)(1)(ii)(E)

A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

(h)(1)(iii)

Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:

(h)(1)(iii)(A)

Kept confidential; and

(h)(1)(iii)(B)

Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

(h)(1)(iv)

The employer shall maintain the records required by paragraph (h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.1020.

(h)(2)

Training Records.

(h)(2)(i)

Training records shall include the following information:

(h)(2)(i)(A)

The dates of the training sessions;

(h)(2)(i)(B)

The contents or a summary of the training sessions;

(h)(2)(i)(C)

The names and qualifications of persons conducting the training; and

..1910.1030(h)(2)(i)(D)

(h)(2)(i)(D)

The names and job titles of all persons attending the training sessions.

(h)(2)(ii)

Training records shall be maintained for 3 years from the date on which the training occurred.

(h)(3)

Availability.

(h)(3)(i)

The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

(h)(3)(ii)

Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary.

(h)(3)(iii)

Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.1020.

..1910.1030(h)(4)

(h)(4)

Transfer of Records.

(h)(4)(i)

The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.1020(h).

(h)(4)(ii)

If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

(i)

Dates.

(i)(1)

Effective Date. The standard shall become effective on March 6, 1992.

(i)(2)

The Exposure Control Plan required by paragraph (c) of this section shall be completed on or before May 5, 1992.

(i)(3)

Paragraph (g)(2) Information and Training and (h) Record keeping shall take effect on or before June 4, 1992.

(i)(4)

Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Personal Protective Equipment, (d)(4) Housekeeping, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, and (g)(1) Labels and Signs, shall take effect July 6, 1992.

**State of New York
Executive Chamber
No. 26
EXECUTIVE ORDER**

ESTABLISHING A MANAGEMENT SYSTEM FOR EMERGENCY RESPONSE

WHEREAS, on occasion disasters occur that threaten the public health, safety and lives of the Citizens of the State;

WHEREAS, it is necessary and desirable to ensure that all State and local emergency agencies and personnel coordinate their efforts to efficiently provide emergency relief and disaster recovery aid;

WHEREAS, to facilitate efficient and effective assistance to those impacted it is important that all State and local emergency response agencies and personnel utilize common terminology, integrated communications, consolidated action plans, unified command, modular organization, manageable span of control, comprehensive resource management and designated incident facilities during emergencies or disasters;

WHEREAS, the Incident Command System, as developed by the National Interagency Incident Management System, sets forth standardized procedures for managing personnel, communications, facilities and resources;

WHEREAS, the Incident Command System procedures are used by the Federal Emergency Management Agency, National Fire Academy, National Fire Protection Association, National Wildfire Coordinating Group, and other states;

WHEREAS, the Incident Command System is an integral part of various emergency management training programs currently taught throughout the State;

WHEREAS, the Occupational Safety and Health Administration requires the establishment of a site-specific Incident Command System to handle emergency responses; and

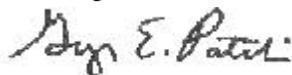
WHEREAS, the Disaster Preparedness Commission Task Force on Command and Control and the State Emergency Response Commission endorse a standardized Incident Command System;

NOW, THEREFORE, I, GEORGE E.PATAKI, Governor of the State of New York, by the virtue of the authority vested in me by the Constitution and Laws of the State of New York, do hereby establish the National Interagency Incident Management System -- Incident Command System as the State standard command and control system during emergency operations.

GIVEN under my hand and the Privy Seal of
The State in the City of Albany this
LS fifth day of March in the year one
Thousand nine hundred ninety-six.

BY THE Governor

/s/ George E. Pataki



/s/ Bradford J. Race, Jr.
Secretary to the Governor

INTRODUCTION TO ICS

INTRODUCTION TO THE INCIDENT COMMAND SYSTEM

PURPOSE AND SCOPE

This section will introduce you to and define ICS. The section will provide you with a brief history of ICS and its evolution into an effective system for emergency management. This section will also introduce the ICS organization and describe each ICS function and its responsibilities during an incident. This section will include the key concepts and principles of ICS and introduce important terms that you will need to know to function in an ICS structure. Because many of the terms, concepts, and principles presented in this section will be new to you, be sure to spend enough time on them to ensure that you thoroughly understand the material.

WHAT IS ICS?

ICS is the model tool for *command*, *control*, and *coordination* of a response and provides a means to coordinate the efforts of individual agencies as they work toward the common goal of stabilizing the incident and protecting life, property, and the environment. ICS uses principles that have been proven to improve efficiency and effectiveness in a business setting and applies the principles to emergency response. Why do you need to know about ICS? We live in a complex world in which responding to emergencies, from single-car accidents to large-scale disasters, often requires cooperation among several agencies. In an emergency, you and other personnel from your agency may be called upon to help with the response. Given the current movement toward using an ICS structure for emergency response, it is likely, therefore, that you will function in an ICS environment. In an emergency, you may not be working for your day-to-day supervisor, or you may be working in a different location. Thus, emergency response operations are *not* “business as usual.”

This section will provide you with information that you will need to work in an ICS environment, including the rationale for using ICS and how ICS can be used to manage all types of incidents. It also will describe the basic ICS organization, how ICS can form the basis for an effective emergency management system, and how ICS can enhance EOC operations.

When Is ICS Used?

ICS has been proven effective for responding to all types of incidents, including:

- ◆ Hazardous materials (HazMat) incidents.
- ◆ Planned events (e.g., celebrations, parades, concerts, official visits, etc.)
- ◆ Response to natural hazards
- ◆ Single and multi-agency law enforcement incidents
- ◆ Lack of comprehensive *resource management strategy*
- ◆ Fires
- ◆ Incidents involving multiple casualties
- ◆ Multi-jurisdictional and multi-agency incidents
- ◆ Air, rail, water, or ground transportation accidents
- ◆ Wide-area search and rescue missions
- ◆ Pest eradication programs
- ◆ Private sector emergency management programs

Federal law requires the use of ICS for response to HazMat incidents. Many States are adopting ICS as their standard for responding to all types of incidents. ICS has been endorsed by the American Public Works Association and the International Association of Chiefs of Police and has been adopted by the National Fire Academy as its standard for incident response. ICS is included in the National Fire Protection Association (NFPA) “Recommended Practice for Disaster Management” (NFPA1600). ICS is also part of the National Interagency Incident Management System (NIIMS).

ICS History

ICS was developed in the 1970s in response to a series of major wild-land fires in southern California. At that time, municipal, county, State, and Federal fire authorities collaborated to form the Firefighting Resources of California Organized for Potential Emergencies (FIRESCOPE). FIRESCOPE identified several recurring problems involving multi-agency responses, such as:

- ◆ *Nonstandard terminology* among responding agencies
- ◆ Lack of capability to *expand and contract* as required by the situation
- ◆ *Nonstandard and nonintegrated communications*
- ◆ Lack of *consolidated action plans*
- ◆ Lack of *designated facilities*.

Efforts to address these difficulties resulted in the development of the original ICS model for effective incident management. Although originally developed in response to wildfires, ICS has evolved into an all-risk system that is appropriate for all types of fire and non-fire emergencies. Much of the success of ICS has resulted directly from applying:

- ◆ A common organizational structure
- ◆ Key management principles in a standardized way

ICS ORGANIZATION

Many incidents, whether major accidents (such as HazMat spills), minor incidents (such as house fires and utility outages), or emergencies and major disasters (such as tornadoes, hurricanes, and earthquakes), require a response from a number of different agencies. Regardless of the size of the incident or the number of agencies involved in the response, all incidents require a coordinated effort to ensure an effective response and the efficient, safe use of resources.

To understand this concept better, review the examples of incidents that are listed and record the agencies that probably would be involved in each incident and the resources that each agency would offer.

Example 1: A multi-car traffic accident has occurred, in which two people have been injured. There is potential damage to a bridge abutment.

Potential Response Agencies:

Potential Resources:

Example 2: A water main break has disrupted all major utilities. The break has caused local flooding of a major road and several local businesses.

Potential Response Agencies:

Potential Resources:

Example 3: High winds from a coastal storm have caused widespread loss of electricity and have left debris cluttering most of the roads in a 50 square-mile area. Several electric wires have been knocked down and are lying across the roadway. Damage is so widespread that the electric company expects that it will take several days to repair the damage. The wind chill for the area is expected to be below zero degrees during that timeframe.

Potential Response Agencies:

Potential Resources:

Example 1: A multi-car traffic accident has occurred, in which two people have been injured. There is potential damage to a bridge abutment.

Potential Response Agencies:

Law Enforcement

EMS Paramedics

Public Works/Highway Dept.

Fire Department

Potential Resources:

Police officers, Communications equipment Flares, blockades, etc.

Ambulance(s), Emergency medical equipment
Communications equipment

Structural engineer(s), HazMat cleanup equipment, Road signs, blockades, etc.

Firefighters, Fire apparatus, Communications equipment

Example 2: A water main break has disrupted all major utilities. The break has caused local flooding of a major road and several local businesses.

Potential Response Agencies:

Law Enforcement

Fire Firefighters

Public Works/Highway Dept.

Utility Companies

Emergency Management EOC

Potential Resources:

Police officers, Communications equipment

Fire Apparatus, Communications equipment

Repair equipment, Flares, blockades, etc, Trucks, Repair personnel

Repair personnel, Trucks, Repair equipment, Natural gas detection equipment

Communications equipment

Example 3: High winds from a coastal storm have caused widespread loss of electricity and have left debris cluttering most of the roads in a 50 square-mile area. Several electric wires have been knocked down and are lying across the roadway. Damage is so widespread that the electric company expects that it will take several days to repair the damage. The wind chill for the area is expected to be below zero degrees during that timeframe.

Potential Response Agencies:

Emergency Management EOC

Law Enforcement

Fire Firefighters

Electric Company

Public Works/Highway Dept.

The American Red Cross

Potential Resources:

Communications equipment

Police officers, Communications equipment
Flares, blockades, etc.

Fire apparatus, Communications equipment

Repair personnel, Repair equipment, Trucks

Repair personnel, Road signs, blockades, etc.

Shelter facilities, Shelter personnel, Feeding stations

NOTE: This incident may be large enough to require activation of the EOC. Other agencies (Department of Transportation (DOT), schools, and National Guard) also may respond in these examples. The agencies and equipment in this example are for illustration only.

As you can see from reviewing the examples, no single agency or department can handle an emergency situation of any scale alone. Everyone must work together to manage the emergency. To coordinate the effective use of all of the available resources, agencies need a formalized management structure that lends consistency, fosters efficiency, and provides direction during a response.

The ICS organization is built around five major components:

- ◆ Command
- ◆ Planning
- ◆ Operations
- ◆ Logistics
- ◆ Finance/Administration

These five major components are the foundation upon which the ICS organization develops. They apply during a routine emergency, when preparing for a major event, or when managing a response to a major disaster. In small-scale incidents, all of the components may be managed by one person, the *Incident Commander*. Large-scale incidents usually require that each component, or *section*, is set up separately. As you will see later, each of the primary ICS sections may be divided into smaller functions as needed.

The ICS organization has the capability to expand or contract to meet the needs of the incident, but **all incidents, regardless of size or complexity, will have an Incident Commander**. A basic ICS operating guideline is that the Incident Commander is responsible for on-scene management until command authority is transferred to another person, who then becomes the Incident Commander.

Each of the major components of the ICS organization is described in the sections that follow.

The Command Function

The command function is directed by the Incident Commander, who is the person in charge at the incident, and who must be fully qualified to manage the response. Major responsibilities for the Incident Commander include:

- ◆ Performing command activities, such as establishing command and establishing the ICP
- ◆ Protecting life and property
- ◆ Controlling personnel and equipment re-sources
- ◆ Maintaining accountability for responder and public safety, as well as for task accomplishment
- ◆ Establishing and maintaining an effective liaison with outside agencies and organizations, including the EOC, when it is activated.

Incident management encompasses:

- ◆ Establishing command
- ◆ Ensuring responder safety
- ◆ Assessing incident priorities
- ◆ Determining operational objectives
- ◆ Developing and implementing the Incident Action Plan (IAP)
- ◆ Developing an appropriate organizational structure
- ◆ Maintaining a manageable span of control
- ◆ Managing incident resources
- ◆ Coordinating overall emergency activities
- ◆ Coordinating the activities of outside agencies
- ◆ Authorizing the release of information to the media
- ◆ Keeping track of costs

An effective Incident Commander must be assertive, decisive, objective, calm, and a quick thinker. To handle all of the responsibilities of this role, the Incident Commander also needs to be adaptable, flexible, and realistic about his or her limitations. The Incident Commander also needs to have the capability to delegate positions appropriately as needed for an incident. **Initially, the Incident Commander will be the senior first-responder to arrive at the scene.** As additional responders arrive, command will transfer on the basis of who has primary authority for overall control of the incident. As incidents grow in size or become more complex, the responsible jurisdiction or agency may assign a more highly qualified Incident Commander. At transfer of command, the outgoing Incident Commander must give the incoming Incident Commander a full briefing and notify all staff of the change in command.

As incidents grow, the Incident Commander may delegate authority for performing certain activities to others, as required. When expansion is required, the Incident Commander will establish the other *Command Staff* positions.

- ◆ The *Information Officer* handles all media inquiries and coordinates the release of information to the media with the Public Affairs Officer at the EOC.
- ◆ The *Safety Officer* monitors safety conditions and develops measures for ensuring the safety of all assigned personnel.
- ◆ The *Liaison Officer* is the on-scene contact for other agencies assigned to the incident.

The Incident Commander will base the decision to expand (or contract) the ICS organization on three major incident priorities:

- ◆ **Life safety.** The Incident Commander's first priority is *always* the life safety of the emergency responders and the public.
- ◆ **Incident stability.** The Incident Commander is responsible for determining the strategy that will:
 - Minimize the effect that the incident may have on the surrounding area
 - Maximize the response effort while using resources efficiently.

The size and complexity of the command system that the Incident Commander develops should be in keeping with the *complexity* (i.e., level of difficulty in the response) of the incident, not the size (which is based on geo-graphic area or number of resources).

Property conservation. The Incident Commander is responsible for minimizing damage to property while achieving the incident objectives. As incidents become more involved, the Incident Commander can activate additional *General Staff* sections (that is, Planning, Operations, Logistics, and/or Finance/Administration), as necessary. Each Section Chief, in turn, has the authority to expand internally to meet the needs of the situation.

The Planning Section

In smaller events, the Incident Commander is responsible for planning, but when the incident is of larger scale, the Incident Commander establishes the *Planning Section*. The Planning Section's function includes the collection, evaluation, dissemination, and use of information about the development of the incident and status of re-sources. This section's responsibilities can also include creation of the Incident Action Plan (IAP), which defines the response activities and resource utilization for a specified time period. (IAPs will be described in more detail later in this course.)

The Operations Section

The *Operations Section* is responsible for carrying out the response activities described in the IAP. The Operations Section Chief coordinates Operations Section activities and has primary responsibility for receiving and implementing the IAP. The Operations Section Chief reports to the Incident Commander and determines the required resources and organizational structure within the Operations Section.

The Operations Section Chief's main responsibilities are to:

- ◆ Direct and coordinate all operations, ensuring the safety of Operations Section personnel
- ◆ Assist the Incident Commander in developing response goals and objectives for the incident
- ◆ Implement the IAP
- ◆ Request (or release) resources through the Incident Commander
- ◆ Keep the Incident Commander informed of situation and resource status within operations.

The Logistics Section

The *Logistics Section* is responsible for providing facilities, services, and materials, including personnel to operate the requested equipment for the incident. This section takes on great significance in long-term or extended operations. It is important to note that the Logistics Section functions are geared to support the incident responders. For example, the Medical Unit in the Logistics Section provides care for the incident responders not civilian victims.

The Finance/Administration Section

Though sometimes overlooked, the *Finance/Administration Section* is critical for tracking incident costs and reimbursement accounting. Unless costs and financial operations are carefully recorded and justified, reimbursement of costs is difficult, if not impossible. The Finance/Administration Section is especially important when the incident is of a magnitude that may result in a Presidential Declaration. Each of these functional areas can be expanded into additional organizational units with further delegation of authority. They also may be contracted as the incident deescalates.

ICS CONCEPTS AND PRINCIPLES

The adaptable ICS structure is composed of major components to ensure quick and effective resource commitment and to minimize disruption to the normal operating policies and procedures of responding organizations. Remember that ICS concepts and principles have been tested and proven over time in business and industry and by response agencies at all governmental levels.

ICS training is required to ensure that all who may become involved in an incident are familiar with ICS principles. In this section you will find how the application of these concepts and principles makes ICS work.

An ICS structure should include:

- ◆ Common terminology
- ◆ A modular organization
- ◆ Integrated communications
- ◆ Unity of command
- ◆ A unified command structure
- ◆ Consolidated IAPs
- ◆ A manageable span of control
- ◆ Designated incident facilities
- ◆ Comprehensive resource management

Common terminology is essential in any emergency management system, especially when diverse or other than first-response agencies are involved in the response. When agencies have slightly different meanings for terms, confusion and inefficiency can result. Do you know what a Staging Area is? Will all responders understand what a Staging Area is? In ICS, major organizational functions, facilities, and units are pre-designated and given titles. ICS terminology is standard and consistent among all of the agencies involved.

To prevent confusion when multiple incidents occur at the same time within the same jurisdiction, or when the same radio frequency must be used for multiple incidents, the Incident Commander will specifically name his or her incident. For example, an incident that occurs at 14th and Flower might be called "Flower Street Command." One that occurs at 14th and Penn could be called "Penn Street Command."

Other guidelines for establishing common terminology include:

- ◆ Response personnel should use common names for all personnel and equipment re-sources, as well as for all facilities in and around the incident area
- ◆ Radio transmissions should use clear text (that is, plain English, without "ten" codes or agency-specific codes)

All common terminology applies to all organizational elements, position titles, and resources. A *modular organization* develops from the top-down organizational structure at any incident. "Top-down" means that, at the very least, the Command function is established by the first-arriving officer who becomes the Incident Commander. As the incident warrants, the

Incident Commander activates other functional areas (i.e., sections). In approximately 95 percent of all incidents, the organizational structure for operations consists of command and single resources (e.g., one fire truck, an ambulance, or a tow truck). If needed, however, the ICS structure can consist of several layers. In this unit, we have described the two top layers: Command and General Staff. Other layers may be activated as warranted.

Integrated communications is a system that uses a common communications plan, standard operating procedures, clear text, common frequencies, and common terminology. Several communication networks may be established, depending on the size and complexity of the incident.

Unity of command is the concept by which each person within an organization reports to only one designated person. A *unified command* allows all agencies with responsibility for the incident, either geographic or functional, to manage an incident by establishing a common set of incident objectives and strategies. Unified command does *not* mean losing or giving up agency authority, responsibility, or accountability.

The concept of unified command means that all involved agencies contribute to the command process by:

- ◆ Determining overall objectives
- ◆ Planning jointly for operational activities while conducting integrated operations
- ◆ Maximizing the use of all assigned resources
- ◆ Under unified command, the following always apply:
 - The incident functions under a single, coordinated IAP
 - One Operations Section Chief has responsibility for implementing the IAP
 - One ICP is established.

Consolidated IAPs describe response goals, operational objectives, and support activities. The decision to have a written IAP is made by the Incident Commander.

ICS requires written plans whenever:

- ◆ Resources from multiple agencies are used
- ◆ Several jurisdictions are involved
- ◆ The incident is complex (e.g., changes in shifts of personnel or equipment are required)

IAPs should cover all objectives and support activities that are needed during the entire operational period. A written plan is preferable to an oral plan because it clearly demonstrates responsibility, helps protect the community from liability suits, and provides documentation when requesting State and Federal assistance. IAPs that include the measurable goals and objectives to be achieved are always prepared around a timeframe called an *operational period*.

Operational periods can be of various lengths, but should be no longer than 24 hours. Twelve-hour operational periods are common for large-scale incidents. The Incident Commander determines the length of the operational period based on the complexity and size of the incident.

A manageable span of control is defined as the number of individuals one supervisor can manage effectively. **In ICS, the span of control for any supervisor falls within a range of three to seven resources, with five being the optimum.** If those numbers increase or decrease, the Incident Commander should reexamine the organizational structure.

Designated incident facilities include:

- ◆ An *Incident Command Post* at which the Incident Commander, the Command Staff, and the General Staff oversee all incident operations
- ◆ *Staging Areas* at which resources are kept while awaiting incident assignment

Other incident facilities may be designated for incidents that are geographically dispersed, require large numbers of resources, or require highly specialized resources.

Comprehensive resource management:

- ◆ Maximizes resource use
- ◆ Consolidates control of single resources
- ◆ Reduces the communications load
- ◆ Provides accountability
- ◆ Reduces freelancing
- ◆ Ensures personnel safety
- ◆ All resources are assigned to a status condition
- ◆ *Assigned* resources are performing active functions
- ◆ *Available* resources are ready for assignment
- ◆ *Out-of-service* resources are not ready for assigned or available status

Any changes in resource location and status must be reported promptly to the Resource Unit by the person making the change. Personnel accountability is provided throughout all of ICS. All personnel must check in as soon as they arrive at an incident. Resource units, assignment lists, and unit logs are all ways for personnel to be accounted for. When personnel are no longer required for the response, they must check out so that they can be removed from the resource lists.

The ICS principles can and should be used for all types of incidents, both small and large from a warrant execution to a hostage situation or a search for a missing child. Because ICS can be used at virtually any type of incident of any size, it is important that all responders use the ICS approach.

ICS AND THE EMERGENCY OPERATIONS CENTER

Most jurisdictions maintain an EOC as part of their community's emergency preparedness program. An EOC is where department heads, government officers and officials, and volunteer agencies gather to coordinate their response to an emergency event.

The proper interface between the EOC and the on-scene management should be worked out in advance, if possible. In the following scenario, you will see how having people work together during an emergency saves time and lives.

Scenario: A train derailment has caused a hazardous materials spill along a railroad track in a community of 10,000. Fire, law enforcement, and public works authorities have responded to the incident. An ICS Incident Command Post is established with the fire Battalion Chief as Incident Commander.

As the situation deteriorates, the Incident Commander orders a limited evacuation of 150 people in the immediate area, which is within the Incident Commander's statutory authority. Recognizing the threat of an explosion, the Incident Commander wants a larger area cleared as a precautionary measure and transmits this concern to the Fire Chief at the main station. The Fire Chief asks the Mayor to issue an evacuation order for over half the city. The Mayor does so under the State statutes and directs that the EOC be activated.

The Incident Commander is in overall command of the incident scene, with the committed resources under his command and direction. The large-scale evacuation, which is beyond the capabilities of the ICS ICP to manage effectively, will be managed by the EOC.

The EOC manages the community-wide resources necessary to complete the evacuation. The EOC requests resources through mutual aid and establishes traffic control points at key evacuation junctions. The EOC establishes shelters with the cooperation of the city's social services agency and the American Red Cross. The EOC transmits regular public service messages with evacuation directions over the Emergency Alert System (EAS). Meanwhile, the ICS Information Officer briefs reporters at the scene of the emergency on the current events surrounding the incident. After a period of time, the Incident Commander sends a request to the EOC for personnel to relieve incident scene teams. The EOC locates the resources, directs them to staging areas established by the ICS operation, and releases them to the Incident Commander's control. Meanwhile, the EOC requires status updates from the Incident Commander to determine how long the shelters must remain open. The EOC determines resource distribution of food and sanitation facilities among the shelters operating under the ICS network.

As you can see from the scenario, the Incident Command structure and the EOC function together with the same goals, but function at different levels of responsibility. The Incident Command operation is responsible for on-scene response activities, and the EOC is responsible for the entire community-wide response to the event. (Note that the EOC also can function under an ICS structure.)

