

### Ambulance Permit Renewal Check List—2025/2026

| Vendor         | Contact Person    |
|----------------|-------------------|
| STAR Ambulance | Brooke Entsminger |

| Item                                                                                                               | Yes | No | Other            |
|--------------------------------------------------------------------------------------------------------------------|-----|----|------------------|
| Completed signed renewal application form                                                                          | X   |    |                  |
| Copy of, or description of Applicant's policy or program for vehicle maintenance                                   | X   |    |                  |
| List or description of Applicant's radio equipment                                                                 | X   |    |                  |
| Valid California Highway Patrol inspection report for each ground ambulance                                        | X   |    |                  |
| Applicant's quality management practices and policies                                                              | X   |    |                  |
| Staffing and hiring policies                                                                                       | X   |    |                  |
| Organizational chart of management staff                                                                           | X   |    |                  |
| Resume of training, orientation program and experience of the Applicant in the transportation and care of patients | X   |    |                  |
| Legible copies of current California Driver's License for each employee listed in the application.                 |     |    |                  |
| Copies of EMT Certification and/or Paramedic Licensure cards                                                       |     |    |                  |
| Current Fee Schedule                                                                                               | X   |    |                  |
| Certificate of insurance as required by the Humboldt County Risk Manager                                           |     |    |                  |
| Application fee in the amount of \$319 for each service area payable to Humboldt County                            |     | X  | Waved—non-profit |

| Specific Items for Permit Officer to Review |
|---------------------------------------------|
|                                             |

|                  | Yes | No | Other |
|------------------|-----|----|-------|
| Permit Approved? |     |    |       |

Approved by: Chackton, W.D.

Date: 6/18/25

Internal document not to be released.



**County of Humboldt  
Eureka, California  
Ambulance Service Permit Renewal Application**

Pursuant to Humboldt County Code, Title V, Division 5  
Emergency Medical Services System

| <b>Applicant – DO NOT FILL OUT THIS SECTION</b> |                                                          |
|-------------------------------------------------|----------------------------------------------------------|
| <b>Date Received:</b>                           |                                                          |
| <b>Application Fee of \$196.00 Received:</b>    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <b>Proof of Liability Insurance Attached:</b>   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <b>Resumes Attached:</b>                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**Applicants – Please completely fill out this section and provide all requested information/verifications:**

**Level of Service:** ☒ Basic Life Support ☒ Advanced Life Support

☐ Non-Emergency Transport (check all that apply)

|                                     |                              |                      |                         |
|-------------------------------------|------------------------------|----------------------|-------------------------|
| <b>Ambulance Service Full Name:</b> | Southern Trinity Area Rescue |                      |                         |
| <b>Name of Contact Person:</b>      | Brooke Entsminger            |                      |                         |
| <b>Mailing Address:</b>             | PO Box 4                     | <b>City/Zip Code</b> | Mad River, 95552        |
| <b>Physical Address:</b>            | 321 Mad River Rd             | <b>City</b>          | Bridgeville/ Mad River  |
| <b>Telephone/ Fax Numbers</b>       | 707-574-6616 x2090           | <b>E-Mail</b>        | bentsminger@we-care.org |



**County of Humboldt**  
**Eureka, California**

**VEHICLES:**

In conformity with the County Ordinance concerning the Permitting of Ambulance Service, the Applicant requests permission from the Permit Officer to operate the following ambulance vehicles:

|           | <b>Year</b> | <b>Model/Make</b> | <b>Vehicle Identification Number</b> | <b>License Plate #</b> | <b>Length of Time In Use<br/>(Include current mileage shown on odometer)</b> | <b>State or Federal Aviation Agency License Number</b> | <b>Description of Color Scheme, Insignia Name, Monogram, or Distinguishing Characteristics</b> |
|-----------|-------------|-------------------|--------------------------------------|------------------------|------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <b>1.</b> | 2022        | Ford F350         | 1FDRF3HT7NDA00417                    | 74452P3                | 3 YEARS<br>(3274)                                                            |                                                        | Type 1 Ambulance, STAR logo in black silver , and maroon                                       |
| <b>2.</b> | 2014        | Ford E350         | 1FDSS3EL8EDB14606                    | 1481361                | 9 YEARS<br>(53688)                                                           |                                                        | Type 2 Ambulance, Southern Trinity Area Rescue written on side with Cardiac pattern.           |
| <b>3.</b> |             |                   |                                      |                        |                                                                              |                                                        |                                                                                                |



**County of Humboldt  
Eureka, California**

- ☒ Attach a copy, or provide a description, of Applicant's policy or program for maintenance of vehicles.
- ☒ Attach a list, or provide a description of, Applicant's radio communication equipment.
- ☒ Attach evidence of **currently valid California Highway Patrol inspection report** for each ground ambulance vehicle listed in the application.
- ☒ Applicant certifies that it has reviewed and meets the requirements set forth in Humboldt County Code, Title V, Division 5, Sections 551-5 (Standards for Ambulance Service Permit) and 551-9 (Standards for Ambulance Equipment and Operations).
- ☒ Attach copies, or provide descriptions of the following:
  - ☒ Applicant's quality management practices and policy;
  - ☒ Staffing and hiring policies;
  - ☒ Organizational chart of management staff;
  - ☒ Resume of the training, orientation program, and experience of the Applicant in the transportation and care of patients; and
  - ☒ Knowledge of and/or involvement in the Humboldt County Emergency Medical Services system.
- ☒ Attach legible copies of current California Driver's License for each employee listed above.
- ☒ Provide copies of EMT certification and/or Paramedic licensure cards.
- ☒ Applicant certifies that the individuals listed above are qualified, duly licensed and/or certified drivers, attendants, and attendant-drivers, and said individuals are currently compliant with any and all applicable training, licensing, and permitting requirements set forth by local, state, and federal law and regulations.





**County of Humboldt**  
**Eureka, California**

subrogation against COUNTY, its officers, officials, agents, representatives, volunteers, and employees. In all cases the above insurance shall include Employers Liability coverage with limits of not less than One Million Dollars (\$1,000,000) per accident for bodily injury and disease.

4. Insurance Notices must be sent to:

County of Humboldt  
Attention: Risk Management  
825 5<sup>th</sup> Street, Room 131  
Eureka, CA 95501

5. The Comprehensive General Liability shall provide that the COUNTY, its officers, officials, employees, representatives, agents, and volunteers, are covered as additional insured for liability arising out of the operations performed by or on behalf of CONSULTANT. The coverage shall contain no special limitations on the scope of protection afforded to the County, its officers, officials, employees, and volunteers. Said policy shall also contain a provision stating that such coverage:

- a. Includes contractual liability.
- b. Does not contain exclusions as to loss or damage to property caused by explosion or resulting from collapse of buildings or structures or property underground commonly referred to "XCU Hazards".
- c. Is primary insurance as regards to County of Humboldt.
- d. Does not contain a pro-rata, excess only, and/or escape clause.
- e. Contains a cross liability, severability of interest or separation of insureds clause.

☒ Attach the Certificate of Liability Insurance naming the County of Humboldt certificate holder.



**County of Humboldt**  
**Eureka, California**  
**Required Paperwork Checklist**

- ☒ Application complete
- ☒ Certificate of Automobile and liability coverage
- ☒ Verification that each vehicle listed in application has been certified by the California Highway Patrol and/or the Health Officer pursuant to County Ordinance Section 551-9
- ☒ Certificate of Workers Compensation Insurance, compensation coverage including endorsement of additional insured and waiver of subrogation.
- ☒ Proposed Rates & Schedule of Charges
- ☒ All requested documentation of Applicant's policies and programs (as set forth in the application) are attached and complete

☒ Application fee or proof of payment of application fee *waived - non profit*

Vehicles

Excludes -

\* Vehicle Maintenance  
Policy

COPY

Southern Trinity Area Rescue

**Transportation Safety Policies**

2008

**Southern Trinity Health Services  
153-A Van Duzen Road  
Mad River, CA 95552**



## **Incidents, Accidents, and Collisions**

### **Incident Reports**

Drivers shall use Incident Reports to document rider/driver accidents or any unusual occurrences (other than vehicle collisions). [Form 31: Incident Report]

These might include:

1. Interactions with doctors and nurses
2. Gatekeeper information
3. Rider complaints

### **Auto Collisions**

**Southern Trinity Health Services shall have accident kits** for all drivers. A kit shall be kept in all vehicles owned by Southern Trinity Health Services and should be provided to volunteer drivers operating POV's. Drivers shall be instructed to follow the procedures contained in the accident kit.

