

**RULES  
OF  
THE TENNESSEE DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF EMERGENCY MEDICAL SERVICES**

**CHAPTER 1200-12-01  
GENERAL RULES**

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**1200-12-01-.01 SANITATION OF AMBULANCE.**

- (1) All ambulances operating pursuant to the provisions of T.C.A. Chapter 140 of Title 68, must meet the following standards. For the purpose of this regulation, the word "sanitary" shall mean the absence of dirt, dust, stains, odors, rodents, vermin, or foreign substances.
- (2) Patient Compartment
  - (a) Floor must be sanitary.
  - (b) Cabinets or storage areas must be sanitary.
  - (c) All material covering seats, and in headliner must be sanitary.
  - (d) All equipment in patient compartment must be clean and in workable condition.
  - (e) Windows must be clean, unbroken, and in workable condition.
  - (f) All doors leading into passenger compartment must open properly, close tightly with all handles working.
  - (g) Compartment must be watertight and free of drafts.
  - (h) All equipment must be contained in such a manner as to be sanitary at all times.
  - (i) Oxygen if present, must be medical grade and cylinder contain at all times at least 500 PSI.
- (3) Drivers Compartment
  - (a) Must be sanitary.

(Rule 1200-12-01-.01, continued)

- (b) All doors must open properly and close tightly with all handles working.
- (c) Windows and windshield must be clean and free of cracks.
- (d) Rear view mirror must be free of cracks.
- (e) Seat belts must be in place and in usable condition.
- (f) Compartment must be watertight and free of drafts.

**Authority:** T.C.A. §§68-140-501, 68-140-504, and 68-140-507. **Administrative History:** Original rule filed March 20, 1974; effective April 19, 1974. Amendment filed August 7, 2009; effective November 5, 2009.

**1200-12-01-.02 AMBULANCE SAFETY, DESIGN, AND CONSTRUCTION STANDARDS.**

- (1) All ambulances operating pursuant to the provisions of Chapter 140 of Title 68, Tennessee Code Annotated, must meet the following standards.
  - (a) All lights must function properly and in accordance with applicable federal and state motor vehicle laws and regulations pursuant to T.C.A. § 55-9-402.
  - (b) All emergency lights must function in the way in which they were designed to function.
  - (c) Emergency audible warning devices must function in the way in which they were designed to function.
  - (d) Body must be free of dents and rust.
  - (e) Tires must have at least four thirty-seconds inch (4/32") tread.
  - (f) Braking system must function properly and safely.
  - (g) Steering system must function properly.
  - (h) All safety devices must function properly.
  - (i) All equipment in the patient compartment must be adequately secured.
  - (j) Oxygen tanks must bear a current static pressure date.
  - (k) Exhaust system must function to original standards.
  - (l) Patient compartment must be free of safety hazards.
  - (m) All ambulances (and invalid vehicles) shall have an operating odometer.
  - (n) The owner or operating agent of the ambulance shall subject the vehicle to a periodic mechanical safety inspection which shall be documented for the department.
    - 1. Periodic mechanical safety inspection shall mean an inspection conducted at least annually, or every thirty-thousand (30,000) miles after a vehicle registers two hundred thousand (200,000) miles, whichever first occurs. The inspector must attest that the vehicle is mechanically safe, roadworthy, and maintained to federal and state laws applicable for such vehicles.

(Rule 1200-12-01-.02, continued)

2. Mechanical safety inspections shall be conducted by a mechanic with factory training and certification from the original (motor vehicle) equipment manufacturer or the equivalent certification for Emergency Vehicle Technicians (EVT) or from the Institute for Automotive Service Excellence (ASE) Mechanics certification.
  3. Mechanical safety inspections shall be conducted in addition to the vehicle and equipment inspections by EMS Division personnel, following the procedures identified in the form or electronic records format adopted by the board.
  4. Records of the periodic mechanical safety inspection shall be submitted upon the initial permit application to the Division of Emergency Medical Services, and shall be maintained for as long as the chassis is actively licensed or permitted. Such records and supporting documents consisting of repair orders and routine maintenance shall be available and submitted for inspection by an authorized representative of the department.
  5. Upon observation of possible mechanical safety defects by an authorized representative of the department, or upon citation from a law enforcement agency, a vehicle shall be subject to unscheduled inspection to verify safe operation.
  6. Upon failure of an inspection, an ambulance shall be immediately removed from service until such deficiencies are corrected that may in any way impair the safe operation of the ambulance or vehicle.
- (2) Design and Construction - Any vehicle permitted pursuant to Chapter 140 of Title 68 shall be maintained according to the standards and specifications that follow: Standards for Emergency Ambulance vehicles.
- (3) General Vehicle Requirements
- (a) The color of exterior surface shall be white.
  - (b) A single, solid ambulance (Omaha) orange stripe shall be displayed. This single uninterrupted band must be placed horizontally in line with the bottom of the vehicle and extend downward from the window line no less than six (6) inches and no more than fourteen (14) inches.
  - (c) The orange stripe must extend from the front grill to the rear tail light.
  - (d) Emblems and Markings. The vehicle shall display at least the following markings:
    1. The word Ambulance in mirror image, in blue block letters, on the front of the vehicle with "Star of Life" on either side of not less than four (4) inches in height.
    2. The word Ambulance in blue block letters not less than six (6) inches in height placed on each side of vehicle. The "Star of Life" on each side of vehicle shall not be less than twelve (12) inches in height.
    3. Rear of vehicle shall have the word Ambulance in blue block letters and "Star of Life" on each door (if single door, one on either side of word Ambulance.)
    4. The vehicle roof shall have a "Star of Life" not less than thirty-two (32) inches in height.

(Rule 1200-12-01-.02, continued)

5. Numbering used as vehicle call numbers may be placed on the sides, rear, and roof, not to exceed three numbers in any one location. Numerals shall be no larger than fourteen (14) inches in height. Allowable colors for numbering include Blue, Orange, Black, Gold, Green, and Red.
6. Each service shall identify its ambulances with lettering or a service trademark or emblem identifying the service.
  - (i) Service emblem shall be a business or corporate insignia or marking adopted by the service for identifying purposes, and may be representative of their corporate trademark, institutional affiliation, or governmental agency seal.
  - (ii) The service is prohibited from displaying any lettering or emblem which may falsely suggest an affiliation with a business or government, or profess an accreditation which the service has not attained or maintained.
  - (iii) Lettering or decals which serve a functional and useful purpose, such as identifying specialty care capability or special community programs, may be displayed in addition to the service name. No decals or service marks shall be displayed for advertising purposes of other than the ambulance service licensee.
  - (iv) The service emblem or lettering shall not be overprinted or superimposed over the Ambulance lettering or "Star of Life" emblems otherwise required by these rules.
  - (v) The service emblem or lettering shall not disrupt the orange stripe except for the front doors of the ambulance cab or rear doors.
  - (vi) The service emblem shall not be larger than twenty-five (25) inches by twenty-five (25) inches.
- (e) The emergency ambulance shall be equipped with flashing or oscillating warning lights on the front, sides, and rear of the vehicle, red in color, with a center-mounted white (clear) flashing light visible to the front. One or more amber flashing lights may be visible to the rear. Switching arrangements may provide either synchronized or alternating red warning lights on the front, sides, and rear of the vehicle. Warning lights shall meet minimum photometric standards as described in KKK-A-1822E or its successor standard.
- (f) Communications and Warning Devices shall include a two-way radio with State designated emergency medical telecommunications frequencies and an audible warning and public address system.

1. Two-way Radio (Mobile).

Mobile radio equipment shall include VHF capabilities at a minimum, as established in Rule 1200-12-01-.08 (EMS Telecommunications), or means of alternative compliance as established in Rule 1200-12-01-.08. Radio control functions for the VHF and dispatch radio shall be accessible to the vehicle operator. The medical communication radio (or radio controls) shall be available in the patient compartment and comply with the respective regional frequency use plans and radio standards as published in the State EMS Telecommunications Plan.

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2. Audible Warning and Public Address System

A combination electronic siren with integral public address system and radio amplification shall be provided. Control functions shall provide public address, radio, manual, wail and yelp selections with remote siren control from the driver's position.

3. A mechanical siren or air horn shall be permissible as additional equipment.

(g) Patient compartment dimensions shall provide at a minimum:

1. Inside height of at least 60 inches, floor to ceiling.

2. Inside length from compartment divider to rear door of at least 116 inches.

(h) Ambulance Vehicles. All ground ambulances placed in service or obtaining an initial permit with a service in the State of Tennessee shall be manufactured according to the Federal "Star of Life" KKK-A-1822 specification applicable on the date of manufacture. All ambulances must be maintained in accordance with the standards specified in effect upon their date of manufacture. Copies of applicable versions of the specifications are available at cost upon request from the Division office.

(4) Special Vehicle Requirements.

Vehicles used exclusively for the provision of neonatal intensive care and transportation between medical facilities shall conform with the following standards for design and construction.

(a) Exterior surfaces, emblems, and markings shall conform to specifications enumerated under subparagraph (3)(i), Federal Specification Ambulance-Emergency Medical Care Vehicle.

(b) Additional markings, legends, or logos may be used to identify the provider and purpose for special vehicles, except that no letter shall exceed six inches in height. Legends such as "Neonatal Intensive and Critical Care Transport" may be substituted for the word "Ambulance" in exterior markings.

(c) Warning lights and siren shall be furnished in accordance with Federal Specification-Ambulance 3.14.6, except that side flood lights shall not be required.

(d) Vehicle crashworthiness shall be assured with roll-cage construction, evidenced by compliance with the Ambulance Manufacturer's Division Standards of the Truck Body and Equipment Association or comparable construction under written statement and performance bond by the manufacturer.

(e) Doors shall provide access to the rear and curb-side of the patient compartment. Where the vertical lift distance of the patient loading area exceeds 28 inches, a ramp or electrical/hydraulic lift shall be furnished to facilitate patient loading.

(f) Environmental systems on the unit shall meet heating/air conditioning standards as specified in Federal Specifications Ambulance.

(g) Vehicle electrical systems shall be provided to furnish 110 volt AC power sufficient to sustain 3,000 watts at 60 cycles. The unit shall be equipped with a back-up power system sufficient to operate patient care equipment in the event of failure of the main

(Rule 1200-12-01-.02, continued)

power system. The 110 volt system shall incorporate a ground fault interrupter device for protection against electrical hazards.

