

Ambulance Supplemental Questionnaire

Today's Date: _____

BASIC INFORMATION:

1. Named Insured: _____
2. DBA: _____
3. Is this a new venture? Yes No If yes, provide resume and business plan.
4. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? Yes No
If Yes, please explain on separate sheet.
5. Has your business had a change of ownership in the past 3 years? Yes No
If Yes, please explain: _____
6. Has your business been involved in consolidations of separate entities? Yes No
If Yes, please explain: _____
7. Is your service involved in activities or operations other than EMS? Yes No
If Yes, please explain: _____

OPERATIONAL INFORMATION:

1. List the major metropolitan area(s) served:
 - a. _____
 - b. _____
2. The number of ambulance calls in the past 12 months? Emergency _____ Non Emergency _____
The estimated ambulance calls in the next 12 months? Emergency _____ Non Emergency _____
3. The number of paratransit/wheelchair calls in the past 12 months? _____
The estimate of paratransit/wheelchair calls in the next 12 months? _____
4. Does your service perform the following?

<input type="checkbox"/> Advanced Life Support	<input type="checkbox"/> Basic Life Support	<input type="checkbox"/> Capnography or Capnometry
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> Endotracheal Intubation	<input type="checkbox"/> IV Therapy or Monitoring
<input type="checkbox"/> Manual Defibrillation	<input type="checkbox"/> Mechanical Ventilation	<input type="checkbox"/> Pulse Oximetry
<input type="checkbox"/> Telemetry	<input type="checkbox"/> Thrombolytic Therapy	<input type="checkbox"/> 12-Lead EKG Monitoring
5. Number of full and part time employees/volunteers that drive or provide patient care:

Paramedics _____	Critical Care Paramedics _____
Registered Nurses _____	Emergency Medical Tech (EMT-B) _____
Advanced EMT (EMT-A or EMT-I) _____	Emergency Medical Responder _____
Advanced EMT (EMT-A or EMT-I) _____	(First Responder, EMR) _____
Non-Emergency Medical Tech _____	Other _____

TOTAL _____

6. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago	Renewal Date 2 years ago
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			
Wheelchair Vans			
Stretcher Vans			
Ambulatory Vehicles			

7. Number of Ambulance by type: Type I _____ Type II _____ Type III _____
8. Does your service have a Medical Director? Yes No Duties: _____
9. Do your medical protocols meet all local, state and federal requirements? Yes No

10. Patient Handling: Stretcher

- a. Select all Stretcher types used at your service and give the brand and number of each type:

Type of Stretcher	Brand	Number
X-Frame		
Fold Away Undercarriage		
Power Cot		
Bariatric Cot		
Other		

- b. Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? Yes No
- c. Does your service have a mandatory lift assist policy? Yes No
- d. Select the engineering controls used at your service and give the brand and number of each type:

Engineering Control	Brand	Number
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

11. Patient Handling: Wheelchair

- a. Name the wheelchair tie-down occupant restraint system (WTORS) you use:

- b. Provide product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.
- c. If you do not use a commercially developed WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its occupant.
- d. Please provide the section of your SOP that addresses the transportation of a scooter and its user.

12. Do you transport prisoners or others whose pick up site is determined by their legal status? Yes No
- If Yes, please list the contracts responsible for these transports and provide a copy of your restraint policy including obligations regarding client escape: _____

13. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)

- a. Brand name of systems(s): _____
- b. Date the system was installed: _____
- c. Number of vehicles currently installed with the system: _____
- d. Employee responsible for the management of the OBM: Name: _____

14. What are your hours of operation? _____

15. Number of hours per shift for employees? _____

16. Dispatch

- a. Is your dispatch center a Public Safety Answering Point (PSAP)? Yes No
 If No, please check the following if it applies:
 PSAP directly dispatches your units.
 PSAP refers calls to your service for internal dispatch.
 You do not interact with a PSAP.
- b. Check the functions performed by your internal dispatchers:
 Dispatch emergency requests for your service. Dispatch non-emergency requests for your service.
 Schedule routine ambulance transfers. Schedule wheelchair/paratransit transfers.
 Screen calls to determine whether or not an ambulance will be sent.
- c. How many years experience are dispatchers required to have prior to hiring? _____
- d. Are your dispatchers Emergency Medical Dispatch Certified? Yes No
- e. Describe your in-house training for dispatchers, including length of training: _____
-
- f. The name of the dispatch software used: _____