**Typically these kits include:**

1. Witnesses cards
2. Measurement tool
3. Pen or pencil
4. Chalk
5. Form to diagram accident
6. Emergency numbers and procedures

### ***Procedures and Record Keeping***

1. Complete and accurate records of any collision or claim of collision, no matter how slight, must be kept in a permanent file. "Permanent" refers to "as long as is required by law." Drivers should not admit fault to anyone other than the manager or police.
2. Any claim of bodily injury or property damage must be reported to the manager immediately. Collision reports must be completed by the driver of the vehicle and reviewed by the Manager within 24 hours.
3. All collisions, no matter how slight, should be reported to the Sponsoring Organization, and a collision report submitted. However, in the event of a serious collision, the volunteer driver should contact Southern Trinity Health Services immediately. A serious collision involves severe property damage, personal injury or the potential for media involvement. [Form 32: Collision Report]

### *The Collision Scene*

1. In the rare case that a serious or disabling collision occurs, ideally the Manager, or designated representative, should immediately go to the scene of the collision to provide support and information. It is the responsibility of the Manager to represent the program at the collision scene in a way that avoids any further liability. The Manager should bring a camera to the scene to assist with the review process.
2. Because drivers can be injured or become distraught at the scene of a collision, collision procedures and guidelines should be an important part of orientation training for new drivers.
3. It is important that the driver document who was in his/her vehicle and any vehicle that was involved in the collision. This can be done with a disposable camera which is part of the vehicle's emergency equipment.

### *Procedures for Managers at the Scene of a Collision*

Collisions of any type can be an upsetting situation for the driver. A distraught or injured driver can increase liability for the program by what he/she says at the collision scene. For example, when a driver tells riders or bystanders, "I'm so sorry, it's my fault," the potential for claims made against the program will dramatically increase. The program should pay claim expenses it is responsible for, but it should not pay additional expenses because of erroneous statements made at the scene of the collision.

### **Managers should consider the following factors when called to the scene of an accident:**

1. Assure that riders are accounted for and are receiving proper emergency services.
2. Separate the driver from the collision scene.
3. Speak for the program and the driver.
4. The driver should be available to answer questions from police and fire authorities.

### *Media Relations at the Scene of a Collision*

Poor media relations at the scene of a collision can cause additional liability. Managers and program representatives should be familiar with and follow procedures when communicating with the media. Guidelines should be in place for employees or volunteers at the scene of a collision. The guidelines may include:

1. Assume the media is present.
2. Project a professional image.
3. Maintain control of the situation.
4. Do not quote hearsay or speculation.

5. Do not accept responsibility for the collision.
6. Explain "no comment" by saying, "I don't have enough information to answer that question accurately."
7. Never speak "Off the Record".
8. When interviewed on camera or video, carefully select the background. Stand in front of a neutral background, not in front of the crash.
9. Contact Southern Trinity Health Services immediately in the event of a serious collision.

#### *Collision Review*

A Review Committee, consisting of the Manager and other program representatives, is responsible for reviewing collision reports. In the event of a collision, the committee comes together to review the details of the collision and make recommendations. All collisions must be evaluated for preventability. In each case, preventability is evaluated on the basis of the following statement: "Did the driver do everything reasonably possible to avoid the circumstances that led to this collision?"

## **Driver Records**

**Southern Trinity Health Services shall have a file containing** all pertinent information about each driver. The Federal Privacy Act covers volunteer drivers. All personal information about the driver should be covered by a written confidentiality policy that parallels the organization's personnel policies. The following is a list of the documents, and related information, to be maintained in driver files: [Form 33: Personnel Records Checklist]

1. Original volunteer/employment application
2. Interview and reference check documentation
3. Criminal history documentation
4. Department of Motor Vehicles (DMV) history report and any subsequent history reports generated
5. Copy of current drivers license
6. Copy of training certifications
7. On-going objective documentation
8. Any documentation relevant to performance
9. Copy of current personal automobile insurance card. Insurance must be at least the State of California's minimum coverage requirement for POV drivers. Personal auto insurance verification must be kept current.

## **Vehicle Records**

**A vehicle file shall contain sections where the following documentation is maintained:**

1. Vehicle maintenance schedule
2. Maintenance records
3. Maintenance receipts
4. Description of maintenance completed
5. Daily pre-trip inspections
6. Inventory of safety equipment
7. Maintenance records for related safety equipment (i.e. fire extinguishers)

## **Rider Records**

**Southern Trinity Health Services shall maintain specific information on the riders using the services.** The rider information must be collected and properly maintained using a database or an adequate system done by hand if the agency does not have access to a computer. Rider information, collected by Southern Trinity Health Services, will be used primarily for reporting purposes. In the event of an emergency, this information can also be valuable. Rider records should contain the following information:

1. Rider's name
2. Address
3. Phone number
4. Age



# Southern Trinity Health Services Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

## Description of STAR Radio Equipment

|         |                                   |
|---------|-----------------------------------|
| TK7360H | Kenwood 50 Watt Mobile Radio      |
| KPS13   | DC Power Supply                   |
| KMB24   | Base Station Mounting Case        |
| KMC9C   | Desk Microphone                   |
| FG1523  | VHF Base Station Antenna          |
| TK2180  | Kenwood Hand held portable radios |

COPY

STAR owns and maintains multiple base station radios with base station antenna, at the clinic, which is our main dispatch center, as well as at each volunteer dispatcher's house.

STAR maintains Kenwood Mobile Radios in each ambulance it operates.

STAR has multiple Kenwood hand held portable radios. 2 are kept at the clinic ambulance station, the rest are kept by each volunteer responder at their home for use while on duty or on a call.

STAR owns and maintains a repeater on the ridge behind Dinsmore to boost communication in eastern Humboldt County from Pickett Peak.



STATE OF CALIFORNIA  
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

**SPECIAL VEHICLE IDENTIFICATION CERTIFICATE/PERMIT**

CHP 301 (REV 4-97) OPI 062

CHP AREA: 175

CHP Certificate/Permit Number: **1956- 14202**

ISSUED: 11/23/2024 EXPIRES: 11/23/2025

AREA:

☐ INITIAL ☐ DUPLICATE  
☐ REPLACEMENT ☒ RENEWAL

☒ EMERGENCY AMBULANCE CERTIFICATE ☐ ARMORED CAR CERTIFICATE  
☐ AUTHORIZED EMERGENCY VEHICLE PERMIT\*

VEHICLE YEAR & MAKE: **2014 FORD E 350**

VEHICLE LICENSE NO. **1481361 CA**

VIN: **1FDSS3EL8EDB14606**

\*Authorized Emergency Vehicle Permit Issued pursuant to Vehicle Code Section 2416 (a) ( ) for

NAME AND MAILING ADDRESS

**24**  
SOUTHERN TRINITY HEALTH SERVICES  
SOUTHERN TRINITY AREA RESCUE  
321 VAN DUZEN ROAD  
MAD RIVER CA, 95552-

PROPERTY OF CALIFORNIA HIGHWAY PATROL

This certificate/permit, or a facsimile thereof, shall be carried in the vehicle at all times. It is non-transferable and shall be surrendered to the CHP upon demand or as required by regulation.



STATE OF CALIFORNIA  
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

**SPECIAL VEHICLE IDENTIFICATION CERTIFICATE/PERMIT**

CHP 301 (REV 4-97) OPI 062

CHP AREA: 175

CHP Certificate/Permit Number: **1956- 18888**

ISSUED: 11/23/2024 EXPIRES: 11/23/2025

AREA:

☐ INITIAL ☐ DUPLICATE  
☐ REPLACEMENT ☒ RENEWAL

☒ EMERGENCY AMBULANCE CERTIFICATE ☐ ARMORED CAR CERTIFICATE  
☐ AUTHORIZED EMERGENCY VEHICLE PERMIT\*

VEHICLE YEAR & MAKE: **2022 FORD E-350**

VEHICLE LICENSE NO. **74452P3 CA**

VIN: **1FDRF3HT7NDA00417**

\*Authorized Emergency Vehicle Permit Issued pursuant to Vehicle Code Section 2416 (a) ( ) for

NAME AND MAILING ADDRESS

**24**  
SOUTHERN TRINITY HEALTH SERVICES  
SOUTHERN TRINITY AREA RESCUE  
321 VAN DUZEN ROAD  
MAD RIVER CA, 95552-

PROPERTY OF CALIFORNIA HIGHWAY PATROL

This certificate/permit, or a facsimile thereof, shall be carried in the vehicle at all times. It is non-transferable and shall be surrendered to the CHP upon demand or as required by regulation.