- (h) Patient compartment shall be so designed to provide the following:
  - 1. One transport incubator configured to allow observation from at least two sides of the patient which shall be capable of being secured in the vehicle.
  - 2. An open bed warmer to allow various stabilization procedures.
  - 3. Compartments for appropriate storage of materials such as culture media and medications.
  - 4. Fixtures to ensure proper hand cleansing during a transport.
  - 5. Illumination at the primary patient care area of at least 75 foot candles.
  - 6. Safety features, to include:
    - (i) Cabinet corners and latches, sculpted, padded, or recessed to prevent undue injury during sudden deceleration.
    - (ii) Safety devices shall include:
      - (I) A grab rail or hand strap, secured according to Federal Motor Vehicle Safety Standards for safety restraints.
      - (II) Safety belts shall be provided at all attendant seats.
      - (III) Safety restraint devices for infants for use when the vehicle is in motion.
- (i) Patient care equipment shall include the means to provide and monitor mechanical ventilation, and an oxygen system with sufficient capacity to deliver a minimum continuous flow of 8 liters per minute for at least four hours. The installed oxygen system shall be capable of delivering specific monitored blended oxygen concentrations.
- (5) A licensed ambulance provider may operate a temporary ambulance upon a written acknowledgment from the Department's representative under the following conditions:
  - (a) A vehicle used to replace a permitted ambulance, when the permitted vehicle has been removed from service for repair or maintenance, when such temporary vehicle is not owned or normally operated by the service; or
  - (b) A vehicle acquired to replace a permitted ambulance, with conversion of title to the service or its agent, following the submission to the Division of vehicle information and the appropriate fee, shall be allowed to operate up to fifteen (15) days pending inspection by the department.
  - (c) Each provider shall assure compliance with all rules applicable to the operation of the vehicle as follows:
    - 1. The replacement vehicle shall comply with all design, construction, equipment and safety standards as promulgated under paragraphs (1) (2) and (3).

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2. Insurance coverage obtained by rider or policy revision shall be in evidence pursuant to rule 1200-12-01-.07.
  3. The provider must immediately notify the Division of Emergency Medical Services in writing when the unit is placed in service, submitting information to include:
    - (i) the license and vehicle identification numbers of the substitute or replacement vehicle, and
    - (ii) the permit number of the unit for which the replacement is substituted.
  4. Non-standard radio equipment may be authorized for temporary use in vehicles provided such authorization is requested in writing before placing the vehicle is placed in service. The request should include a reasonable, projected time period over which the non-standard equipment is expected to be used, and the basic capabilities of such equipment.
- (d) Vehicles added to an existing fleet, requiring evidence of additional supplies and equipment to extend service, shall not be operated under temporary authorizations, but may be operated under a letter of approval filed by the Division's authorized representative following payment of fees to the Division's principal office, and evidence of satisfactory inspection by the authorized representative, pending the issuance of a permit.
- (e) A letter of approval from a Division representative shall not be substituted for a vehicle permit for any period exceeding ninety (90) days.
- (6) Upon inspection, any vehicle deemed unacceptable and failing an inspection shall be immediately removed from service until approved for return to service by the Division's authorized representative.

**Authority:** T.C.A. §§68-140-504, 68-140-506, 68-140-507, and 68-140-526. **Administrative History:** Original rule filed March 20, 1974; effective April 19, 1974. Amendment filed February 8, 1983; effective May 16, 1983. Amendment filed November 30, 1984; effective February 12, 1985. Amendment filed April 8, 1987; effective May 23, 1987. Amendment filed May 27, 1988; effective July 11, 1988. Amendment filed March 7, 1989; effective April 21, 1989. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed August 11, 1993; effective October 25, 1993. Amendment filed June 1, 2007; effective August 15, 2007. Amendment 1200-12-01-.02(1)(o) filed August 7, 2009; withdrawn November 2, 2009. Amendment filed August 7, 2009; effective November 5, 2009.

**1200-12-01-.03 EMERGENCY MEDICAL SERVICES EQUIPMENT AND SUPPLIES.** Each provider shall maintain the required equipment for the level of service to provide appropriate emergency care and where applicable, patient care during transport, on each vehicle permitted.

- (1) Definitions - as used in this rule, the following terms and abbreviations shall have these meanings:
  - (a) (E) – “Essential device” shall mean any item critical for lifesaving patient care and which by its absence would jeopardize patient care.
  - (b) (M) – “Minimal equipment or devices” shall mean such equipment and supplies provided in sufficient amounts for patient care, but when missing may not result in serious harm to a patient.

(Rule 1200-12-01-.03, continued)

- (c) "Optional equipment or devices" shall mean any item of elective use, which shall be operational and sanitary.
  - (d) "Specifications" shall refer to the federal standards and performance requirements for equipment and devices recognized within the emergency medical services industry and adopted by the board, which include the following:
    - 1. Federal Specification for Ambulances, KKK-A-1822E, dated June 1, 2002, or its successor.
    - 2. Standard Specification for Minimum Performance Requirements for EMS Ground Vehicles, F 1230-89, American Society of Testing and Materials, November, 1989, or its successor.
    - 3. Federal Motor Vehicles Safety Standards cited under 49 CFR Part 571.
- (2) Safety devices shall be provided to include:
- (a) Fire extinguishers (E) - Two (2) ABC dry chemical, multipurpose 5 lb. unit, in restraint brackets. One mounted in the driver/cab compartment or in a body compartment reachable from outside the vehicle. On ambulances an extinguisher shall be located in the patient compartment or in a cabinet within the patient compartment.
  - (b) Three (3) bi-directional reflective triangles (E) - approved per FMVSS 125, for any transport vehicle.
  - (c) Flashlights (M) - 4.5 volt or better, three cell or lantern type for scene use, one accessible to the driver and one provided for technician use. At least one flashlight shall be provided for a first responder unit.
- (3) Oxygen inhalation, ventilation, and airway management devices shall be supplied providing:
- (a) Resuscitation and airway devices including:
    - 1. Adjuncts for ventilation: (If disposable or single use devices are furnished, a spare unit shall be supplied on all ambulances.)
      - (i) bag-valve device (E) - with a bag volume of at least 1600 milliliters with oxygen reservoir for adult use.
      - (ii) bag-valve device (E) - with a bag-volume of 450 milliliters with oxygen reservoir for pediatric use.
      - (iii) resuscitation masks (E) -in adult, pediatric (child) and infant sizes.
      - (iv) oropharyngeal airways (M) - in at least five different sizes.
      - (v) nasopharyngeal airways (M) - in at least five different sizes.
      - (vi) dual lumen airway device (such as the Combitube or Pharyngeal Tracheal Lumen Airway) that has been approved by the EMS Board. (M).
      - (vii) end-tidal carbon dioxide (CO<sub>2</sub>) detectors, for adult and pediatric use. (E).
    - 2. Oxygen delivery devices:

(Rule 1200-12-01-.03, continued)

- (i) An installed oxygen supply (E) - with a capacity of at least 2,000 liters of oxygen shall be supplied on all ambulances.
    - (I) Cylinders shall be restrained in an approved manner.
    - (II) Pressure regulator and flow meters shall comply with 3.12.1.1, Federal Specifications for Ambulances and automatically supply a line pressure of 50 psi.
    - (III) At least two distribution outlets and flow meters shall be operable in the compartment.
  - (ii) Portable oxygen (E) - shall be provided with at least 300 liter, or "D" size cylinders.
    - (I) The oxygen unit and spare cylinders shall be restrained in an approved manner.
    - (II) Pressure regulator and flow meter shall comply with 3.12.2, Federal Specifications for Ambulances.
    - (III) A full spare cylinder (M) - shall be provided except on first responder units.
  - (iii) Administration devices shall include at least two of each item: (E) for items, (M) for amounts.
    - (I) Oxygen supply tubing of at least 48 inches length.
    - (II) Oxygen Masks including, adult non-rebreathing high concentration, pediatric non-rebreathing high concentration, and an infant medium concentration.
    - (III) Adult nasal cannula.
    - (IV) Humidifiers shall be optional, but when supplied shall be single patient use.
3. Endotracheal intubation devices shall be supplied on advanced life support units, to include: (E) for items, (M) for amounts.
- (i) Laryngoscope handles with operable batteries in adult and pediatric sizes, appropriate for use with (ii).
  - (ii) Laryngoscope blades in sizes:
    - (I) 0, straight,
    - (II) 1, straight,
    - (III) 2, straight,
    - (IV) 2, curved,
    - (V) 3, straight,

(Rule 1200-12-01-.03, continued)

- (VI) 3, curved
  - (VII) 4, straight
  - (VIII) 4, curved.
  - (iii) Endotracheal tubes, individually packaged in a sanitary sealed envelope or plastic package in:
    - (I) Uncuffed sizes in the pediatric range, one of each size 2.5 to 6.0mm. (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0 mm)
    - (II) Cuffed sizes in the adult range, one of each size 6.5 to 8.5 millimeters. (6.5, 7.0, 7.5, 8.0, and 8.5 mm)
  - (iv) Six packets of sterile surgical lubricant or equivalent.
  - (v) Stylets, adult and pediatric.
  - (vi) Syringe for cuff inflation, 10cc, with plain Luer tip.
  - (vii) Magill forceps in adult and pediatric sizes.
  - (viii) Esophageal detection device
- (b) Suction devices and supplies shall include the following items:
1. Installed suction (E) - with vacuum gauge, a control, and collection bottle as specified in 3.12.3, Federal Specifications for Ambulances.
    - (i) At least two sets of suction tubing, six feet in length shall be supplied. (E) for item, (M) for amount.
    - (ii) Suction tubing and adapters (E) - shall be provided for endotracheal aspiration of meconium allowing direct connection of suction to the endotracheal tube. (E)
  2. A portable suction aspirator (E) - shall be supplied as specified in 3.12.4, Federal Specifications for Ambulances.
    - (i) A collection bottle (disposable preferred) of at 500 milliliters shall be provided.
    - (ii) At least two sets of suction tubing, two feet or more in length shall be provided. (E) for items, (M) for amount.
  3. Suction supplies (M) - shall include rigid and flexible tips.
    - (i) At least two rigid, Yankauer style tips shall be provided.
    - (ii) Two sets of suction catheters shall be provided by BLS transport and ALS units; each set to consist of size 6, 8, 10, 14 and 16 French catheters.
- (4) Diagnostic and assessment devices shall include:
- (a) Sphygmomanometer with inflation bulb and gauge with: (E)

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1. Adult blood pressure cuff (E) - on all units.
  2. Pediatric blood pressure cuff (M) - except on first responder units.
  3. Adult large or thigh blood pressure cuff (M) - except on first responder units.
- (b) Stethoscope (E)
- (c) Bandage shears (M)
- (d) Items (b) and (c) may be carried as personally assigned equipment, provided the service has a posted policy regarding supply of these devices.
- (e) Pulse oximeter with sensors for use with adult and pediatric patients.
- (5) Bandages and dressing material shall include:
- (a) Two (2) rolls of surgical adhesive tape (M), at least one inch in width.
  - (b) Six (6) rolls of conforming gauze roller bandage (M), at least three inches in width.
  - (c) Six (6) triangular bandages (M) with a minimum base at least forty-two (42) inches.
  - (d) Twenty-five (25) sterile 4" by 4" dressings (M).
  - (e) Eight (8) composite pad sterile compresses, abdominal (ABD)/combine dressings (M).
  - (f) Two sterile occlusive dressings of white petrolatum coated gauze or plastic membrane film at least 3" by 3" (M).
  - (g) Two burn sheets (M) separately packaged, sterile or clean, at least 60 by 60 inches.
  - (h) Saline solution or sterile water for irrigation (M), in plastic containers sufficient to supply 2000 milliliters on each transport vehicle.
- (6) Immobilization devices provided on all units except first responder units:
- (a) Two long spinal immobilization devices or backboards (E) - whole body splints, or approved devices capable of immobilizing a patient with suspected spinal injuries.
    1. Straps or restraints which immobilize the patient at or about the chest, pelvis, and knees shall be provided.
    2. Wooden devices shall be sealed with finishes to prevent splintering and aid decontamination.
  - (b) One short spinal immobilization device consisting of a clam-shell, wrap around type vest. (E)
    1. Device shall provide spinal immobilization for the seated patient.
    2. Device shall include affixed restraint straps, head straps and integral padding.
    3. Device with straps and accessories shall be maintained in a separate case or carrier bag.