If the EOC does operate under the ICS structure, it must be careful not to confuse personnel at the EOC with the same personnel on site. As you can see, ICS is a management system that works both for the responding agencies and for the community.

SUMMARY

This section has covered the main components of an ICS structure:

- ◆ Command
- ◆ Planning
- ◆ Operations
- ◆ Logistics
- ◆ Finance/Administration
- ◆

The *Incident Commander* has overall control over the incident. In a small incident, he or she may assume the responsibilities of all components. In larger or more complex incidents, the Incident Commander may assign other members of the *Command Staff*, including an *Information Officer*, a *Safety Officer*, and/or a *Liaison Officer*. The Incident Commander also may assign *General Staff*, who serve as *Section Chiefs* for the Planning, Operations, Logistics, and Finance/Administration Sections. The Section Chiefs have the authority to expand or contract their operations as the demands of the incident increase or decrease.

ICS operates according to basic principles to ensure quick and effective resource commitment and to minimize disruption of usual operating policies and procedures of responding organizations.

These principles include:

- ◆ *Common terminology*, which ensures that all responders use terms that are standard and consistent
- ◆ *A modular organization*, which enables the ICS structure to expand or contract to meet the needs of the incident
- ◆ *Integrated communications*, which establishes a common communications plan, standard operating procedures, clear text, common frequencies, and common terminology
- ◆ *Unity of command*, where each person within an organization reports to only one designated person
- ◆ *A unified command structure*, which allows all agencies with responsibility for the incident, either geographic or functional, to manage an incident by establishing a common set of incident objectives and strategies
- ◆ *Consolidated IAPs*, which describe response goals, operational objectives, and support activities
- ◆ *A manageable span of control*, which limits the number of resources that any supervisor may control to between three and seven, with five being optimal
- ◆ *Designated incident facilities*, which include an ICP and may include Staging Areas
- ◆ Other incident facilities may be designated depending on the requirements of the incident
- ◆ *Comprehensive resource management*, which maximizes resource use, consolidates control of single resources, reduces the communications load, provides accountability, reduces freelancing, and ensures personnel safety.

These principles should be used for all types of incidents, both small and large. At larger or more complex incidents, the ICS structure in the field will work with personnel in the EOC (which also may be organized under ICS principles). The Incident Command and the EOC function together and work toward the same goals, but their responsibilities are at different levels. The Incident Command operation is responsible for on-scene response activities, and the EOC is responsible for community-wide resource management.

Section Eleven

Public Health Law Article 30 and 30A

**ARTICLE 30
and
ARTICLE 30A
of the
STATE OF NEW YORK
PUBLIC HEALTH LAW
Emergency Medical Services**

**REVISIONS AS PROVIDED FOR BY
CHAPTER 190 OF THE LAWS OF 2001
CHAPTER 349 OF THE LAWS OF 2001
CHAPTER 563 OF THE LAWS OF 2001**

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services
433 River Street
Hedley Building, Suite 303
Troy, New York 12180-2299
518-402-0996
FAX: 518-402-0985**

**ARTICLE 30
EMERGENCY MEDICAL SERVICES**

Section

- 3000. Declaration of policy and statement of purpose.
- 3000-a. Emergency medical treatment.
- 3000-b. Automated External Defibrillators: Public Access Providers
- 3000-c. Epinephrine auto-injector devices
- 3000-d. Availability of resuscitation equipment in certain public places.
- 3001. Definitions.
- 3002. New York State emergency medical services council.
- 3002-a. State emergency medical advisory committee.
- 3003. Regional emergency medical services councils
- 3003-a. EMS program agencies.
- 3003-b. Emergency medical service training; cable television
- 3004. REPEALED
- 3004-a. Regional emergency medical advisory
- 3005. Ambulance service certificates
- 3005-a. Staffing standards; ambulance services and advanced life support first response services.
- 3005-b. Emergency Medical Technician five year re-certification Demonstration program
- 3006. Quality improvement program.
- 3007. Notice of alternative destination.
- 3008. Applications for determinations of public need.
- 3009. Continuation of existing services.
- 3010. Area of operation; transfers.
- 3011. Powers and duties of the department and the commissioner.
- 3012. Enforcement.
- 3013. Immunity from liability.
- 3014. Construction.
- 3015. Separability.
- 3016. Continuance of rules and regulations.
- 3017. Emergency Medical Service, Suffolk County.
- 3030. Advanced life support services.
- 3031. Advanced life support system.
- 3032. Rules and regulations.

**ARTICLE 30-A
EMERGENCY MEDICAL SERVICES TRAINING**

- 3050. Short title.
- 3051. Declaration of purpose.
- 3052. Establishment of a training program for emergency medical service personnel.
- 3053. Reporting.

SECTION 3000. DECLARATION OF POLICY AND STATEMENT OF PURPOSE.

The furnishing of medical assistance in an emergency is a matter of vital concern affecting the public health, safety and welfare. Prehospital emergency medical care, the provision of prompt and effective communication among ambulances and hospitals and safe and effective care transportation of the sick and injured are essential public health services.

It is the purpose of this article to promote the public health, safety and welfare by providing for certification of all advanced life support first response services and ambulance services; the creation of regional emergency medical services councils; and a New York state emergency medical services council to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication standards for advanced life support first response services and ambulance services.

SECTION 3000-A. EMERGENCY MEDICAL TREATMENT.

1. Except as provided in subdivision six of section six thousand six hundred eleven, subdivision two of section six thousand five hundred twenty-seven, subdivision one of section six thousand nine hundred nine and sections six thousand five hundred forty-seven and six thousand seven hundred thirty-seven of the education law, any person who voluntarily and without expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill, or injured, shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such emergency treatment unless it is established that such injuries were or such death was caused by gross negligence on the part of such person. Nothing in this section shall be deemed or construed to relieve a licensed physician, dentist, nurse, physical therapist or registered physician's assistant from liability for damages for injuries or death caused by an act or omission on the part of such person while rendering professional services in the normal and ordinary course of his or her practice.

2. (i) A person who, or entity, partnership, corporation, firm or society that, purchases or makes available resuscitation equipment that facilitate first aid, an automated external defibrillator or an epinephrine auto-injector device as required by law or local law, or (ii) the emergency health care provider with a collaborative agreement under section three thousand-b of this article with respect to an automated external defibrillator, or (iii) the emergency health care provider with a collaborative agreement under section three thousand-c of this article with respect to use of an epinephrine auto-injector device shall not be liable for damages arising either from the use of that equipment by a person who voluntarily and without expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or medical emergency, or from the use of defectively manufactured equipment; provided that this subdivision shall not limit the person's or entity's, partnership's, corporation's, firm's, society's or the emergency health care provider's liability for his, her or its own negligence, gross negligence or intentional misconduct.

SECTION 3000-B. AUTOMATED DEFIBRILLATORS: PUBLIC ACCESS PROVIDERS

1. Definitions. As used in this section, unless the context clearly requires otherwise, the following terms shall have the following meanings:

A) "Automated external defibrillator" means a medical device, approved by the United States Food and Drug Administration, that: (I) is capable of recognizing the presence or absence, in a patient, of ventricular fibrillation and rapid ventricular tachycardia; (II) is capable of determining, without intervention by an operator, whether defibrillation should be performed on the patient; (III) upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to the patient's heart; and (IV) then, upon action by an operator, delivers an appropriate electrical impulse to the patient's heart to perform defibrillation.

B) "Emergency Health Care Provider" means: (I) a physician with knowledge and experience in the delivery of emergency cardiac care; or (II) a hospital licensed under article twenty-eight of this chapter that provides emergency cardiac care.

C) "Public access defibrillation provider" means a person, firm, organization or other entity possessing or operating an automated external defibrillator pursuant to a collaborative agreement under this section.

D) "Nationally-recognized organization" means a national organization approved by the department for the purpose of training people in use of an automated external defibrillator.

2. Collaborative agreement. A person, firm, organization or other entity may purchase, acquire, possess and operate an automated external defibrillator pursuant to a collaborative agreement with an emergency health care provider. The

collaborative agreement shall include a written agreement that incorporates written practice protocols, and policies and procedures that shall assure compliance with this section. The public access defibrillation provider shall file a copy of the collaborative agreement with the department and with the appropriate regional council prior to operating the automated external defibrillator.

3. Possession and operation of automated external defibrillator. Possession and operation of an automated external defibrillator by a public access defibrillation provider shall comply with the following:

A) No person may operate an automated external defibrillator unless the person has successfully completed a training course in the operation of an automated external defibrillator approved by a nationally-recognized organization or the state emergency medical services council, and the completion of the course was recent enough to still be effective under the standards of the approving organization. However, this section shall not prohibit operation of an automated external defibrillator, (I) by a health care practitioner licensed or certified under title VIII of the education law or a person certified under this article acting within his or her lawful scope of practice or (II) by a person acting pursuant to a lawful prescription.

B) The public access defibrillation provider shall cause the automated external defibrillator to be maintained and tested according to applicable standards of the manufacturer and any appropriate government agency.

C) The public access defibrillation provider shall notify the regional council of the existence, location and type of any automated external defibrillator it possess.

D) Every use of an automated external defibrillator on a patient shall be immediately reported to the appropriate local emergency medical services system, emergency communications center or emergency vehicle dispatch center as appropriate and promptly reported to the emergency health care provider.

E) The Emergency Health Care Provider shall participate in the regional quality improvement program pursuant to subdivision one of section three thousand four-A of this article.

4. Application of other laws. A) Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability. B) Operation of an automated external defibrillator pursuant to this section shall not constitute the unlawful practice of a profession under title VIII of the education law.

SECTION 3000-C. EPINEPHRINE AUTO-INJECTOR DEVICES.

1. Definitions as used in this section:

(A) "eligible person, firm, organization, or other entity" means,

(i) an ambulance service or advanced life support first response service; a certified first responder, emergency medical technician, or advanced emergency medical technician, who is employed by or an enrolled member of any such service;

(ii) a children's overnight camp as defined in subdivision one of section thirteen hundred ninety-one of this chapter, a summer day camp as defined in subdivision one of section thirteen hundred ninety-six of this chapter, a traveling summer day camp as defined in subdivision one of section thirteen hundred ninety-nine-b of this chapter or a person employed by such a camp; or

(iii) any other person, firm, organization or entity designated pursuant to regulations of the commissioner in consultation with other appropriate agencies; and all subject to regulations of the commissioner.

(B) "emergency health care provider" means (i) a physician with knowledge and experience in the delivery of emergency care; or (ii) a hospital licensed under article twenty-eight of this chapter that provides emergency care.

2. Collaborative agreement. Any eligible person, firm, organization or other entity may purchase, acquire, possess and use epinephrine auto-injector devices pursuant to a collaborative agreement with an emergency health care provider. The collaborative agreement shall include a written agreement that incorporates written practice protocols, and policies and procedures that shall ensure compliance with the provisions of this section. The person, firm, organization or entity shall file a copy of the collaborative agreement with the department and with the appropriate Regional Council prior to using any epinephrine auto-injector device.

3. Possession and use of epinephrine auto-injector devices. Possession and use of epinephrine auto-injector devices shall be limited as follows:

a. no person shall use an epinephrine auto-injector device unless such person shall have successfully completed a training course in the use of epinephrine auto-injector devices approved by the commissioner pursuant to the rules of the department. This section does not prohibit the use of an epinephrine auto-injector device (i) by a health care practitioner licensed or certified under title eight of the education law acting within the scope of his or her practice, or (ii) by a person acting pursuant to a lawful prescription.

b. every person, firm, organization and entity authorized to possess and use epinephrine auto-injector devices pursuant to this section shall use, maintain and dispose of such devices pursuant to regulations of the department.

c. every use of an epinephrine auto-injector device pursuant to this section shall immediately be reported to the emergency health care provider.

4. Application of other laws.

a. use of an epinephrine auto-injector device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

b. purchase, acquisition, possession or use of an epinephrine auto-injector device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or article thirty-three of this chapter.

c. any person otherwise authorized to sell or provide an epinephrine auto-injector device may sell or provide it to a person authorized to possess it pursuant to this section.

SECTION 3000-D. AVAILABILITY OF RESUSCITATION EQUIPMENT IN CERTAIN PUBLIC PLACES.

1. For the purposes of this section, the following terms shall be defined as follows:

a. "Bar" means any establishment which is devoted to the sale and service of alcoholic beverages for on-premises consumption and in which the service of food, if served at all, is incidental to the consumption of such beverages.

b. "Health club" means any commercial establishment offering instruction, training or assistance and/or facilities for the preservation, maintenance, encouragement or development of physical fitness or well being. "Health club" as defined herein shall include, but not be limited to health spas, health studios, gymnasiums, weight control studios, martial arts and self defense schools or any other commercial establishment offering a similar course of physical training.

c. "Owner or operator" means the owner, manager, operator or other person having control of an establishment.

d. "Public place" means a restaurant, bar, theater or health club.

e. "Restaurant" means any commercial eating establishment which is devoted, wholly or in part, to the sale of food for on-premises consumption.

f. "Resuscitation equipment" means: (i) an adult exhaled air resuscitation mask, for which the Federal Food and Drug Administration has granted permission to market, accompanied by a pair of disposable gloves, and (ii) a pediatric exhaled air resuscitation mask, for which the Federal Food and Drug Administration has granted permission to market, accompanied by a pair of disposable gloves.

g. "Theater" means a motion picture theater, concert hall, auditorium or other building used for, or designed for the primary purpose of, exhibiting movies, stage dramas, musical recitals, dance or other similar performances.

2. The owner or operator of a public place shall have available in such public place resuscitation equipment in quantities deemed adequate by the department. Such equipment shall be readily accessible for use during medical emergencies. Any information deemed necessary by the commissioner shall accompany the resuscitation equipment. Resuscitation equipment shall be discarded after a single use.

3. The owner or operator of a public place shall provide notice to patrons, by means of signs, printed material or other means of written communication, indicating the availability of resuscitation equipment for emergency use and providing information on how to obtain cardiopulmonary resuscitation training. The type, size, style, location, and language of such notice shall be determined in accordance with rules, promulgated by the commissioner. In promulgating such rules, the commissioner shall take into consideration the concerns of the public places within the scope of this section. If the department shall make signs available pursuant to this subsection, it may charge a fee to cover printing, postage and handling expenses.

4. Any owner or operator of a public place, his or her employee or other agent, or any other person who voluntarily and without expectation of monetary compensation renders emergency treatment using the resuscitation equipment required pursuant to this section, to a person who is unconscious, ill or injured, shall only be liable pursuant to section three thousand-a of this article.

5. Nothing contained in this section shall impose any duty or obligation on any owner or operator of a public place, his or her employee or other agent, or any other person to provide resuscitation assistance to the victim of a medical emergency.

6. Nothing in this section shall be construed to restrict the power of any county, city, town, or village to adopt and enforce additional local laws, ordinances, or regulations which comply with at least the minimum applicable standards set forth in this article.

SECTION 3001. DEFINITIONS.

As used in this article, unless the context otherwise requires:

1. "Emergency medical service" means initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.

2. "Ambulance service" means an individual, partnership, association, corporation, municipality or any legal or public entity or subdivision thereof engaged in providing emergency medical care and the transportation of sick or injured persons by motor vehicle, aircraft or other forms of transportation to, from, or between general hospitals or other health care facilities.

3. "Voluntary ambulance service" means an ambulance service (i) operating not for pecuniary profit or financial gain, and (ii) no part of the assets or income of which is distributable to, or ensures to the benefit of, its members, directors or officers except to the extent permitted under this article.

4. "Voluntary advanced life support first response service" means advanced life support first response service (i) operating not for pecuniary profit or financial gain, and (ii) no part of the assets or income of which is distributable to, or ensures to the benefit of, its members, directors or officers except to the extent permitted under this article.

5. "Certified first responder" means an individual who meets the minimum requirements established by regulations pursuant to section three thousand two of this article and who is responsible for administration of initial life saving care of sick and injured persons.

6. "Emergency medical technician" means an individual who meets the minimum requirements established by regulations pursuant to section three thousand two of this article and who is responsible for administration or supervision of initial emergency medical care and transportation of sick or injured persons.

7. "Advanced emergency medical technician" means an emergency medical technician who has satisfactorily completed an advanced course of training approved by the state council under regulations pursuant to section three thousand two of this article.

8. "State council" means the New York State emergency medical services council established pursuant to this article.

9. "Regional council" means a regional emergency medical services council established pursuant to this article.

10. "Enrolled member" means any member of a voluntary ambulance service or voluntary advanced life support first response service who provides emergency medical care or transportation of sick or injured persons without expectation of monetary compensation.

11. "Advanced life support care" means definitive acute medical care provided, under medical control, by advanced emergency medical technicians within an advanced life support system.

12. "Advanced life support system" means an organized acute medical care system to provide advanced life support care on site or en route to, from, or between general hospitals or other health care facilities.

13. "Advanced life support mobile unit" means an ambulance or advanced life support first response vehicle approved to provide advanced life support services pursuant to this article.

14. "Qualified medical and health personnel" means physicians, registered professional nurses and advanced emergency medical technicians competent in the management of patients requiring advanced life support care.

15. "Medical control" means: (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility and (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state emergency medical services council and the commissioner, and implemented by regional medical advisory committees.

16. "Regional medical advisory committee" means a group of five or more physicians, and one or more non-voting individuals representative of each of the following: hospitals, basic life support providers, advanced life support providers and emergency medical services training sponsor medical directors approved by the affected regional emergency medical services councils.

17. "Advanced life support first response service" means an organization which provides advanced life support care, but does not transport patients.

18. "EMS program agency" means a not-for-profit corporation or municipality designated by the state council and approved by the affected regional council or councils to facilitate the development and operation of an emergency medical services system within a region as directed by the regional council under this article.

19. "Operator" means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of an ambulance service or advanced life support first response service.

20. "Mutual aid agreement" means a written agreement, entered into by two or more ambulance services or advanced life support first response services possessing valid ambulance service or advanced life support first response service certificates

or statements of registration, for the organized, coordinated, and cooperative reciprocal mobilization of personnel, equipment, services, or facilities for back-up or support upon request as required pursuant to a written mutual aid plan. An ambulance service and advanced life support first response service may participate in one or more mutual aid agreements.

21. "Primary territory" means the geographic area or subdivisions listed on an ambulance service certificate or statement of registration within which the ambulance service may receive patients for transport.

SECTION 3002. NEW YORK STATE EMERGENCY MEDICAL SERVICES COUNCIL.

1. There is hereby created in the department of health the New York State emergency medical services council. The state council shall consist of thirty-one members. Fourteen members to the state council shall be appointed by the commissioner and shall be representative of each geographic area of the state. At least one member shall be representative of the interests of the general public. Other members shall be knowledgeable in various aspects of emergency medical services and shall include, but not be limited to, representatives of voluntary ambulance services, advanced life support first response services, ambulance services operating for profit, municipal ambulance services, hospitals, a statewide organization representing volunteer fire services, municipal tax districts providing ambulance services, physicians, and nurses. The commissioner shall also appoint a representative from each regional council, from nominations received from the appropriate regional council. The members of the state council shall elect a chairperson from among the members of the state council by a majority vote of those present, who shall serve for a term of one year and until a successor is elected.

2. The state council shall have the power, by an affirmative vote of a majority of those present, subject to approval by the commissioner, to enact, and from time to time, amend and repeal, rules and regulations establishing minimum standards for ambulance services, ambulance service certification, advanced life support first response services, the provision of prehospital emergency medical care, public education, the development of a statewide emergency medical services system, the provision of ambulance services outside the primary territory specified in the ambulance services' certificate and the training, examination, and certification of certified first responders, emergency medical technicians, and advanced emergency medical technicians; provided, however, that such minimum standards must be consistent with the staffing standards established by section three thousand five-a of this article. Until January first, nineteen hundred ninety-seven, no minimum standards shall be established for services provided by a voluntary ambulance service operating solely pursuant to a statement of registration issued under section three thousand four. The curriculum for certified first responder training shall not exceed fifty-one hours including prerequisites. The state council shall have the same powers granted to regional councils by this article in any region of the state in which a regional council has not been established.

2-a. In furtherance of the powers set forth in subdivision two of this section, the state council shall provide to the trustees of the state university of New York such information and recommendations as may be requested by such trustees to assist such trustees' study of the feasibility of community colleges' and state university of New York agricultural and technical colleges' offering credit and noncredit courses which would satisfy the educational requirements for certification and recertification of emergency medical technicians and advanced emergency medical technicians.

2-b. (This section effective until 7/1/2006) The commissioner, in consultation with the state emergency medical services council, shall develop a pilot program in at least six regions of the state (including the western New York and capital regions) to allow emergency medical technicians and advanced emergency medical technicians who have been in continuous practice, who have demonstrated competence in completion of appropriate continuing education, to renew their certification under subdivision two of this section without requiring the completion of a written examination. In implementing this program the commissioner shall contract with and use the standards established by a nationally recognized organization that certifies emergency medical technicians and advanced emergency medical technicians. However, no pilot program shall include employees of a municipal ambulance service in cities with a population over one million. Renewals of certification under the demonstration program shall be deemed equivalent to renewals under subdivision two of this section for purposes of this article.

Within one year of developing the demonstration program and annually thereafter, the commissioner shall report to the legislature on the impact of the program on the quality of patient care, the effectiveness of the program in retaining certified emergency medical technicians and advanced emergency medical technicians, and the feasibility of replacing the state's certification program with a national certification program.

3. Upon appeal from the appropriate regional council, the state council shall have the power, by an affirmative vote of a majority of those present, to amend, modify and reverse determinations of the regional councils made pursuant to subdivision five of section three thousand three and section three thousand eight of this article. All determinations of the state council respecting applications for ambulance service certificates or statements of registration or respecting the revocation, suspension (except temporary suspension), limitation or annulment of an ambulance service certificate shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made

within sixty days after service in person or by registered or certified mail of a copy of the determination upon the applicant or holder of the certificate.

3-a. Upon appeal from the applicant, the department, or any concerned party, the state council shall have the power, by an affirmative vote of a majority of those present, to amend, modify and reverse determinations of the regional councils made pursuant to subdivision five-a of section three thousand three of this article. All determinations of the state council with respect to exemptions shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail.

4. The term of office of each member shall be two years. Vacancies shall be filled by appointment for the remainder of an unexpired term. The members shall continue in office until the expiration of their terms and until their successors are appointed and have qualified. No member shall be appointed to the state council for more than four consecutive terms.

5. The state council shall meet as frequently as its business may require. The presence of a majority of the members shall constitute a quorum. The members of the state council shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

6. The commissioner, upon request of the state council, shall designate an officer or employee of the department to act as secretary of the state council, and shall assign from time to time such other employees as the state council may require.

7. No civil action shall be brought in any court against any member, officer or employee of the state council for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer or employee of the state council, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

8. The state council shall, after consultation with the department and the regional councils, forward to the commissioner not later than December first an estimate of the amounts needed to provide adequate funding for emergency medical services training including advanced life support at the local level, regional medical emergency services councils, emergency medical services program agencies, the state emergency medical services council or other emergency medical services training programs to carry out the purposes of this article and article thirty-A of this chapter. Such estimate shall be transmitted without change by the commissioner to the governor, the division of the budget, the temporary president of the senate, the speaker of the assembly, and the fiscal and health committees of each house of the legislature.

SECTION 3002-A. STATE EMERGENCY MEDICAL ADVISORY COMMITTEE.