STATE OF CALIFORNIA  
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL

**EMERGENCY AMBULANCE  
NON-TRANSFERABLE LICENSE**

CHP 360A (REV. 01-00) OPI 062

SERVICE NAME AND PHYSICAL ADDRESS *(only if different from below)*

**SOUTHERN TRINITY HEALTH SERVICES**

**SOUTHERN TRINITY AREA RESCUE**

**321 VAN DUZEN ROAD**

**MAD RIVER CA, 95552-**

SERVICE NAME AND MAILING ADDRESS

**SOUTHERN TRINITY HEALTH SERVICES**

**SOUTHERN TRINITY AREA RESCUE**

**321 VAN DUZEN ROAD**

**MAD RIVER CA, 95552-**

Attention: **LEE LUPTON, CEO**

| CONTROL NUMBER     | LICENSE NUMBER | ISSUE DATE                         | EFFECTIVE DATE                              | EXPIRATION DATE |
|--------------------|----------------|------------------------------------|---------------------------------------------|-----------------|
| 1956               | 1956           | 9/19/2024                          | 11/23/2024                                  | 11/23/2025      |
| CHP CARRIER NUMBER | LOCATION       | <input type="checkbox"/> Duplicate | <input type="checkbox"/> Replacement        |                 |
| CA-                | 175            | <input type="checkbox"/> Initial   | <input checked="" type="checkbox"/> Renewal |                 |

**PROPERTY OF THE CALIFORNIA HIGHWAY PATROL (CHP)**

This license is NON-TRANSFERABLE and must be surrendered to the CHP upon demand or as required by law. A majority change in ownership or control of the licensed activity shall require a new license. This license may be renewed within the 30-day period prior to the expiration date indicated above.

Ambulance operations must cease immediately upon expiration of this license. THERE IS NO GRACE PERIOD FOR A LICENSED ACTIVITY. The Department will accept an application for renewal during the 30-day period following the license expiration date provided all required documentation is complete and accompanied by the initial license fee of \$200.00. For license information contact CHP, Research and Planning Section at (916) 843-3440.

|                                                                                   |      |                                                                                   |
|-----------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------|
|  | 3501 | <b>Emergency Medical Services System<br/>Quality Improvement Program (EMSQIP)</b> |
| Nor-Cal EMS Policy & Procedure Manual                                             |      | Documentation and Quality Improvement                                             |
| Effective Date: 4/07/2021                                                         |      | Next Revision: 4/07/2024                                                          |
| Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR                                    |      | SIGNATURE ON FILE                                                                 |

## Authority

Health and Safety Code Division 2.5, California Code of Regulations, Title 22, Division 9. California Administrative Code, Title 22, Division 9, Chapter 1.5, 2, 3 and the Health and Safety Code, Division 2.5, Section 1797.220

## Purpose

To establish Emergency Medical Services Quality Improvement Program(EMSQIP) requirements for EMS system participants.

## Policy

- 1) AED/BLS/ALS/LALS prehospital provider organizations and base/modified base hospitals shall submit a written EMSQIP to Nor-Cal EMS for review and approval every five (5) years. The written EMSQIP shall include the following minimum information (template provided):
  - a) Provider name and management structure, including QI coordinator, medical director, and internal QI structure. Include an organizational chart if available.
  - b) Description of how, how often and who collects/analyzes QI indicator data.
  - c) Description of how and how often QI indicator data is shared with QI committees, technical advisory committees, peer review groups, management, etc.
  - d) Description of how the provider communicates QI activities to external stakeholders (other EMS system participants, elected officials, the public, etc.).
  - e) Description of the provider's approach to performance improvement and the process used to implement changes.
  - f) Description of how provider policies and procedures are developed/revised, and how staff are educated/trained on new/revised policies and procedures.
  - g) Description of how staff are educated/trained on new/revised Nor-Cal EMS policies and protocols.
  - h) Description of the process for ensuring staff complete other required EMS education/training.
- 2) All AED/BLS/ALS/LALS EMS system participants shall participate in the Nor-Cal EMS EMSQIP which may include providing records for program monitoring and evaluation.
- 3) AED/BLS/ALS/LALS EMS system participants shall develop a performance improvement plan when their EMSQIP identifies a need for improvement. Collaboration with Nor-Cal EMS and/or other EMS system participants will collaborate to identify system issues, will be discussed at MAC/AMAC, and a year plan will be determined.
- 4) All agencies with Nor-Cal EMS will be sent a year-end report form, requesting data of pre-determined criteria and narrative reviews. This data can be pulled from agency ePCRs/PCRs.
- 5) All provider agencies:
  - a) Peer Review Audit form is available for use for EMSQIP in your agency. You may submit the forms with the year-end report for those PCRs within the criteria.
  - b) The Optional Scope Utilization form shall be submitted within 7 days of the use of optional scope skills/medications.
  - c) Optional Skills training rosters shall be submitted yearly to Nor-Cal EMS.



## **SOUTHERN TRINITY HEALTH SERVICES**

|                                                             |                                                                                               |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <b>Section: Operations</b>                                  | <b>Approved by: CQI and Board of Directors</b>                                                |
| <b>Policy: Continuous Quality Improvement Program (CQI)</b> | <b>Adopted Date: 7/1/2004</b>                                                                 |
| <b>Reference Number: OPS.030</b>                            | <b>Last CQI Review and Approval: 10/23/14</b><br><b>Last BOD Review and Approval: 2/22/12</b> |
| <b>Page 1 of 7</b>                                          | <b>Next Review and Approval: 10/28/14</b>                                                     |

### **Policy**

**COPY**

To establish and outline the structure and function of Southern Trinity Health Services (STHS) Continuous Quality Improvement Program.

### **Purpose/Goal**

The primary mission of Southern Trinity Health Services is to improve the quality of life in Southern Trinity and Southeastern Humboldt Counties by providing access to quality, comprehensive, innovative, and integrated health care and emergency medical services regardless of ability to pay. STHS acknowledges that quality health care and the systems that support that care must be the foundation of a successful health care organization. STHS is committed to providing optimal health care for its patients consistent with regulatory and accepted standards of practice established by the STHS medical staff.

Southern Trinity Health Services recognizes that the patient experience is influenced by every aspect of the services provided and by every employee and volunteer the patient encounters. The Continuous Quality Improvement Program must be organization wide and include medical, dental, behavioral health, emergency medical services, transportation, facility, business, administrative services and the Southern Trinity Health Services Board of Directors.

### **Procedure**

The Quality Improvement Plan assesses each area of care individually and how they interact and support patient care as a whole. The Quality Improvement process will utilize both internal and external audit systems; track and review defined clinical indicators and outcomes; sentinel events and 'near miss' incidents; patient comments, both formal and anecdotal, negative and positive; and employee reports, observations, concerns and comments.

The Continuous Quality Improvement Committee is responsible for ensuring the compliance of all policies and procedures of the organization both clinical and operational. Refer to OPS.O 19 Policy Development and Approval for further information.

Southern Trinity Health Services is committed to fostering an open and supportive environment for identifying, reporting, discussing and correcting events before they become problems. Resolution will be sought through examining systems; policy, products, tools, procedures, and education. Solutions will be rewarded; finger pointing and blame will be discouraged. Individual corrective actions, if necessary, will be conducted in private, and documented appropriately.

## **Continuous Quality Improvement - CQI Committee**

The CQI Committee provides the leadership necessary to develop implement and oversee quality related activities. The active participation of departmental leadership is necessary to demonstrate that Southern Trinity Health Services is committed to quality and safety.

The CQI Committee is an organization-wide group composed of representatives from all departments. The following are the minimum requirements for CQI Committee composition:

- Executive Director
- Medical Director
- Dental Director
- Behavioral Health Director
- Financial Officer/Administrative/ Fiscal Representative
- Operations Officer – Patient flow, Front Office Representative
- Provider Representatives – Medical and Dental Back Office
- Risk Manager/Loss Control/ Facilities Representative
- Quality Assurance Coordinator, RN
- Board of Directors Representative

The Executive Director or designee serves as chair of the CQI Committee with responsibility for setting and approving agendas, leading meetings and providing leadership in the selection of CQI activities and priorities. The Executive Director may designate a CQI Coordinator with responsibility for carrying out the administrative activities necessary to conduct Committee business. The Coordinator will ensure that meetings are held at least 10-12 times per year, that minutes of meetings are taken, distributed, records and documents are maintained for HRSA reporting purposes and prepared for Board of Directors approval each month, and that scheduled activities proceed according to the established calendar.

The Committee will evaluate the effectiveness of the Continuous Quality Improvement Program annually at the February meeting per the CQI reporting calendar Cycle I.

### ***Subcommittees of the CQI Committee***

The CQI Committee will form individual or joint subcommittees to investigate significant or recurrent events, to address an ongoing need to protect confidentiality and to identify opportunities for improvement. All subcommittees shall provide a written report to the full CQI Committee. The following subcommittees are designated as permanent individual or joint committees as CQI Committee deem appropriate to meet the requirement:

**The Chronic Pain Subcommittee** is tasked with monitoring the Chronic Pain Program, including but not limited to overall results, outcomes, problems, appropriateness and consistency of care delivered, review of individual patient care plans referred by the providers, and all requests by providers to withdraw opiate therapy due to violations of the pain contract. Subcommittee membership is limited to Medical, Behavioral Health, and Dental providers, Executive Management, and the Risk Manager to protect confidentiality. The subcommittee shall meet monthly and shall submit a report to the full CQI Committee which full protects individual patient information.