(Rule 1200-12-01-.03, continued)

- (c) Two cervical spinal immobilization devices or head immobilizers designed to prevent lateral head movement of the restrained patient. (M)
    - 1. Four disposable or plastic covered foam blocks with tape or restraint straps may be provided to fulfill this requirement.
    - 2. Commercial devices shall include accompanying straps or restraint materials.
    - 3. Sand bags shall not fulfill this requirement due to the potential for weight shifts of the fill material.
  - (d) Two sets of cervical collars (M) - shall be provided in the following sizes. (Combinations of adjustable-type collars are acceptable to provide at least two adult and two pediatric/infant collars):
    - 1. Pediatric - Infant sized cervical collars are highly recommended in addition to pediatric size ranges.
    - 2. Small adult.
    - 3. Medium adult.
    - 4. Large adult.
  - (e) Upper extremity splints (M) - shall include at least two devices or sets of fabricated splints for immobilization of arm injuries.
    - 1. Board splints, when provided, shall be padded and at least fifteen inches length.
    - 2. Inflatable splints shall not fulfill this requirement.
  - (f) Lower extremity splints (M) - shall include at least two devices or sets of fabricated splints for immobilization of leg injuries.
    - 1. Board splints, when provided, shall be padded and at least thirty-six inches length.
    - 2. Inflatable splints shall not fulfill this requirement.
  - (g) Lower extremity traction splints (E) - shall be provided with necessary attachments to achieve immobilization of femoral fractures involving both lower extremities.
- (7) Immobilization devices on first responder units shall include one set of cervical collars, as identified in (6)(d) and at least one set of upper and lower extremity splints as identified in (6)(e) and (6)(f).
- (8) Patient care supplies shall include:
- (a) Containers for human waste and emesis with a bedpan, urinal, and emesis basin or suitable substitute on all patient transport vehicles. (M)
    - 1. Tissues shall be provided for secretions and toilet use.
    - 2. At least two emesis containers shall be provided.

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- (b) Blankets (M) - or protective patient covers with thermal insulating capabilities.
  - 1. Two blankets for adults
  - 2. One baby blanket and head covering (Cloth or non-woven fabric).
- (c) Four sheets (M) - of linen or disposable material for cot and patient covers.
- (d) An obstetrical emergencies pack or O.B. kit (E) - shall provide the following items, but shall not be required on first responder units:
  - 1. Drape towel or underpad,
  - 2. Gauze dressings,
  - 3. Sterile gloves,
  - 4. Bulb syringe or aspirator,
  - 5. Cord clamps and/or umbilical ties,
  - 6. Plastic bags and ties for placental tissues,
  - 7. Infant receiving blanket or swaddling materials, and
  - 8. A head covering shall be provided.
- (9) Infection control supplies shall include:
  - (a) Appropriate personal protective equipment (M) - conforming to Occupational Safety and Health Administration rules including, but not limited to, the following:
    - 1. Disposable gloves sized for the crew,
    - 2. Fluid proof gowns or lab coats,
    - 3. Two face masks (NIOSH approved to at least N-95 standards)
    - 4. Eye shields or protective face shields, and
    - 5. Protective footwear or shoe covers.
  - (b) Materials for decontamination and disposal of potentially infected waste (M) - to include:
    - 1. Red plastic bags or trash bags labeled for biohazard, with at least two bags 24" by 30".
    - 2. A puncture resistant container shall be supplied for sharps disposal in a locking-style bracket or in a locked compartment within the ambulance. Sheath style or single use containers shall be disposed of in larger approved containers.
    - 3. Antiseptic hand cleaner and an Environmental Protection Administration approved hospital grade disinfectant for equipment application.

(Rule 1200-12-01-.03, continued)

- (10) Intravenous therapy supplies shall be required on all ambulances as follows: (E) for items, (M) for amounts.
  - (a) Fluid administration sets,
    1. Macro drip, ten to twenty drops per milliliter, three (3) each.
    2. Micro drip, sixty drops per milliliter, three (3) each
  - (b) Antiseptic wipes twelve (12) each.
  - (c) Catheters, over-the-needle type, four (4) sets in each gauge size 14, 16, 18, 20, 22 and 24.
  - (d) Three liters of intravenous solutions, two of which will be crystalloid fluids.
  - (e) Disposable (non-latex) venous tourniquets, sufficient for adult and pediatric use.
  - (f) Intraosseus infusion needles, a minimum of an 18 gauge size shall be required on ALS units.
- (11) Cardiac defibrillators and monitors shall be provided for use by appropriately trained personnel as follows:
  - (a) Advanced life support units shall be equipped with a cardiac monitor, electrocardiographic recorder, and defibrillator. (E)
    1. Cardiac monitoring leads (M) - shall be provided:
      - (i) Six electrodes for adults.
      - (ii) Six electrodes for pediatrics.
    2. A biphasic waveform shall be required on any cardiac monitor/defibrillator purchased for ambulances after the effective date of this rule, and the defibrillator shall provide a minimum setting of ten (10) joules.
  - (b) An automated external defibrillator shall be provided on each staffed ambulance, except those otherwise staffed and equipped to provide advanced life support as identified in paragraph (a) .
  - (c) Automated external defibrillators shall be an optional device for first responder units.
- (12) Medications and required drugs for all ambulance and advanced life support providers shall include: (E) for items, (M) for amounts. Medications must be packaged and stored in accordance with pharmacologic guidelines for sterility, cleanliness, dosage, and expiration.
  - (a) Medications for use by basic emergency medical services on all ambulances shall include:
    1. An anaphylaxis kit of Epinephrine 1:1,000 in a preloaded syringe of 0.3ml per dose, or a Tuberculin syringe with a minimum 5/8 inch, 25 gauge needle, with a sufficient quantity of Epinephrine 1:1,000 to administer two (2) doses to two patients.
    2. Aspirin or therapeutic equivalent for administration to suspected cardiac patients.

(Rule 1200-12-01-.03, continued)

3. Beta-adrenergic agonist (albuterol, etc.) or therapeutic equivalent with appropriate administration devices for acute pulmonary distress.
  4. Nitroglycerine, 1/150 grain (0.4 mg) bottle of thirty (30) tablets or sublingual spray, or therapeutic equivalent.
- (b) Medications for use in definitive and cardiac care shall be provided on advanced life support units. Medications used on advanced level ambulances shall be compatible with current standards as indicated by the American Heart Association's Emergency Cardiovascular Care Committee to include:
1. Cardiovascular medications
    - (i) Adenosine, 6 mg/2ml, sufficient to administer successive doses up to 18 milligrams, or therapeutic equivalent.
    - (ii) Atropine sulfate, at least four (4) prefilled syringes of 1.0mg/10ml, or therapeutic equivalent.
    - (iii) Antiarrhythmic agents to include sufficient amounts for two successive doses of either lidocaine for cardiac arrhythmia (at least four (4) prefilled syringes of 100 mg in 5 milliliters), or Amiodarone (in ampules of 150 to 300 mg to total at least 450 mg), or therapeutic equivalent. Admixtures or premixed solutions shall be provided for a maintenance drip.
    - (iv) Magnesium sulfate, 1 gm sufficient to administer 2 gm in successive doses with dilution, or therapeutic equivalent.
    - (v) Bacteriostatic water and sodium chloride for injection and dilution of medications.
  2. Analgesics, such as morphine, meperidine hydrochloride, nalbuphine (Nubain), butophanol (Stadol), Nitrous oxide, or therapeutic equivalent.
  3. Benzodiazepine anticonvulsant, diazepam (at least two (2) vials or prefilled syringes of ten (10) milligrams/2ml or other benzodiazepine in equivalent amounts sufficient to administer two successive maximum doses, or therapeutic equivalent.
  4. Vasopressor agents, such as Epinephrine 1:10,000, at least four (4) prefilled syringes of 1.0 mg/ml or therapeutic equivalent.
  5. Hypoglycemic countermeasures
    - (i) Glucose testing devices for semi-quantitative blood glucose determinations, with media, calibration strips, and lancets.
    - (ii) Dextrose 50% in water, at least two (2) prefilled syringes of 25 grams in 50 milliliters, or therapeutic equivalent.
    - (iii) Dextrose 25% in water, at least two (2) prefilled syringes of 12.5 grams in 50 milliliters, or therapeutic equivalent.
  6. Narcotic antagonist, Narcan (naloxone). At least two (2) ampules or prefilled syringes of 1mg/ml, or therapeutic equivalent..

(Rule 1200-12-01-.03, continued)

7. Alkalinizing agents, sodium bicarbonate, at least two (2) syringes of 50 mEq in 50 milliliters, or therapeutic equivalent.
  8. Systemic diuretics, furosemide, 10 mg/ml, ampules, vials, or prefilled syringes to total 80 milligrams, or therapeutic equivalent.
  9. Antinauseant, such as promethazine, 25mg/ml, or therapeutic equivalent.
  10. Antihistamine, diphenhydramine, 50 mg, or therapeutic equivalent.
- (c) Syringes for drug administration shall be supplied in at least 1 cc, 3 cc, and 10 cc sizes with needles.
- (d) A length-based drug dosage tape for pediatric resuscitation shall be supplied. (2002 Broselow <sup>TM</sup> or successor edition.)
- (13) Air ambulances shall provide equipment as required in Rule 1200-12-01-.05.
- (14) Equipment requirements as detailed in (3) to (12) shall not apply to vehicles used solely for neonatal critical care transport. Neonatal transport equipment and supplies shall conform to the standards adopted in the Tennessee Perinatal Care System Guidelines for Transportation, Tennessee Department of Health, Maternal and Child Health Section, September, 2001, or the successor publication.
- (15) Inspections of equipment and supplies reflecting deficiencies in essential (E) items or multiple deficiencies of minimum (M) items shall be grounds for failure of inspection. Five or fewer deficiencies or shortage of supplies termed minimal (M) shall receive a warning. Conditional acceptance during inspection may be recognized by the Division's representative when good faith efforts are demonstrated by the provider to acquire or repair minimal equipment, subject to a recheck of any conditional device within forty-five (45) days of the initial inspection.
- (16) Equipment cited for Emergency Medical First Responder vehicles shall be in addition to minimal supplies cited in Rule 1200-12-01-.16.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, 68-140-505, 68-140-506, and 68-140-507.  
**Administrative History:** Original rule filed March 20, 1974; effective April 19, 1974. Amendment filed February 8, 1983; effective May 16, 1983. Amendment filed November 30, 1984; effective February 12, 1985. Amendment filed August 22, 1985; effective September 21, 1985. Amendment filed April 8, 1987; effective May 23, 1987. Amendment filed March 7, 1989; effective April 21, 1989. Repeal and new rule filed January 7, 1997; effective March 23, 1997. Repeal and new rule filed November 16, 2005; effective January 30, 2006. Amendment filed December 16, 2005; effective March 1, 2006. Amendment filed August 7, 2009; effective November 5, 2009.