1. There shall be a state emergency medical advisory committee of the state emergency medical services council consisting of twenty-nine members. Twenty-one members shall be physicians appointed by the commissioner, including one from each regional emergency medical advisory committee and an additional physician from the city of New York and at least one pediatrician, one trauma surgeon, and one psychiatrist. Each of the physicians shall have demonstrated knowledge and experience in emergency medical services. There shall be eight non-physician non-voting members appointed by the chairperson of the state council, at least five of whom shall be members of the state emergency medical services council at the time of their appointment. At least one of the eight shall be an emergency nurse, at least one shall be an advanced emergency medical technician, at least one shall be a basic emergency medical technician, and at least one shall be employed in a hospital setting with administrative responsibility for a hospital emergency department or service. The commissioner shall appoint a physician to chair the committee.

2. The committee shall develop and recommend to the state council statewide minimum standards for: (a) medical control; (b) treatment, transportation and triage protocols, including protocols for invasive procedures and infection control; and (c) the use of regulated medical devices and drugs by emergency medical services personnel certified pursuant to this article. The state emergency medical advisory committee, with the consent of the commissioner, may issue advisory guidelines in any of these areas, which shall not have the force and effect of law unless adopted as rules and regulations by the state emergency medical services council. The state emergency medical advisory committee shall advise the state emergency medical services council prior to the issuance of any guidelines. The committee shall also review protocols developed by regional emergency medical advisory committees for consistency with statewide standards.

2-a. Any decision of the state emergency medical advisory committee regarding medical control, protocols for treatment, triage, or transportation, or the use of regulated medical devices may be appealed to the commissioner by any required regional emergency medical services council, regional emergency medical advisory committee, ambulance service or advanced life support service, or certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected.

3. Each member shall have a term of two years, except that five of those first appointed shall have a term of three years. Members may succeed themselves.

4. The committee shall meet as frequently as its business may require. The presence of a majority of the members shall constitute a quorum. The members of the committee shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

5. No civil action shall be brought in any court against any member, officer or employee of the committee for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the committee, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer, or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

SECTION 3003. REGIONAL EMERGENCY MEDICAL SERVICES COUNCILS.

1. The commissioner, with the approval of the state council, shall designate regional emergency medical services councils on or before January first, nineteen hundred seventy-eight but in no event shall the number of regional councils exceed eighteen. Such regional councils shall be established on the basis of application for designation as regional councils submitted by local organizations, the members of which are knowledgeable in various aspects of emergency medical services. Such application shall describe the geographic area to be served and contain a list of nominees for appointment to membership on such regional councils and a statement as to the proposed method of operation in such detail as the commissioner, with the approval of the state council, shall prescribe.

2. Each regional council shall be comprised of at least fifteen but not more than thirty members to be initially appointed by the commissioner, with the approval of the state council, from nominations submitted by local organizations applying for establishment as the regional council. Not less than one-third of the membership of the regional councils shall be representatives of ambulance services and the remaining membership of the regional councils shall consist of, but not be limited to, representatives of existing local emergency medical care committees, physicians, nurses, hospitals, health planning agencies, fire department emergency and rescue squads, public health officers and the general public. The county EMS coordinator, established pursuant to section two hundred twenty-three-b of the county law, of any county within the region shall serve as an ex officio member of the regional council; provided, however, nothing in this subdivision shall prevent a county EMS coordinator from serving as a voting member of a regional council. Members of each regional council shall be residents living within the geographic area to be served by the regional council. The presence of a majority of members shall constitute a quorum.

3. Each regional council shall have the power to:

(a) have a seal and alter the same at pleasure;

(b) acquire, lease, hold, and dispose of real and personal property or any interest therein for its purposes;

(c) make and alter by-laws for its organization and internal management, and rules and regulations governing the exercise of its powers and the fulfillment of its purposes under this article; such rules and regulations must be filed with the secretary of state and the state EMS council;

(d) enter into contracts for employment of such officers and employees as it may require for the performance of its duties; and to fix and determine their qualifications, duties, and compensation, and to retain and employ such personnel as may be required for its purposes; and private consultants on a contract basis or otherwise, for the rendering of professional or technical services and advice;

(e) enter into contracts, leases, and subleases and to execute all instruments necessary or convenient for the conduct of its business, including contracts with the commissioner and any state agency or municipal entity; and contracts with hospitals and physicians for the purposes of carrying out its powers under this article;

(f) undertake or cause to be undertaken plans, surveys, analyses and studies necessary, convenient or desirable for the effectuation of its purposes and powers, and to prepare recommendations and reports in regard thereto;

(g) fix and collect reasonable fees, rents, and other charges for the use of its equipment and the provision of its services;

(h) contract for and to accept any gifts or grants, subsidies, or loans of funds or property, or financial or other aid in any form from the federal or state government or any agency or instrumentality thereof; or from any other source, public or private, and to comply, subject to the provisions of this article, with the terms and conditions thereof; provided, however, that the councils may contract for payment of debt evidenced by bonds or notes or other evidence of indebtedness, either directly or through a lease purchase agreement;

(i) recommend to the department approval of training course sponsors within its region, and to develop, promulgate and implement annually an EMS training plan which addresses the needs of its region;

(j) enter into contracts or memoranda of agreement with other regional councils to provide services in a joint or cooperative manner; and to enter into contracts or memoranda of agreement with an EMS program agency to carry out one or more of its responsibilities under this article;

(k) procure insurance against any loss or liability in connection with the use, management, maintenance, and operation of its equipment and facilities, in such amounts and from such insurers as it reasonably deems necessary;

(l) approve regional medical advisory committee nominees;

(m) provide focused technical assistance and support to those voluntary ambulance services operating under exemptions, to assist such services in progressing toward the uniform standards established pursuant to this section. Such assistance and support shall include, but not be limited to, volunteer recruitment and management training; and

(n) do all things necessary, convenient and desirable to carry out its purposes and for the exercise of the powers granted in this article.

4. Each regional council shall have the responsibility to coordinate emergency medical services programs within its region, including but not limited to, the establishment of emergency medical technician courses and the issuance of uniform emergency medical technician insignia and certificates.

5. The regional council shall have the responsibility to make determinations of public need for the establishment of additional emergency medical services and ambulance services and to make the determinations of public need as provided in section three thousand eight. The regional council shall make such determination by an affirmative vote of a majority of all of those members consisting of voting members.

5-A The regional emergency medical services council is authorized to grant an exemption from the staffing standards set forth in section three thousand five-a of this article to a voluntary ambulance service operating solely with enrolled members or paid emergency medical technicians which has demonstrated a good faith effort to meet the standards and is unable to meet such standards because of factors deemed appropriate by the regional council. An exemption shall be for a period not to exceed two years and shall be conditioned on the participation by the voluntary service in a program to achieve compliance which shall include technical assistance and support from the regional council tailored to the needs and resources at the local level, as provided by paragraph (m) of subdivision three of the section, to be funded by the New York state emergency medical services training account established pursuant to section ninety-seven-q of the state finance law, such account as funded by a chapter of the laws of nineteen hundred ninety-three. Nothing shall prevent the regional council from issuing subsequent exemptions. Such exemptions shall have no effect whatsoever on the insurability of the organization receiving such exemption and such exemption shall not be used as a basis for increasing insurance rates or premiums related thereto, notwithstanding any other provision of law, rule, regulation, or commissioner's ruling or advisory to the contrary. Prior to issuing an exemption, the regional council shall provide written notice by certified mail to the chief executive officers of all general hospitals and municipalities in the county or counties within which the service requesting an exemption operates. Such notice shall provide opportunity for comment on the issuance of the exemption. Notice of the determination of the regional council shall be provided within ten days of the determination to the applicant, the department, and any party receiving notification of the application who requests notice of the determination. The applicant, the department, or any concerned party may appeal the determination of the regional council to the state council within thirty days after the regional council makes its determination.

6. The term of office of members of the regional council shall be four years, except that of those members first appointed, at least one-half but not more than two-thirds shall be for terms not to exceed two years.

7. Each regional council shall meet as frequently as its business may require.

8. The commissioner, upon request of the regional council, may designate an officer or employee of the department to act as secretary of the regional council, and may assign from time to time such other employees as the regional council may require.

9. No civil action shall be brought in any court against any member, officer or employee of any designated regional council for any act done, failure to act, or statement or opinion made, while discharging his duties as a member, officer or employee of the regional council, without leave from a justice of the supreme court, first had and obtained. In any event such member, officer or employee shall not be liable for damages in any such action if he shall have acted in good faith, with reasonable care and upon probable cause.

10. (a) The department shall provide each regional council with the funds necessary to enable such regional council to carry out its responsibilities as mandated under this section within amounts appropriated therefor.

(b) Such funds shall be provided upon approval by the department of an application submitted by a regional council. The application shall contain such information and be in such form as the commissioner shall require pursuant to rules and regulations which he shall promulgate after consultation with the state council in order to effect the purposes and provisions of this subdivision.

SECTION 3003-A. EMS PROGRAM AGENCIES.

1. As provided by agreement with the commissioner or regional councils based on needs identified by the regional emergency medical services councils, an EMS program agency may be responsible for facilitating quality improvement of emergency medical care within its region, staffing the regional emergency medical advisory committees provided for in section three thousand four-a of this article, providing prehospital education programs approved by the department, and other activities to support and facilitate regional emergency medical services systems.

2. The programs developed by the agencies established by subdivision one of this section shall be implemented beginning in nineteen hundred ninety-three using funds collected by the New York state emergency medical services training account, established within the miscellaneous special revenue fund - 339 by section ninety-seven-q of the state finance law.

3. The portion of the funds collected by the emergency medical services training New York state account, established and allocated within the miscellaneous special revenue fund - 339 by section ninety-seven-q of the state finance law, shall be adequate to support the costs incurred in implementing the programs described in subdivision one of this section.

SECTION 3003-b. EMERGENCY MEDICAL SERVICE TRAINING; CABLE TELEVISION

Notwithstanding any other provision of law to the contrary, the department shall allocate funds from the New York state emergency medical services training account established pursuant to section ninety-seven-q of the state finance law for the purpose of establishing a pilot project in the county of Orange under the control and supervision of the Hudson Valley emergency medical service council for the purpose of providing training to emergency medical service field providers by means of cable television or other broadcast medium programming produced by a group such as the Fire Training Education Network. The Hudson Valley emergency medical service council shall on or before December fifteenth, two thousand prepare and file with the commissioner and the state council a report with recommendations concerning, among other things, the effectiveness of such programming in training emergency medical services field providers.

SECTION 3004. REPEALED AS OF JULY 1, 1993.

SECTION 3004-A. REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEES.

1. Regional emergency medical advisory committees shall develop policies, procedures, and triage, treatment, and transportation protocols which are consistent with the standards of the state emergency medical advisory committee and which address specific local conditions. Regional emergency medical advisory committees may also approve physicians to provide on line medical control, coordinate the development of regional medical control systems, and participate in quality improvement activities addressing system-wide concerns. Hospitals and prehospital medical care services shall be authorized to release patient outcome information to regional emergency medical advisory committees for purposes of assessing prehospital care concerns. Regional quality improvement programs shall be presumed to be an extension of the quality improvement program set forth in section three thousand six of this article, and the provisions of subdivisions two and three of such section three thousand six shall apply to such programs.

2. The committee shall nominate to the commissioner a physician with demonstrated knowledge and experience in emergency medical services to serve on the state emergency medical advisory committee.

3. No civil action shall be brought in any court against any member, officer or employee of the committee for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the committee, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer, or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

4. Any decision of a regional emergency medical advisory committee regarding provision of a level of care, including staffing requirements, may be appealed to the state emergency medical advisory committee by any regional EMS council, ambulance service, advanced life support service, certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected. No action shall be taken to implement a decision regarding existing levels of care or staffing while an appeal of such decision is pending. Any decision of the state emergency medical advisory committee may be appealed pursuant to subdivision two-a of section three thousand two-a of this article.

SECTION 3005. AMBULANCE SERVICE CERTIFICATES.

1. No ambulance service operating for profit, hospital ambulance service or municipal ambulance service of a city of over one million population shall operate on or after September first, nineteen hundred seventy-five unless it possesses a valid ambulance service certificate issued pursuant to this article. Effective January first, nineteen hundred ninety-seven, no ambulance service shall be operated unless it possesses a valid ambulance service operating certificate issued pursuant to this article or has been issued a statement of registration. No advanced life support first response service shall operate unless it possesses a valid advanced life support first responder service operating certificate. Effective January first, two thousand, no ambulance service shall be operated unless it possesses a valid operating certificate.

2. The department shall issue an initial certificate to an ambulance service certified prior to the effective date of this section upon submission of proof that it is the holder of a valid ambulance service certificate and is otherwise in compliance with provisions of section three thousand nine of this article.

2-a. Prior to January first, two thousand, the department shall issue an initial certificate to a registered ambulance service in possession of a valid registration provided that such service has been issued an exemption issued by a regional council pursuant to subdivision five-a of section three thousand three of this article.

3. The department shall issue an initial certificate to an advanced life support first response service upon submission of proof that such advanced life support first response service is staffed and equipped in accordance with rules and regulations promulgated pursuant to this article and is otherwise in compliance with provisions of section three thousand nine of this article.

4. A certificate issued to an ambulance service or advanced life support first response service shall be valid for two years. The initial certification fee shall be one hundred dollars. Thereafter the biennial fee shall be in accordance with the schedule of fees established by the commissioner pursuant to this article. However, there shall be no initial or renewal certification fee required of a voluntary ambulance service or voluntary advanced life support first response service.

5. No initial certificate (except initial certificates issued pursuant to subdivision two of this section) shall be issued unless the commissioner finds that the proposed operator or operators are competent and fit to operate the service and that the ambulance service or advanced life support first response service is staffed and equipped in accordance with rules and regulations promulgated pursuant to this article.

6. No ambulance service or advanced life support first response service shall begin operation without prior approval of the appropriate regional council, or if there is no appropriate regional council established such ambulance service or advanced life support first response service shall apply for approval from the state council as to the public need for the establishment of additional ambulance service or advanced life support first response service, pursuant to section three thousand eight of this article.

7. Applications for a certificate shall be made by the owner of an ambulance service or advanced life support first response service operating for profit or the responsible official of a voluntary ambulance service or advanced life support first response service upon forms provided by the department. The application shall state the name and address of the owner and such other information as the department may require pursuant to rules and regulations.

8. For purposes of this article, competent means that any proposed operator of any ambulance service or advanced life support first response service who is already or had been within the last ten years an incorporator, director, sponsor, principal stockholder, or operator of any ambulance service, hospital, private proprietary home for adults, residence for adults, or non-profit home for the aged or blind which has been issued an operating certificate by the state department of social services, or a halfway house, hostel, or other residential facility or institution for the care, custody, or treatment of the mentally disabled subject to the approval by the department of mental hygiene, or any invalid coach service subject to approval by the department of transportation, is rendering or did render a substantially consistent high level of care. For purposes of this subdivision, the state emergency medical services council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to define substantially consistent high level of care with respect to ambulance services, advanced life support first response services, and invalid coaches, except that the commissioner may not find that a consistently high level of care has been rendered where there have been violations of the state EMS code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety, or welfare of any patient, and (ii) were recurrent or were not promptly corrected. For purposes of this article, the rules adopted by the state hospital review and planning council with respect to subdivision three of section twenty-eight hundred one-a of this chapter shall apply to other types of operators. Fit means that the operator or proposed operator (a) has not been convicted of a crime or pleaded nolo contendere to a felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or sale of drugs and (b) is not or was not subject to a state or federal administrative order relating to fraud or embezzlement, unless the commissioner finds that such conviction or such order does not demonstrate a present risk or danger to patients or the public.

SECTION 3005-A. STAFFING STANDARDS; AMBULANCE SERVICES AND ADVANCED LIFE SUPPORT FIRST RESPONSE SERVICES.

1. The following staffing standards shall be in effect unless otherwise provided by this section:

(a) effective January first, nineteen hundred ninety-seven the minimum staffing standard for a registered ambulance service shall be a certified first responder with the patient;

(b) effective January first, two thousand, the minimum staffing standard for a voluntary ambulance service shall be an emergency medical technician with the patient;

(c) the minimum staffing standard for all other ambulance services shall be an emergency medical technician with the patient; and

(d) the minimum staffing standard for an advanced life support first response service shall be an advanced emergency medical technician with the patient. Circumstances permitting other than advanced life support care by an advanced life support first response service may be established by rule by the state council, subject to the approval of the commissioner.

2. Any service granted an exemption by the regional council pursuant to subdivision five-a of section three thousand three of this article shall be subject to the standards and terms of the exemption.

3. Notwithstanding any other provision of the article, the effective date of the standards established by this section shall be delayed by one year for each fiscal year, prior to January first, two thousand, in which the amounts appropriated are less than that which would have been expended pursuant to the provisions of section ninety-seven-q of the state finance law.

SECTION 3005-B. EMERGENCY MEDICAL TECHNICIAN FIVE YEAR RE-CERTIFICATION DEMONSTRATION PROGRAM. [expired and repealed July 1, 2008]

1. There is hereby created within the Department a demonstration program (referred to in this section as the "program") to allow emergency medical technicians and advanced emergency medical technicians who have been in continuous practice and who have demonstrated competence in applicable behavioral and performance objectives, to be re-certified for a five year period. No person shall be re-certified under the program unless he or she has completed at least one hundred thirty hours of instruction in emergency medical services as approved by the commissioner, including, but not limited to pediatrics, geriatrics, environmental emergencies, legal issues, emergency vehicle operations course and medical emergencies. Renewals of certification under the program shall be deemed equivalent to renewals under subdivision two of section three thousand two of this article.

2. This program shall be limited to persons who are in practice in the following counties: Delaware, Fulton, Hamilton, Montgomery, Nassau, Otsego, Schoharie or Suffolk. The commissioner may limit the number of participants in the program, except that such limit shall be no less than one thousand participants

3. Within a year after implementing the program and annually thereafter, the commissioner shall report to the governor and the legislature on the impact of the program on the quality of patient care and the effectiveness of the program in retaining and recruiting certified emergency medical technicians and advanced emergency medical technicians.

4. The commissioner in consultation with the state emergency medical services council, shall make regulations necessary to implement this section.

SECTION 3006. QUALITY IMPROVEMENT PROGRAM.

1. By January first, nineteen hundred ninety-seven, every ambulance service and advanced life support first response service shall establish or participate in a quality improvement program, which shall be an ongoing system to monitor and evaluate the quality and appropriateness of the medical care provided by the ambulance service or advanced life support first response service, and which shall pursue opportunities to improve patient care and to resolve identified problems. The quality improvement program may be conducted independently or in collaboration with other services, with the appropriate regional council, with an EMS program agency, with a hospital, or with another appropriate organization approved by the department. Such program shall include a committee of at least five members, at least three of whom do not participate in the provision of care by the service. At least one member shall be a physician, and the others shall be nurses, or emergency medical technicians, or advanced emergency medical technicians, or other appropriately qualified allied health personnel. The quality improvement committee shall have the following responsibilities:

(a) to review the care rendered by the service, as documented in prehospital care reports and other materials. The committee shall have the authority to use such information to review and to recommend to the governing body changes in administrative policies and procedures, as may be necessary, and shall notify the governing body of significant deficiencies;

(b) to periodically review the credentials and performance of all persons providing emergency medical care on behalf of the service;

(c) to periodically review information concerning compliance with standard of care procedures and protocols, grievances filed with the service by patients or their families, and the occurrence of incidents injurious or potentially injurious to patients. A quality improvement program shall also include participation in the department's prehospital care reporting system and the provision of continuing education programs to address areas in which compliance with procedures and protocols is most deficient and to inform personnel of changes in procedures and protocols. Continuing education programs may be provided by the service itself or by other organizations; and

(d) to present data to the regional medical advisory committee and to participate in system-wide evaluation.

2. The information required to be collected and maintained, including information from the prehospital care reporting system which identifies an individual, shall be kept confidential and shall not be released except to the department or pursuant to section three thousand four-a of this article.

3. Notwithstanding any other provisions of law, none of the records, documentation, or committee actions or records required pursuant to this section shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided in any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition related to disclosure of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject of which was reviewed at the meeting. The prohibition of disclosure of information from the prehospital care reporting system shall not apply to information which does not identify a particular ambulance service or individual.

4. Any person who in good faith and without malice provides information to further the purpose of this section or who, in good faith and without malice, participates on the quality improvement committee shall not be subject to any action for civil damages or other relief as a result of such activity.

SECTION 3007. NOTICE OF ALTERNATIVE DESTINATION.

In any city having a population of one million or more, whenever an individual is transported by ambulance from one facility to a second facility and the destination is changed, it shall be the responsibility of the senior ambulance dispatcher to inform the facility of origin by telephone of the ultimate destination immediately upon arrival thereat.

SECTION 3008. APPLICATIONS FOR DETERMINATIONS OF PUBLIC NEED.

1. Every application for a determination of public need shall be made in writing to the appropriate regional council, shall specify the primary territory within which the applicant requests to operate, be verified under oath, and shall be in such form and contain such information as required by the rules and regulations promulgated pursuant to this article.

2. Notice of the application shall be forwarded by registered or certified mail by the appropriate regional council to the chief executive officers of all general hospitals, ambulance services, and municipalities operating within the same county or counties where the services seeks to operate. The notice shall provide opportunity for comment.

3. Notice pursuant to this section shall be deemed filed with the ambulance service and municipality upon being mailed by the appropriate regional or state council by registered or certified mail.

4. The appropriate regional council or the state council shall make its determination of public need within sixty days after receipt of the application.

5. The applicant or any concerned party may appeal the determination of the appropriate regional council to the state council within thirty days after the regional council makes its determination.

6. In the case of an application for certification under this article by a municipal ambulance service to serve the area within the municipality, and the municipal ambulance service meets appropriate training, staffing and equipment standards, there should be a presumption in favor of approving the application.

7-a. Notwithstanding any other provision of law and subject to the provisions of this article, any municipality within this state, or fire district acting on behalf of any such municipality, and acting through its local legislative body, is hereby authorized and empowered to adopt and amend local laws, ordinances or resolutions to establish and operate advanced life support first responder services or municipal ambulance services within the municipality, upon meeting or exceeding all standards set by the department for appropriate training, staffing and equipment, and upon filing with the New York State Emergency Medical Services Council, a written request for such authorization. Upon such filing, such municipal advanced

life support first responder service or municipal ambulance service shall be deemed to have satisfied any and all requirements for determination public need for the establishment of additional emergency medical services pursuant to this article for a period of two years following the date of such filing. Nothing in this article shall be deemed to exclude the municipal advanced life support first responder service or municipal ambulance service authorized to be established and operated pursuant to this article from complying with any other requirement or provision of this article or any other applicable provision of law.

7-b. In the case of an application for certification pursuant to this subdivision, for a municipal advanced life support or municipal ambulance service, to serve the area within the municipality, where the proposed service meets or exceeds the appropriate training, staffing and equipment standards, there shall be a strong presumption in favor of approving the application.

SECTION 3009. CONTINUATION OF EXISTING SERVICES.

1. Notwithstanding the provisions of sections three thousand four and three thousand five of this article, if any ambulance service or a predecessor in interest was in bona fide operation as an ambulance service on April first, nineteen hundred seventy-five, within the territory for which application for an ambulance service certificate or voluntary ambulance service statement of registration is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate or statement of registration without requiring proof that there is a public need for such ambulance service and without further proceedings, provided application for such certificate or statement of registration is submitted to the department in accordance with this article prior to September first, nineteen hundred seventy-five. Pending the determination of any such application the continuance of such operation shall be lawful. In all other cases the application shall be decided in accordance with the procedures provided for in section three thousand four, or three thousand five of this article and such application shall be approved or denied accordingly. An application pursuant to this section shall be deemed filed with the department upon being mailed to the department by registered or certified mail.