The Chronic Disease subcommittee is tasked with reviewing data for conditions identified in the STHS Health Care Plan, the Uniform Data System report structure, and other chronic conditions identified from time to time. The subcommittee shall monitor trends, compare them to established benchmarks and goals, and recommend improvements to the CQI Committee utilizing the PDSA model. The subcommittee shall consist of the Medical, Behavioral Health, Dental providers, Executive Management, and the Risk Manager, and shall meet monthly.

### **Confidentiality**

The review of patient data, employee performance data and other information of a sensitive nature is vital to the success of the quality improvement process. Southern Trinity Health Services requires all data to be protected. Information will only be reviewed and discussed in office spaces. All reports are confidential and will only be used for the quality improvement processes. All patient identification information shall be removed, as will all provider data for aggregate reports. Any discussion requiring patient or employee identification will be done in private.

### **Objectives**

1. To ensure the delivery of patient care at the maximum achievable level of quality in a safe and cost effective manner.
2. To ensure the effective "hand-off" of patient care between providers and other internal and external sources of care, including support and administrative services.
3. To develop effective systems for continuous problem assessment/identification, corrective action planning, plan implementation and evaluation of organization processes and services.
4. To develop a system of accurate comprehensive data collection methods to track, trend and report quality indicators for the organization and for external reporting compliance.
5. To educate all health care professionals and staff in the philosophy procedures and practices of quality assessment.
6. To utilize information gained in quality assessment activities to direct continuing medical education at STHS.
7. To increase knowledge and participation in quality improvement activities at STHS.
8. To identify opportunities for improvement and institute continuous improvement strategies as appropriate.
9. To demonstrate the program's overall impact on improving the quality of care delivered by STHS.

### **QI Process**

1. The Southern Trinity Health Services Health Care Plan identifies specific Health Care Goals and performance measures. The individual elements are reviewed annually by the CQI Committee on a three month rotating schedule as specified in the CQI reporting calendar Cycle I.
2. The Clinical tracking measures are developed from the Health Care Plan. The Health Care Plan defines internal goals, and establishes external benchmarking standards to be met or exceeded. The Clinical tracking measures are reviewed, progress noted, and corrective action decided upon on as scheduled in the QI reporting calendar Cycle I.

3. Quality Assurance measures including calibration of equipment, lab tracking, referral tracking, audit reports, and other regular inspection reports.
4. Quality Assurance measures are reviewed as set forth in the CQI reporting calendar Cycle 2.
5. Risk Management issues are reviewed as set forth in the CQI reporting calendar Cycle 3. Specific review items are included, but will also include any issue brought to the committee, or any issue of concern to any committee member.
6. Peer Review of assessment, treatment plans, and outcomes is a very important component of STHS CQI program. Southern Trinity Health Services is committed to fostering an open and supportive environment for identifying, reporting, discussing and correcting events before they become problems. The peer review process is intended to improve care to our patients, not to place blame. Generalized peer review results will be reviewed as indicated in the CQI reporting calendar Cycle 2. Specific concerns not able to be resolved via the peer review process will be directed to the Medical Director.
7. Identification of potential system problems or breakdowns
  - a. Quality control test reports
  - b. Peer review audits
  - c. Patient complaints and grievances
  - d. Incident reports
  - e. Medical and dental record audits
  - f. Clinical tracking reports
  - g. Equipment Damage report forms
  - h. Variance report forms
  - i. Other sources may include: patient care evaluation studies, financial data, productivity reports, disease management reviews, time and motion studies, patient flow studies.
  - j. Any report of an unusual nature may be considered by the CQI Committee. Anonymous or anecdotal reports will be considered generally, specific allegations will be considered on a case by case basis.

#### **Collecting and analyzing data**

STHS utilizes a tracking registry IMS/Medi-Tab in its Health Care Plan for maintaining, monitoring and improving quality of care for common chronic diseases and assuring optimal delivery of preventive services.

- |                                              |                                    |
|----------------------------------------------|------------------------------------|
| a. Data Collection and Information Resources | b. Reports from organization staff |
| c. Medical and dental records review         | d. Clinical tracking indicators    |
| e. Patient satisfaction surveys              | f. Employee satisfaction surveys   |
| g. Employee concerns and suggestions         | h. Patient warnings and dismissals |

#### **The Process Improvement Model**

STHS uses the PDSA (Plan, Do, Study, Act) method of process improvement to prevent adverse occurrences. If an item is entered into the CQI Committee meeting agenda, it will be followed at each meeting, and will be removed when satisfactory results have been achieved. The general flow should be similar to the following:

- a. Problem/Project Identification
- b. Entered into Problem/Project log by QI coordinator
- c. Initial investigation/action plan developed by QI coordinator
- d. Initial findings reported to QI Committee (or sub-committee) for review
- e. Action plan developed and executed by QI coordinator or other individual as assigned by QI Committee
- f. Results of action plan reported to QI Committee
- g. If resolved, determine review period
- h. If unresolved, revise and execute action plan

### **Incident Reporting**

The purpose of reporting incidents is to identify problems or potential problems that may result in unsafe, unhealthy circumstances and outcomes in the practice. The completion of an incident/variance report demonstrates conscientiousness and concern for those involved. Communication in the form of positive feedback to providers and staff on improvements made as a result of reported incidents reinforces use of the system as a non-punitive means of identifying problems and developing solutions. Other purposes include the following:

- a. To provide a record of the incident and to document factual information about the event.
- b. To encourage staff to identify incidents, near misses, and hazards.
- c. To provide for prompt treatment of any injuries that may have occurred.
- d. To notify responsible individuals about incidents and hazards and to allow for prompt investigation of circumstances surrounding an incident.
- e. To analyze information generated from reporting incidents and hazards and to take actions to prevent recurrence and improve safety.
- f. To provide documentation as a part of an incident investigation, an OSHA or other required agency reports, workers compensation claim processes, disability or insurance claims.

Incident/variance reports are confidential, internal documents and are maintained in confidential risk management files. Incident/variance reports are not placed in patient medical records.

### **CQI Information Distribution**

In order to ensure organization wide support and involvement of the entire organization, written minutes of the CQI Committee monthly meetings are submitted to the Medical Director, Executive Director for review, comment and action as appropriate. Board review and action where necessary shall be noted in the Board Meeting Minutes.

Southern Trinity Health Services also recognized that it is vital to the continued success of the Quality Improvement process that overall results, concerns, patterns and information are communicated to all employees and volunteers. This will be accomplished by discussion with all employees during the departmental team meetings. Significant findings or changes will be communicated at the monthly all staff meeting or at a special meeting if the Executive Director determines it necessary or beneficial.

**Attachment A: CQI Reporting Calendar**

**Cycle 1 January, April, July, October      Healthcare Plan Review & Tracking**

**Clinical Tracking**

- a. Early entry into prenatal care
- b. Childhood immunizations
- c. Cervical cancer screening
- d. Weight assessment and education – children
- e. Weight assessment and education – adult
- f. Tobacco use assessment
- g. Tobacco use intervention/education
- h. Asthmatic care
- i. Coronary artery disease/lipid therapy
- j. Ischemic Vascular Disease/antithrombotic therapy
- k. Colorectal cancer screening
- l. Adolescent and adult depression screening
- m. Early intervention for HIV care
- n. Diabetes A1c tracking
- o. Hypertension
- p. Birth weight
- q. Oral health
- r. Pain control

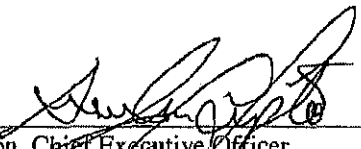
**Cycle 2 February, May, August, November      Quality Assurance**

- a. Annual Evaluation of CQI Program effectiveness (February)
- b. Pharmacy Report
- c. X-ray QC Report
- d. Lab OC Report
- e. Lab Tracking
- f. Referral Tracking
- g. STAR Quarterly QA Report
- h. Peer Review
- i. Patient Satisfaction Survey – continuous

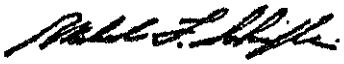
**Cycle 3 March, June, September, December      Risk Management/Compliance/HR**

- a. Patient warnings/dismissals
- b. Variance/Incident reports (medication errors, infectious disease, injuries/falls, HIPAA, etc.)
- c. Loss Control/Safety reports and Forms
- d. Policies & Procedures/Protocols/Standards
- e. Credentialing/privileging/competency
- f. Clinic licenses and certification updates – lab, x-ray etc.
- g. Job Descriptions/Scope – providers and support staff
- h. Employee evaluations – providers and support staff
- i. Training updates - HIPAA, Infectious Disease, EMT, CPR, ACLS, OSHA, etc.
- j. Employee Satisfaction Survey