**1200-12-01-.04 EMERGENCY MEDICAL TECHNICIAN (EMT).** All persons desiring licensure as an Emergency Medical Technician pursuant to T.C.A. Title 68, Chapter 140 must comply with the following requirements and standards.

- (1) Emergency Medical Technician Licensure Requirements
  - (a) Must be at least eighteen (18) years of age.
  - (b) Be able to read, write, and speak the English language.
  - (c) Must possess an academic high school diploma or a general equivalency diploma (G.E.D).

(Rule 1200-12-01-.04, continued)

- (d) Must have no history within the past three years of habitual intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the person's ability to practice as an emergency medical technician.
- (e) Must present evidence to the Division of Emergency Medical Services of a medical examination certifying physical health sufficient to conduct activities associated with patient care, including, but not limited to, visual acuity, speech and hearing, use of all extremities, absence of musculoskeletal deformities, absence of communicable diseases, and suitable emotional fitness to provide for the care and lifting of the ill or injured. This information shall be provided on a form approved by the Board and shall be consistent with the provisions of the Americans with Disabilities Act and the requirements of National Registry of Emergency Medical Technicians.
- (f) Must successfully complete an approved basic Emergency Medical Technician course including all license examinations.
  - 1. Written Examination
    - (i) Achieve a passing score on a Board approved written examination with a minimum score as established by the Board.
    - (ii) Applicants who fail to pass the examination shall be eligible to reapply for examination.
  - 2. Practical Examination
    - (i) All applicants must successfully complete an EMS Board approved practical examination.
    - (ii) Applicants who fail to pass the practical examination shall be eligible to reapply for examination.
  - 3. All applicants must complete all requirements for licensure within two (2) years of completion of the training course and program.
- (g) Must submit an Application for Licensure form as provided by the Division of Emergency Medical Services.
- (h) Must remit the appropriate licensure and application fees, if applicable, as determined under rule 1200-12-01-.06.
  - 1. An applicant shall cause to be submitted to the administrative office of the Division of Emergency Medical Services, directly from the vendor identified in the Division's licensure application materials, the result of a criminal background check.
- (2) EMT Paramedic Requirements
  - (a) Must meet all the Emergency Medical Technician licensure requirements in paragraph (1).
  - (b) Must successfully complete an EMT Paramedic course accredited or recognized by the Division of Emergency Medical Services of the Tennessee Department of Health.

(Rule 1200-12-01-.04, continued)

- (c) Must successfully complete an EMS Board approved Emergency Medical Technician Paramedic level course and all license examinations.
  - 1. Written Examination
    - (i) Achieve a passing score on a Board approved written examination with a minimum score as established by the Board.
    - (ii) Applicants who fail to pass the examination shall be eligible to reapply for examination.
  - 2. Practical Examination
    - (i) An EMS Board approved practical examination must be successfully completed by all applicants.
    - (ii) Applicants who fail to pass the practical examination shall be eligible to reapply for examination.
  - 3. All applicants must complete all requirements for licensure within two (2) years of completion of the training course and program.
- (d) Must submit an Application for Licensure form as provided by the Division of Emergency Medical Services.
- (e) Must remit the appropriate licensure and application fees, if applicable, as determined under rule 1200-12-01-.06.
- (3) Responsibilities of the Emergency Medical Technician when providing patient care:
  - (a) The EMT shall perform initial patient survey, shall provide emergency care through careful assessment of the patient, and shall recognize injuries and illness. The EMT shall also gain knowledge of pre-existing medical conditions, previously prescribed medications, medical preference, and identification of the patient.
    - 1. Emergency Medical Technicians and Emergency Medical Technician-Paramedics shall be permitted to perform extended skills or procedures when such treatment is conducted under authorized medical control.

The following definitions shall apply under this part:

- (i) "Medical Control" shall mean the instruction and advice provided by a physician and the orders by a physician or nurse authorized under written agreement which define the treatment of a patient, where direct communication, written protocols, or standing orders are provided, and such procedures are in accordance with locally or regionally approved medical practices.
- (ii) "Protocols" shall mean a ranking or formal listing of procedures that may be utilized for patient care after physician or medical facility communications have been established.
- (iii) "Standing Orders" shall mean orders based on an agreement established by a medical practitioner, or the staff of a medical facility or association, delegating authority to agents within their control to commence treatment

(Rule 1200-12-01-.04, continued)

and authorizing procedures for patient care that may be utilized until the patient is presented for continuing medical care.

2. Emergency Medical Technicians or students during training in an accredited program may receive instruction in extended skills and authorization for procedures, including the administration or use of physician controlled devices for:
  - (i) treatment of anaphylaxis with epinephrine, respiratory distress with inhaled bronchodilators, suspected chest pain with aspirin and suspected cardiac conditions with lingual or sublingual nitroglycerine;
  - (ii) airway management with Board approved airway procedures;
  - (iii) venipuncture and intravenous fluid therapy with EMS Board approved solutions; and
  - (iv) treatment of hypoglycemia with blood glucose monitoring and administration of intravenous dextrose solutions.
3. Emergency Medical Technician Paramedics or students during training in accredited programs may utilize the following procedures under medical control.
  - (i) perform electrocardiographic monitoring, recognize and treat cardiac dysrhythmias
  - (ii) perform gastric, esophageal, or tracheal intubation and suction.
  - (iii) administer intravenous solutions or blood products by peripheral venipuncture of scalp, extremities, and external jugular veins or intraosseous infusions, or by pre-established indwelling lines.
  - (iv) administer by oral, parenteral, endotracheal, or other indicated means, medications of any of the following classes of drugs:
    - (I) antiarrhythmic agents
    - (II) chronotropic agents
    - (III) vagolytic agents
    - (IV) analgesic agents
    - (V) alkalinizing agents
    - (VI) vasopressor agents
    - (VII) anticonvulsive agents; and
    - (VIII) other drugs which may be deemed necessary by the ordering physician.
  - (v) perform chest decompression
  - (vi) perform cricothyrotomy

(Rule 1200-12-01-.04, continued)

4. Emergency Medical Services personnel may defer administration of extended skills or treatment under the following circumstances:
    - (i) when the technician acknowledges inadequate proficiency to perform the procedure;
    - (ii) when the technician cannot understand the orders or the situation limits control at the scene of the emergency; or
    - (iii) when the procedure is judged to be inappropriate to the condition of the patient, the EMT or EMT-Paramedic should so advise the physician providing such orders, within prudent and professional conduct.
  - (b) The EMT shall render necessary emergency care through supportive assistance for conditions requiring transport for definitive medical care including medical emergencies, behavioral emergencies, illness, disease or infirmity.
  - (c) The EMT shall report essential information concerning the patient, the patient's medical condition, and treatment to the medical personnel who assume responsibility for continuing care of the patient.
  - (d) The EMT shall effectively utilize EMS Telecommunications for coordination and information exchange with EMS dispatchers, medical facilities, physicians, and systems users, and shall conduct radio transmissions appropriately with regard for rules, regulations, and procedures.
  - (e) Emergency Medical Services personnel authorized by the Division shall maintain a current course completion certificate in basic life support procedures at the professional rescuer/health care provider level.
  - (f) A person licensed as an Emergency Medical Technician – Intravenous Therapy or as a Paramedic may administer immunizations for the H1N1 virus only as follows:
    1. during the current 2009 H1N1 public health emergency as declared by the Secretary of the United States Department of Health and Human Services,
    2. using intramuscular or nasal routes,
    3. under a protocol of a county health department or Tennessee Department of Health office,
    4. at the site of a public health H1N1 immunization program, and
    5. if the Emergency Medical Technician – Intravenous Therapy or paramedic has successfully completed training approved or conducted by a county health department or the Tennessee Department of Health for the H1N1 immunizations.
- (4) License Classification for the Emergency Medical Technician. Upon remitting the license fee, if applicable, and approval of the appropriate application, individuals completing license procedures will be licensed in a category representative of the experience and additional qualifications recognized by the Division of Emergency Medical Services.
- (a) Emergency Medical Technician: a person who has successfully completed the EMT training course and who has qualified by examinations to perform pre-hospital

(Rule 1200-12-01-.04, continued)

emergency patient care. Upon demonstration of additional training and successful completion of qualifying examinations, the EMT may initiate and administer intravenous fluid therapy, and other procedure(s) approved by the EMS Board as listed in paragraph (3), upon the order of a physician or authorized registered nurse.

- (b) Emergency Medical Technician-Paramedic: a person who has successfully completed an accredited program in Tennessee for Emergency Medical Technician-Paramedics or comparable training and education in another state, and received endorsement from the training institution; who has successfully completed written and practical qualifying examinations; and who is licensed to practice advanced emergency medical care upon the order or under the supervision of a physician or authorized registered nurse.
  - (c) Licensures in categories previously established by the EMS Board shall continue in effect until expiration or renewal within the categories established above.
- (5) Violation of proscribed acts of the EMT and EMT-Paramedic as listed in T.C.A. §68-140-511 shall be cause for revocation, suspension, or denial of license renewal.
- (6) License Renewal Requirements.
- (a) Emergency Medical Technicians shall qualify for license renewal by completing the following requirements.
    - 1. Submit the renewal application and appropriate fee (if applicable) with documentation of all requirements prior to the expiration date of the license cycle.
    - 2. Submit proof of current registration with the National Registry of Emergency Medical Technicians; or
    - 3. Complete a patient care-oriented license renewal examination with a minimum score of seventy percent (70%); or
    - 4. Complete two (2.0) Continuing Education Units (CEU) or two (2.0) college credit hours (semester) in EMT-related studies, as approved by the Division.
      - (i) The due date for completion of the required continuing education is the expiration date of the EMT's license renewal.
      - (ii) All EMT's must retain independent documentation of completion of all continuing education hours. This documentation must be retained for a period of four (4) years from the end of the renewal period in which the continuing education was acquired. This documentation must be produced for inspection and verification, if requested by the Division during its verification process. Certificates verifying the individual's completion of the continuing education program(s) shall consist of one or more of the following:
        - (I) continuing education program's sponsor, date, length in hours awarded, program title, licensed individual's name, and license number; or
        - (II) an original letter on official stationery from the continuing education program's sponsor indicating date, length in hours awarded, program title, licensed individual's name, and license number.

