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# Non-Emergency Transport Questionnaire Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Named Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DBA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a new venture? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years in business? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your EMS License been suspended, under revocation or in an administrative sanction in the last 5 years?

YES NO

1. List the major metropolitan area(s) served?

A.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The number of Ambulance calls in the past 12 months: Emergency \_\_\_\_\_\_\_\_\_\_\_ Non-Emergency\_\_\_\_\_\_
2. The number of Para-transit/wheelchair calls in the past 12 months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your service perform the following services?

|  |  |  |
| --- | --- | --- |
| **Advanced Life Support** | **Conscious Sedation** | **Manual Defibrillation** |
| **Basic Life Support** | **Endotracheal Intubation** | **Mechanical Ventilation** |
| **IV Therapy/Monitoring** | **Pulse Oximetry** | **12-Lead EKG Monitoring** |
| **Administer Anesthesia** | **OTHER** |  |

1. Number of full time and part time employees that drive or provide patient care.

|  |  |  |
| --- | --- | --- |
| **Paramedics** | **RN/Flight Nurses** | **EMT- A/ EMT- I** |
| **EMT- B** | **First Responders** | **Other** |
| **Volunteers** |

\\*\*\*\*\*\* Are shifts separated? For example: Emergency employees are assigned to emergency only duty and Non-Emergency employees are assigned to non-emergency duty only? \*\*\*\*\*\*\*\*\*\*

YES NO

**What are the vehicle counts in your fleet?**

|  |  |  |
| --- | --- | --- |
| **Ambulances** | **Paratransit Vehicles** | **Wheelchair van** |
| **Stretcher Vans** | **Passenger Vans** | **Air ambulances** |

**Patient Handling (select all the stretcher types your fleet has)**

|  |  |  |
| --- | --- | --- |
| **X- Frame** | **Fold-Away** | **Power-Cot** |
| **Bariatric Cot** | **Stair Chair** | **Wheelchair lifts** |
| **Ramps with winches** | **Other** |  |

Is there use of knee, chest and over the shoulder safety restraints on the stretchers?

Do you have a mandatory lift assist policy in place? YES NO At what weight? \_\_\_\_\_\_\_\_

**Do you transport prisoners YES NO mental patients YES NO**

**Does your company have a dispatch center?**

1. Do they dispatch emergency requests YES NO
2. Do they dispatch non-emergency requests YES NO
3. Do they schedule routine ambulance transfers YES NO
4. Do the schedule routine wheelchair/Paratransit runs YES NO

**Do you participate in any of the following?**

|  |  |  |
| --- | --- | --- |
| **Air Ambulance** | **Water Rescue** | **Aerial Rescue** |
| **Off Shore EMS** | **Tactical Medical Service** | **Confined Space Rescue** |
| **Car/Motocross Events** | **High School Sports EMS** | **Horse Racing EMS** |
| **Concert EMS** | **Professional Sports EMS** | **Night Club EMS** |
| **Rave Event EMS** |  |  |

**Vehicle Maintenance:**

1. Is there a condition report completed on each transport vehicle & its equipment on each shift? YES NO
2. Who performs the maintenance on your fleet?

In-House (certified) mechanic Outside (certified) mechanic)

**Human Resources/Licensing:**

1. Title of the person responsible for training and performing license confirmation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. What applies to your employee selection process:

|  |  |  |
| --- | --- | --- |
| **Written application** | **Background check** | **MVR Check** |
| **Evidence of pertinent certification** | **Drug Screen** | **Previous ambulance experience check** |

1. Does this person confirm that all license requirements are met yearly? CPR and State and Federal guidelines? YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Owner/Director Date