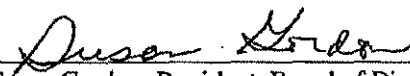
Approved

  
\_\_\_\_\_  
Lee Lupton, Chief Executive Officer

10/28/14  
Date

  
\_\_\_\_\_  
Michael Schafle, Medical Director

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Susan Gordon, President, Board of Directors

10.28.14  
Date

Attachment A: CQI Reporting Calendar

Forms: QI Tracking Log

References & Controlling Documents:

PAL 2001-16

PAL 2002-22 BPHC Credentialing & Privileging

PAL 2011-05

PAL 2014-09 Notice of HRSA FTCA Health Center Policy Manual

Other STHS policies:

OPS.009 Referral policy

OPS.010 Hospital Visit tracking policy

OPS.011 Lab results tracking

OPS.012 Imaging tracking

OPS.007 Incident reporting

OPS.019 Policy Development and Approval

OPS.031 Credentialing policy

OPS.042 Pharmacy & Supply Ordering

OPS.049 Patient Satisfaction Assessment

CLN.008 Peer Review Procedure

CLN.009 Drug Room

Accreditation Association for Ambulatory Healthcare (AAAHC) accreditation documents

National Committee for Quality Assurance (NCQA)

Revisions and Reviews:

Adopted 7/11/2004

Revision 11/16/2010, 2/22/2011, 3/22/2011, 6/21/2011, 10/28/2014



# Southern Trinity Health Services Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

## **Certification Information: (EMT, AEMT, Paramedic, EMD Only)**

- ☐ CPR Card Exp: \_\_\_\_\_
- ☐ EMT State Certification Number: \_\_\_\_\_ Exp: \_\_\_\_\_
- ☐ AEMT Local Accreditation Agency: ☐ NorCal ☐ North Coast
- ☐ Paramedic License Number: \_\_\_\_\_ Exp: \_\_\_\_\_
- ☐ Emergency Medical Dispatch Number: \_\_\_\_\_ Exp: \_\_\_\_\_

## **Required Copies**

- ☐ Adult/Child Abuse & Domestic Violence Reporting Requirements
- ☐ Confidentiality/Security Agreement
- ☐ Copy of Driver's License (Front & Back)
- ☐ Copy of Ambulance Endorsement
- ☐ Copy of Green Driver's Medical Card (Front & Back)
- ☐ Copy of EMT/AEMT/Paramedic/EMD Card (Front & Back)
- ☐ Copy of Auto Insurance (Responders only)
- ☐ Pull Notice Program Authorization (Drivers Only)
- ☐ Copy of CPR Card

| For STAR Management Use Only |             |
|------------------------------|-------------|
| Initial Start Date:          |             |
| Radio Information:           | Model: S/N: |
| Radio Call Sign:             |             |
| Equipment Assigned:          |             |





# Southern Trinity Health Services

## Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

### Certification Information: (EMT, AEMT, Paramedic, EMD Only)

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| For STAR Management Use Only |             |
|------------------------------|-------------|
| Initial Start Date:          |             |
| Radio Information:           | Model: S/N: |
| Radio Call Sign:             |             |
| Equipment Assigned:          |             |

- Never showing, discussing, or disclosing confidential, sensitive information, or PHI to or with anyone who does not have the legal authority or the "need to know"
- Storing confidential, sensitive information in a place physically secure from access by unauthorized persons
- Never removing confidential, sensitive, or PHI from the work area without authorization
- Disposing confidential, sensitive, or PHI by utilizing an approved method of destruction, which includes shredding, burning, or certified or witnessed destruction. Never disposing such information in the wastebaskets or recycle bins
- Reporting any violation of confidentiality, privacy, or security policies

## PENALTIES

Unauthorized access, use, modification, disclosure, or destruction is strictly prohibited. The penalties for unauthorized access, use, modification, disclosure, or destruction may include disciplinary action up to and including termination of employment and/or criminal or civil action.

Southern Trinity Health Services reserves the right to monitor and record all network activity including e-mail, with or without notice, and therefore users should have no expectations of privacy in the use of these resources.

## DISCLAIMERS

Nothing in this document creates any express or implied contractual rights. All employees are employed on an at-will basis. Employees have the right to terminate their employment at any time, and Southern Trinity Health Services retains a similar right.

*I certify that I have read, understood, and accept the Confidentiality Agreement above.*

Full Name

Department

Signature

Date

Signature

Date

TO BE PLACED IN EMPLOYEE'S PERSONNEL FILE  
SOUTHERN TRINITY HEALTH SERVICES

**Confidentiality / Security Agreement**

I have received Health Insurance Portability and Accountability Act (HIPAA) training and as such, I understand that while performing my official duties I may have access to protected health information. Protected Health Information (PHI) means Individually Identifiable health information that is transmitted or maintained in any form or medium. Protected health information is **NOT** open to the public. Special precautions are necessary to protect this type of information from unauthorized access, use, modification, disclosure, or destruction.

I agree to protect the following types of information:

All data elements described as protected health information (PHI) including but not limited to:

- Addresses
- Telephone numbers
- Fax numbers
- Electronic Mail addresses
- Social security numbers
- Medical record numbers
- Birth date
- Date of death
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial number, including license plate numbers
- Device identifiers and serial numbers
- Full face photographic images and any comparable images
- Client information (such as, disability insurance claimants, recipients of public social services, participants of state/federal programs, employers, etc.)
- Information about how automated systems are accessed and operate
- Any other proprietary information
- Any other unique identifying number characteristic, or code

I agree to protect PHI by:

All of the following means including but not limited to:

- Accessing, using, or modifying confidential, sensitive, or PHI only for the purpose of performing my official duties
- Never attempting to access information by using a user identification code or password other than my own
- Never sharing passwords with anyone or storing passwords in a location accessible to unauthorized persons.
- Never exhibiting or divulging the contents of any record or report except to fulfill a work assignment.

Issued: February 21, 2003 rev 7.26.2011

## ADULT/CHILD ABUSE & DOMESTIC VIOLENCE REPORTING REQUIREMENTS

California law requires that medical practitioners, non-medical practitioners, health practitioners and child care custodians working in health clinics and other specified public or private facilities be informed of their duty to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence.

*Please read the following carefully and sign where indicated.*

Section 11166 of the Penal code requires any child care custodian, medical practitioner, non-medical care practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she suspects has been the victim of a **child abuse** to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Any person who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist, as required, is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than five hundred dollars (\$500) or by both. The law also provides that a person who does report as required, or who provides a child protective agency with access to a victim, shall not be civilly or criminally liable for doing so.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of a health facility who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a **dependent adult** who he or she knows has been the victim of physical abuse, or who has injuries under circumstances which are consistent with abuse, to report the known or suspected instance of physical abuse to an adult protective services agency or a local law enforcement agency immediately, or as soon as practically possible, by telephone, and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. reporting is required where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred.

Sections 11160-11163 of the California Penal Code require that any health practitioner employed in a health facility, clinic or physician's office who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a patient whom he or she knows or reasonably suspects has suffered from any wound or injury inflicted as a result of **domestic violence or spousal abuse** shall immediately, or as soon as is reasonably possible, file a telephone report to the local law enforcement agency followed by a written report within two working days.

Failure to comply with these reporting requirements may lead to a fine of up to \$1,000 and/or up to six months in jail. A health practitioner who makes a report in accordance with this article shall not incur civil or criminal liability as a result of any report required or authorized by this article. Your clinical supervisor and Medical Center Administration should be notified whenever you believe that you may be required to report suspected abuse or violence.

I certify that I have read and understand this statement and will comply with my obligations under the dependent adult abuse, child abuse, and domestic violence reporting laws.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position/Department

Issued: February 21, 2003 rev 7.26.2011



A Public Service Agency

## EMPLOYER PULL NOTICE PROGRAM

### AUTHORIZATION FOR RELEASE OF DRIVER RECORD INFORMATION

I, \_\_\_\_\_, California Driver License Number, \_\_\_\_\_,  
hereby authorize the California Department of Motor Vehicles (DMV) to disclose or otherwise make available, my driving  
record, to my employer, \_\_\_\_\_

COMPANY NAME

I understand that my employer may enroll me in the Employer Pull Notice (EPN) program to receive a driver record report at  
least once every twelve (12) months or when any subsequent conviction, failure to appear, accident, driver's license suspension,  
revocation, or any other action is taken against my driving privilege during my employment.