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5. Dates for license renewal examinations will be scheduled by the Division and approved by the EMS Board.
- (b) Emergency Medical Technician-Paramedics shall qualify for license renewal by completing the following requirements.
1. Submit the renewal application and appropriate fee (if applicable) with documentation of all requirements prior to the expiration date of the license cycle.
  2. Submit proof of current registration with the National Registry of Emergency Medical Technicians; or
  3. Complete a license renewal examination with a minimum score of seventy percent(70%); or
  4. Complete three (3.0) Continuing Education Units or three (3.0) college credit hours (semester) in EMT or paramedical related studies, as approved by the Division.
    - (i) The due date for completion of the required continuing education is the expiration date of the EMT-P's license renewal.
    - (ii) All EMT-P's must retain independent documentation of completion of all continuing education hours. This documentation must be retained for a period of four (4) years from the end of the renewal period in which the continuing education was acquired. This documentation must be produced for inspection and verification, if requested by the Division during its verification process. Certificates verifying the individual's completion of the continuing education program(s) shall consist of one or more of the following:
      - (I) continuing education program's sponsor, date, length in hours awarded, program title, licensed individual's name, and license number; or
      - (II) an original letter on official stationery from the continuing education program's sponsor indicating date, length in hours awarded, program title, licensed individual's name, and license number.
  5. Dates for license renewal examinations will be scheduled by the Division and approved by the EMS Board.
  6. EMT-Paramedic renewal shall qualify for renewal of the EMT license.
- (c) License renewal examinations and continuing education units will not be required of persons when a license expiration date is assigned for periods of less than one (1) year. Proportional adjustments may be made in continuing education unit requirements.
- (7) Reinstatement of a lapsed license
- (a) Emergency Medical Technician
1. When the license has lapsed for one (1) year or less, an individual may reinstate the license by meeting and completing all applicable license and license renewal

(Rule 1200-12-01-.04, continued)

- standards, successfully completing the EMT license written examination (attaining a minimum score as established by the Board) and submitting all applicable fees.
2. When the license has lapsed for more than one (1) year, but less than two (2) years an individual may reinstate the license by completion of an EMS Board approved refresher course, achieving a passing score on a Board approved written examination with a minimum score as established by the Board, and successfully completing an EMS Board approved practical examination, and submitting all applicable fees.
  3. When the license has lapsed for two (2) years or more, an individual must complete the EMT course in its entirety and comply with license requirements in effect under paragraph (1).
- (b) The EMT-Paramedic
1. When the license has lapsed for one (1) year or less, an individual may reinstate the license by meeting and completing all applicable license and license renewal standards, successfully completing the Board approved EMT-P license written examination (attaining a minimum score as established by the Board), and submitting all applicable fees.
  2. When the license has lapsed for more than one (1) year, but less than two (2) years an individual may reinstate the license by completion of an EMS Board approved EMT-P refresher course, achieving a passing score on a Board approved Paramedic written examination with a minimum score as established by the Board, successfully completing an EMS Board approved EMT-P practical examination, and submitting all applicable fees.
  3. When the license has lapsed for two (2) years or more, an individual must complete the EMT-Paramedic course in its entirety and comply with license requirements in effect under paragraph (2).
- (c) For the purpose of renewal of a Emergency Medical Technician license which has expired, the EMS Board authorizes the Department to renew and condition the license for "Good Cause" when the Division receives written notification and a request for consideration within sixty (60) days of expiration. If no notification is initiated by the individual, then "Good Cause" cannot be applied.
1. "Good Cause" for delayed compliance with the regulations shall include:
    - (i) personal illness or hospitalization;
    - (ii) extensive travel or relocation within the affected time period;
    - (iii) conflicting professional or educational schedules (military);
    - (iv) immediate family illness or death; or
    - (v) extraordinary circumstances beyond the control of the licensee.
  2. The following reasons shall not constitute "Good Cause":
    - (i) failure to submit necessary forms or fees by the expiration date;

(Rule 1200-12-01-.04, continued)

- (ii) willful defiance of rules; or
    - (iii) possession of an expired license for more than sixty-one (61) days without inquiry to the Division concerning renewal status.
  - (d) Persons who have completed a continuing education or renewal examination within their prior license period may reinstate an expired license by submitting appropriate documentation, the license fee and renewal application, and the reinstatement fee of twenty-five dollars (\$25.00) within sixty (60) days of their expiration date.
- (8) Out-of-state requirements for License. Any EMT or EMT-Paramedic who holds current certification/license from another state or country and who has successfully completed an approved U.S. Department of Transportation EMT or EMT-Paramedic course or equivalent curriculum may apply for Tennessee EMT or EMT-Paramedic license by complying with the following:
- (a) conform to all license requirements for Tennessee Emergency Medical Technicians or EMT-Paramedics; and
  - (b) submit appropriate documentation of extended skills training conducted by an authorized instructor of a Tennessee Accredited EMS Training Institution; or documentation of extended skills training from an authorized training agency of another state or country; and
  - (c) successful completion of any EMS Board approved written and practical examinations; and,
  - (d) submit the appropriate application forms and fees, if applicable, to the Division of Emergency Medical Services.
- (9) Out-of-state requirements for License of federal or ex-federal employees. Any EMT or EMT-Paramedic who has successfully completed an approved U.S. Department of Transportation EMT Basic or EMT Paramedic course while employed with the federal government and who holds current certification from National Registry of Emergency Medical Technicians for the Emergency Medical Technician-Basic or Emergency Medical Technician-Paramedic may apply for Tennessee EMT or EMT-Paramedic license by complying with the following:
- (a) conform to all license requirements for Tennessee Emergency Medical Technicians or EMT-Paramedics; and
  - (b) submit appropriate documentation of extended skills training conducted by an authorized instructor of a Tennessee Accredited EMS Training Institution; or documentation of extended skills training from a federally approved training agency; and
  - (c) submit the appropriate application forms and fees, if applicable, to the Division of Emergency Medical Services.
- (10) Personnel licensed by the Department, upon a change of name or address shall notify the Division of Emergency Medical Services in writing within thirty (30) days of such change. Notifications for renewal or disciplinary action shall be posted to the address listed on file with the Division and, unless returned by the post office, shall constitute effective notice for renewal or action upon license status. Return by the post office shall be interpreted as a willful violation for failure to retain a current address on file.
- (11) Retirement of an EMS professional license

(Rule 1200-12-01-.04, continued)

- (a) A currently licensed EMT or EMT-P who wishes to permanently retire his or her license shall submit the following information to the Division:
    - 1. A properly completed permanent retirement affidavit form to be furnished by the Division.
    - 2. Other documentation which may be required by the Division pursuant to this purpose.
  - (b) Any EMS professional who has filed the required information for permanent retirement of his or her license shall be permitted to use the appropriate title:
    - 1. For emergency medical technicians, EMT Retired or EMTR.
    - 2. For emergency medical technician-paramedics, EMT-Paramedic Retired, or EMT-PR.
- (12) Reinstatement of a retired EMS professional license.
- (a) A reinstatement applicant whose license has been retired two years or less may reinstate his or her license by completing the following requirements:
    - 1. Payment of all past due renewal fees, reinstatement, and state regulatory fees pursuant to Rule 1200-12-01-.06; and
    - 2. Submission of documentation to prove satisfactory health and good character.
  - (b) If a reinstatement applicant's license has been retired for more than two years, an applicant must complete refresher training requirements and written and practical examinations that have been approved by the board for the level of licensure for which reinstatement has been applied.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, 68-140-506, 68-140-508, 68-140-509, 68-140-511, 68-140-517, 68-140-518, 68-140-520, 68-140-525, and 42 USC §247d-6d. **Administrative History:** Original rule filed March 20, 1974; effective April 19, 1974. Amendment filed February 4, 1976; effective March 5, 1976. Repeal and new rule filed February 8, 1983; effective May 16, 1983. Amendment filed November 30, 1984, effective February 12, 1985. Amendment filed August 22, 1985; effective September 21, 1985. Amendment filed February 21, 1986; effective May 13, 1986. Amendment filed September 18, 1986; effective December 29, 1986. Amendment filed April 8, 1987; effective May 23, 1987. Amendment filed June 30, 1987; effective August 14, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed January 17, 1989; effective March 3, 1989. Amendment filed September 24, 1990; effective November 8, 1990. Amendment filed October 21, 1993; effective January 4, 1994. Amendment filed April 13, 1994; effective June 27, 1994. Amendment filed August 5, 1996; effective October 19, 1995. Amendment filed August 29, 2003; effective November 12, 2003. Amendment filed December 16, 2005; effective March 1, 2006. Amendments filed April 13, 2006; effective June 27, 2006. Amendment filed September 21, 2007; effective December 5, 2007. Emergency rule filed October 27, 2009; effective through April 25, 2010.

**1200-12-01-.05 AIR AMBULANCE STANDARDS.** All air ambulance service providers and crew members operating in Tennessee must comply with Chapter 140 of Title 68 of the Tennessee Code Annotated and this Rule. Failure to comply shall subject the service providers and/or its personnel to disciplinary action pursuant to T.C.A. §68-140-511.

- (1) Definitions - As used in this Rule, the following terms shall have the following meanings:

(Rule 1200-12-01-.05, continued)

- (a) Crew Member - Any person employed by an air ambulance service with the intent to function in the performance of duties aboard any aircraft during flight.
  - (b) Flight crew member - Any person employed by an air ambulance service with the intent to be engaged as the pilot of an aircraft.
  - (c) Flight coordinator - Any person functioning for an air ambulance service with duties for initial acknowledgement of requests, telecommunications, and flight following.
  - (d) Public Use Air Ambulance Service - Any service conducted by a local or state government unit and/or associated with operations for police patrol or fire fighting, conducted without compensation for patient transport.
  - (e) Regular Medical Crew Members - Any person with the intent to be engaged in day-to-day flight mission assignment as distinguished from a medical crew member who is employed to serve on an occasional flight mission or as a specialty crew member.
  - (f) Special Equipment - Any device or number of devices and supplies which shall be approved by the medical director of an air ambulance service for the medical care of a particular patient.
  - (g) Specialty Crew Members - Any person substituted by the medical director of an air ambulance service for a Specialty Mission.
  - (h) Specialty Mission - An assignment for air ambulance service for which the specified needs of a particular patient require the substitution of particular medical care providers and/or equipment as may be approved by the medical director.
- (2) Air Ambulance Design and Navigational Equipment.
- (a) All fixed-wing aeromedical aircraft shall comply with all applicable Federal Aviation Regulations for the type of operation and aircraft, and shall be designed for the provision of patient care as follows:
    - 1. Aircraft doors shall accommodate passage of a supine litter patient without rotation of more than 30 degree roll or 45 degree pitch
    - 2. At least 30 inches (76cm) of vertical head space shall exist above the head of the stretcher with sufficient attendant access from at least one side of the litter without obstruction.
    - 3. Lighting for the patient area shall afford necessary observation by medical personnel. Fixed or portable lamps may be used to comply with this standard.
  - (b) Civil helicopter aeromedical programs that are licensed or authorized or operating in the State of Tennessee shall operate in compliance with Federal Aviation Regulations, 14 C.F.R. Parts 91 and 135. Public-use aeromedical programs shall comply with applicable Federal Aviation Regulations, 14 C.F.R. Parts 91 and 135.
  - (c) All helicopters performing aeromedical missions shall be equipped with avionics and instruments necessary to enable the pilot to execute an instrument approach under instrument meteorological conditions and shall include:
    - 1. Two very high frequency transceivers, notwithstanding the provisions of applicable Federal Aviation Regulations regarding inoperable equipment. One transceiver shall be capable of operating on the designated EMS frequency;