2. Notwithstanding the provisions of section three thousand five of this article, if any advanced life support first response service or a predecessor in interest was in bona fide operation as an advanced life support first response service at the intermediate, critical care, or paramedic level on January first, nineteen hundred ninety-three, within the territory for which application for a certificate is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate without requiring that there is a public need for such service and without further proceedings, provided application for such certificate or statement of registration is submitted to the department in accordance with this article prior to January first, nineteen hundred ninety-four. Notwithstanding the provisions of section three thousand five of this article, if any advanced life support first response service or a predecessor in interest was in bona fide operation as an advanced life support first response service at the EMT-defibrillation level on July first, nineteen hundred ninety-three, within the territory for which application for a certificate is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate without requiring that there is a public need for such service and without further proceedings, provided application for such certificate or statement of registration is submitted to the department in accordance with this article prior to January first, nineteen hundred ninety-four. Pending the determination of any such application, the continuance of such operation shall be lawful. In all other cases the application shall be decided in accordance with the procedures provided in section three thousand five of this article and such application shall be approved or denied accordingly. An application pursuant to this section shall be deemed filed with the department upon being mailed to the department by certified or registered mail.

SECTION 3010. AREA OF OPERATION; TRANSFERS.

1. Every ambulance service certificate or statement of registration issued under this article shall specify the primary territory within which the ambulance service shall be permitted to operate. An ambulance service shall receive patients only within the primary territory specified on its ambulance service certificate or statement of registration, except:

- (a) when receiving a patient which it initially transported to a facility or location outside its primary territory;
- (b) as required for the fulfillment of a mutual aid agreement authorized by the regional council;
- (c) upon express approval of the department and the appropriate regional emergency medical services council for a maximum of sixty days if necessary to meet an emergency need; provided that in order to continue such operation beyond the

sixty day maximum period necessary to meet an emergency need, the ambulance service must satisfy the requirements of this article, regarding determination of public need and specification of the primary territory on the ambulance service certificate or statement of registration; or

(d) an ambulance service or advanced life support first response service organization formed to serve the need for the provision of emergency medical services in accordance with the religious convictions of a religious denomination may serve such needs in an area adjacent to such primary territory and, while responding to a call for such service, the needs of other residents of such area at the emergency scene. Any ambulance service seeking to operate in more than one region shall make application to each appropriate regional council. Whenever an application is made simultaneously to more than one regional council, the applications submitted to the regional councils shall be identical, or copies of each application shall be submitted to all the regional councils involved.

2. No ambulance service certificate shall be transferable unless the regional council and the department reviews and approves the transfer as follows:

(a) Any change in the individual who is the sole proprietor of an ambulance service shall only be approved upon a determination that the proposed new operator is competent and fit to operate the service.

(b) Any change in a partnership which is the owner of an ambulance service shall be approved based upon a determination that the new partner or partners are competent and fit to operate the service. The remaining partners shall not be subject to a character and fitness review.

(c) Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the owner of an ambulance service, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of ten percent or more of the stock or voting rights thereunder by any person, shall be approved based upon a determination that the new stockholder or stockholder proposing to obtain ten percent or more of the stock or voting rights thereunder of such corporation is competent and fit to operate the service. The remaining stockholders shall not be subject to a character and fitness review.

(d) Any transfer of all or substantially all of the assets of a corporation which owns or operates a certified ambulance service shall be approved based upon a determination that the individual, partnership, or corporation proposing to obtain all or substantially all of the assets of the corporation is competent and fit to operate the service.

(e) Any transfer affected in the absence of the review and approval required by this section shall be null and void and the certificate of such ambulance service shall be subject to revocation or suspension.

3. Nothing contained in this section shall be construed to prohibit any voluntary ambulance service authorized by its governing authority to do so from transporting any sick or injured resident of its primary territory from any general hospital or other health care facility licensed by the department, whether or not such general hospital or health care facility is within the service's primary territory, to any other general hospital or health care facility licensed by the department for further care, or to such resident's home. Nothing contained in this section shall be construed to prohibit any proprietary ambulance service authorized by its governing body to do so from transporting any sick or injured patient from any general hospital or other health care facility licensed by the department whether or not such general hospital or health care facility is within the service's primary territory, to any other general hospital or health care facility licensed by the department within the service's primary territory for further care, or to such patient's home, if such patient's home is within its primary territory. Any ambulance service owned by or under contract to a general hospital licensed by the department may transport any specialty patient from any other general hospital or health care facility licensed by the department to the hospital owning such ambulance service, or with which it has a contract. Categories of specialty patients shall be defined by rule by the state emergency medical services council, subject to the approval of the commissioner.

4. No ambulance service certificate of an ambulance service which has discontinued operations for a continuous period in excess of thirty days shall be transferable without the approval of the appropriate regional council.

SECTION 3011. POWERS AND DUTIES OF THE DEPARTMENT AND THE COMMISSIONER.

1. The department may inquire into the operation of ambulance services and advanced life support first response services and conduct periodic inspections of facilities, communication services, vehicles, methods, procedures, materials, staff and equipment. It may also evaluate data received from ambulance services and advanced life support first response services.

2. The department may require ambulance services and advanced life support first response services to submit periodic reports of calls received, services performed and such other information as may be necessary to carry out the provisions of this article.

3. The commissioner, with the advice and consent of the state council, shall designate not more than eighteen geographic areas within the state wherein a regional emergency medical services council shall be established. In making the determination of a geographic area, the commissioner shall take into consideration the presence of ambulance services,

hospital facilities, existing emergency medical services committees, trained health personnel, health planning agencies and communication and transportation facilities; and shall establish a separate regional emergency medical services council for the county of Nassau. The commissioner shall promote and encourage the establishment of a regional emergency medical services council in each of said designated areas.

4. The commissioner may propose rules and regulations and amendments thereto for consideration by the state council. The commissioner shall establish a schedule of certification fees for ambulance services and advanced life support first response services other than voluntary ambulance services and voluntary advanced life support first response services.

5. For the purpose of promoting the public health, safety and welfare the commissioner is hereby authorized and empowered to contract with voluntary ambulance services and municipal ambulance services, or with the fire commissioners of fire districts operating voluntary ambulance services, upon such terms and conditions as he shall deem appropriate and within amounts made available therefor, for reimbursement of the necessary and incidental costs incurred by such ambulance services in order to effectuate the provisions of this article.

6. The commissioner is hereby authorized, for the purposes of effectuating the provisions of this article in the development of a statewide emergency medical service system, to contract with any ambulance service or with the fire commissioners of fire districts operating certified voluntary ambulance services for the use of necessary equipment upon such terms and conditions as the commissioner shall deem appropriate.

7. The commissioner may recommend to the state council minimum qualifications for certified first responders (which shall not exceed fifty-one hours), emergency medical technicians and advanced emergency medical technicians in all phases of emergency medical technology including but not limited to, communications, first aid, equipment, maintenance, emergency techniques and procedures, patient management and knowledge of procedures and equipment for emergency medical care.

8. The commissioner shall provide every certified ambulance service and advanced life support first response service with an official insignia which may be attached to every vehicle owned or operated by a certified ambulance service or advanced life support first response service.

9. The department shall provide the state council with such assistance as the council may request in order to carry out its responsibilities as set forth in subdivision two-a of section three thousand two of this article.

10. The commissioner is hereby authorized and empowered to extend the certification for emergency medical technicians or advanced emergency medical technicians who have been federally ordered to active military duty, other than for training, related to the Persian Gulf crisis and whose certification will expire during their military duty. The extended certification shall be for the period of military duty and for six months after they have been released from active military duty.

11. The commissioner, with the advice and consent of the state council, shall promulgate rules and regulations necessary to ensure compliance with the provisions of subdivision two of section sixty-seven hundred thirteen of the education law.

SECTION 3012. ENFORCEMENT.

1. Any ambulance service or advanced life support first response service certificate issued pursuant to section three thousand five of this article may be revoked, suspended, limited or annulled by the department upon proof that the operator or certificate holder or one or more enrolled members or one or more persons in his employ:

(a) has been guilty of misrepresentation in obtaining the certificate or in the operation of the ambulance service or advanced life support first response service; or

(b) has not been competent in the operation of the service or has shown inability to provide adequate ambulance services or advanced life support first response service; or

(c) has failed to pay the biennial certification fee as required except in the case of any voluntary ambulance service or voluntary advanced life support first response service; or

(d) has failed to file any report required by the provisions of this article or the rules and regulations promulgated thereunder; or

(e) has violated or aided and abetted in the violation of any provision of this article, the rules and regulations promulgated or continued thereunder, or the state sanitary code; or

(f) had discontinued operations for a period in excess of one month; or

(g) a voluntary ambulance service or voluntary advanced life support first response service has failed to meet the minimum staffing standard and has not been issued an exemption, except that such certificate shall not be suspended or

revoked unless the commissioner finds that an adequate alternative service exists. The commissioner shall consider the recommendation of the regional emergency medical services council in making a finding; or

(h) an ambulance service operating for profit has failed to meet the minimum staffing standard; or

(i) has been convicted of a crime or pleaded nolo contendere to a felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or sale of drugs, unless the commissioner finds that such conviction does not demonstrate a present risk or danger to patients or the public; or

(j) is or was subject to a state or federal administrative order relating to fraud or embezzlement, unless the commissioner finds that such order does not demonstrate a present risk or danger to patients or the public.

2. Proceedings under this section may be initiated by any person, corporation, association, or public officer, or by the department by the filing of written charges with the department. Whenever the department seeks revocation or suspension of a certificate of an ambulance service or an advanced life support first response service, a copy of the charges shall be referred to the appropriate regional council for review and recommendation to the department prior to a hearing. Such recommendation shall include a determination as to whether the public need would be served by a revocation, suspension, annulment or limitation. If there is no appropriate regional council established, the state council shall make such determination and present to the department its recommendations.

3. No certificate shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended without a hearing and without the approval of the appropriate regional council or state council for a period not in excess of thirty days upon notice to the certificate holder following a finding by the department that the public health, safety or welfare is in imminent danger.

4. The commissioner shall fix a time and place for the hearing. A copy of the charges and the recommendations of the appropriate regional council or state council together with the notice of the time and place of the hearing, shall be mailed to the certificate holder by registered or certified mail, at the address specified on the certificate, at least fifteen days before the date fixed for the hearing. The appropriate regional council may be a party to such hearing. The certificate holder may file with the department, not less than five days prior to the hearing, a written answer to the charges.

SECTION 3013. IMMUNITY FROM LIABILITY.

1. Notwithstanding any inconsistent provision of any general, special or local law, a voluntary ambulance service or voluntary advanced life support first response service described in section three thousand one of this article and any member thereof who is a certified first responder, an emergency medical technician, an advanced emergency medical technician or a person acting under the direction of an emergency medical technician or advanced emergency medical technician and who voluntarily and without the expectation of monetary compensation renders medical assistance in an emergency to a person who is unconscious, ill or injured shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such medical assistance in an emergency unless it is established that such injuries were or such death was caused by gross negligence on the part of such certified first responder, emergency medical technician or advanced emergency medical technician or person acting under the direction of an emergency medical technician or advanced emergency medical technician

2. Nothing in this section shall be deemed to relieve any such voluntary ambulance service or voluntary advanced life support first response service from liability for damages or injuries or death caused by an act or omission on the part of any person other than a certified first responder, an emergency medical technician, advanced emergency medical technician or person acting under the direction of an emergency medical technician or advanced emergency medical technician acting in behalf of the voluntary ambulance service or voluntary advanced life support first response service.

3. Nothing in this section shall be deemed to relieve or alter the liability of any such voluntary ambulance service or members for damages or injuries or death arising out of the operation of motor vehicles.

4. A certified first responder, emergency medical technician or advanced emergency medical technician, whether or not he or she is acting on behalf of an ambulance service, or advanced life support first response service, who voluntarily and without the expectation of monetary compensation renders medical assistance in an emergency to a person who is unconscious, ill or injured shall not be liable for damages alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such medical assistance in an emergency unless it is established that such injuries were or such death was caused by gross negligence on the part of such certified first responder, emergency medical technician or advanced emergency medical technician.

5. Notwithstanding any inconsistent provision of any general, special or local law, any physician who voluntarily and without the expectation of monetary compensation provides indirect medical control, as defined in paragraph (b) of subdivision fifteen of section three thousand one of this article, to a voluntary ambulance service or voluntary advanced life

support first response service described in section three thousand one of this article shall not be liable for damages for injuries or death alleged to have been sustained by any person as a result of such medical direction unless it is established that such injuries or death were caused by gross negligence on the part of such physician.

SECTION 3014. CONSTRUCTION.

Notwithstanding any inconsistent provision of any general, special or local law, the provisions of this article shall be deemed to apply to the city of New York.

SECTION 3015. SEPARABILITY.

If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this article directly involved in the controversy in which the judgment shall have been rendered.

SECTION 3016. CONTINUANCE OF RULES AND REGULATIONS.

All rules and regulations heretofore adopted by the commissioner pertaining to all ambulance services shall continue in full force and effect as rules and regulations until duly modified or superseded by rules and regulations hereafter adopted and enacted by the state council pursuant to section three thousand two of this article.

SECTION 3017. EMERGENCY MEDICAL SERVICE, SUFFOLK COUNTY.

[effective until 1/1/2003]

1. No ambulance service or advanced life support first response service shall respond to any call or request for emergency medical services within a town, village or fire district in Suffolk County that currently provides ambulance service or advanced life support services first response service, if the municipality has designated one or more ambulance services or advanced life support first response services to respond to such calls unless:

- (a) the service is so designated;
- (b) the response is in accordance with a mutual aid plan approved by the appropriate regional emergency medical services council;
- (c) the response is to a verbal mutual aid request from a designated service;
- (d) the service was specifically requested to respond by the patient or someone acting on behalf of that patient; or
- (e) the response site is a hospital licensed under Article 28 of this chapter for a transfer to another such facility.

2. Every ambulance service or advanced life support first response service shall disclose as part of any solicitation or advertisement in Suffolk County that there is a fee for services rendered, if in fact there is a fee charged for the performance of such service.

3. Every ambulance service or advanced life support first response service that operates in Suffolk County and has vehicles which travel through communities with designated ambulance service or advanced life support first response service shall require its drivers and emergency medical technicians:

- (a) to immediately notify a central alarm or other publicly operated dispatch entity, or a person designated under Section 209-b of the general municipal law to receive calls for emergency services for the purpose of dispatching emergency medical services whenever an emergency is found in a public place;
- (b) to evaluate the need to transport any patient found in extremis to a hospital; and
- (c) to comply with appropriate instructions from the dispatch entity. The dispatch entity, when appropriate, may instruct the service to transport any patient to an appropriate hospital.

SECTION 3030. ADVANCED LIFE SUPPORT SERVICES.

Advanced life support services provided by an advanced emergency medical technician, shall be

- (1) provided under the direction of qualified medical and health personnel utilizing patient information and data transmitted by voice or telemetry,

- (2) limited to the category or categories in which the advanced emergency medical technician is certified pursuant to this article, and
- (3) recorded for each patient, on an individual treatment-management record.

SECTION 3031. ADVANCED LIFE SUPPORT SYSTEM.

Advanced life support system must

- (1) be under the overall supervision and direction of a qualified physician with respect to the advanced life support services provided,
- (2) be staffed by qualified medical and health personnel,
- (3) utilize advanced emergency medical technicians whose certification is appropriate to the advanced life support services provided,
- (4) utilize advanced support mobile units appropriate to the advanced life support services provided,
- (5) maintain a treatment-management record for each patient receiving advanced life support services, and
- (6) be integrated with a hospital emergency, intensive care, coronary care or other appropriate service.

SECTION 3032. RULES AND REGULATIONS.

The state council, with the approval of the commissioner, shall promulgate rules and regulations to effectuate the purposes of sections three thousand thirty and three thousand thirty-one of this article.

SECTION 3050. SHORT TITLE.

This article shall be known and may be cited as the "emergency medical services personnel training act of nineteen hundred eighty-six".

SECTION 3051. DECLARATION OF PURPOSE.

Emergency medical services provided to those suffering from sudden illness or injury have potential to reduce the incidence of disability and death and are therefore, invaluable. A training program of high quality is the key to assuring that emergency medical services personnel have the knowledge and skills to care for acutely ill and injured patients in a manner which will prevent further illness and injury. There is therefore a need to provide flexible, diverse and high quality training opportunities which are reasonably available, particularly to volunteers who devote considerable time, effort, and often personal resources, to improve or retain their knowledge and skills. The state has a responsibility to support and further the work of those who provide emergency medical care by providing needed instructional resources.

The purpose of this article is to expand and improve training opportunities for emergency medical service personnel, thereby benefiting all the residents of New York state who rely on the services of these personnel.

SECTION 3052. ESTABLISHMENT OF A TRAINING PROGRAM FOR EMERGENCY MEDICAL SERVICES PERSONNEL.

- 1. There is hereby established a training program for emergency medical services personnel including, but not limited to, first responders, emergency medical technicians, advanced emergency medical technicians and emergency vehicle operators.
- 2. The commissioner shall provide state aid within the amount appropriated to entities such as local governments, regional emergency medical services councils, and voluntary agencies and organizations to conduct training courses for emergency medical services personnel and to conduct practical examinations for certification of such personnel. The commissioner shall establish a schedule for determining the amount of state aid provided pursuant to this section.

(a) Such schedule may include varying rates for distinct geographic areas of the state and for various course sizes, giving special consideration to areas with the most need for additional emergency medical technicians. In determining the need for additional emergency medical technicians, the commissioner shall use measurements such as the average number of emergency medical technicians per ambulance service, the ratio of emergency medical technicians per square mile, the average number of calls per service and the percentage of calls to which an emergency medical technician has responded, provided such data is available to the commissioner.

(b) Such schedule shall provide sufficient reimbursement to permit sponsors to offer basic emergency medical technician courses which adhere to curricula approved by the New York state emergency medical services council and the commissioner without the need to charge tuition to participants.

3. Upon request, the commissioner shall provide management advice and technical assistance to regional emergency medical services councils, county emergency medical services coordinators, and course sponsors and instructors to stimulate the improvement of training courses and the provision of courses in a manner which encourages participation. Such advice and technical assistance may relate to, but need not be limited to the location, scheduling and structure of courses.

4. The department is authorized, either directly or through contractual arrangement, to develop and distribute training materials for use by course instructors and sponsors, to recruit additional instructors and sponsors, and to provide training courses for instructors.

5. The commissioner shall conduct a public service campaign to recruit additional volunteers to join ambulance services targeted to areas in need for additional emergency medical technicians.

SECTION 3053. REPORTING

Advance life support first response services and ambulance services registered or certified pursuant to article thirty of this chapter shall submit detailed individual call reports on a form to be provided by the department, or may submit data electronically in a format approved by the department. The state emergency medical services council, with the approval of the commissioner, may adopt rules and regulations permitting or requiring ambulance services whose volume exceeds twenty thousand calls per year to submit call report data electronically. Such rules shall define the data elements to be submitted, and may include requirements that assure availability of data to the regional emergency medical advisory committee.

NOTES

Section Twelve

10 NYCRR Part 800 – Emergency Medical Services Code

**CHAPTER VI OF TITLE 10 (HEALTH)
of the
Official Compilation of Codes, Rules and Regulations**

STATE EMERGENCY MEDICAL SERVICES CODE

PART 800

EMERGENCY MEDICAL SERVICES

Amendments:

- 800.15 regarding AED became effective October 19, 1994**
- 800.21 regarding ambulance service policies and reporting, effective November 30, 1994**
- 800.20 regarding course curricula, effective July 15, 1998**

Statutory Authority: Public Health Law, Article 30

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services
433 River Street, 6th Fl.
Troy, NY 12180-2299
518-402-0996**

**CHAPTER VI TITLE 10 (HEALTH)
STATE EMERGENCY MEDICAL SERVICES CODE
PART 800**

General

Section

- 800.1 Title**
- 800.2 Applicability of other Laws, Codes, Rules and Regulations**
- 800.3 Definitions**
- 800.4 Signs and Advertisements**
- 800.5 Requirements for an advanced life support system**

Emergency Medical Services Personnel

- 800.6 Initial Certification Requirements**
- 800.7 Reexaminations**
- 800.8 Recertification Requirements**
- 800.9 Continuing Education**
- 800.10 Reexaminations**
- 800.11 Advanced Emergency Medical Technician Certification**
- 800.12 Reciprocal Certification Requirements**
- 800.13 Certification**
- 800.14 Emergency Medical Technicians Certified by States Bordering New York**
- 800.15 Required Conduct**
- 800.16 Suspension or Revocation of Certification**
- 800.17 Period of Certification**
- 800.18 Lapsed Certification**
- 800.19 Demonstration Projects**
- 800.20 Course Sponsors**

Certified Ambulance Services

- 800.21 General Requirements**
- 800.22 Requirements for Certified Ambulance Vehicle Construction**
- 800.23 General Requirements Related to Equipment**
- 800.24 Equipment Requirements for Certified Ambulance Service**
- 800.25 Special Use Vehicles**
- 800.26 Emergency Ambulance Service Vehicle Equipment Requirements**

Aircraft and Boats

800.27 Aircrafts and Boats

Pre-hospital DNR Orders

800.90 Non-hospital Orders Not to Resuscitate General

SECTION 800.1 TITLE

This Chapter shall be known and may be cited as the "State Emergency Medical Services Code."

800.2 APPLICABILITY OF OTHER LAWS, CODES, RULES AND REGULATIONS

Except as otherwise provided in this Chapter, ambulance services shall comply with all pertinent Federal laws, State laws and those provisions of county, city, town and village charters, special and local laws, ordinances and any codes, rules or regulations promulgated thereunder having general application thereto.

800.3 DEFINITIONS

The following definitions shall apply to this Chapter unless the context otherwise requires:

- (a) Department means the New York State Department of Health.
- (b) Commissioner means the State Commissioner of Health.
- (c) Person means an individual, partnership, association, corporation or any other legal entity whatsoever.
- (d) Emergency medical service means a service engaged in providing initial emergency medical assistance including, but not limited to, the treatment of trauma, burns and respiratory, circulatory and obstetrical emergencies.
- (e) Ambulance means a motor vehicle, airplane, boat or other form of transport especially designed and equipped to provide emergency medical services during transit.
- (f) Ambulance service means a person engaged in providing emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft or other form of transportation to facilities providing hospital services.

(g) **Voluntary ambulance service** means an ambulance service (i) operating not for financial profit and (ii) no part of the assets or income of which is distributable to, or enures to the benefit of, its members, directors or officers except to the extent permitted under article 30.

(h) **Municipal ambulance service** means an ambulance service operated by a municipality or agency thereof and staffed by municipal employees or an ambulance service operated by a county or agency thereof and staffed by county employees.

(i) **Hospital ambulance service** means an ambulance service owned and operated by a hospital as defined in article 28 of the Public Health Law.

(j) **Certified ambulance service** means an ambulance service having an ambulance service certificate issued by the department pursuant to section 3005 or 3006 of the Public Health Law.

(k) **Certificate of inspection** means a windshield sticker affixed to the lower right hand corner of the windshield of the ambulance. The sticker signifies that the vehicle has been inspected and approved by the Department for operation in a certified ambulance service.

(l) **New vehicle** means a vehicle of recent manufacture placed in service for the first time.

(m) **Emergency ambulance service vehicle** means a vehicle that is owned or operated by an ambulance service that is used to transport emergency medical personnel and equipment to sick or injured persons.

(n) **Emergency medical technician** means a person certified as either an advanced emergency medical technician or an emergency medical technician-basic pursuant to these regulations.

(o) **Emergency medical technician-basic** means a person certified pursuant to these regulations as an emergency medical technician-basic.

(p) **Advanced emergency medical technician** means a person certified pursuant to these regulations as an emergency medical technician-intermediate, an emergency medical technician-critical care, or an emergency medical technician-paramedic.

(q) **State Council** means the New York State Emergency Medical Services Council established pursuant to section 3002 of article 30 of the Public Health Law.