17. Mark all your business is involved in and complete the total annual percentage for each operation.

- | | | | | | |
|--|---|--|---|--|---|
| <input type="checkbox"/> Air Ambulance | % | <input type="checkbox"/> Water Rescue | % | <input type="checkbox"/> Tactical Medic Services | % |
| <input type="checkbox"/> Aerial Rescue | % | <input type="checkbox"/> Off-shore EMS | % | <input type="checkbox"/> Confined Space Rescue | % |
- Special Events: Car/Motocross Races Horse Races Concerts
 High School Sports Professional Sports Night Clubs Rave Events

18. If air or water rescue performed is coverage for the watercraft and aircraft provided elsewhere? Yes No

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? Yes No
 If No, please explain: _____
2. Who performs the maintenance on your fleet? In-house Mechanic Outside Service
 Are they certified by the manufacturer? Yes No
3. Do you keep maintenance repair records on file for each vehicle? Yes No
 If No, please explain: _____
4. Do you perform any after-market vehicle modifications? Yes No
 If No, please explain: _____
5. Do you have a Medical Equipment Maintenance Program? (i.e. AEDs, gurneys, etc.) Yes No

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee hiring and orientation:
 Name: _____ Title: _____
2. Check all that apply to your employee selection process:
 Written Application Job Specific Physical Examination
 Psychological Testing Criminal Background Check MVR Check
 Obtain evidence of Pertinent Certification Licensure Post Employment Drug Screening
3. Is previous ambulance driving experience required on new hires? Yes No If Yes, how many years? _____
4. Please provide the name of the driver training program(s) that you provide or participate in: _____

Number of Classroom Hours: _____ Number of Behind the Wheel Hours: _____

5. What is your employee turnover rate? _____
6. Explain training done for patient securement. _____
7. Minimum & maximum ages for drivers? _____ Minimum _____ Maximum
8. Do your guidelines state a minimum hiring age? Yes No Do you hire outside your guidelines? Yes No
9. Process in place to ensure all employees are properly trained and certified for their designation? Yes No

SAFETY/RISK MANAGEMENT

1. Is a record kept of each request for service? Yes No
2. Is a trip ticket for billing purposes completed for each transport? Yes No
3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed?
 Yes No N/A
4. What percent of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content?
_____ %
How frequently are they reviewed? Daily Weekly Other _____
Who is responsible for the reviews? Name _____ Title _____
5. At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated? _____
6. Do you have protocols stating when EWS is to be activated? Yes No
7. Are your vehicles always locked when unattended? Yes No
8. Do you require third party riders (non patient/non EMS personnel) to sit in the front passenger seat unless the patient's well being requires the rider to be in the back of the ambulance? Yes No
9. Does your service maintain accident files? Yes No If yes, how long do you keep the files? _____
10. Are safety violations (i.e. auto crashes) part of your progressive discipline process? Yes No
11. Does your service have a Medical Equipment Failure policy? Yes No
If Yes, does it address checking, charging and replacing batteries for medical equipment? Yes No
12. Do you have a violent patient restraint policy? Yes No
13. Do you allow EMT students to ride along on calls? Yes No
If Yes, how many annually? _____
Are you looking for coverage under this policy? Yes No
What duties are they allowed to perform? _____
14. Safety review process in place? Yes No Details: _____
15. Securement and audit controls in place for all medications? Yes No

WORKERS' COMPENSATION

- Name of Carrier: _____
- Policy #: _____ Eff. Dates: _____ to _____
- Employers Liability Limit: \$ _____
- Bodily Injury by Accident: \$ _____ Each Accident
- Bodily Injury by Disease: \$ _____ Policy Limit
- Bodily Injury by Disease: \$ _____ Each Employee
- Does your Workers Compensation policy include volunteers as insured's by endorsement? _____