(Rule 1200-12-01-.05, continued)

2. Two very high frequency omnidirectional ranging (VOR) receivers;
  3. One nondirectional beacon (NDB) receiver;
  4. One glide slope receiver;
  5. Transponder meeting requirements of FAA TSO C-112, (Mode S), or C74b or TSO-C74C as appropriate; and
  6. FAA approved navigational aids and current IFR charts for the area of operations.
- (3) Air Ambulance Medical Equipment and Supplies.
- (a) Fixed-Wing Medical Equipment and Supplies - The following medical equipment and supplies shall be provided on each flight aboard the aircraft and shall be stored and secured within the flight compartment by suitable restraints.
1. Litter - A litter or stretcher with at least two sets of restraining straps shall be supplied, secured as required by the supplemental type certification for the aircraft utilized.
  2. Suction Apparatus - A suction device shall be provided, capable of 12 inches mercury vacuum. Sterile suction catheters and a rigid suction tip shall be provided for adult and pediatric patients.
  3. Bag/Valve/Mask Resuscitator - Bag/Mask resuscitator(s) shall be provided for the adult or pediatric patient, with clear masks and an oxygen reservoir and connections to achieve 95% fraction inspired oxygen.
  4. Airways - Oropharyngeal airways shall be provided for infants, children, and adults.
  5. Resuscitation Board - Unless a rigid stretcher or spineboard is employed for patient transfer, a suitable board for cardiac compression shall be provided.
  6. Medical Oxygen Equipment - Oxygen equipment shall be furnished capable of adjustable flow from 2 to 15 liters per minute. Masks and supply tubing for adult and pediatric patients shall allow administration of variable oxygen concentrations from 24% to 95% fraction inspired oxygen. Medical oxygen shall be provided for 150% of the scheduled flight time by a unit secured within the aircraft.
  7. Sanitary Supplies - Sanitary supply items provided for fixed-wing flights shall include a bedpan, urinal, towelettes, tissues, emesis bags, and plastic trash disposable bags.
  8. Sheets and Blankets - Sheets and blankets shall be provided for each patient transported.
  9. Patient Assessment Devices - Devices for adult and pediatric patient assessment shall be provided, including:
    - (i) Flashlight and/or penlight,

(Rule 1200-12-01-.05, continued)

- (ii) Stethoscope,
    - (iii) Sphygmomanometer and blood pressure cuffs, and
    - (iv) Dressings and bandages.
  10. Medications deemed suitable by the aeromedical consultant shall be provided as appropriate for the crew and patient.
- (b) Helicopter Medical Equipment and Supplies - Unless the service's Medical Director approves substitution of special equipment for specialty missions, the following medical equipment and supplies shall be provided on each helicopter, and all equipment shall be stored and secured by suitable restraints:
  1. Litter - A litter or stretcher with at least two sets of restraining Amps shall be supplied, secured as required by the supplemental type certification for the aircraft utilized
  2. Suction Apparatus - An installed and portable suction device shall be provided, capable of 12 inches mercury vacuum. Sterile suction catheters and a rigid suction tip shall be provided for adult and pediatric patients.
  3. Bag/Valve/Mask Resuscitator - Bag/Mask resuscitator(s) shall be provided for the adult and pediatric patient, with clear masks and an oxygen reservoir and connections to achieve 95% fraction inspired oxygen.
  4. Airway - Maintenance devices shall be provided for adult and pediatric patients including oropharyngeal airways, endotracheal tubes, laryngoscope with assorted blades, and accessory items for intubation.
  5. Resuscitation Board - Unless a rigid stretcher or spineboard is employed for patient transfer, a suitable board for cardiac compression shall be provided.
  6. Medical Oxygen Equipment - Oxygen equipment shall be furnished capable of adjustable flow from 2 to 15 liters per minute. Masks and supply tubing for adult and pediatric patients shall allow administration of variable oxygen concentrations from 24% to 95% fraction inspired oxygen. An installed oxygen system shall supply a minimum 1,800 liter supply. A portable system shall supply at least 300 liters.
  7. Protective Cover - A protective cover shall be supplied for each patient.
  8. Patient Assessment Devices - Devices and supplies shall be available for adult and pediatric patient assessment, to include:
    - (i) Sphygmomanometer and blood pressure cuffs,
    - (ii) Stethoscope,
    - (iii) Doppler stethoscope, and
    - (iv) Electrocardiographic monitor/recorder and defibrillator.
  9. Trauma Supplies - Sterile dressings, roller bandages, pneumatic antishock trousers, and semi-rigid cervical collars shall be supplied.

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10. Intravenous fluids and administration devices shall be provided.
  11. Medications - Appropriate medications including the advanced life support medications described in a Rule 1200-12-01-.03(2)(b) shall be provided.
  12. Neonatal transport equipment shall conform to the standards adopted in the Tennessee Perinatal Care System Guidelines for Transportation, Tennessee Department of Health and Environment, Maternal and Child Health Section, September, 1985 or successor publication.
- (4) Air Ambulance Safety Equipment, Procedures and Training and Standards. Each aeromedical service shall assure that aircraft are equipped to promote safe scene access, that procedures are established for safe operation, and that adequate training has been conducted for personnel in placement and use of emergency equipment and emergency and safety procedures.
- (a) Safety and Survival Equipment shall be required on all helicopter air ambulances which shall include:
    1. Illumination of the tail of the aircraft.
    2. Search light of at least 300,000 candlepower for night scene and landing area illumination.
    3. Survival kit with signaling devices and personal survival items.
  - (b) Landing Zone Preparation Procedures shall be published for distribution to ground ambulance services specifying the following minimum requirements:
    1. An 80 by 80 foot square perimeter shall be required for day operations; a 100 by 100 foot square perimeter shall be required for night operations.
    2. Landing areas shall be clear of trees, wire or other obstructions.
    3. Landing areas shall be clear of loose debris.
    4. Touchdown areas shall be smooth and as level as possible.
    5. Perimeter obstructions - Wires, trees, poles, lights, and other hazards must be marked or clearly identified to the pilot.
    6. Night landing areas shall be clearly identified by lights at the perimeter boundary.
  - (c) Safety Training shall be provided by each helicopter air ambulance service for all Flight Crew Members, Medical Crew Members, Specialty Crew Members, and Flight Coordinators.
    1. Safety training provided annually shall include the following:
      - (i) Ground emergency procedures,
      - (ii) Inflight safety procedures,
      - (iii) Aircraft safety equipment
      - (iv) Hazardous material identification training,

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- (v) Emergency shut down aircraft engines,
  - (vi) Electrical shut down of the aircraft,
  - (vii) Use of the emergency locator transmitter,
  - (viii) Emergency use of the aircraft avionics system to include appropriate emergency frequencies,
  - (ix) Demonstrated ability to use onboard fire equipment to include engine and cabin fire extinguishers,
  - (x) Emergency exits of the aircraft,
  - (xi) Passenger safety briefings,
  - (xii) Roles and responsibilities for patient safety and flight duties, and
  - (xiii) Crash protection and survival techniques.
2. Flight coordinators and ground support personnel functioning for an air ambulance service shall be trained to promote safe operations, to include:
- (i) Helipad safety precaution,
  - (ii) Landing zone standards and scene control,
  - (iii) Radio communications,
  - (iv) Fire prevention and fire suppression, and
  - (v) Accident and incident notification and documentation.
3. Instruction materials shall be offered by the air ambulance service that will familiarize other EMS providers within their response area with the requirements for establishing landing zones, control of the landing area, and ground to air communications.
- (5) Air Ambulance Personnel and Qualifications.
- (a) Pilot
- 1. For all air ambulances the pilot shall possess a minimum commercial pilot's certificate with an instrument rating and in a category appropriate to the aircraft utilized and meet all applicable Federal Aviation Regulations for the type of operation and aircraft.
  - 2. For all helicopter air ambulance services:
    - (i) Each pilot shall possess a Commercial Helicopter Certificate with Instrument Helicopter ratings and 3000 hours of flight time which shall include the following:
      - (l) 2000 hours of flight time in helicopters with at least 1000 hours in turbine helicopters;

(Rule 1200-12-01-.05, continued)

- (II) 200 hours of night flight time of which 100 hours must have been helicopter flight time.
  - (ii) An instrument flight and night flight proficiency check will be required before accepting missions.
  - (iii) Pilot training shall include factory school or equivalent. Flight time shall include five hours of local orientation for all pilots, of which two hours shall be night time flight.
  - (iv) Each pilot shall successfully complete an instrument proficiency check ride every six months.
  - (v) Pilot staffing shall consist of four permanently assigned pilots per regularly deployed aircraft and a sufficient number of relief pilots for adequate coverage.
  - (vi) No pilot shall receive compensation on a "per flight" incentive nor shall patient factors which may unduly influence flight acceptance be communicated to the pilot before a flight plan and departure status are confirmed.
- (b) Medical Crew
1. Each patient transported by a fixed-wing air ambulance shall be accompanied by either a physician, a registered nurse, or an EMT or an EMT-P, meeting recommendations of the American Medical Association Air Ambulance Guidelines (U.S. Department of Transportation Publication DOT HS 806 703, Revised May, 1986, or its successor publication), and so recognized by a letter of authorization from the service's aeromedical consultant.
  2. Each transport of patients by a helicopter air ambulance shall require staffing by a regular medical crew which as a minimum standard shall consist of one Registered Nurse licensed in the State of Tennessee and another licensed or certified medical provider (i.e., EMT-P, Respiratory Therapist, Nurse, or Physician). The composition of the medical team may be altered for specialty missions upon order of the medical director of the air ambulance service.
  3. All regular medical crew members serving on helicopter air ambulances shall be determined physically fit for duty by the program medical director.
    - (i) An annual medical examination shall be documented.
    - (ii) A preplacement Class II FAA Flight Physical certificate or equivalent physical examination shall be documented.
  4. Registered Nurse Qualifications - A Registered Nurse serving as a regular medical crew member on a helicopter air ambulance shall meet the following criteria:
    - (i) Have three years of registered nursing experience with two years experience in critical care nursing.
    - (ii) Possess current licensure as a registered nurse in Tennessee unless exempted by T.C.A. §63-7-102(8).