(r) **Regional Council** means a regional emergency medical services council established pursuant to section 3003 of article 30 of the Public Health Law.

(s) **Certified first responder** means a person certified pursuant to these regulations as a first responder.

(t) **Certified instructor coordinator** means a person certified pursuant to these regulations to serve as the lead instructor for courses leading to certification as an emergency medical technician or certified first responder.

(u) **Advanced life support system** means a method for the provision of initial emergency medical assistance under medical direction and supervision including, but not limited to, one or more of the following services:

- (1) administration of intravenous fluids;
- (2) administration of drugs;
- (3) intubation;
- (4) manual defibrillation; and
- (5) other services as approved by the commissioner and council.

(v) Primary territory means that area listed on an ambulance service certificate or certificate of registration in which the service may receive (pick up) patients.

(w) Certified laboratory instructor means a person certified pursuant to these regulations to instruct in psychomotor skills, candidates in courses leading to certification as an emergency medical technician or certified first responder.

(x) Course Sponsor means a person approved by the department to conduct EMS Educational Programs as one or more of the following specific types of course sponsor:

(1) Basic Life Support Sponsor - a course sponsor authorized by the department to conduct original and refresher CFR, EMT and EMT-D courses.

(2) Advanced Life Support Sponsor - a course sponsor authorized by the department to conduct all basic life support courses, EMT-I and EMT-CC original and refresher courses, and the EMT-P original and refresher courses.

(3) Continuing Education Course Sponsor - a course sponsor authorized by the department to conduct one or more of the following courses: Critical Trauma Care, Ambulance Accident Prevention Seminar, Combined EMT refresher/CTC, Certified Instructor Coordinator, Certified Lab Instructor, Certified Instructor Update, Prehospital Pediatric Care Course, EMS Dispatcher Course, Crash Victim Extrication, Emergency Vehicle Operator, Infection Control Workshop, or other continuing education courses developed by the department. Approval as a continuing education course sponsor is specific to the actual courses that the sponsor is authorized to offer and not all sponsors will be approved to offer all types of courses.

(y) Learning Contract means an informal written agreement between a student and a course sponsor which specifies requirements to complete the course and the policies of the sponsor.

(z) DNR bracelet means an item meeting the Department of Health specification in section 800.90 of this Part which may be worn by a person who has been issued a valid non-hospital order not to resuscitate.

(aa) Automated External Defibrillation (AED) means defibrillation by a certified first responder, emergency medical technician or advanced emergency medical technician using an external defibrillator that incorporates an electronic rhythm analysis system that limits the delivery of an electrical counter shock to a rhythm for which defibrillation is medically indicated. The external defibrillator may be either a fully automatic or semiautomatic (shock-advisory) type.

(bb) "mutual aid agreement" means a written agreement, entered into by two or more ambulance services or advanced life support first response services for the organized, coordinated and cooperative reciprocal mobilization of personnel, equipment, services or facilities for back-up or support upon request as required pursuant to a written mutual aid plan.

(cc) "call receipt interval" means the elapsed time from receipt of a request for emergency assistance by the service or its dispatch agency to the time a staffed ambulance or ALSFR vehicle is en route to the reported location of the incident.

(dd) "Advanced life support (ALS) care" means definitive acute medical care provided under medical control, by advanced emergency medical technicians within an advanced life support system.

(ee) "Advanced life support first responder (ALSFR) service" means any person or organization which provides advanced life support care, but does not transport patients.

(ff) "Advanced life support first response (ALSFR) vehicle" means a designated vehicle or conveyance operated by an ALSFR service, which brings advanced life support equipment and personnel authorized to provide ALS care to a location to provide such care.

(gg) "Quality improvement program" means a program which seeks to improve and enhance the quality and appropriateness of patient care and clinical performance of the service.

(hh) "Governing authority" means in the case of a fire district, the board of fire commissioners; or in the case of a municipality, the municipality's legislative body; or in the case of a corporation, the board of directors; or in the case of a hospital, the governing body; or in the case of a partnership, each of the partners; or in the case of a sole proprietorship, the proprietor; or in the case of an unincorporated association all the members of the association.

(ii) "EMS service" means an ambulance service or an advanced life support first response service.

(jj) "Authorized EMS response vehicle" means any vehicle, conveyance, boat or aircraft meeting the requirements of this part authorized by the governing authority and operated by an EMS service for the purpose of providing certified personnel and equipment to an event dispatched as an EMS response.

800.4 SIGNS AND ADVERTISEMENTS

(a) The word "ambulance" may not be displayed on a vehicle, aircraft, or boat except on a vehicle, aircraft, or boat registered with the department as an ambulance except to comply with 800.21(e).

(b) Services desiring to advertise the operation of aircraft and boats shall comply with the requirements of this Part.

800.5 REQUIREMENTS FOR AN ADVANCED LIFE SUPPORT SYSTEM

(a) An advanced life support system must meet the following requirements:

(1) designation of a qualified physician to provide medical supervision and direction;

(2) integration with a hospital emergency service, or intensive care, coronary care, or other appropriate hospital unit.

(b) An ambulance, when providing advanced life support services, must meet the requirements of Sections 800.23 and 800.24 of this Part and utilize a treatment record provided by or approved by the department, including submission of such record for use in quality assurance programs.

(c) An advanced life support system providing prehospital intermediate care must include the following:

- (1) voice communications to receive medical direction;
- (2) equipment and supplies to provide prehospital intermediate care; and
- (3) staffing by a certified emergency medical technician-intermediate, emergency medical technician-critical care; or emergency medical technician-paramedic, as appropriate.

(d) An advanced life support system providing prehospital critical care and/or EMT-Paramedic services must include the following:

- (1) voice communications to receive medical direction;
- (2) bio-telemetry;
- (3) equipment and supplies to provide prehospital critical care and/or EMT-paramedic services; and
- (4) staffing by a certified emergency medical technician-critical care or emergency medical technician-paramedic, as appropriate.

Emergency Medical Services Personnel

800.6 INITIAL CERTIFICATION REQUIREMENTS

To qualify for initial certification, an applicant shall:

(a) file a completed application bearing the applicant's original signature in ink with the department on a form provided by the department;

(b) be at least 18 years of age prior to the last day of the month in which he/she is scheduled to take the written certification examination, except that a certified first responder must be at least 16 years of age prior to the last day of the month scheduled to take the written certification examination;

(c) satisfactorily complete the requirements of a state-approved course in emergency medical technology given by a state-approved course sponsor at one of the following levels for which certification is available:

- (1) certified first responder (CFR);
- (2) emergency medical technician-basic (EMT);
- (3) emergency medical technician-defibrillation (EMT-D);
- (4) emergency medical technician-intermediate (EMT-I);
- (5) emergency medical technician-critical care (EMT-CC);
- (6) emergency medical technician-paramedic (EMT-P);
- (7) certified laboratory instructor (CLI); or
- (8) certified instructor coordinator (CIC).

(d) after completion of all course requirements, but within one year thereafter, pass the state practical skills examination, if applicable, for the level at which certification is sought;

(e) within one year after passing the practical skills examination, pass the state written certification examination for the level at which certification is sought except at the certified instructor coordinator level and certified lab instructor level; and

(f) not have any convictions for a crime or crimes related to murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs or currently be under charges for such a crime, unless the department finds that such conviction or charges do not demonstrate a present risk or danger to patients.

800.7 REEXAMINATIONS - APPLICANTS FOR INITIAL CERTIFICATION

(a) Candidates who have failed the practical skills examination must complete a refresher or an original certification course for the level of certification sought prior to being admitted to another practical skills examination at the same level of certification. Such candidates may be admitted once to a practical skills examination at a lower level of certification within one year after the last attempt at the level originally sought.

(b) Candidates who have failed the written certification exam after two attempts must complete a refresher or original certification course at the appropriate level prior to being admitted to another written certification exam at the same level of certification. Such candidates may be admitted once to a written certification examination at a lower level of certification, within one year after the last attempt at the level originally sought.

800.8 RECERTIFICATION REQUIREMENTS

To qualify for recertification, an applicant shall:

(a) file a completed application bearing the applicant's original signature in ink with the department on a form provided by the department;

(b) possess New York State certification at or above the level at which recertification is sought except as provided in section 800.18 of these regulations;

(c) pass the State practical skills examination for the level at which recertification is sought;

(d) within one year after passing the practical skills examination, pass the state written certification examination for the level at which certification is sought; and

(e) not have any convictions for any crime or crimes related to murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs or currently be under charges for such a crime, unless the department finds that such conviction or charges do not demonstrate a present risk or danger to patients.

800.9 CONTINUING EDUCATION

Candidates for recertification may complete a New York State approved original or refresher course at the appropriate level or engage in continuing education activities in order to maintain their knowledge and skills prior to admission to the practical and written certification examinations.

800.10 REEXAMINATIONS - APPLICANTS FOR RECERTIFICATION

(a) Candidates who have failed the practical skills examination must complete a refresher or original certification course for the level of certification sought prior to being admitted to another practical skills examination at the same level of certification. Such candidates may be admitted once to a practical skills examination at a lower level of certification within one year after the last attempt at the level of certification originally sought.

(b) Candidates who have failed the written certification exam after two attempts must complete a refresher or original certification course for the level of certification sought prior to being admitted to another written certification exam at the same level of certification. Such candidates may be admitted once to a written certification examination at a lower level of certification within one year after the last attempt at the level of certification initially sought.

800.11 ADVANCED EMERGENCY MEDICAL TECHNICIAN CERTIFICATION

(a) A candidate, to qualify for initial certification at any level above emergency medical technician-defibrillation, in addition to meeting the requirements set forth in section 800.6, shall:

(1) have current certification as an emergency medical technician-basic at the time of the written certification examination; and

(2) submit documentation of satisfactory completion of an internship approved by the course sponsor for any course for which an internship is described in the curriculum.

(b) No person certified pursuant to these regulations or required to be certified (see Article 30 of the Public Health Law) shall practice above the level of emergency medical technician-basic except as part of an advanced life support system.

800.12 RECIPROCAL CERTIFICATION REQUIREMENTS

(a) To qualify for New York State certification based on out-of-state emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-critical care, or emergency medical technician-paramedic credentials, a person must be currently certified or licensed by another state. The other state's training must be equivalent to or more stringent than New York State training and examination requirements.

(b) The applicant must:

(1) demonstrate a need for certification, such as New York State residence (or) employment opportunity;

(2) submit a written request for New York State certification, including a copy of the out-of-state credentials and complete an application for certification on a form to be provided by the department;

(3) pay in advance a filing fee of twenty-five dollars for certified first responder or emergency medical technician-basic certification or fifty dollars for any other level of certification;

(4) not have any convictions for any crime or crimes related to murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs or currently be under charges for such a crime unless the department finds that such conviction or charges do not demonstrate a present risk or danger to patients; and

(5) be at least eighteen years of age.

800.13 CERTIFICATION

The department:

(a) shall grant reciprocal certification to any qualified person with out-of-state certification or licensure, provided that there are no outstanding violations or charges of violations of the rules or laws governing emergency medical services in the state(s) in which the person holds certification or licensure.

(1) Such certification shall expire on the same date as the applicant's out-of-state certification, except that such certification shall be for no more than three years.

(2) Candidates who are required to pass both the written and practical skills examinations as part of this process shall have the expiration of their certifications determined by section 800.17.

(b) may require the candidate to pass the written or practical skills examinations in order to determine the equivalency of training; and

(c) shall keep the processing fee, even if the application for certification is denied.

800.14 EMERGENCY MEDICAL TECHNICIANS CERTIFIED BY STATES BORDERING NEW YORK

Emergency medical technicians certified by Vermont, Massachusetts, Connecticut, New Jersey, or Pennsylvania may practice in New York State without New York State certification, while

(a) transferring a patient across the border between New York State and the certifying state; or

(b) providing emergency medical care in New York State pursuant to a mutual aid agreement with a New York State certified or registered ambulance service. The mutual aid agreement must be in writing, signed by an authorized officer of both ambulance services, and must delineate the protocols to be adhered to by the out-of-state emergency medical technicians and shall be on file with the department.

800.15 REQUIRED CONDUCT

Every person certified at any level pursuant to these regulations shall:

(a) at all times maintain the confidentiality of information about the names, treatment, and conditions of patients treated except:

(1) a prehospital care report shall be completed for each patient treated when acting as part of an organized prehospital emergency medical service, and a copy shall be provided to the hospital receiving the patient and to the authorized agent of the department for use in the State's quality assurance program;

(2) to the extent necessary and authorized by the patient or his or her representative in order to collect insurance payments due;

(3) to the extent otherwise authorized by law;

(b) when acting as a certified first responder, an emergency medical technician, or advanced emergency medical technician, treat patients in accordance with applicable State-approved protocols, unless authorized to do otherwise for an individual patient by a medical control physician; and

(c) comply with the terms of a non-hospital order not to resuscitate when provided with such order issued on the standard form prescribed by the Department of Health, or when a DNR bracelet, developed by the Department of Health to identify individuals for whom a non-hospital order not to resuscitate has been issued, is identified on the patient's body.

(1) emergency medical services personnel may disregard the order not to resuscitate if:

(i) they believe in good faith that consent to the order has been revoked, or that the order has been canceled, or

(ii) family members or others on the scene, excluding such personnel, object to the order and physical confrontation appears likely.

(2) Hospital emergency service physicians may direct that the order be disregarded if other significant and exceptional medical circumstances warrant disregarding the order.

(3) No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably in good faith pursuant to this subdivision a non-hospital order not to resuscitate, for disregarding such order pursuant to paragraph (1) or (2) of this subdivision or for other actions taken reasonably in good faith pursuant to this subdivision.

(d) not use an automated external defibrillator unless:

(1) he is acting as a certified first responder, emergency medical technician or advanced emergency medical technician; and

(2) under medical control; and

(3) when authorized by and serving with an agency providing emergency medical services which has been approved by the regional emergency medical advisory committee to provide AED level care within the EMS system; and

(4) after completing AED training which meets or exceeds the state minimum AED curriculum.

800.16 SUSPENSION OR REVOCATION OF CERTIFICATION

Any certification issued pursuant to this Part may be suspended for a fixed period, revoked or annulled, or the certificate holder may be censured, reprimanded, or fined in accordance with section 12 of the Public Health Law, after a hearing conducted pursuant to section 12-a of the Public Health Law, the department determines that the certificate holder:

(a) has failed to comply with the requirements of section 800.15 of this Part;

(b) has been found guilty of either fraud, deceit, incompetence, patient abuse, theft, or dishonesty in the performance of the certificant's duties and practice;

(c) has been found guilty of fraud or deceit in the procuring of certification;

(d) has been convicted of any crime or crimes related to murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse or sale of drugs unless the department finds that such conviction or charges do not demonstrate a present risk or danger to patients;

(e) has provided patient care or driven an ambulance or other emergency medical services response vehicle while under the influence of alcohol or any other drug affecting physical coordination or intellectual functions;

(f) has knowingly aided or abetted another in practice as an emergency medical technician who is not certified as such; or

(g) has held him or herself out as being certified at a higher level than actually certified, or has used skills restricted to individuals holding a higher level of certification.

800.17 PERIOD OF CERTIFICATION

(a) Expiration of initial certification. A candidate's initial certification shall expire at 11:59 p.m. on the last day of the month 37 months following the month in which the candidate passed the written certification examination.

(b) Expiration of subsequent certifications.

(1) A candidate who completes the requirements of section 800.8 during the last nine months of his or her certification shall have his or her certification extended for an additional thirty-six months;

(2) The certification of a candidate who completes the requirements of section 800.8 at any other time while certified shall expire at 11:59 p.m. on the last day of the month 37 months following the month in which the candidate passed the written certification examination.

(3) The certification of a candidate who recertifies pursuant to section 800.18 shall expire at 11:59 p.m. on the last day of the month 37 months following the month in which the candidate passes the written certification examination.

800.18 LAPSED CERTIFICATION

(a) During the twelve months immediately following the expiration of certification, a candidate may recertify by meeting the requirements of section 800.8.

(b) After the first day of the thirteenth month immediately following the expiration of certification, a candidate may recertify by completing the requirements of section 800.8 and by successfully completing a refresher course and corresponding practical skills and written certification examinations at or below the level at which certification was held.

800.19 DEMONSTRATION PROJECTS

(a) Purpose. The State Emergency Medical Services Council may authorize, after review by the appropriate regional emergency medical services council and subject to the approval of the Commissioner, demonstration projects of a limited duration for the purpose of demonstrating either:

- (1) new skills not currently practiced by CFRs, EMTs or AEMTs, or
- (2) the appropriateness of moving a skill to another level.

(b) Requirements of demonstration projects.

(1) The Commissioner shall specify the duration of the project and the requirements for evaluation of the project.

(2) The State Emergency Medical Services Council shall recommend the training requirements for each project, including the knowledge and skill objectives, subject to the approval of the Commissioner.

800.20 COURSE SPONSORS

(a) Approval of course sponsors.

(1) When applying for original approval or re-approval, every course sponsor shall file a completed application on a form provided by the Department.

(2) Approval of a course sponsor shall be for no more than two years. Approvals shall expire on July 1. One half the approvals of sponsors conducting courses on the effective date of this part shall expire on the next succeeding July 1 and the other half shall expire on the second succeeding July 1.

(3) Original and renewal sponsorship applications shall be reviewed by the appropriate regional emergency medical services council, which shall forward its recommendation to the department within 45 days of receiving the application. If the regional council is a course sponsor, it shall consider only the capability of the sponsor to meet the requirements of this part. If the regional council is not a course sponsor, it may consider the size of the potential student pool and the impact of an additional sponsor on the ability of existing sponsors to sustain a student body of adequate size. The department, when making a determination with regard to original and renewal sponsorship applications, shall consider the capability of the sponsor to meet the requirements of this part, the size of the potential student pool and the impact of an additional sponsor on the ability of existing sponsors to sustain a student body of adequate size.

(4) The application for approval shall include the names of all certified instructor coordinators and certified lab instructors who will be providing instructional services.

(b) Course planning. Each course sponsor shall on or before July 1 and January 1 of each year submit to the appropriate regional emergency medical services councils and the department a projected schedule of courses for the next six months, including the course type, tentative dates and locations, and proposed certified instructor coordinators.

(c) All course sponsors shall meet the following requirements:

(1) Administration. Course sponsors shall comply with the following administrative requirements:

(i) The course sponsor shall file applications for courses by the deadline included in a schedule supplied by the Department;

(ii) The course sponsor shall not admit students who do not meet the age requirements for certification in accordance with this Part, or who do not meet the requirements for entry into a refresher course (i.e., previous completion of an original course);

(iii) The course sponsor shall submit student applications, in accordance with a schedule supplied by the department;

(iv) The course sponsor shall certify to the department those students who have met the requirements of the curriculum approved by the department and the State Emergency Medical Services Council.

(2) **Equipment and Supplies.** Supplies and equipment adequate for the provision of instruction shall be available consistent with the curriculum and sufficient for the number of students enrolled.

(3) **Instructional Faculty.** Every course except continuing education courses shall have a Certified Instructor Coordinator. Each continuing education course shall be conducted by faculty who have completed an instructor training course, conducted by the Department, for that specific course. The lab faculty of all courses except continuing education courses shall include one or more certified laboratory instructors.

(4) **Admission Policies and Procedures.** Admission of students shall be made in accordance with clearly defined and published policies of the course sponsor, which shall be available to the department on request. Specific academic, health related, and technical requirements for admission shall also be clearly defined and published. The standards and prerequisites for admission shall be made known to all individuals expressing an interest in enrollment.

(5) **Curricula.** All emergency medical services training courses that result in state certification shall meet the following minimum standards regarding curricula for the specified certification level.

(i) Any curriculum for each specified certification level must contain the following minimum course content areas:

(a) **Certified First Responder (CFR):**

(1) basic adult and pediatric patient assessment, including history taking, physical assessment, and determination of vital signs;

(2) basic cardiopulmonary resuscitation (CPR);

(3) basic airway management and oxygen therapy;

(4) basic hemorrhage control;

(5) manual stabilization of the spine;

(6) spinal immobilization, including application of a rigid extrication collar; and

(7) emergency childbirth.

(b) **Emergency Medical Technician-Defibrillation (EMT-D).** In addition to the requirements of clause (a) of this subparagraph:

(1) basic management of soft tissue injuries;

(2) basic management of suspected fractures;

(3) basic management of shock and use of medical anti-shock trousers;

(4) basic management of medical and traumatic emergencies, adult and pediatric;

(5) adult automated external defibrillation; and

(6) basic management of behavioral emergencies.

(c) **Emergency Medical Technician-Intermediate (EMT-I).** In addition to the requirements of clauses (a) and (b) of this subparagraph:

(1) advanced airway management with endotracheal intubation and other definitive airways; and

(2) peripheral intravascular therapy.

(d) Emergency Medical Technician-Critical Care (EMT-CC). In addition to the requirements of clauses (a), (b) and (c) of this subparagraph:

- (1) medication administration;
- (2) fundamentals of electrocardiogram (EKG) rhythm interpretation and manual defibrillation;
- (3) advanced management of life-threatening cardiovascular emergencies;
- (4) synchronized cardioversion;
- (5) advanced management of respiratory emergencies;
- (6) advanced management of endocrine emergencies; and
- (7) advanced management of anaphylaxis, poisoning, drug abuse and overdose.

(e) Emergency Medical Technician-Paramedic (EMT-P). In addition to the requirements of clauses (a), (b), and (d) of this subparagraph:

- (1) advanced electrocardiogram (EKG) rhythm interpretation;
- (2) advanced management of cardiovascular emergencies;
- (3) chest decompression;
- (4) surgical airways;
- (5) transcutaneous pacing;
- (6) advanced management of central nervous system emergencies;
- (7) advanced management of acute abdomen, genitourinary and reproductive system emergencies;
- (8) advanced management of environmental emergencies;
- (9) advanced management of geriatric emergencies;
- (10) advanced management of pediatric emergencies;
- (11) advanced management of obstetrical and gynecological (OB/GYN) emergencies;
- (12) management of neonatal emergencies; and
- (13) management of behavioral emergencies including pharmacological interventions.

(ii) The department shall maintain and provide for distribution of the approved model curriculum and any publication that directly relates to an approved emergency medical technician services training course curriculum. This material shall be available for public inspection and copying at the New York State Department of Health, Office of Regulatory Reform, Empire State Plaza, Corning Tower Building, Room 2415, Albany, New York 12237.

(iii) Use by course sponsors of the model curriculum developed by the New York State Emergency Medical Services Council (SEMSC) and approved by the Commissioner or her/his designee shall not require further review or approval. All other proposed curricula shall be reviewed by the SEMSC for compliance with the minimum standards described in the paragraph, and its recommendation shall be provided to the Commissioner or her/his designee for approval.

(6) Evaluation. Evaluation of students shall be conducted on a recurring basis and with sufficient frequency to provide the student, course medical director and certified instructor coordinator with valid and timely indicators of the student's progress toward and the achievement of the competencies and objectives stated in the curriculum. In order to ensure effectiveness of student evaluation, the test instruments and

evaluation methods shall undergo at least annual review. When appropriate, reviews shall result in the update, revision, or formulation of more effective test instruments or evaluation methods. The reviewers shall include at least a certified instructor coordinator.

(7) Identification. Students at clinical or internship sites shall be clearly identified by name and student status, using nameplate, uniform, or other apparent means to distinguish them from other personnel.