I am not driving in a capacity that requires mandatory enrollment in the EPN program pursuant to California Vehicle Code  
(CVC) Section 1808.1(k). I understand that enrollment in the EPN program is in an effort to promote driver safety, and that my  
driver license report will be released to my employer to determine my eligibility as a licensed driver for my employment.

EXECUTED AT: CITY

COUNTY

STATE

DATE

SIGNATURE OF EMPLOYEE

X

I, \_\_\_\_\_, of \_\_\_\_\_,  
AUTHORIZED REPRESENTATIVE COMPANY NAME

do hereby certify under penalty of perjury under the laws in the State of California, that I am an authorized representative of  
this company, that the information entered on this document is true and correct, to the best of my knowledge and that I am  
requesting driver record information on the above individual to verify the information as provided by said individual. This  
record is to be used by this employer in the normal course of business and as a legitimate business need to verify information  
relating to a driving position not mandated pursuant to CVC Section 1808.1. The information received will not be used for any  
unlawful purpose. I understand that if I have provided false information, I may be subject to prosecution for perjury (Penal  
Code Section 118) and false representation (CVC Section 1808.45). These are punishable by a fine not exceeding five  
thousand dollars (\$5,000) or by imprisonment in the county jail not exceeding one year, or both fine and imprisonment. I  
understand and acknowledge that any failure to maintain confidentiality is both civilly and criminally punishable pursuant to  
CVC Sections 1808.45 and 1808.46.

EXECUTED AT: CITY

COUNTY

STATE

DATE

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE

X

To obtain a driver record on a prospective employee you may submit an INF 1119 form. To add this driver to the EPN Program  
you must submit the applicable forms: INF 1100, INF 1102, INF 1103, INF 1103A form. You may obtain forms at our website  
at [www.dmv.ca.gov/otherservices](http://www.dmv.ca.gov/otherservices), or by calling 916-657-6346.

**THIS FORM MUST BE COMPLETED AND RETAINED AT THE EMPLOYER'S PRINCIPAL PLACE OF BUSINESS AND  
MADE AVAILABLE UPON REQUEST TO DMV STAFF.**

**DO NOT RETURN THIS FORM TO DMV.**



# Southern Trinity Health Services Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

## Management Staff Organization

Lee Lupton – CEO



Amanda Huber- CEO



Brooke Entsminger – EMS Manager



Paramedics



Dispatchers & EMT's



Drivers

COPY



# Southern Trinity Health Services Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

COPY

## Resume

### Training:

- STAR is certified through Nor Cal EMS to instruct EMT and AEMT courses. STAR instructors put on one new course per calendar year.
- STAR has Continuing Education meetings for all local responders once a month with chart reviews included. STAR CE provider number 64-5308.
- STAR is linked with Redwood Memorial Hospital to attend Chart Review through teleconference when they are held at the hospital for North Coast EMS.
- STAR participates and organizes training opportunities with other emergency services (ex – USFS, REACH Air ambulance, Southern Trinity Volunteer Fire, Coast Guard and many more) on a regular basis.
- STAR provides dispatch training.

### Orientation:

- New STAR volunteers are required to fill out the new volunteer packet (included in attached papers) and provide all documentation required on it.
- New volunteers are brought in to practice driving as well as become oriented to the ambulance before being put on the schedule.
- Volunteers who will be providing patient care are scheduled as a third person on crew until ready to provide care independently and they have been observed by current responders.

STAR has been operating as an Emergency Medical Transport 911 Ambulance service since 1979. Regular training and education of all responders is required for their certification and by STAR. Responders must remain current for the best patient care possible.



## Southern Trinity Health Services Southern Trinity Area Rescue

*Serving Southern Trinity & Southeastern Humboldt Since 1979*

### **Humboldt County EMS System**

**Southern Trinity Area Rescue (STAR), acknowledges that North Coast EMS oversees EMS systems within Humboldt County. STAR understands that it's operating Policies and Procedures are dictated by Nor Cal EMS, and that Nor Cal EMS has an agreement with North Coast EMS and St Joes Health System – Redwood Memorial Hospital (RMH), for STAR to operate with RMH as its base hospital and primary place to transport patients.**

COPY



**AMBULANCE SERVICES PROVIDED**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Unit Dispatched 304 ☐  
305 ☐

Responder # \_\_\_\_\_ Name \_\_\_\_\_

Responder # \_\_\_\_\_ Name \_\_\_\_\_

Responder # \_\_\_\_\_ Name \_\_\_\_\_

**TIMES**Dispatched \_\_\_\_\_  
ENROUTE \_\_\_\_\_  
On Scene \_\_\_\_\_  
LEFT SCENE \_\_\_\_\_  
At Destination \_\_\_\_\_  
AVAILABLE \_\_\_\_\_  
Cancelled \_\_\_\_\_  
Back at Base \_\_\_\_\_**MILES**Beginning \_\_\_\_\_  
On Scene \_\_\_\_\_  
response miles ( \_\_\_\_\_ )  
At Destination \_\_\_\_\_  
patient miles ( \_\_\_\_\_ )  
Back at Base \_\_\_\_\_**ADVANCED LIFE SUPPORT**

| ALS                         | Code    | Fee         |
|-----------------------------|---------|-------------|
| ALS Non-Emergency Transport | A0426   | \$ 2,200.00 |
| ALS1 Emergency Transport    | A0427   | \$ 2,400.00 |
| ALS2 Emergency Transport    | A0433   | \$ 2,600.00 |
| Multiple Patient # _____    | A0370.5 | \$ 2,400.00 |

**BASIC LIFE SUPPORT**

| BLS                         | Code    | Fee         |
|-----------------------------|---------|-------------|
| BLS Non-Emergency Transport | A0428   | \$ 1,700.00 |
| BLS Emergency Transport     | A0429   | \$ 1,900.00 |
| Multiple Patient # _____    | A0362.1 | \$ 1,900.00 |

**OTHER SERVICES/PROCEDURES**

| Procedures                 | Code  | Fee       |
|----------------------------|-------|-----------|
| EKG/ECG Monitor            | 93005 | \$ 146.00 |
| Oxygen/Oxygen Supplies     | A0422 | \$ 100.00 |
| Extra Ambulance Attendant  | A0424 | \$ 150.00 |
| Ground Transport Miles     | A0425 | \$ 40.00  |
| Assessment- On Scene / AMA | A0998 | \$ 485.00 |
| Wait Time _____ hrs        | A0420 | 200.00/hr |



## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

4/10/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an **ADDITIONAL INSURED**, the policy(ies) must have **ADDITIONAL INSURED** provisions or be endorsed. If **SUBROGATION IS WAIVED**, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

|                                                                                        |                                                                   |                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------|
| <b>PRODUCER</b><br>Pauli-Shaw Insurance Agency<br>627 7th Street<br>Arcata CA 95521    | <b>CONTACT NAME:</b> Laura Knight                                 |                                    |
|                                                                                        | <b>PHONE (A/C, No, Ext):</b> 707-822-7251                         | <b>FAX (A/C, No):</b> 707-826-9021 |
| <b>INSURED</b><br>Southern Trinity Area Rescue, Inc.<br>PO Box 4<br>Mad River CA 95552 | <b>E-MAIL ADDRESS:</b> laura@pauli-shaw.com                       |                                    |
|                                                                                        | <b>INSURER(S) AFFORDING COVERAGE</b>                              |                                    |
|                                                                                        | <b>INSURER A:</b> Arch Specialty Insurance Company                |                                    |
|                                                                                        | <b>INSURER B:</b> State Compensation Insurance Fund of California |                                    |
|                                                                                        | <b>INSURER C:</b>                                                 |                                    |
|                                                                                        | <b>INSURER D:</b>                                                 |                                    |
| <b>INSURER E:</b>                                                                      |                                                                   |                                    |
| <b>INSURER F:</b>                                                                      |                                                                   |                                    |