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- (iii) Enroll in an EMT training course within twelve months of employment and obtain state certification as an Emergency Medical Technician.
      - (iv) Obtain and maintain advanced nursing certification within twelve months of employment through one of the following programs:
        - (I) Certified Emergency Nurse.
        - (II) Critical Care Registered Nurse.
  - 5. EMT Paramedic Qualifications - An EMT-Paramedic serving as a regular medical crew member on a helicopter air ambulance shall be certified and have three years experience as an EMT-P, with two years experience as a paramedic in an advanced life support service.
  - 6. Physician Qualifications - The qualifications of a physician serving as a regular medical crew member on a helicopter air ambulance shall be determined by the medical director. At a minimum, each physician shall:
    - (i) Hold current certification in the advanced trauma life support course, and
    - (ii) Hold current certification in advanced cardiac life support.
  - 7. Each regular medical crew member on a helicopter air ambulance shall have and maintain certification in Advanced Cardiac Life Support and Pediatric Advanced Life Support, or obtain certification within six months of employment and restrict flight duty by accompanying another certified provider until so certified.
  - 8. Each regular medical crew member on a helicopter air ambulance shall have and maintain training in an Advanced Trauma Life Support, Flight Nurse Advanced Trauma Care Course, Basic Trauma Life Support, Pre-hospital Trauma Life Support course, or Trauma Nurse Core Course, or obtain training within six months of employment and restrict flight duty by accompanying another trained provider until so trained.
  - 9. Each regular medical crew member shall complete and document training in mission specific procedures as established by the medical director and such federal, state or local agencies with authority to regulate air ambulance services.
  - 10. Medical crew members on a helicopter air ambulance shall not exceed 24 hours of consecutive duty time or more than 48 hours of duty time within a 72 hour period. Adequate provision for crew rest and time for meals shall be provided for the medical flight crew.
  - 11. Specialty crew members shall be trained in safety procedures and appropriate aeromedical procedures commensurate with the mission.
- (c) Aeromedical Consultant - On all fixed-wing air ambulance services an aeromedical consultant, who must be a physician licensed to practice within the jurisdiction of the base of operations, shall advise on the restrictions and medical requirements for patient transport.
  - (d) Medical Director - All helicopter air ambulance services shall have medical direction from a physician who shall be:

(Rule 1200-12-01-.05, continued)

1. Licensed in the State of Tennessee; and
  2. Board certified or eligible for Board certification by a professional association or society in a Surgical Specialty, Internal Medicine, Pediatrics, Emergency Medicine, Family Practice, or Aerospace Medicine; and
  3. Certified in Advanced Cardiac Life Support; and
  4. Certified in Advanced Trauma Life Support.
- (e) Medical Control Physician - Reserved for future use.
- (f) All helicopter air ambulance services shall have flights coordinated by designated flight coordinators.
1. As a minimum qualification flight coordinators shall be certified Emergency Medical Technicians with at least two years of emergency medical or emergency communications experience.
  2. Flight coordinators shall have training in FAA approved procedures for flight coordination and telecommunications, which shall include:
    - (i) Map reading, aeronautical chart interpretation and basic navigation and flight planning;
    - (ii) Weather terminology and procedures for flight service weather advisories;
    - (iii) Flight following and ground-to-air telecommunications; and
    - (iv) Procedures for accident and incident policies.
  3. Flight coordinators shall not be required to work more than 16 hours in any one 24 hour period or more than 72 hours in any work week.
- (6) Flight Coordination and Telecommunications. A flight coordination office shall be provided for each helicopter air ambulance service for processing requests, initiating responses, telecommunications, and flight following. This office shall be physically isolated from emergency room or admitting areas to minimize distractions. This office shall be staffed 24 hours per day on a continuous basis.
- (a) Operations Manual for Flight Control Office - A detailed manual of policies and procedures shall be available for reference in the flight coordination office. Personnel shall be familiar and comply with policies contained within the manual, which shall include:
1. Procedures for acceptance of requests and referral or denial of service,
  2. Geographical boundaries and features for the service area,
  3. Criteria for the medical conditions and indications or contraindications for flight
  4. Procedures for call verification and advisories to the requesting party,
  5. Acceptable destinations and landing areas,
  6. Weather advisory procedures and policies for minimum flight operations,

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7. Procedures for pilot and flight crew assignment and notification including rosters for personnel,
  8. Radio and telephone communications procedures,
  9. Policies and procedures for accidents and incidents,
  10. Procedures for informing requesting party of flight procedures, helicopter arrival, and termination of flight,
  11. Flight following procedures which shall assure air/ground position reports at intervals not to exceed fifteen minutes.
    - (i) Information for each flight following shall be recorded on an appropriate form.
    - (ii) Position reporting shall use a map or aeronautical reference system with established locational descriptions.
  12. Procedures shall be established for communications failure or overdue aircraft.
  13. Emergency protocols shall be established for downed aircraft search and rescue.
- (b) Telecommunications - The flight coordination center for a helicopter air ambulance service shall include radio and telephone equipment to enable personnel to contact the helicopters and crew and promote safe operations. Telecommunications devices shall include the following:
1. EMS Communications on the established frequencies of 155.205 MHz, 155.340 MHz, and/or upon such specific channels or frequencies as may be designated within each region as are approved and published as a supplement to the State EMS Telecommunications Plan,
  2. Direct telephone circuits accessible by flight coordination personnel, and
  3. Tape logging or recording equipment for both telephone and radio messages.
- (7) Helicopter Air Ambulance Response and Destination Guidelines and Procedures. Response to emergency medical situations by helicopter air ambulance services shall be governed by medical necessity. Procedures for initiation of requests, medical responsibility and destination coordination shall be governed by this Rule.
- (a) Medical Necessity
1. Helicopter air ambulance response is appropriate when the information available at the time of transport indicates the patient has an anticipated medical or surgical need requiring transport or transfer and without helicopter transport the patient would be placed at significant risk for loss of life or impaired health; and,
    - (i) Available alternative methods may impose additional risk to the life or health of the patient; or
    - (ii) Available alternative methods would make ambulance services unavailable or severely limited in the community service area; or

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- (iii) Where speed and critical care capabilities of the helicopter are essential; or
    - (iv) Where the patient is inaccessible to ground ambulances or distance to a hospital from the scene would require unnecessarily prolonged ground travel time; or
    - (v) Where the patient transfer is delayed in entrapment, traffic congestion, or other barriers; or
    - (vi) Where advanced life support is unavailable or subject to response time in excess of twenty minutes.
  - 2. Specialty Missions with specialized medical care personnel, medical products and equipment, emergency supplies, and special assistance for major casualty incidents or disasters, or mutual aid to other aeromedical services are medically necessary when their availability might decrease the risk of aggravation or deterioration of the patient's condition.
  - (b) Request Initiation Procedures - Procedures for initiation of requests shall be established in writing to include documentation of the following:
    - 1. Means of access,
    - 2. Call criteria and incident criteria, and
    - 3. Notification to the requesting party of the estimated time of arrival of the helicopter.
  - (c) Medical Responsibility - Medical responsibility will be assumed by the medical flight crew personnel upon arrival at the scene.
  - (d) Interfacility transfers shall not be initiated unless an appropriate physician at the receiving institution has accepted the patient for transfer.
  - (e) Destination - The destination of a patient shall be established pursuant to Rule 1200-12-01-.11(7).
- (8) Records and Reports
- (a) Fixed-wing aircraft records shall include the following:
    - 1. A record on each patient transported providing:
      - (i) Name of the person transported,
      - (ii) Date of flight,
      - (iii) Origin and destination of flight,
      - (iv) Presenting illness or injury, or medical condition necessitating air ambulance service,
      - (v) Flight crew and medical personnel,
      - (vi) Accessory ground ambulance services, and

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- (vii) Medical facilities transferring and receiving the patient.
- 2. Each fixed-wing air ambulance service shall report the number of air ambulance transfers performed annually, on the form provided for such purposes to the Division of Emergency Medical Services.
- (b) Helicopter Air Ambulance Services - Records and reports shall be required for the dispatch, personnel, flights, patient care and incidents or accidents involving any helicopter air ambulance.
  - 1. Tape recordings of telecommunications shall be retained for at least thirty days.
  - 2. Flight following or related equipment records shall be retained for at least 30 days.
  - 3. A patient record shall include the patient's name, date of transport, origin and destination of flight chief complaint, documentation of treatment during transport, and medical care providers. A copy shall be provided to the receiving facility.
- (c) All records of medical services shall be retained for at least five years.
- (9) Compliance. Compliance with the foregoing regulations shall not relieve the air ambulance operator from compliance with other statutes, rules, or regulations in effect for medical personnel and emergency medical services, involving licensing and authorizations, insurance, prescribed and proscribed acts and penalties.
- (10) Separation of Services. Ground ambulance services, categorized in accordance with rule 1200-12-01-.14 shall remit a separate application and fee for operation of an air ambulance service, and air ambulance service shall constitute a separate class of license and authorization from the Board and Department.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, and 68-140-507. **Administrative History:** Original rule filed March 20, 1974; effective April 19, 1974. Amendment filed November 30, 1984; effective February 12, 1985. Amendment filed February 4, 1988; effective March 20, 1988. Amendment filed June 28, 1988; effective August 12, 1988. Amendment filed August 11, 1993; effective October 25, 1993. Amendment filed January 7, 1997; effective March 23, 1997. Repeal and new rule filed January 7, 1997; effective March 23, 1997.

#### **1200-12-01-.06 SCHEDULE OF FEES.**

- (1) The fees are as follows:
  - (a) Application fee for licensure or certification - A fee to be paid by all applicants as indicated, including those seeking licensure by reciprocity. It must be paid each time an application for licensure is filed.
  - (b) Endorsement/verification - A fee paid for each level of certification or endorsement as may be recognized by the Board within each category of personnel license.
  - (c) Examination fee - A fee paid each time an applicant requests to sit for any initial, retake, or renewal test or examination, written or practical.
  - (d) License fee - A fee to be paid prior to the issuance of the initial license.

(Rule 1200-12-01-.06, continued)

- (e) License Renewal fee - A fee to be paid by all license holders. This fee also applies to personnel who may reinstate an expired or lapsed license.
  - (f) Reinstatement fee - A fee to be paid when an individual fails to timely renew a license or certification.
  - (g) Replacement license or permit fee - A fee to be paid when a request is made for a replacement when the initial license has been changed, lost, or destroyed.
  - (h) Volunteer non-profit ambulance services eligible for reduced license fees under paragraph (5) shall be provided by all volunteer personnel and shall not assess any fees for their services, and shall be primarily supported by donations or governmental support for their charitable purposes.
- (2) All fees shall be established pursuant to the rules approved by the Board.
  - (3) All fees for initial licensing or certification shall be submitted to the Division of Emergency Medical Services to the attention of the Revenue Control office. Fees shall be payable by check or money order payable to the Tennessee Department of Health.
  - (4) Emergency Medical Services Personnel Fees – Personnel applying for licensure, certification, authorization, renewal, or reinstatement shall remit application processing and license fees as follows.