(8) Fair Operational Practices. Announcements and advertising shall accurately reflect the program offered. Student and faculty recruitment, student admission, and faculty employment practices shall be non-discriminatory with respect to race, color, creed, sex, age and national origin. The course sponsor shall have written policies which shall be approved by the department as being consistent with the curriculum, equitable in their treatment of students and in compliance with the requirements of this Part. Such policies shall be issued to all students at the first course session or earlier covering each of the following subjects:

- (i) course goals and objectives,
- (ii) interim testing requirements and pass/fail criteria,
- (iii) interim exam retesting,
- (iv) attendance requirements and make-up procedure,
- (v) requirements regarding personal conduct and ethics,
- (vi) emergency class cancellation procedure,
- (vii) course termination/expulsion and appeal procedure,
- (viii) textbooks required,
- (ix) tuition refund schedule, and
- (x) a student-course sponsor learning contract for all refresher courses.

(9) Record keeping.

(i) The course sponsor shall maintain for a period of at least five years, files which contain the following documentation on individual students. There shall be a system for accessing individual information.

- (a) individual attendance record,
- (b) signed student-course sponsor learning contract if applicable,
- (c) interim examination results,
- (d) practical skills examination sheets, and
- (e) clinical experience documentation and field internship experience documentation which show the student achieved the objectives of the clinical and field internship experiences and who evaluated the student's performance.

(ii) The course sponsor shall maintain on file for a period of at least five (5) years individual course files which shall contain the following documentation:

- (a) for state funded courses, financial records showing all sources of funding and all expenditures for each course,
- (b) a list of the names of each faculty member,
- (c) the certification exam grades and other documentation received from the department pertaining to each individual course,
- (d) a copy of each interim examination administered, or a record of where it can be found and
- (e) a copy of the course application, schedule and course approval from the department.

- (iii) The course sponsor shall maintain the names, last known addresses, business telephone numbers, and qualifications of all faculty. This information shall be maintained on file for the duration of the faculty member's working association with the sponsor plus 5 years.

(10) Sponsor's Medical Director. Each course sponsor shall have a physician medical director, who shall be responsible for assuring the medical accuracy and medical appropriateness of the educational program and supervising all advanced life support course clinical and internship programs. The sponsor's medical director may delegate the medical direction of a specific course to another physician, provided that the department is notified in writing at least thirty days prior to the start of the course.

(11) Practical Skills Examinations. The course sponsor shall follow the administrative procedures issued by the department for conducting the practical skills examination.

(d) The following requirements apply to advanced life support course sponsors and accredited paramedic course sponsors:

(1) Clinical Resources. Clinical affiliations shall be established and confirmed in written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision. Students shall have access to patients who present common problems encountered in the delivery of advanced emergency care so that the students may meet the clinical objectives. Supervision in the clinical setting shall be provided by program instructors or hospital personnel, such as nurses or physicians, if they have been approved by the program to function in such roles. The ratio of instructors to students in the clinical facilities shall be no greater than 1:6.

(2) Fair Operational Practices. Each sponsor shall have written policies which shall be approved by the department as being consistent with the curriculum, equitable in their treatment of students and in compliance with the requirements of this Part. Such policies shall be issued to all students at the first course session, or earlier, covering each of the following subjects:

- (i) clinical experience requirements and objectives,
- (ii) field internship experience requirements and objectives.

(3) Evaluation. The annual review of test instruments and evaluation methods shall be conducted by the sponsor's medical director and one or more certified instructor coordinators.

Certified Ambulance Services

800.21 GENERAL REQUIREMENTS

An ambulance service shall:

- (a) have a valid Department of Health certificate of inspection and Department of Motor Vehicles certificate of inspection on each vehicle at all times while it is in service;

(b) withdraw from service any ambulance or emergency ambulance service vehicle which is not in compliance with requirements of this part, or not in compliance with requirements of the Department of Motor Vehicles. Any vehicle with holes (from rust, poor gaskets, etc.) into the patient compartment must also be withdrawn from service;

(c) notify the department in writing when any ambulance or emergency ambulance service vehicle is permanently removed from service. Such vehicles must have removed all departmental certification stickers and logos;

(d) display an out-of-service sticker supplied by the department on any vehicle taken temporarily out of service in accordance with the departmental procedures currently in effect;

(e) display on the exterior of both sides and the back of all ambulance and emergency ambulance service vehicles the name of the service in letters not less than 3 inches in height and clearly legible. The logo provided by the department shall also be displayed on both sides and the back of every ambulance and shall be removed upon sale or transfer of the vehicle;

(f) maintain an ambulance which shall conform to the standards set forth in this Part;

(g) equip any ambulance or emergency ambulance service vehicle placed in service with the minimum equipment set forth in this part.

(h) have on each call at least one attendant who is a certified emergency medical technician in attendance with the patient at all times except for transfers between hospitals. Another licensed health care provider specifically authorized in writing by a physician may serve as the patient care attendant on transfers between hospitals. The ambulance service shall maintain the physician's order for three years. A licensed driver shall drive the ambulance;

(i) transport all patients in the patient compartment except in extenuating circumstances documented on the record of the call;

(j) make available for inspection, with or without notice, to representatives of the department all vehicles, materials, equipment, personnel records, procedures, and facilities;

(k) maintain current and accurate personnel files for all drivers, certified first responders, emergency medical technicians, and advanced emergency medical technicians, showing qualifications, training and certifications, and health records, including immunization status. Employee health records shall be maintained separately and in compliance with all applicable requirements. Information contained in such personnel files shall be reviewed annually, and may be disclosed only to authorized individuals. Training records must include at a minimum:

- (1) copies of state issued certifications;
- (2) all records of additional or specialized training; and
- (3) all records of any in-service and continuing education programs;

(l) maintain a record of each ambulance call in accordance with the provisions of section 800.32 of this part;

(m) maintain adequate and safe storage facilities for equipment, clean supplies and linen, soiled linen and waste at the place where the ambulance is based;

(n) maintain the interior of the vehicles and equipment in a clean and sanitary condition;

(o) operate only within its primary territory except:

(1) when receiving a patient which it initially delivered to a facility outside its primary territory; or

(2) in response to a request for mutual aid from another certified or registered ambulance service; or

(3) in response to a mutual aid plan implemented by a central dispatch agency on behalf of a certified or registered ambulance service or on behalf of a county or city emergency management office; or

(4) if a voluntary service, when transporting a patient who is a resident of the primary operating territory; or

(5) by approval of the department or the appropriate regional emergency medical services council for up to 60 days if the expansion of territory is necessary to meet an emergency need.

(p) have and enforce written policies concerning:

(1) mutual aid, including any required authorizations and agreements, to request the response of the nearest, appropriate, available EMS service(s). The written plan shall consider the incident location and access to it, location of the mutual aid agency, primary service territory, authorized level of service, staff availability and any other pertinent information when identifying the mutual aid agency;

(2) coverage of the ambulance service's response area when it is unable to respond to emergency call for assistance;

(3) the maximum call receipt interval for all emergency calls for assistance, except for MCI or disaster situations;

(4) actions to be taken if the maximum call receipt interval determined in (3) is exceeded and an ambulance has not yet started toward the incident location;

(5) authorization and protocols for a central dispatch agency to send a mutual aid service when the service does not or cannot respond;

(6) minimum qualifications and job descriptions for all patient care providers, drivers and EMS dispatchers;

(7) physical, health and immunization requirements for all patient care providers and drivers, including provisions for biennial review and updating of such requirements;

(8) preventive maintenance requirements for all authorized EMS response vehicles and patient care equipment;

(9) cleaning and decontamination of authorized EMS response vehicles and equipment;

(10) equipping and inspection of all authorized EMS response vehicles;

(11) reporting by the agency of suspected:

(i) crimes;

- (ii) child abuse;
- (iii) patient abuse; and/or
- (iv) domestic violence, including any directed toward elderly persons;

(12) responsibilities of patient care providers when:

- (i) a patient cannot be located;
- (ii) entry can not be gained to the scene of an incident;
- (iii) a patient judged to be in need of medical assistance refuses treatment and/or transportation;
- (iv) patients seek transportation to a hospital outside the area in which the service ordinarily transports patients;
- (v) a receiving hospital requests that a patient be transported to another facility before arrival at the hospital;
- (vi) treating minors;
- (vii) treating or transporting patients with reported psychiatric problems; and/or
- (viii) confronted with an unattended death.

(13) infection control practices and a system for reporting, managing and tracking exposures and ensuring the confidentiality of all information that is in compliance with all applicable requirements,

(14) by July 1, 1995 have a response plan for hazardous material incidents. Participation in a county or regional plan will meet this requirement.

(15) by July 1, 1996 have a response plan for multiple casualty incidents. Participation in a county or regional MCI plan will meet this requirement.

(q) upon discovery by or report to the governing authority of the ambulance service, report to the Department's Area Office by telephone no later than the following business day and in writing within 5 working days every instance in which:

(1) a patient dies, is injured or otherwise harmed due to actions of commission or omission by a member of the ambulance service;

(2) an EMS response vehicle operated by the service is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician;

(3) any member of the ambulance service is killed or injured to the extent requiring hospitalization or care by a physician while on duty;

(4) patient care equipment fails while in use, causing patient harm;

(5) it is alleged that any member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or drugs;

(r) On or in a form approved by the Department, maintain a record of all unexpected authorized EMS response vehicle and patient care equipment failures that could have resulted in harm to a patient and the corrective actions taken. A copy of this record shall be submitted to the Department with the EMS service's biennial recertification application.

800.22 REQUIREMENTS FOR CERTIFIED AMBULANCE VEHICLE CONSTRUCTION. ALL AMBULANCES SHALL:

- (a) have the following headroom:
 - (1) if placed in-service after January 1, 1980 have a minimum of 54 inches headroom in the patient compartment measured from floor to ceiling, or
 - (2) if placed in-service on or before January 1, 1980, have a minimum of 48 inches headroom in the patient compartment, measured from floor to ceiling;
- (b) have a clear interior width to accommodate two recumbent patients with adequate room for an attendant to provide patient care;
- (c) have a patient compartment, longer at the head and foot than the patient carrying device, and must have adequate space to allow an attendant to work at the head of the patient;
- (d) have seat belts on all seats in the driver's and patient compartments, including the squad bench;
- (e) have two-way voice communication equipment to provide communication with hospital emergency departments directly or through a dispatcher, throughout the duration of an ambulance call within their primary operating area. It shall be licensed by the Federal Communications Commission in other than the Citizens Band. Alternate communication systems are subject to approval of the department as being equivalent in capability.
- (f) have a curbside door large enough to allow for removal of a recumbent patient on a stretcher or cot;
- (g) have all ambulances built after July 1, 1990, equipped with a heating, ventilation and air conditioning system which maintains the patient compartment at approximately 75 degrees Fahrenheit regardless of outside temperature;
- (h) have all cots and devices used to transport patients secured while in motion. Such capability shall be demonstrated to the department upon inspection. These shall be crash resistant.

800.23 GENERAL REQUIREMENTS RELATED TO EQUIPMENT

- (a) All equipment shall be clean, sanitary, and operable.
- (b) The emergency medical technician must be able to operate all equipment on board the ambulance or emergency ambulance service vehicle within the scope of his/her certification.
- (c) Any volume of liquid in excess of 249 milliliters stored in the ambulance must be in plastic containers.
- (d) Insofar as practical, all equipment in every vehicle shall be secured to the vehicle whenever the vehicle is in motion.
- (e) All pressurized gas cylinders shall be secured and in compliance with Federal DOT hydrostatic test expiration dates;

(f) If controlled substances, drugs or needles are carried, there shall be a securely locked cabinet in which these items are stored when not in use.

800.24 EQUIPMENT REQUIREMENTS FOR CERTIFIED AMBULANCE SERVICE

All ambulances in a certified ambulance service shall be equipped with the following unless exempted pursuant to section 800.25:

(a) Patient transfer equipment consisting of:

- (1) wheeled ambulance cot capable of supporting the patients in the Fowlers position;
- (2) a device capable of carrying a second recumbent patient;
- (3) a device enabling ambulance personnel to carry a sitting patient over stairways and through narrow spaces where a rigid litter cannot be used. The requirements of paragraphs (2) and (3) of this subdivision may be satisfied by use of one combination device capable of both operations;
- (4) all litters and cots used to transport patients shall be secured using crash resistant fasteners. The ambulance shall be equipped with securing devices such that two patient carrying devices can be simultaneously secured; and
- (5) ambulance cots and other patient carrying devices shall be equipped with at least two, two-inch wide web straps with fasteners to secure the patient to the device and the cot.

(b) Airway, ventilation, oxygen and suction equipment consisting of:

- (1) a manually operated self-refilling adult-size bag valve mask ventilation device capable of operating with oxygen enrichment, and clear adult-size masks with air cushion;
- (2) four oropharyngeal airways in adult sizes;
- (3) portable oxygen with a minimum 350 liter capacity (medical "D" size) with pressure gauge, regulator and flow meter and one spare cylinder, medical "D" size or larger. The oxygen cylinders must contain a minimum of 1000 PSI pressure;
- (4) an in-ambulance oxygen system with a minimum 1200 liter capacity (two medical "E" size) with yoke(s), or CDC fitting, pressure gauges, regulators, and flow meters capable of delivering oxygen to two patients at two different flow rates of up to 15 liters per minute simultaneously.
- (5) four each, non-rebreather oxygen masks, and four nasal cannulae;
- (6) portable suction equipment capable, according to the manufacturers specifications, of producing a vacuum of over 300 millimeters of mercury when the suction tube is clamped. This will meet the 800.24(b)(7) requirement if equipped to operate off the ambulance electrical system;
- (7) installed adjustable suction capable of producing a vacuum of over 300 millimeters of mercury when tube is clamped; and
- (8) two plastic Yankauer-type wide bore pharyngeal tips individually wrapped.

(c) Immobilization equipment consisting of:

- (1) one full size (at least 72 inches long and 16 inches wide) backboard with necessary straps capable of immobilizing the spine of a recumbent patient;
- (2) one half length spinal immobilization device with necessary straps capable of immobilizing the spine of a sitting patient;

- (3) one traction splinting device for the lower extremity; and
- (4) two of each of the following size padded boards, with padding at least 3/8 inches thick:
 - (i) 4 1/2 feet by 3 inches
 - (ii) 3 feet by 3 inches or equivalent device
 - (iii) 15 inches by 3 inches or equivalent device

(5) one set of rigid extrication collars capable of limiting movement of the cervical spine. The set shall include large, medium and small adult-size rigid extrication collars which permit access to the patient's anterior neck; and

(6) a device or devices capable of immobilizing the head of a patient who is secured to a long backboard.

(d) Bandaging and dressing supplies consisting of:

- (1) twenty-four sterile gauze pads 4 inches by 4 inches;
- (2) three rolls adhesive tape in two or more sizes;
- (3) ten rolls of conforming gauze bandages in two or more sizes;
- (4) two sterile universal dressings approximately 10 inches by 30 inches;
- (5) ten large sterile dressings 5 inches by 9 inches minimum;
- (6) one pair bandage shears;
- (7) two sterile bed-size burn sheets;
- (8) six triangular bandages;
- (9) one liter of sterile normal saline in plastic container(s) within the manufacturer's expiration date;

and

- (10) roll of plastic or aluminum foil or equivalent sterile occlusive dressing.

(e) Emergency childbirth supplies in a kit, consisting of the following sterile supplies:

- (1) disposable gloves;
- (2) scissors or scalpel;
- (3) umbilical clamps or tape;
- (4) bulb syringe;
- (5) drapes; and
- (6) 1 individually wrapped sanitary napkin.

(f) Miscellaneous and special equipment in clean and sanitary condition consisting of:

- (1) linen and pillow on wheeled ambulance cot and spare pillow, two sheets, two pillow cases, and two blankets;
- (2) four cloth towels;
- (3) one box facial tissues;
- (4) two emesis containers;
- (5) one adult size blood pressure cuff with gauge;
- (6) stethoscope;
- (7) carrying case for essential emergency care equipment and supplies;
- (8) four chemical cold packs;
- (9) one male urinal;

- (10) one bed pan;
- (11) two sets masks and goggles or equivalent;
- (12) two pair disposable rubber or plastic gloves;
- (13) one liquid glucose or equivalent;
- (14) six sanitary napkins individually wrapped; and
- (15) one pen light or flashlight.

(g) Safety equipment consisting of:

- (1) six flares or three U.S. Department of Transportation approved reflective road triangles;
- (2) one battery lantern in operable condition; and
- (3) one Underwriters' Laboratory rated five pound U.L.-rated ABC chemical fire extinguisher or any extinguisher having a U.L. rating of 10BC.

(h) Pediatric equipment consisting of:

- (1) pediatric bag valve mask, equipped with oxygen reservoir system;
- (2) clear face masks in newborn, infant and child sizes, inflatable rim (or mask with minimal under-mask volume) to fit above;
- (3) two each nasal cannula, and two each oxygen masks including non-rebreather in the pediatric size;
- (4) two each oropharyngeal newborn, infant and child size airways;
- (5) sterile suction catheters, two each in sizes 5, 8 and 10 french;
- (6) two sterile DeLee type suction catheters #10 or modified suction traps, or two small bulb syringes;
- (7) one sterile single use disposable oxygen humidification setup;
- (8) child and infant size blood pressure cuffs with gauge(s);
- (9) one rigid extrication collar in pediatric size;
- (10) one pediatric stethoscope (interchangeable type acceptable);
- (11) one commercially prepared infant swaddler.

800.25 SPECIAL USE VEHICLES

A vehicle used exclusively for a special purpose, such as the transportation of neonates, may be authorized by the Commissioner, pursuant to a written application by the service, to not carry specific items of equipment otherwise required by these regulations if the equipment is shown to be unnecessary for the special use proposed.

800.26 EMERGENCY AMBULANCE SERVICE VEHICLE EQUIPMENT REQUIREMENTS

Any emergency ambulance service vehicle (other than an ambulance) shall be equipped and supplied with:

(a) Emergency care equipment consisting of:

- (1) twelve sterile 4"x4" gauze pads;
- (2) adhesive tape, 3 rolls assorted sizes;

- (3) six rolls conforming gauge bandage, assorted sizes;
- (4) two universal dressings, minimum 10 by 30 inches;
- (5) six 5"x9" (minimum size) sterile dressings or equivalent;
- (6) one pair of bandage shears;
- (7) six triangular bandages;
- (8) sterile normal saline in plastic container (1/2 litre minimum) within the manufacturer's expiration date;
- (9) one air occlusive dressing;
- (10) one liquid glucose or equivalent;
- (11) disposable sterile burn sheet;
- (12) sterile O.B. kit;
- (13) blood pressure sphygmomanometers cuff in adult and pediatric sizes and stethoscope;
- (14) three rigid extrication collars capable of limiting movement of the cervical spine. These collars shall include small, medium and large adult sizes; and
- (15) carrying case for essential equipment and supplies.

(b) Oxygen and resuscitation equipment consisting of:

- (1) portable oxygen with a minimum 350 liter capacity with pressure gauge regulator and flow meter medical "D" size or larger. The oxygen cylinder must contain a minimum of 1000 PSI pressure;
- (2) manually operated self-refilling bag valve mask ventilation devices in pediatric and adult sizes with a system capable of operating with oxygen enrichment and clear adult, and clear pediatric-size masks with air cushion;
- (3) four oropharyngeal airways in a range of sizes child through adult individually wrapped or boxed;
- (4) two each: disposable non-rebreather oxygen masks, and disposable nasal cannula individually wrapped;
- (5) portable suction equipment capable, according to the manufacturer's specifications, of producing a vacuum of over 300 m.m. Hg when the suction tube is clamped and including two plastic Yankauer wide bore pharyngeal suction tips, individually wrapped; and
- (6) pen light or flashlight.

(c) A two-way voice communications enabling direct communication with the agency dispatcher and the responding ambulance vehicle on frequencies other than citizens band.

(d) Safety equipment consisting of:

- (1) six flares or three U.S. Department of Transportation approved reflective road triangles;
- (2) one battery lantern in operable condition; and
- (3) one Underwriters' Laboratory rated five pound ABC fire extinguisher or any extinguisher having a UL rating of 10BC.

(e) Extrication equipment consisting of:

- (1) one short backboard or equivalent capable of immobilizing the cervical spine of a sitting patient. The backboard shall have at least two 2" x 9' long web straps with fasteners unless straps are affixed to the device; and
- (2) one blanket.

Aircraft and boats

800.27 AIRCRAFT AND BOATS

(a) Ambulance services desiring to operate aircraft and boats to transport emergency patients shall file with the Commissioner all forms required of a certified ambulance service and will be governed by all sections of this Part referring to a certified ambulance service.

(b) When the condition of the mode of transport and the configuration of the aircraft or boat provides a hardship, a variance may be obtained from the regulations by petitioning the Commissioner for said variance.

Pre-hospital DNR Orders

800.90 NON-HOSPITAL ORDERS NOT TO RESUSCITATE

(a) A non-hospital order not to resuscitate shall consist of a form issued by the Department bearing the name of the person to whom the order applies, that person's date of birth, the issuing physician's signature and a hand-printed or typewritten name and license number, and the date of issuance.

(b) A DNR bracelet shall consist of a piece of metal no less than 1.5 inches in length and no less than one-half inch in width with the symbol commonly referred to as the caduceus on the obverse and the words "Do Not Resuscitate" in letters of no less than 16 point size on the reverse. The ends of the piece of metal shall be linked to one another with material of sufficient strength as to be serviceable for ordinary use. A caduceus is a representation of a staff with one entwined snake and one wing at the top.

(c) DNR bracelets may be sold for use only by persons who have been issued a valid nonhospital order not to resuscitate.

NOTES

NOTES



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates: 88-20, 98-12, 99-02

No. 00 – 13

Date: 11/01/00

**Re: The Operation Of
Emergency Medical
Services Vehicles**

Page 1 of 7

The Operation of Ambulances and Other EMS Response Vehicles Including a *Model* Standard Operating Procedure for EMS Agencies

PURPOSES

1. To describe the legal requirements in New York State for driving ambulances and other EMS response vehicles.
2. To establish a standard in New York State for EMS response vehicle emergency operations.
3. To create a climate to help reduce the number of crashes and accidents and thereby reduce the injuries and property damage associated with EMS response vehicle emergency operations.
4. To provide information to develop educational programs for EMS emergency vehicle operators.

BACKGROUND

The epidemic of ambulance vehicle crashes and accidents that had been identified has continued and has involved the loss of civilian life and injury to civilians and EMS personnel. The magnitude of the problem requires that every NYS EMS agency be made aware of the problem and take immediate steps to reduce the potential for these accidents.

New York State Department of Motor Vehicle statistics illustrate a consistent yearly frequency of over 400 ambulance accidents or crashes, injuring almost 2 persons per day. These statistics also show that most of these accidents are avoidable. Based on these statistics, if each EMS response vehicle were able to stop at every controlled intersection, 75% of all of these accidents could be prevented.