**COVERAGES****CERTIFICATE NUMBER:** 1970374704**REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE                                                                                                                                                                                                                                                                                                          | ADDL INSD | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS                                                                                                                                                                                                                                           |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|---------------|-------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A        | <input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b><br><input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR<br><br>GEN'L AGGREGATE LIMIT APPLIES PER:<br><input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC<br>OTHER: | Y         |          | MEPK10488100  | 4/1/2025                | 4/1/2026                | EACH OCCURRENCE \$ 1,000,000<br>DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000<br>MED EXP (Any one person) \$ 5,000<br>PERSONAL & ADV INJURY \$ 1,000,000<br>GENERAL AGGREGATE \$ 10,000,000<br>PRODUCTS - COMP/OP AGG \$ 10,000,000<br>\$ |
| A        | <input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b><br><input checked="" type="checkbox"/> ANY AUTO<br><input type="checkbox"/> OWNED AUTOS ONLY<br><input type="checkbox"/> HIRED AUTOS ONLY<br><input type="checkbox"/> SCHEDULED AUTOS<br><input type="checkbox"/> NON-OWNED AUTOS ONLY                     | Y         |          | MEPK10488100  | 4/1/2025                | 4/1/2026                | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000<br>BODILY INJURY (Per person) \$<br>BODILY INJURY (Per accident) \$<br>PROPERTY DAMAGE (Per accident) \$<br>\$                                                                                  |
| A        | <input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b><br><input type="checkbox"/> EXCESS LIAB<br><input type="checkbox"/> OCCUR<br><input type="checkbox"/> CLAIMS-MADE<br><input type="checkbox"/> DED <input type="checkbox"/> RETENTIONS                                                                             |           |          | MEUM09377200  | 4/1/2025                | 4/1/2026                | EACH OCCURRENCE \$ 2,000,000<br>AGGREGATE \$ 4,000,000<br>\$                                                                                                                                                                                     |
| B        | <input checked="" type="checkbox"/> <b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b><br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below                                                                                          | Y/N       | N/A      | 9377888-25    | 4/1/2025                | 4/1/2026                | PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/><br>E.L. EACH ACCIDENT \$ 1,000,000<br>E.L. DISEASE - EA EMPLOYEE \$ 1,000,000<br>E.L. DISEASE - POLICY LIMIT \$ 1,000,000                                                   |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Re: Ambulance Service Permit  
When required by written contract or agreement the following may apply:  
Additional Insured  
Waiver of Subrogation  
When available, form(s) may be attached.

**CERTIFICATE HOLDER****CANCELLATION**

County of Humboldt Dept of Public Health  
529 I Street  
Eureka CA 95501  
USA

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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*Work comp*



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
4/10/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

|                                                                                     |  |                                                                                                                                                                     |               |
|-------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| <b>PRODUCER</b><br>Pauli-Shaw Insurance Agency<br>627 7th Street<br>Arcata CA 95521 |  | <b>CONTACT NAME:</b> Laura Knight<br><b>PHONE (A/C, No, Ext):</b> 707-822-7251<br><b>FAX (A/C, No):</b> 707-826-9021<br><b>E-MAIL ADDRESS:</b> laura@pauli-shaw.com |               |
|                                                                                     |  | <b>INSURER(S) AFFORDING COVERAGE</b>                                                                                                                                | <b>NAIC #</b> |
|                                                                                     |  | INSURER A : Arch Specialty Insurance Company                                                                                                                        | 21199         |
|                                                                                     |  | INSURER B : State Compensation Insurance Fund of California                                                                                                         | 35076         |
|                                                                                     |  | INSURER C :                                                                                                                                                         |               |
|                                                                                     |  | INSURER D :                                                                                                                                                         |               |
|                                                                                     |  | INSURER E :                                                                                                                                                         |               |
|                                                                                     |  | INSURER F :                                                                                                                                                         |               |

**COVERAGES** **CERTIFICATE NUMBER:** 393977146 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE                                                                                                                                                                                                                                                                                               | ADDL INSD | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS                                                                                                                                                                                                                                           |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|---------------|-------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A        | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY<br><input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br><input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC<br>OTHER: | Y         | Y        | MEPK10486100  | 4/1/2025                | 4/1/2026                | EACH OCCURRENCE \$ 1,000,000<br>DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000<br>MED EXP (Any one person) \$ 5,000<br>PERSONAL & ADV INJURY \$ 1,000,000<br>GENERAL AGGREGATE \$ 10,000,000<br>PRODUCTS - COMP/OP AGG \$ 10,000,000<br>\$ |
| A        | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY<br><input checked="" type="checkbox"/> ANY AUTO<br><input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY<br><input type="checkbox"/> HIRED AUTOS ONLY                                                |           |          | MEPK10486100  | 4/1/2025                | 4/1/2026                | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000<br>BODILY INJURY (Per person) \$<br>BODILY INJURY (Per accident) \$<br>PROPERTY DAMAGE (Per accident) \$<br>\$                                                                                  |
| A        | <input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB<br><input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE<br><input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$                                                                             |           |          | MEUM09377200  | 4/1/2025                | 4/1/2026                | EACH OCCURRENCE \$ 2,000,000<br>AGGREGATE \$ 4,000,000<br>\$                                                                                                                                                                                     |
| B        | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below                                                                                                                          | Y/N       | N/A      | 9377888-25    | 4/1/2025                | 4/1/2026                | PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/><br>E.L. EACH ACCIDENT \$ 1,000,000<br>E.L. DISEASE - EA EMPLOYEE \$ 1,000,000<br>E.L. DISEASE - POLICY LIMIT \$ 1,000,000                                                   |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Re: Measure Z Funding Grant.  
 When required by written contract or agreement the following apply subject to endorsement:  
 Additional Insured - County of Humboldt, its agents, officers, officials, employees and volunteers  
 Primary Wording  
 Waiver of Subrogation  
 When available, form(s) may be attached.

## CERTIFICATE HOLDER

## CANCELLATION

|                                                                                                 |                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| County of Humboldt<br>Attn: Risk Management<br>825 5th Street, Rm 131<br>Eureka CA 95501<br>USA | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.<br><br>AUTHORIZED REPRESENTATIVE<br><i>Joshua Martinez</i> |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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**ARCH INSURANCE COMPANY**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**ADDITIONAL INSURED**

Insured: Southern Trinity Area Rescue Inc.

Policy No.: MEPK10486100 Effective Date: 4/1/2025

This endorsement modifies the insurance provided under the following:

**BUSINESS AUTO COVERAGE FORM**

|                 |                        | Schedule |                                                                                                |
|-----------------|------------------------|----------|------------------------------------------------------------------------------------------------|
| <u>AUTO NO.</u> | <u>DESCRIPTION</u>     |          | <u>ADDITIONAL INSURED</u>                                                                      |
|                 | All Vehicles on Policy |          | County of Humboldt<br>Dept of Public Health Attn: Clarke Guzzi 529 I Street<br>Eureka CA 95501 |

Paragraph c. of 1. Who Is An Insured in A. Coverage under Section II – Liability Coverage includes the person or organization shown in the Schedule, but only with respect to "bodily injury" or "property damage" resulting from the ownership, maintenance or use of the covered "auto(s)" shown in the Schedule by an "insured" described in Paragraphs a. or b. of 1. Who Is An Insured in A. Coverage under Section II – Liability Coverage.

In the event of cancellation of the policy, we will send advance written notice of cancellation to the person or organization shown in the schedule at the address shown in the schedule.

**CALIFORNIA INSURANCE IDENTIFICATION CARD**

COMPANY NUMBER 11150 COMPANY ARCH INSURANCE COMPANY ☒ COMMERCIAL ☐ PERSONAL

POLICY NUMBER MEPK10486100 EFFECTIVE DATE 04/01/2025 EXPIRATION DATE 04/01/2026

YEAR 2022 MAKE/MODEL Ford Ambulance VEHICLE IDENTIFICATION NUMBER 1FDRF3HT7NDA00417

## AGENCY/COMPANY ISSUING CARD

McNeil & Company, Inc.  
P.O. Box 5670  
67 Main Street  
Cortland, NY 13045

## INSURED

Southern Trinity Area Rescue Inc.  
321 Van Duzen Rd  
Mad River, CA95526

SEE IMPORTANT NOTICE ON REVERSE SIDE

**CALIFORNIA INSURANCE IDENTIFICATION CARD**

COMPANY NUMBER 11150 COMPANY ARCH INSURANCE COMPANY ☒ COMMERCIAL ☐ PERSONAL

POLICY NUMBER MEPK10486100 EFFECTIVE DATE 04/01/2025 EXPIRATION DATE 04/01/2026

YEAR 2014 MAKE/MODEL Ford Ambulance VEHICLE IDENTIFICATION NUMBER 1FDSS3EL8EDB14606

## AGENCY/COMPANY ISSUING CARD

McNeil & Company, Inc.  
P.O. Box 5670  
67 Main Street  
Cortland, NY 13045

## INSURED

Southern Trinity Area Rescue Inc.  
321 Van Duzen Rd  
Mad River, CA95526

SEE IMPORTANT NOTICE ON REVERSE SIDE

**CALIFORNIA INSURANCE IDENTIFICATION CARD**

COMPANY NUMBER 11150 COMPANY ARCH INSURANCE COMPANY ☒ COMMERCIAL ☐ PERSONAL

POLICY NUMBER MEPK10486100 EFFECTIVE DATE 04/01/2025 EXPIRATION DATE 04/01/2026

YEAR 2015 MAKE/MODEL Weekender Travel Trailer VEHICLE IDENTIFICATION NUMBER 4X4TWDS29FMD54572

## AGENCY/COMPANY ISSUING CARD

McNeil & Company, Inc.  
P.O. Box 5670  
67 Main Street  
Cortland, NY 13045

## INSURED

Southern Trinity Area Rescue Inc.  
321 Van Duzen Rd  
Mad River, CA95526

SEE IMPORTANT NOTICE ON REVERSE SIDE

Additional Information

APPROVAL TO PROVIDE  
ADVANCED LIFE SUPPORT TRANSPORT

SOUTHERN TRINITY AREA RESCUE (STAR)

EMT/AEMT/PARAMEDIC

THIS AGREEMENT is entered into by and between SOUTHERN TRINITY AREA RESCUE (STAR), hereinafter referred to as PROVIDER, and NORTHERN CALIFORNIA EMS, INC., a California non-profit corporation, hereinafter referred to as NOR-CAL EMS.