EMS emergency response vehicles must be operated in a manner that provides for due regard and the safety of all persons and property. Safe arrival and patient welfare shall always have priority over unnecessary speed or hazardous driving practices while enroute to an incident or to the hospital. The NYS Vehicle and Traffic Law (V&T) authorizes *privileges* that ambulance and other emergency vehicle drivers may use

during an emergency operation. Modern EMS practices,^{1 2 3} including the use of Emergency Medical Dispatch (EMD), EMT and Advanced EMS training and the patient treatment modalities available today, dramatically reduce the need for emergency operations

LEGAL BACKGROUND

The NYS Vehicle and Traffic (V&T) Law states the following ⁴:

§ 114-b. *Emergency Operations – the operation, or parking, of an authorized emergency vehicle, when such vehicle is engaged in transporting a sick or injured person... Emergency operation shall not include returning from such service.*

§ 101. *Authorized emergency vehicles – every ambulance, ... emergency ambulance service vehicle.*

§ 1104 *Authorized Emergency Vehicles –*

(a) *The driver of an authorized emergency vehicle, when involved in an emergency operation, may exercise the privileges set forth in this section, but subject to the conditions herein stated.*

(b) *The driver of an authorized emergency vehicle may:*

1. *Stop, stand or park irrespective of the provisions of this title;*
2. *Proceed past a steady red signal, a flashing red signal or a stop sign, but only after slowing down as may be necessary for safe operations;*
3. *Exceed the maximum speed limits so long as he does not endanger life or property;*
4. *Disregard the regulations governing directions of movement or turning in specified directions.*

(c) *Except for an authorized emergency vehicle operated as a police vehicle, the exemptions herein granted to an authorized emergency vehicle shall apply only when audible signals are sounded from any said vehicle while in motion by bell, horn, siren, electronic device or exhaust whistle as may be reasonably necessary, and when the vehicle is equipped with at least one lighted lamp so that from any direction, under normal atmospheric conditions from a distance of five hundred feet from such vehicle, at least one red light will be displayed and visible.*

(e) **THE FOREGOING PROVISIONS SHALL NOT RELIEVE THE DRIVER OF AN AUTHORIZED EMERGENCY VEHICLE FROM THE DUTY TO DRIVE WITH DUE REGARD ⁵ FOR THE SAFETY OF ALL PERSONS, NOR SHALL SUCH PROVISIONS PROTECT THE DRIVER FROM THE CONSEQUENCES OF HIS RECKLESS DISREGARD FOR THE SAFETY**

1. Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport, NAEMSP & NASEMSD, Prehospital and Disaster Medicine, April-June 1994.

2. Scope of Performance of EMS Ambulance Operations F1517-94, American Society for Testing and Materials .

3. National Fire Protection Association (NFPA) Part 1500, section 4-2

4. NYS MV&T Law, italics provided to indicate direct quotation

5. A principle of legal accountability in which a review of the specific circumstances of a crash or accident will determine if a reasonably careful person, performing similar duties and under similar circumstances would act in the same manner. This legal concept is analogous to the prudent man in ordinary liability cases.

OF OTHERS.

DISCUSSION

It is important to note that the V&T law does not define specific operations permitted by the various types of emergency vehicles, such as police, fire or EMS. Generally personal opinion and tradition, not statute or regulation have defined the perception of requirements for ambulance emergency operations. An example is the mistaken belief that an ambulance's red lights must be on if a patient is on board. *This historical precedent must change.* There is no requirement that emergency operations be used for any EMS response.

Emergency operations in EMS *are always an affirmative* decision that is made at the time of each response. Today, EMD, industry data, EMS educational materials, legal case precedents, and other industry practices set a standard of care for emergency vehicle operation which is binding on all EMS providers. Drivers of emergency vehicles are reminded that they solely bear the responsibility for driving safely and with due regard. There is no immunity from liability provided in NYS law for driving.

Operating a vehicle in emergency mode is one of the most dangerous activities that an EMS provider is routinely involved in. Careful consideration must always be given for the lives and safety of the driver, the crew, the patient and for the safety of every other person that the vehicle will encounter during the call.

NYS – EMS POLICY

- *Every EMS response vehicle must be driven safely at all times, operating at a speed commensurate with the needs of the patient and the safety of all involved. Drivers exercising any of the V&T Law privileges must do so cautiously and with due regard for the safety of all others.*

- **Types of Responses -**
 - **Non-emergency Operations** - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run, shall be considered to be a non-emergency operation. **All non-emergency operations shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used.** During a non-emergency operation, the EMS response vehicle shall be driven in a safe manner and is not authorized to use any emergency vehicle privileges as provided for in the V&T Law.

 - **Emergency Operations - shall be limited to** any response to the scene where the driver of the emergency vehicle actually perceives, based on instructions received or information available to him or her, the call to be a true emergency. EMD dispatch classifications ⁶, indicating a true or potentially true emergency

6. i.e. Emergency Medical Dispatch, U.S. Dept. of Transportation, Feb. 1996

should be used to determine the initial response type. **Patient assessments made by a certified care provider, should determine the response type to the hospital.** In order for a response to be a true or potentially true emergency, the operator or EMT/AEMT must have an articulable⁷ reason to believe that emergency operations may make a difference in patient outcome. **During an emergency operation headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.**

- Each EMS response vehicle operator must recognize that the emergency vehicle has no absolute right of way, it is qualified and cannot be taken forcefully⁸.
- During emergency operations every EMS response vehicle must be operated in such a manner and at such a speed upon approaching an intersection, controlled by a traffic control device so as to permit safe passage through the intersection. Before entering the intersection the operator must reduce the speed of the vehicle to be able to stop the vehicle if necessary to permit such safe passage. **They should come to a complete stop if they have a red signal or stop sign.**⁹
- **Every EMS response vehicle must stop upon encountering a stopped school bus with red lights flashing; any non controlled railroad crossing or railroad crossing at which safety gates and/or warning lights are activated or if requested by a police officer.**
- EMS response vehicles are discouraged from using escorts or traveling in convoys due to the extreme dangers associated with multiple emergency vehicles operating in close proximity to each other. For the purpose of this policy statement and any developed from it emergency vehicles should maintain a spacing of at least 300 – 400 feet between them in ideal driving conditions and more when visibility is limited or road conditions are less than ideal.¹⁰
- At emergency scenes the use of emergency warning lights must be governed by the need to protect the safety of all personnel, patients and the public. In some cases the use of emergency lights should be minimized.
- **Per Part 800.21 of NYCRR, every NYS ambulance or ALSFR service must have and enforce a written policy which describes the authorized practices for driving EMS response vehicles by their members or employees.** The service policy must be consistent with this policy and must include the following:
 - A definition of emergency and non-emergency call types, including dispatch criteria for determining the type of call,
 - A description of the authorization required to use emergency operations on dispatch and enroute to the hospital, including call types, dispatcher and crew chief authority and other criteria,

7. Capable of being expressed in coherent verbal form, American Heritage Dictionary.

8. EMT Legal Bulletin, Vol. 15, No. 4, Med/Law publishers, Inc.

9 NFPA 1500 4-2.7(b)(c)

10 U.S. DOT, NHTSA Emergency Vehicle Operator Course, Ambulance

- A statement regarding exceeding the posted speed limit,
 - A statement regarding the speed permitted and stopping requirements through intersections which are uncontrolled or controlled,
 - Frequency and content of driver screening and training requirements for individuals authorized by the service to drive an EMS response vehicle. and
 - Insurance company driver screening including age, driving record, training, and other requirements.
- Every NYS-EMS agency shall have a training program¹¹ for all individuals authorized by the service to drive an EMS emergency response vehicle. The program shall include a curriculum, approved instructors, and frequency of training and documentation.
 - Every NYS EMS agency shall have a notification policy in the event of an accident or crash. This shall be consistent with Part 800.21(p).
 - A prompt, *safe* response can be attained by:
 - Knowing where you are going.
 - Having all personnel on board, seated with seat belts secured unless actively performing necessary emergency medical care.¹²
 - Leaving the station in a safe and standard manner:
 - quickly boarding the vehicle
 - opening station doors fully
 - Using warning devices to move with and around traffic and to request the right-of-way.
 - Driving defensively, at reasonable speeds, slowing or stopping at all intersections and giving approaching traffic adequate time to recognize the vehicle and yield the right of way.
 - Using pre-planned response routes which take into account hazards, construction, traffic density, etc.

11. NYS-EMS Ambulance Accident Prevention Seminar, DOT EVOC, National Safety Council, programs provided by Insurance Carrier, etc.

12 NFPA 1500 4-3.1.1

MODEL SERVICE SPECIFIC POLICY

The following model policy may be easily adopted by any EMS service to be included as a part of the service's policies and standard operating procedures.

<Service Name>

Policy and Standard Operating Procedure for Emergency Vehicle Operations

Purpose - There shall be established a system for the safe operation of all EMS emergency response vehicles.

Scope - These policies are binding on every driver and certified care provider in charge of patient care.

Types of Responses -

Non – emergency Operations - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run shall be considered to be a non-emergency operation.

Emergency Operations - shall be limited to any response to a scene, which is perceived to be a true emergency situation. True emergencies are defined by EMD and dispatch policy for a response to any situation in which there is a high probability of death or life threatening illness or injury. The risk of emergency operations must be demonstrably able to make a difference in patient outcome.

Emergency Vehicle Operations

First and Foremost - *DO NO Harm !*

1. Emergency operations are authorized only to responses deemed by dispatch protocol to be emergency in nature where the risks associated with emergency operations demonstrably make a difference in patient outcome.
2. Upon dispatch, emergency operations are only authorized when the dispatch call type justifies an emergency response.
3. All operations considered non-emergency shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used. During a non-emergency operation, the EMS response vehicle should be driven in a safe manner and is not authorized to use any emergency vehicle privileges as

provided for in the V&T Law.

4. Emergency operations are authorized at a scene when it is necessary to protect the safety of EMS personnel, patients or the public.
5. EMS response vehicles do not have an absolute right of way, it is qualified and cannot be taken forcefully
6. During an emergency operation the vehicle's headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.
7. Once on the scene, the decision for determining the type of response for additional EMS vehicles responding to the scene shall be made by a NYS certified provider following assessment of the scene and all patients. It will be the responsibility of that certified responder to notify the dispatcher or other responding units of the type of response that is warranted, emergency or non-emergency.
8. The EMT/AEMT in charge of patient care, following assessment of the patient, shall be responsible for determining the response type enroute to the hospital
9. EMS response vehicles shall not exceed posted speed limits by more than ten (10) miles per hour.
10. EMS response vehicles shall not exceed posted speed limits when proceeding through intersections with a green signal or no control device.
11. When an EMS response vehicle approaches an intersection, with or without a control device, the vehicle must be operated in such a manner as to permit the driver to make a safe controlled stop if necessary.
12. When an EMS response vehicle approaches a red light, stop sign, stopped school bus or a non controlled railroad crossing, the vehicle must come to a *complete stop*.
13. The driver of an EMS response vehicle must account for all lanes of traffic prior to proceeding through an intersection and should treat each lane of traffic as a separate intersection.
14. When an EMS response vehicle uses the median (turning lane) or an oncoming traffic lane to approach intersections, they must come to a complete stop before proceeding through the intersection with caution.
15. When traffic conditions require an EMS response vehicle to travel in the oncoming traffic lanes, the maximum speed is twenty (20) miles per hour.
16. The use of escorts and convoys is discouraged. Emergency vehicles should maintain a minimum distance of 300 – 400 feet when traveling in emergency mode in ideal conditions. This distance should be increased when conditions are limited.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates: 88-20, 98-12, 99-02

No. 00 – 13

Date: 11/01/00

**Re: The Operation Of
Emergency Medical
Services Vehicles**

Page 1 of 7

**The Operation of Ambulances and Other EMS Response Vehicles
Including a *Model* Standard Operating Procedure for EMS Agencies**

PURPOSES

1. To describe the legal requirements in New York State for driving ambulances and other EMS response vehicles.
2. To establish a standard in New York State for EMS response vehicle emergency operations.
3. To create a climate to help reduce the number of crashes and accidents and thereby reduce the injuries and property damage associated with EMS response vehicle emergency operations.
4. To provide information to develop educational programs for EMS emergency vehicle operators.

BACKGROUND

The epidemic of ambulance vehicle crashes and accidents that had been identified has continued and has involved the loss of civilian life and injury to civilians and EMS personnel. The magnitude of the problem requires that every NYS EMS agency be made aware of the problem and take immediate steps to reduce the potential for these accidents.

New York State Department of Motor Vehicle statistics illustrate a consistent yearly frequency of over 400 ambulance accidents or crashes, injuring almost 2 persons per day. These statistics also show that most of these accidents are avoidable. Based on these statistics, if each EMS response vehicle were able to stop at every controlled intersection, 75% of all of these accidents could be prevented.

EMS emergency response vehicles must be operated in a manner that provides for due regard and the safety of all persons and property. Safe arrival and patient welfare shall always have priority over unnecessary speed or hazardous driving practices while enroute to an incident or to the hospital. The NYS Vehicle and Traffic Law (V&T) authorizes *privileges* that ambulance and other emergency vehicle drivers may use

during an emergency operation. Modern EMS practices,^{1 2 3} including the use of Emergency Medical Dispatch (EMD), EMT and Advanced EMS training and the patient treatment modalities available today, dramatically reduce the need for emergency operations

LEGAL BACKGROUND

The NYS Vehicle and Traffic (V&T) Law states the following ⁴:

§ 114-b. *Emergency Operations – the operation, or parking, of an authorized emergency vehicle, when such vehicle is engaged in transporting a sick or injured person... Emergency operation shall not include returning from such service.*

§ 101. *Authorized emergency vehicles – every ambulance, ... emergency ambulance service vehicle.*

§ 1104 *Authorized Emergency Vehicles –*

(a) *The driver of an authorized emergency vehicle, when involved in an emergency operation, may exercise the privileges set forth in this section, but subject to the conditions herein stated.*

(b) *The driver of an authorized emergency vehicle may:*

1. *Stop, stand or park irrespective of the provisions of this title;*
2. *Proceed past a steady red signal, a flashing red signal or a stop sign, but only after slowing down as may be necessary for safe operations;*
3. *Exceed the maximum speed limits so long as he does not endanger life or property;*
4. *Disregard the regulations governing directions of movement or turning in specified directions.*

(c) *Except for an authorized emergency vehicle operated as a police vehicle, the exemptions herein granted to an authorized emergency vehicle shall apply only when audible signals are sounded from any said vehicle while in motion by bell, horn, siren, electronic device or exhaust whistle as may be reasonably necessary, and when the vehicle is equipped with at least one lighted lamp so that from any direction, under normal atmospheric conditions from a distance of five hundred feet from such vehicle, at least one red light will be displayed and visible.*

(e) **THE FOREGOING PROVISIONS SHALL NOT RELIEVE THE DRIVER OF AN AUTHORIZED EMERGENCY VEHICLE FROM THE DUTY TO DRIVE WITH DUE REGARD ⁵ FOR THE SAFETY OF ALL PERSONS, NOR SHALL SUCH PROVISIONS PROTECT THE DRIVER FROM THE CONSEQUENCES OF HIS RECKLESS DISREGARD FOR THE SAFETY**

1. Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport, NAEMSP & NASEMSD, Prehospital and Disaster Medicine, April-June 1994.

2. Scope of Performance of EMS Ambulance Operations F1517-94, American Society for Testing and Materials .

3. National Fire Protection Association (NFPA) Part 1500, section 4-2

4. NYS MV&T Law, italics provided to indicate direct quotation

5. A principle of legal accountability in which a review of the specific circumstances of a crash or accident will determine if a reasonably careful person, performing similar duties and under similar circumstances would act in the same manner. This legal concept is analogous to the prudent man in ordinary liability cases.

OF OTHERS.

DISCUSSION

It is important to note that the V&T law does not define specific operations permitted by the various types of emergency vehicles, such as police, fire or EMS. Generally personal opinion and tradition, not statute or regulation have defined the perception of requirements for ambulance emergency operations. An example is the mistaken belief that an ambulance's red lights must be on if a patient is on board. *This historical precedent must change.* There is no requirement that emergency operations be used for any EMS response.

Emergency operations in EMS *are always an affirmative* decision that is made at the time of each response. Today, EMD, industry data, EMS educational materials, legal case precedents, and other industry practices set a standard of care for emergency vehicle operation which is binding on all EMS providers. Drivers of emergency vehicles are reminded that they solely bear the responsibility for driving safely and with due regard. There is no immunity from liability provided in NYS law for driving.

Operating a vehicle in emergency mode is one of the most dangerous activities that an EMS provider is routinely involved in. Careful consideration must always be given for the lives and safety of the driver, the crew, the patient and for the safety of every other person that the vehicle will encounter during the call.

NYS – EMS POLICY

- *Every EMS response vehicle must be driven safely at all times, operating at a speed commensurate with the needs of the patient and the safety of all involved. Drivers exercising any of the V&T Law privileges must do so cautiously and with due regard for the safety of all others.*

- **Types of Responses -**
 - **Non-emergency Operations** - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run, shall be considered to be a non-emergency operation. **All non-emergency operations shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used.** During a non-emergency operation, the EMS response vehicle shall be driven in a safe manner and is not authorized to use any emergency vehicle privileges as provided for in the V&T Law.

 - **Emergency Operations - shall be limited to** any response to the scene where the driver of the emergency vehicle actually perceives, based on instructions received or information available to him or her, the call to be a true emergency. EMD dispatch classifications ⁶, indicating a true or potentially true emergency

6. i.e. Emergency Medical Dispatch, U.S. Dept. of Transportation, Feb. 1996

should be used to determine the initial response type. **Patient assessments made by a certified care provider, should determine the response type to the hospital.** In order for a response to be a true or potentially true emergency, the operator or EMT/AEMT must have an articulable⁷ reason to believe that emergency operations may make a difference in patient outcome. **During an emergency operation headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.**

- Each EMS response vehicle operator must recognize that the emergency vehicle has no absolute right of way, it is qualified and cannot be taken forcefully⁸.
- During emergency operations every EMS response vehicle must be operated in such a manner and at such a speed upon approaching an intersection, controlled by a traffic control device so as to permit safe passage through the intersection. Before entering the intersection the operator must reduce the speed of the vehicle to be able to stop the vehicle if necessary to permit such safe passage. **They should come to a complete stop if they have a red signal or stop sign.**⁹
- **Every EMS response vehicle must stop upon encountering a stopped school bus with red lights flashing; any non controlled railroad crossing or railroad crossing at which safety gates and/or warning lights are activated or if requested by a police officer.**
- EMS response vehicles are discouraged from using escorts or traveling in convoys due to the extreme dangers associated with multiple emergency vehicles operating in close proximity to each other. For the purpose of this policy statement and any developed from it emergency vehicles should maintain a spacing of at least 300 – 400 feet between them in ideal driving conditions and more when visibility is limited or road conditions are less than ideal.¹⁰
- At emergency scenes the use of emergency warning lights must be governed by the need to protect the safety of all personnel, patients and the public. In some cases the use of emergency lights should be minimized.
- **Per Part 800.21 of NYCRR, every NYS ambulance or ALSFR service must have and enforce a written policy which describes the authorized practices for driving EMS response vehicles by their members or employees.** The service policy must be consistent with this policy and must include the following:
 - A definition of emergency and non-emergency call types, including dispatch criteria for determining the type of call,
 - A description of the authorization required to use emergency operations on dispatch and enroute to the hospital, including call types, dispatcher and crew chief authority and other criteria,

7. Capable of being expressed in coherent verbal form, American Heritage Dictionary.

8. EMT Legal Bulletin, Vol. 15, No. 4, Med/Law publishers, Inc.

9 NFPA 1500 4-2.7(b)(c)

10 U.S. DOT, NHTSA Emergency Vehicle Operator Course, Ambulance

- A statement regarding exceeding the posted speed limit,
 - A statement regarding the speed permitted and stopping requirements through intersections which are uncontrolled or controlled,
 - Frequency and content of driver screening and training requirements for individuals authorized by the service to drive an EMS response vehicle. and
 - Insurance company driver screening including age, driving record, training, and other requirements.
- Every NYS-EMS agency shall have a training program¹¹ for all individuals authorized by the service to drive an EMS emergency response vehicle. The program shall include a curriculum, approved instructors, and frequency of training and documentation.
 - Every NYS EMS agency shall have a notification policy in the event of an accident or crash. This shall be consistent with Part 800.21(p).
 - A prompt, *safe* response can be attained by:
 - Knowing where you are going.
 - Having all personnel on board, seated with seat belts secured unless actively performing necessary emergency medical care.¹²
 - Leaving the station in a safe and standard manner:
 - quickly boarding the vehicle
 - opening station doors fully
 - Using warning devices to move with and around traffic and to request the right-of-way.
 - Driving defensively, at reasonable speeds, slowing or stopping at all intersections and giving approaching traffic adequate time to recognize the vehicle and yield the right of way.
 - Using pre-planned response routes which take into account hazards, construction, traffic density, etc.

11. NYS-EMS Ambulance Accident Prevention Seminar, DOT EVOC, National Safety Council, programs provided by Insurance Carrier, etc.

12 NFPA 1500 4-3.1.1

MODEL SERVICE SPECIFIC POLICY

The following model policy may be easily adopted by any EMS service to be included as a part of the service's policies and standard operating procedures.

<Service Name>

Policy and Standard Operating Procedure for Emergency Vehicle Operations

Purpose - There shall be established a system for the safe operation of all EMS emergency response vehicles.

Scope - These policies are binding on every driver and certified care provider in charge of patient care.

Types of Responses -

Non – emergency Operations - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run shall be considered to be a non-emergency operation.

Emergency Operations - shall be limited to any response to a scene, which is perceived to be a true emergency situation. True emergencies are defined by EMD and dispatch policy for a response to any situation in which there is a high probability of death or life threatening illness or injury. The risk of emergency operations must be demonstrably able to make a difference in patient outcome.

Emergency Vehicle Operations

First and Foremost - *DO NO Harm !*

1. Emergency operations are authorized only to responses deemed by dispatch protocol to be emergency in nature where the risks associated with emergency operations demonstrably make a difference in patient outcome.
2. Upon dispatch, emergency operations are only authorized when the dispatch call type justifies an emergency response.
3. All operations considered non-emergency shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used. During a non-emergency operation, the EMS response vehicle should be driven in a safe manner and is not authorized to use any emergency vehicle privileges as

provided for in the V&T Law.

4. Emergency operations are authorized at a scene when it is necessary to protect the safety of EMS personnel, patients or the public.
5. EMS response vehicles do not have an absolute right of way, it is qualified and cannot be taken forcefully
6. During an emergency operation the vehicle's headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.
7. Once on the scene, the decision for determining the type of response for additional EMS vehicles responding to the scene shall be made by a NYS certified provider following assessment of the scene and all patients. It will be the responsibility of that certified responder to notify the dispatcher or other responding units of the type of response that is warranted, emergency or non-emergency.
8. The EMT/AEMT in charge of patient care, following assessment of the patient, shall be responsible for determining the response type enroute to the hospital
9. EMS response vehicles shall not exceed posted speed limits by more than ten (10) miles per hour.
10. EMS response vehicles shall not exceed posted speed limits when proceeding through intersections with a green signal or no control device.
11. When an EMS response vehicle approaches an intersection, with or without a control device, the vehicle must be operated in such a manner as to permit the driver to make a safe controlled stop if necessary.
12. When an EMS response vehicle approaches a red light, stop sign, stopped school bus or a non controlled railroad crossing, the vehicle must come to a *complete stop*.
13. The driver of an EMS response vehicle must account for all lanes of traffic prior to proceeding through an intersection and should treat each lane of traffic as a separate intersection.
14. When an EMS response vehicle uses the median (turning lane) or an oncoming traffic lane to approach intersections, they must come to a complete stop before proceeding through the intersection with caution.
15. When traffic conditions require an EMS response vehicle to travel in the oncoming traffic lanes, the maximum speed is twenty (20) miles per hour.
16. The use of escorts and convoys is discouraged. Emergency vehicles should maintain a minimum distance of 300 – 400 feet when traveling in emergency mode in ideal conditions. This distance should be increased when conditions are limited.

New York State Vehicle and Traffic Law

Section 100	Definition of Words and Phrases
Section 100-b	Ambulance
Section 101	Authorized Emergency Vehicle
Section 106-a	Civil Defense Emergency Vehicle
Section 113	Driver
Section 114-b	Emergency Operation
Section 115-a	Fire Vehicle
Section 115-c	Emergency Ambulance Service Vehicle
Section 139	Right of Way
Section 375	Equipment
Section 388	Negligence in use of operation of vehicle attributable to owner
Section 396	Use of State or other seal and insignia...
Section 397	Equipping motor vehicles with radio receiving sets capable of receiving signals on frequencies allocated for Police use
Section 1101	Required obedience to traffic laws
Section 1102	Obedience to police officers and flag persons
Section 1104	Authorized emergency vehicles
Section 1110	Obedience to and traffic control devices
Section 1144	Operation of vehicles approach of authorized emergency vehicle
Section 1194	Chemical Tests
Section 1210	Unattended motor vehicle
Section 1214	Opening and closing vehicle doors
Section 1217	Following emergency fire vehicles prohibited
Section 1218	Crossing fire hose
Section 1225	Avoiding intersection or traffic control device
Section 1225-a	Driving on sidewalks
Section 1226	Control of steering mechanisms

Sections of Vehicle and Traffic Law Applicable to Emergency Vehicle Operations

100. Definition of Words and phrases. The following words and phrases when used in this chapter shall, for the purposes of this chapter, have the meanings respectively ascribed to them in this article except where another definition is specifically provided in any title, article or section for application in such title, article or section.

100-b. Ambulance. Every motor vehicle designed, appropriately equipped and used for the purposes of carrying sick or injured persons by a person or entity registered or certified as an ambulance service by the Department of Health.

101. Authorized emergency vehicle. Every ambulance, police vehicle, fire vehicle, civil emergency vehicle, emergency ambulance service vehicle, environmental response vehicle, sanitation patrol vehicle, hazardous materials vehicle, and ordnance disposal vehicle of the armed services of the United States.

106-a. Civil defense emergency vehicle. Every communication vehicle, rescue vehicle owned by the state, a county, town, city or village and operated for civil defense purposes and equipped and marked as a civil defense emergency communications or rescue vehicle in compliance with the rule and regulations of the state civil defense commission.

Section 113. Driver. Every person who operates or drives or is in actual physical control of a vehicle. Whenever the terms "chauffeur" or "operator" or "chauffeurs license" or Aoperator=s license@ are used in this chapter, such terms shall be deemed to mean driver and driver's license respectively.

Section 114-b. Emergency Operation. The operation, or parking, of an authorized emergency vehicle, when such vehicle is engaged in transporting a sick or injured person, transporting prisoners, pursuing an actual or suspected violator of the law, or responding to, or working or assisting at the scene of an accident, disaster, police call, alarm of fire, actual potential release of hazardous material or other emergency. Emergency operation shall not include returning from such service.

Section 115-a. Fire Vehicle. Every vehicle operated for fire service purposes owned and identified as being owned by the state, a public authority, a county, town, city, village or fire district, or a fire corporation subject to the provisions of subdivision (e) of section fourteen hundred two of the not-for-profit corporation law or a fire company as defined in section one hundred of the general municipal law. Any of the following vehicles shall be fire vehicles only for the purpose of section one hundred one of the chapter:

1. a vehicle operated by officials of the office of fire prevention and control in the Department of State.
2. a vehicle ordinarily operated by a chief or assistant chief of a fire department, or a county or deputy county fire coordinator, or county or assistant county fire marshal, or town or assistant town fire coordinator, or such vehicle when operated in an official capacity by or under the direction of such person, and
3. a vehicle specially designed and equipped for fire-fighting purposes which is regularly used for fire-fighting purposes by a fire-fighting unit on property used for industrial, institutional or commercial purposes and which vehicle is owned by the owner or lessee of such property.

Section 115-c. Emergency Ambulance Service Vehicle. An emergency ambulance service vehicle shall be defined as an appropriately equipped motor vehicle owned or operated by an ambulance service as defined in section three thousand one of the public health law and used for the purpose of transporting emergency medical personnel and equipment to sick or injured persons.

Section 139. Right of Way. The right of one vehicle or pedestrian to proceed in a lawful manner in preference to another vehicle or pedestrian approaching under such circumstances of direction, speed and proximity as to give rise to danger of collision unless one grants precedence to the other.

Section 375. Equipment.

26. A gong or siren whistle shall not be used on any vehicle other than an authorized emergency vehicle. This shall not be construed to apply to a gong or siren designed and used solely as a burglar alarm on a vehicle.

41. Colored and flashing lights. The provisions of this subdivision shall govern the affixing and display of lights on vehicles, other than those lights required by law.

1. No light, other than a white light, and no revolving rotating, flashing, oscillating or constantly moving white shall be affixed to, or displayed on any vehicle except as prescribed herein.

2. Red lights and certain white lights. One or more red or combination red and white lights or white light which must be revolving, rotating, flashing or oscillating or constantly moving light, may be affixed to an authorized emergency vehicle, and such lights may be displayed on an authorized emergency vehicle when such vehicle is engaged in an emergency operation, and upon a fire vehicle while returning from an alarm of fire or other emergency.

4. Blue Light. One blue light may be affixed to any motor vehicle owned by a volunteer member of a fire department or on a motor vehicle owned by a member of such person's family residing in the same household or by a business enterprise in which such person has a proprietary interest or by which he is employed, provided such volunteer fireman has been authorized in writing to so affix a blue light by the chief of the fire department or company of which he is a member, which authorization shall be subject to revocation at any time by the chief who issued the same or his successor in office. Such blue light may be displayed by such volunteer fireman on such a vehicle only when engaged in an emergency operation.

5. Green Light. One green light may be affixed to any motor vehicle owned by a member of a volunteer ambulance service, or on a motor vehicle owned by a member of such person's family, or by a business enterprise in which such person has a proprietary interest or by which he is employed, provided such member has been authorized in writing to so affix a green light by the chief officer of such service as designated by the members thereof. Such green light may be displayed by such member of a volunteer ambulance service only when engaged in an emergency operation.

As used in this paragraph volunteer ambulance service means:

a. a non-profit membership corporation (other than a fire corporation) incorporated under or subject to the provisions of the membership corporations law, or any other law, operating its ambulance or ambulances on a non-profit basis for the convenience of the members thereof and their families or of the community or under contract with a county, city, town or village pursuant to section one hundred twenty-two-b of the general municipal law: or

b. an unincorporated association of persons operating its ambulance or ambulances on a non-profit basis for the convenience of the members and their families or of the community.

Section 388. Negligence in use of operation of vehicle attributable to owner.

1. Every owner of a vehicle used or operated in this state shall be liable and responsible for death or injuries to

person or property resulting from negligence in the use or operation of such vehicle, in the business of such owner or otherwise, by any person using or operating the same with the permission, express or implied, of such owner. Whenever any vehicles as herein defined shall be used in combination with one another, by attachment or tow, the person using or operating any one vehicle shall, for the purposes of this section, be deemed to be using or operating each vehicle in the combination, and the owners thereof shall be jointly and severally liable hereunder.

Section 396. Use of State or other seals and insignia on private vehicles prohibited.

3. A person who shall use or display the words "Fire Department," "Fire" or any other sign, lettering or device with the letter "F.D.N.Y." or any other matter indicating ownership, possession or use by a fire department on any motor vehicle or motor cycle not used by a duly organized fire department within this state and not actually operated or used by a member or an employee of a duly organized fire department on a public highway, is guilty of a traffic infraction.

Section 397. Equipping motor vehicles with radio receiving sets capable of receiving signals on frequencies allocated for Police use. A person, not a police officer or peace officer, acting pursuant to his special duties, who equips a motor vehicle with a radio receiving set capable of receiving signals on frequencies allocated for police use or knowingly uses a motor vehicle so equipped or who in any way knowingly interferes with the transmission of radio messages by the police without having first secured a permit so to do from the person authorized to issue such a permit by the local governing body or board of the city, town or village in which such person resides, or where such person resides outside of a city or village in a county having a county police department by the board of supervisors of such county, is guilty of a misdemeanor, punishable by a fine not exceeding one thousand dollars, or imprisonment not exceeding six months, or both. Nothing in this section contained shall be construed to apply to any person who holds a valid amateur radio operator's license issued by the federal communications commission and who operates a duly licensed portable mobile transmitter and in connection therewith a receiver or receiving set on frequencies exclusively allocated by the federal communications commission to duly licensed radio amateurs.

Section 1101. Required obedience to traffic laws. It is unlawful and, unless otherwise declared in this title with respect to particular offenses, it is a traffic infraction for any person to do any act forbidden or failed to perform any act required in this title.

Section 1102. Obedience to police officers and flag persons. No person shall fail or refuse to comply with any lawful order or direction of any police officer or flagperson or other person duly empowered to regulate traffic.

Section 1104. Authorized emergency vehicles.

(a) The driver of an authorized emergency vehicle, when involved in an emergency operation, may exercise the privileges set forth in this section, but subject to the condition herein stated.

(b) The driver of an authorized emergency vehicle may:

1. Stop, stand or park irrespective of the provisions of this title;
2. Proceed past a steady red signal, a flashing red signal or a stop sign, but only after slowing down as may be necessary for safe operation;
3. Exceed the maximum speed limits so long as he does not endanger life or property;
4. Disregard regulations governing directions of movement or turning in specified directions.

(c) Except for an authorized emergency vehicle operated as a police vehicle, the exemptions herein granted to an authorized emergency vehicle shall apply only when audible signals are sounded from any said vehicle while in motion by bell, horn siren, electronic device or exhaust whistle as may be reasonably necessary, and when the vehicle is equipped with at least one lighted lamp so that from any direction, under normal atmospheric conditions from a distance of five hundred feet from such vehicle, at least one red light will be displayed and visible.

(e) The forgoing provisions shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons, nor shall such provisions protect the driver from the consequences of his reckless disregard for the safety of others.

(f) Notwithstanding any other law, rule or regulation to the contrary, an ambulance operated in the course of an emergency shall not be prohibited from using any highway, street or roadway; provided, however, that an authority having jurisdiction over any such highway, street or roadway may specifically prohibit travel thereon by ambulances if such authority shall deem such travel to be extremely hazardous and would endanger patients being transported thereby.

Section 1110. Obedience to and traffic control devices.

(a) Every person shall obey the instructions of any official traffic-control device applicable to him placed in accordance with the provisions of this chapter, unless otherwise directed by a traffic or police officer, subject to the exceptions granted the driver of an authorized emergency vehicle in this title.

Section 1144. Operation of vehicles approach of authorized emergency vehicle.

(a) Upon the immediate approach of an authorized emergency vehicle equipped with at least one lighted lamp exhibiting red light visible under normal atmospheric condition from a distance of five hundred feet to the front of such vehicle other than a police vehicle when operated as an authorized emergency vehicle, and when audible signal are sounded from any said vehicle by siren, exhaust whistle, bell, air-horn or electronic equivalent; the driver of every other vehicle shall yield the right of way and shall immediately drive to a position parallel to, and as close as possible to the right-hand edge or curb of the roadway, or to either edge of a one-way roadway three or more lanes in width, clear of any intersection, and shall stop and remain in such position until the authorized emergency vehicle has passed, unless otherwise directed by a police officer.

(b) This section shall not operate to relieve the driver of an authorized emergency vehicle from the duty to drive with reasonable care for all persons using the highway.

Section 1194. Arrests and Testing.

2. Chemical Tests. (a) When authorized. Any person who operates a motor vehicle in this state shall be deemed to have given consent to a chemical test of one or more of the following: breath, blood, urine, or saliva, for the purpose of determining the alcohol and/or drug content of the blood provided that such test is administered by or at the direction of a police officer with respect to a chemical test of breath, urine or saliva or, with respect to a chemical test of blood, at the direction of a police officer:

Section 1210. Unattended motor vehicle.

(a) No person driving or in charge of a motor vehicle shall permit it to stand unattended without first stopping the engine, locking the ignition, removing the key from the vehicle, and effectively setting the brake thereon and, when standing upon any grade, turning the front wheels to the curb or side of the highway, provided, however, the provision for removing the key from the vehicle shall not require the removal of keys hidden from sight about the vehicle for convenience or emergency.

Section 1214. Opening and closing vehicle doors. No person shall open the door of a motor vehicle on the side available to moving traffic unless and until it is reasonable safe to do so, and can be done without interfering with the movement of other traffic, nor shall any person leave a door open on the side of the vehicle available to moving traffic for a period of time longer than necessary to load or unload passengers.

Section 1217. Following emergency fire vehicles prohibited. The driver of any vehicle other than one on official business shall not follow any authorized emergency fire vehicle in the same lane or adjacent lane to one being used by such fire vehicle at a distance closer than two hundred feet while such fire vehicle is displaying one or more red or combination red and white lights, or one white light which must be revolving, rotating, flashing, oscillating or constantly moving light, nor shall such driver drive into or park his or her vehicle within the block or where there is no block, within one thousand feet of where such fire vehicle has stopped in answer to a fire alarm.

Section 1218. Crossing fire hose. No vehicle shall be driven over and unprotected hose of a fire department when laid down on any street or private driveway, to be used at any fire or alarm of fire, without the consent of the fire department official in command.

Section 1225. Avoiding intersection or traffic control device. No person shall drive across or upon a sidewalk, driveway, parking lot or private property, or otherwise drive off a roadway, in order to avoid an intersection or traffic control device.

Section 1225-a. Driving on sidewalks. No person shall drive a motor vehicle on or across a sidewalk, except that a vehicle may be driven at a reasonable speed, but not more than five miles per hour, on or across a sidewalk in such a manner as not to interfere with the safety and passage of pedestrians thereon, who shall have the right of way, when it is reasonable and necessary:

- (a) to gain access to a public highway, private way or lands or buildings adjacent to such a highway or way;
- (b) in the conduct of work upon a highway, or upon a private way or lands or buildings adjacent to such a highway or way, or
- (c) to plow snow or perform any other public service, for hire, which could not otherwise be reasonably and properly performed.

Section 1226. Control of steering mechanisms. No person shall operate a motor vehicle without having at least one hand or, in the case of a physically handicapped person, at least one prosthetic device or aid on the steering mechanism at all times when the motor vehicle is in motion.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: 99-10, 08-07, 10-05

No. 11-02

Date: March 1, 2011

Re: DNR and Medical Orders for Life-Sustaining Treatment (MOLST)

Page 1 of 5

Purpose

This policy updates all EMS providers and agencies of changes in the laws regarding Do Not Resuscitate (DNR) orders and Medical Orders for Life-Sustaining Treatment (MOLST). The Department now has an approved MOLST form, [DOH-5003](#) Medical Orders for Life-Sustaining Treatment. This form does not replace the Nonhospital Order Not to Resuscitate in either the English or the Spanish version ([DOH-3474](#), [DOH-3474es](#)), but rather provides an alternative. Nonhospital DNR orders are now governed by Public Health Law Article 29-CCC.

Additionally, this policy will provide an introduction to the Family Health Care Decisions Act (FHCDA). FHCDA allows family members or certain other individuals to make health care decisions, including decisions about the withholding or withdrawing of life-sustaining treatment, on behalf of patients who lose their ability to make such decisions and have not prepared advance directives regarding their wishes. **FHCDA went into effect on June 1, 2010.**

Nonhospital Order Not to Resuscitate

The New York State Department of Health has an approved standard **Out of Hospital DNR** form (DOH-3474) that is legally recognized statewide for DNR requests occurring outside of Article 28 licensed facilities. This form is intended for patients not originating from a hospital or nursing home.

For patients with a valid Nonhospital DNR or MOLST form with a DNR order, the Public Health Law allows a standard metal bracelet to be worn by the patient, which includes a caduceus and the words "DO NOT Resuscitate." EMS providers should assume that there is a valid DNR in place when a DNR bracelet is identified on a patient.

Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST is an alternative form for patients to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. Unlike the Nonhospital Order Not to Resuscitate, the MOLST form documents DNI orders and orders regarding other life-sustaining treatment, in addition to DNR orders. MOLST should be honored by EMS agencies, hospitals, nursing homes, adult homes, hospices and other health care facilities and their health care provider staff. MOLST has been approved by the Office of Mental Health and the Office for People With Developmental Disabilities for use as a nonhospital DNR/DNI form for persons with developmental disabilities, or persons with mental illness, who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act.

Chapter 197 of the Laws of 2008 authorized the MOLST form to be used statewide as an alternative form for nonhospital DNR and/or DNI and allowed EMS providers to honor this form in all counties in New York State.

Both the Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) and the MOLST form (DOH-5003) are New York State Department of Health forms. The MOLST form was updated in June 2010 to make it more user-friendly and to align the form with the recently enacted Family Health Care Decisions Act. The MOLST form is currently utilized by many health care systems. **If a patient has a prior version of the MOLST in place and signed by a physician, the form is still considered VALID, and the patient care orders should be honored, unless it is known that the patient's form has been revoked.**

What are the DNR/DNI rules that affect EMS agencies and providers now?

1. Effective July 7, 2008, the MOLST form is approved for use statewide without the need for a standard one-page Nonhospital Order Not to Resuscitate form.
2. EMS agencies must still honor the standard one-page nonhospital DNR form or bracelet.
3. When a patient wears a DNR bracelet, it refers ONLY to the do not resuscitate rules that apply to the nonhospital DNR order. At present there are no nonhospital DNI bracelets.
4. The MOLST form also provides the patient and his/her physician with the ability to give a Do Not Intubate (DNI) order to health care providers including EMS. Refer to Section E on the MOLST form to review DNI information.
5. Occasionally EMS providers may encounter a patient who has a newly completed MOLST that does not have the authorizing physician's signature. While the unsigned MOLST form may provide the EMS provider with information about the patient's treatment preferences, it is **not** a valid DNR or other order. In the case of an unsigned MOLST form EMS providers should:
 1. Initiate resuscitation following applicable state and/or regional protocols;
 2. Obtain clinical information on status of the patient;
 3. Confirm the MOLST form is specific to the patient;
 4. Consult with local medical control and relay the above information; and
 5. Follow the direction of the medical control physician.

What are the differences and similarities between the standard one-page nonhospital DNR order and the MOLST form?

1. The MOLST form ([DOH-5003](#)) is a bright pink multi-page form; however, a photocopy or facsimile of the original form is acceptable and legal. A Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) is a single-page form on white paper with black ink.
2. The MOLST form is meant to be utilized by health care providers across the health care system. It is not limited to EMS agencies; it travels with the patient to different care settings. The Nonhospital Order Not to Resuscitate form is not intended for use in facilities.
3. MOLST provides for end-of-life orders concerning resuscitation and intubation for Advanced EMTs when the patient is in full cardio-pulmonary arrest or has progressive or impending pulmonary failure without acute cardiopulmonary arrest. The Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) only applies to patients in full cardio or pulmonary arrest.
4. Both forms, the MOLST form and the Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) must be authorized by a physician.
5. Unlike the Nonhospital Order Not to Resuscitate form, there are multiple patient orders contained on the MOLST form that are intended for other health care providers to follow in other health care settings such as the hospital or nursing home.
6. The MOLST form gives prehospital care providers and agencies direction regarding the patient's end-of-life treatment orders in Section A (page 1) and Section E (page 2). See below.

Orientation to the MOLST Form, DOH-5003 (June 2010)

Section A – Resuscitation Instructions When Patient has No Pulse and/or is Not Breathing

Section A is titled Resuscitation Instructions When a Patient Has **No Pulse and/or Is Not Breathing**. It provides two boxes, only one of which will be checked. The first box, "**CPR Order: Attempt Cardio-Pulmonary Resuscitation,**" indicates that the patient wants all resuscitation efforts to be made, including defibrillation and intubation, if they are found in cardiac and/or respiratory arrest.

The second box, "**DNR Order: Do Not Attempt Resuscitation (Allow Natural Death),**" indicates the patient does **not** want any resuscitation efforts made, and the patient wishes to be allowed a natural death. This does **not** prevent treatment up to the point of resuscitation.

Section B - Consent for Resuscitation Instructions

This section **MUST** be filled out in accordance with New York State law. A box should always be checked to indicate who consented to the decision, and the name of the decision-maker should be printed. If the signature line is left blank, the box for verbal consent should be checked. If the box for verbal consent is checked, the attending physician who signed the order should have witnessed the consent or two other adult witnesses should be indicated.

Section C – Physician Signature for Sections A and B and for section E

A licensed physician must always sign the orders. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

As with the Nonhospital Order Not to Resuscitate form ([DOH-3474](#)), the MOLST form is required to be reviewed by the physician periodically. However, both forms should be considered valid unless it is known that the medical order has been revoked.

Section D – Advance Directives

This section contains multiple check boxes listing advanced directives for the patient.

Section E – Orders for Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Still Breathing

This section contains several parts containing treatment options that must be reviewed by prehospital care providers and includes:

Treatment Guidelines

- Comfort measures only
- Limited medical interventions
- No limitations

Instructions for Intubation and Mechanical Ventilation

- Do Not Intubate (DNI)
- A trial period
 - Intubation and mechanical ventilation
 - Non-invasive ventilation (e.g. BIPAP)
- Intubation and long-term mechanical ventilation

Future Hospitalization/Transfer

- Do not send to hospital unless pain or severe symptoms cannot otherwise be controlled
- Send to hospital if necessary, based on MOLST orders.

Artificially Administered Fluids and Nutrition

- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube
- No IV fluids
- A trial period of IV fluids

Antibiotics

- Do not use antibiotics
- Limited use of antibiotics
- Use antibiotics

Other Instructions (e.g. dialysis, transfusions)

If any part of Section E is completed, additional consent and a physician signature, similar to Section B, must be documented at the end of this section. Sometimes two boxes will be checked in Section E. If the form was completed in the community (as opposed to a hospital or nursing home), a Public Health Law Surrogate may consent to a nonhospital DNR and/or DNI order, but may not consent to withholding other life-sustaining treatment unless the consent is based on clear and convincing evidence of the patient's wishes. For that reason, the

box for “based on clear and convincing evidence of the patient’s wishes” may be checked in addition to the box for “Public Health Law Surrogate.”

Liability Protection

PHL § 2994-gg provides: "No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this section."

Frequently Asked Questions

What should I do if I am uncertain how to proceed?

Contact Medical Control.

What do I do if the patient has both a nonhospital DNR order and a MOLST form? Which do I honor?

If the forms have different orders, you should follow the form that has the most recently dated authorization. In all instances you should follow the DNI instructions on the MOLST form if the form is signed by a physician, as the nonhospital DNR order does not provide this advice.

What if the old MOLST form was signed prior to June 1, 2010, the date the Family Health Care Decisions Act became effective?

You may honor the previous versions of the form as if it were authorized after the statutory effective date.

Does the MOLST law allow EMS to honor other advance directives?

The law does not expand the ability of EMS personnel to honor advance directives such as a Health Care Proxy or Living Will.

What procedures are, and are not, performed if the patient presents a DNR?

Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest (i.e., when the patient has no pulse and/or is not breathing), NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications. If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided, unless Section E of the MOLST form provides different instructions. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.

CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.

What documentation is required for a patient with a DNR order?

Prehospital care providers should attach a copy of the Out of Hospital DNR form, MOLST form, hospital DNR order and/or copy of the patient’s chart to the patient care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the physician, date signed and other appropriate information.

If the cardiac/respiratory arrest occurred during transport, the DNR form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.

Patients who are identified as dead at the scene need not be transported by ambulance; however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.

MOLST Training

EMS providers and agencies who are interested in more specific training regarding the MOLST form and process may go to <http://www.compassionandsupport.org>. This site has a specific training program for EMS providers. The site contains frequently asked questions and a training video that would be useful to better understand the MOLST form and process.

If you have other questions about this policy guidance please contact your DOH Regional EMS office or you may call 518-402-0996.

Resources

New York State Department of Health MOLST Information:

http://www.health.state.ny.us/professionals/patients/patient_rights/molst/index.htm

MOLST Forms

<http://www.health.state.ny.us/forms/doh-5003.pdf>

Compassion and Support Website:

<http://www.compassionandsupport.org>

MOLST Training Center:

http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center

MOLST EMS Training Page:

http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center/ems_molst_training

Issued and authorized by Lee Burns, Acting Director of the Bureau of EMS