WHEREAS, NOR-CAL EMS is a regional multi-county Local Emergency Medical Services Agency in northern California including Trinity County, and

WHEREAS, PROVIDER desires to be approved by NOR-CAL EMS to provide Advanced Life Support (ALS) and Basic Life Support (BLS) transport services in certain parts of Trinity County, and

WHEREAS, NOR-CAL EMS, contingent upon PROVIDER complying with the conditions set forth below, approves PROVIDER as an ALS and BLS Transport provider,

NOW, THEREFORE, it is agreed by and between the parties hereto as follows:

When signed by both parties this document serves as the approval and designation by NOR-CAL EMS of PROVIDER as a service provider, to provide emergency medical response per provider availability. PROVIDER agrees to have complied with all requirements of this agreement and with all of NOR-CAL EMS' policies and procedures related thereto.

PROVIDER'S primary response area is STAR boundaries, Trinity County.

PROVIDER'S Trinity County office is located at Mad River, California.

This approval is developed in compliance with the current California Health and Safety Code, California Code of Regulations, Title 22, Division 9, Chapters 2, 3 and 4 and NOR-CAL EMS Policies and Procedures. PROVIDER agrees to comply with all California laws applicable to providers of prehospital emergency medical services.

COPY

## **1. PROVIDER REQUIREMENTS**

As an approved service, PROVIDER agrees to comply with all policies and procedures contained in NOR-CAL EMS' Policies and Procedures Manual. By signing this Agreement, PROVIDER affirms that PROVIDER has read and understands the policies and procedures relating to PROVIDER's type of service. PROVIDER further agrees to keep up to date on changes in those policies and procedures and to implement those that require implementation. In addition PROVIDER further agrees to the following:

### **A. EMERGENCY MEDICAL TECHNICIAN OPTIONAL SCOPE OF PRACTICE**

PROVIDER is approved for the following Optional Scope of Practice:

1. Perilaryngeal Airway: Provider will transition from the Combi-tube to the King Airway by July 1, 2014.
2. Automated External Defibrillation

### **B. QUALITY IMPROVEMENT**

1. PROVIDER will allow inspection, at any time, by NOR-CAL EMS, with or without notice, for the purpose of verifying the Provider Agreement, Regulations, and Policies and Procedures compliance.
2. PROVIDER will participate in the NOR-CAL EMS Continuous Quality Improvement (CQI) program.
3. PROVIDER will designate an employee to act as the CQI program manager to oversee and assist in development and ongoing performance of PROVIDER's CQI program.
4. PROVIDER will establish a CQI program, which will identify methods of improving the quality of care provided. PROVIDER may create its own CQI program, or use the NOR-CAL EMS CQI program. PROVIDER will furnish NOR-CAL EMS with a copy of its CQI program for approval, and provide any changes, as they occur.
5. PROVIDER will submit to NOR-CAL EMS, on a quarterly basis, a CQI data analysis summary.

### **C. REPORTS/RECORDS**

1. PROVIDER will supply NOR-CAL EMS with a roster of all prehospital personnel upon request.
2. PROVIDER is to use an electronic Patient Care Record (PCR) system that is compatible with reporting requirement of the California State Emergency Medical Services Authority and make those records available to NOR-CAL EMS.
3. PROVIDER will comply with any requests from NOR-CAL EMS for records or pertinent materials that may be required in the course of investigations, or inquiries.

4. All records maintained pursuant to this policy will be available for inspection, audit, or examination by NOR-CAL EMS, or by their designated representatives, and will be preserved by PROVIDER for at least three (3) years from the termination of the agreement. PROVIDER's records will not be made available to parties or persons outside NOR-CAL EMS without the PROVIDER's prior written consent; unless a subpoena or other legal order compels disclosure.
5. Upon written request of NOR-CAL EMS, PROVIDER will prepare and submit written reports on any incident arising out of services provided under the agreement. NOR-CAL EMS recognizes that any report generated pursuant to this paragraph is confidential in nature and will not be released, duplicated, or made public without the written permission of the PROVIDER or unless a subpoena or other legal order compels disclosure.
6. PROVIDER will ensure that hand-written PCRs are completed by the PROVIDER's personnel, and left at the receiving facility for each patient transported, prior to personnel leaving the facility, for any response, other than another prehospital call. The electronic PCR shall be completed upon return to the PROVIDER's home location or as quickly as feasible.
7. PROVIDER will provide additional information, and reports as NOR-CAL EMS may require, from time to time, to monitor PROVIDER's performance under this agreement.
8. PROVIDER will ensure that written documentation is provided to the receiving facility staff to provide continuity of patient care personnel per NOR-CAL EMS Policies.

#### **D. STANDARDS**

In each instance of an ALS ambulance failure on a medical emergency call, resulting in the inability to continue the response, PROVIDER will submit an Unusual Occurrence Report to NOR-CAL EMS, which will include:

1. How long it took for another ambulance to respond to the same call.
2. Which ambulance service provider responded, and the level of care provided.
3. The reason or suspected reason(s) for vehicle failure, and/or, malfunction.
4. Actions PROVIDER has taken to prevent similar failures.

#### **E. TRAINING**

PROVIDER will designate a training officer to oversee the required training and orientation of all new prehospital personnel employed by PROVIDER. Qualifications for training officers for optional scope and required training procedures are outlined in NOR-CAL EMS Policies and Procedures. PROVIDER will ensure that all employees providing patient care comply with training requirements as established by the State of California and NOR-CAL EMS for their level of certification.



## **F. LEVEL OF SERVICE**

All requirements relating to the level of service authorized contained in the Emergency Medical Service System and the Prehospital Medical Care Personnel Act (California Health and Safety Code) and the regulation derived therefrom are hereby incorporated in this agreement as if fully set forth herein.

## **G. COMPLIANCE WITH LAWS AND POLICIES**

PROVIDER will adhere to all federal, state, county and city statutes, ordinances, and NOR-CAL EMS Policies and Procedures related to operations, including qualification of crews and maintenance of equipment.

## **2. INDEMNITY**

PROVIDER and NOR-CAL EMS shall hold each other harmless and indemnify each other against all claims, suits, actions, costs, counsel fees, expenses, damages, judgments, or decrees, arising out of PROVIDER's performance or failure to perform under this agreement including, but not limited to, bodily injury, including death, or property damage caused by PROVIDER, or any person employed by PROVIDER, or in any capacity during the progress of the work, whether by negligence or otherwise.

## **3. SUSPENSION AND REVOCATION**

NOR-CAL EMS may deny, suspend or revoke the approval of PROVIDER for failure to comply with the provisions of this agreement or NOR-CAL EMS Policies and procedures.

## **4. TERM**

This agreement shall, subject to the limitations contained herein, be for an initial term of twenty-four (24) months beginning February 1, 2014, and shall be automatically renewed for successive twenty-four (24) month periods; provided, however, prior to the renewal, NOR-CAL EMS will issue a letter of renewal or nonrenewal. In the event NOR-CAL EMS issues a nonrenewal letter, that letter shall also serve as a sixty (60) day notice of termination of this Provider Agreement. Any notice required by this approval will be in writing and any notice to NOR-CAL EMS will be to the Chief Executive Officer.

## **5. TERMINATION**

This agreement may be terminated by either party, without cause, by giving sixty (60) days written notice to the other party.

AGREEMENT TO ACT AS BASE HOSPITAL

PROVIDER is assigned to REDWOOD MEMORIAL HOSPITAL, FORTUNA, CA as its Base Hospital, providing medical control as described in the California Health and Safety Code. By signing this agreement the authorized representative of REDWOOD MEMORIAL HOSPITAL agrees that REDWOOD MEMORIAL HOSPITAL will be the base hospital for PROVIDER subject to all the terms and conditions contained in the Base Hospital agreement between NOR-CAL EMS and BASE HOSPITAL.

Base Hospital acknowledges receipt of a fully executed copy of this agreement.

BASE HOSPITAL: REDWOOD MEMORIAL HOSPITAL, FORTUNA

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

*David O'Brien*

DAVID O'BRIEN

PRESIDENT

Date: 1 / 31 / 14