(a) Fees for licensed personnel

	Application	License
1. Emergency Medical Technican –Basic	\$50.00	\$75.00
2. Emergency Medical Technican –Basic -IV	\$70.00	\$80.00
3. Emergency Medical Tech. – Paramedic	\$75.00	\$100.00
4. Emergency Medical Tech. Paramedic Critical Care – Initial Application for Endorsement	\$75.00	
5. Initial Instructor Authorization	\$35.00	

(b) Renewal fees for all classes of licenses in (a)

	License
1. Emergency Medical Technican –Basic	\$65.00
2. Emergency Medical Technican –Basic -IV	\$65.00
3. Emergency Medical Tech. – Paramedic	\$75.00
4. Emergency Medical Tech. Paramedic Critical Care –	\$90.00

(c) Fees for Emergency Medical First Responders

	Application	License
1. Initial Application and Certification	\$20.00	\$25.00
2. Renewal fee		\$24.00

(Rule 1200-12-01-.06, continued)

- (d) Fees for Emergency Medical Dispatcher
 

	Application	License
1. Initial Application and Certification	\$30.00	\$30.00
2. Renewal fee		\$45.00
  
- (e) Application fee for license by interstate reciprocity \$100.00
- (f) When applicable, renewal fees may be pro rated on a birth month renewal system.
- (g) Applicants may also be required to pay a fee directly to the National Registry or other appropriate national or board-approved testing agency.
  
- (5) Service License and Vehicle Permit fee – Ambulance services and invalid services shall permit fees as follows:
 

	License
(a) Initial license fee for a new ground ambulance, invalid, or other regulated ground service	\$5,000.00
(b) Annual renewal fee for (a)	\$500.00
(c) Vehicle Permit fee for each ground vehicle to be permitted in a license period- initial and annual	\$250.00
(d) Initial license fee for volunteer non-profit ambulance service with all volunteer personnel	\$2,000.00
(e) Annual renewal for volunteer non-profit ambulance service with all volunteer personnel	\$250.00
(f) Vehicle Permit fee for each ground vehicle operated by a volunteer non-profit ambulance service	\$100.00
(g) Initial license fee for air ambulance services – fixed wing and helicopter	\$10,000.00
(h) Air Ambulance service – annual renewal fee	\$5,000.00
(i) A repeat inspection fee for a failed inspection of any aircraft or vehicle requiring inspection by the department	\$500.00
  
- (6) A reinstatement fee of \$25.00 shall be paid for each authorization, license, and/or permit prior to reinstatement of an expired authorization, This fee shall be in addition to the fee specified for licenses, permits or certification renewal.
  
- (7) Administrative Documents and Publications fees.
  - (a) Copies from official files and records shall be subject to a charge of fifty cents (\$.50) per page.
  - (b) Publications, or copies of reference documents available from the Division shall include:
 

1. Director of Services	\$5.00
2. Application Materials Packet	\$9.00
3. Complied Statues and Rules	\$9.00
4. Protocols	\$5.00
5. Ambulance Design Specifications	\$5.00
6. Other documents at the authorized cost of publication.	
  - (c) Postage and Handling fees of five dollars (\$5.00) will be applied to any mailing of more than twenty (20) pages.

(Rule 1200-12-01-.06, continued)

- (8) Verification of license status to other states, employers, or agencies shall be subject to a verification fee of fifteen dollars (\$15.00). (Excepting automated telephone inquiries not requiring written documentation.)

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-39-508, 68-140-502, 68-140-504, 68-140-505, 68-140-506, 68-140-508, 68-140-517, and 68-440-506. **Administrative History:** Original rule filed September 22, 1981; effective December 29, 1981. Repeal and new rule filed October 13, 1983; effective January 16, 1984. Amendment filed November 30, 1984; effective February 12, 1985. Amendment filed August 22, 1985; effective September 21, 1985. Amendment filed September 24, 1990; effective November 8, 1990. Amendment filed October 21, 1993; effective January 4, 1994. Amendment filed August 12, 1996; effective October 26, 1996. Amendment filed June 18, 1999; effective September 1, 1999. Amendment filed August 29, 2003; effective November 12, 2003. Amendments filed December 16, 2005; effective March 1, 2006. Amendment filed April 13, 2006; effective June 27, 2006. Amendments filed June 4, 2008; effective August 18, 2008.

### 1200-12-01-.07 INSURANCE COVERAGE.

- (1) All ambulance services and invalid vehicle services operating pursuant to Chapter 140 of Title 68, Tennessee Code Annotated shall maintain for each vehicle owned, and/or operated as an ambulance or invalid vehicle, insurance for vehicular liability coverage of not less than the minimum limits which are set forth in T.C.A. §29-20-403.
- (2) All emergency medical services, first response units and ambulance services shall maintain coverage for negligence (malpractice) or professional liability of not less than three hundred thousand dollars (\$300,000) per occurrence.
- (3) Each ambulance service and invalid vehicle transport service shall maintain general or professional liability coverage for claims arising in transfer of persons to and from their conveyance, and during transport of not less than three hundred thousand dollars (\$300,000) per occurrence.
- (4) Evidence that such insurance is in force and effect shall be furnished to the Division of Emergency Medical Services by the insurer upon application, license renewal, and upon request.
  - (a) Each service shall list the insurance agent, address, telephone number and each carrier and each policy number for insurance required under paragraphs (1), (2), and (3) upon initial and renewal applications, and shall inform the Division of any changes in agent or carrier.
  - (b) Each service shall have the insurance agent and/or carrier submit to the Division verification of coverage in the form of either a notarized affidavit or such certificate or insurance form as shall be approved by the department of commerce and insurance or the department of health.
  - (c) Local government or state entities maintaining coverage under Governmental Tort Liability limits or self insurance programs may demonstrate compliance by submitting to the Division a letter verifying such coverage or alternate limits applicable to paragraphs (1), (2), and (3) attested by the chief risk management official, listing the address and telephone number and claims procedures.
- (5) Air ambulance services shall comply with liability coverage required by the Federal Aviation Administration for air taxi operators, and malpractice and professional liability coverage at not less than three hundred thousand dollars (\$300,000) per occurrence. Air ambulance services shall verify coverage as described in paragraph (4).

(Rule 1200-12-01-.08, continued)

**Authority:** T.C.A. §§4-5-202, 68-140-504, and 68-140-507. **Administrative History:** Original rule filed February 8, 1983; effective May 16, 1983. Amendment filed November 30, 1984; effective February 12, 1985. Amendment filed December 7, 1993; effective February 20, 1994. Repeal and new rule filed December 16, 2005; effective March 1, 2006.

#### 1200-12-01-.08 EMERGENCY MEDICAL SERVICES TELECOMMUNICATIONS.

- (1) EMS Telecommunications, General. All emergency medical service entities, as described in the Tennessee Code Annotated, Section 68-140-202, shall meet the following rules and regulations to provide a statewide emergency medical services telecommunications system.
  - (a) Any radio system associated with, or operating in the Tennessee emergency medical services radio network and located, or proposed to be located, within the legal jurisdiction of the State of Tennessee, is required to submit to the Division of Emergency Medical Services a description of any new installation of radio equipment, or of changes, additions, and deletions to existing radio equipment.
  - (b) Each description shall list equipment identified by manufacturer, model number, quantity, frequency(s) and, in case of fixed station equipment, the antenna height type, location, and the number and location of the control point(s) for the station.
  - (c) Proposed modification to any system involving changes in frequency, radio access to the system, power output, antenna, control point(s), and number of transmitters shall be filed with the Division.
  - (d) The Director, Division of Emergency Medical Services, is delegated the responsibility and authority to review and approve or disapprove applications, system descriptions and system modifications submitted in accordance with these rules prior to their implementation, in order to maintain consistent development of a statewide telecommunications system.
- (2) EMS Telecommunications Resource Coordination Centers, also known as Regional Medical Communications Centers, (RMCC), shall be designated by the Director of the Division of Emergency Medical Services for each emergency medical services area of the state, and shall be charged with the following responsibilities:
  - (a) The RMCC shall be operational twenty-four (24) hours daily and shall coordinate emergency medical services traffic, as required to:
    1. Coordinate radio communications between ambulances, receiving hospitals, and adjacent regional communications centers;
    2. Coordinate emergency medical consultation services for hospitals and ambulance services;
    3. Monitor the status and availability of hospitals and special services throughout the region;
    4. Conduct routine communications checks and systems tests with systems participants; and,
    5. Assist in public health, injury, and disease surveillance programs in association with the Department of Health.
  - (b) The RMCC shall monitor and respond to all EMS telecommunications so directed to the regional center for those messages originating on the designated Tennessee EMS

(Rule 1200-12-01-.08, continued)

radio frequencies in the very high frequency (VHF) high band spectrum. Where applicable, the RMCC shall also:

1. assign the UHF MED channels for real-time use by ambulances within two-way radio range of the center's equipment, assuring an interference-free MED channel for ambulances during multiple or simultaneous runs; and,
  2. monitor and respond to EMS units as enabled on 800 MHz radio systems; and,
  3. shall record all EMS message traffic by date and 2400 hour time and retain the recordings for a minimum of one (1) year.
- (c) The RMCC will maintain and coordinate its activities through a regional committee to promote and conduct quality improvement programs and review, and to guide plans and procedures for daily operations,. This committee shall coordinate development of communications procedures and other regional emergency medical services system planning as necessary for disasters and mass casualty incidents, including specialty care for trauma, burn, cardiac, stroke, and pediatric patients.
1. The committee shall be organized of representatives within the region designated from the following provider agencies and officials:
    - (i) Each hospital with an active emergency department;
    - (ii) Each primary provider of emergency ambulance services, each helicopter air ambulance service, and those private ambulance services with more than ten (10) permitted ambulances;
    - (iii) Regional Emergency Medical Services Consultant, Department of Health;
    - (iv) Regional Hospital Coordinator, Department of Health; and,
    - (v) At least one EMS Medical Director affiliated with an EMS primary provider.
  2. The committee shall elect from its membership of designated representatives, an executive committee and officers to preside at and record the business of the committee, including a chairman, vice-chairman, and secretary, and to function as necessary between the regular meetings of the committee.
  3. The secretary of the committee shall keep minutes of the committee meetings, which shall be available for public inspection, except for those quality improvement oversight activities that are otherwise exempted by law.
  4. Any committee member may place items before the committee for discussion.
- (d) The RMCC shall conduct a continuing education program on its communication equipment, assuring that all employees, including supervisory personnel, can function at the telecommunicator position(s).
- (e) The RMCC will participate with dispatcher and telecommunicator training and promote training for all personnel within the region involved in EMS radio communications.
- (f) The RMCC, within the geographical area of responsibility, shall serve as the coordination point in situations requiring added EMS resources, over those locally available. During a disaster or multiple casualty incident local agencies shall notify the

(Rule 1200-12-01-.08, continued)

RMCC of changes in status and the need for added resources and upon such notification:

1. The RMCC shall receive scene reports and staging area information, and coordinate communications with the local dispatch center or incident command liaison; and
  2. Coordinate emergency medical services resources responding to the incident, including ground and air ambulances, specialty teams, and state officials; and
  3. Notify hospitals in accordance with the anticipated system demands and planned activities and allocate patients among hospitals in accordance with the patients' condition, bed availability, and clinical specialty capabilities.
  4. The RMCC will communicate situational information to health department and emergency management officials, and will maintain liaison with the emergency service coordinators at the State Emergency Operations Center, and other officials as identified by the Department of Health or the Tennessee Emergency Management Agency.
- (g) The RMCC shall operate with professional radio operator techniques at all times, to monitor and promote system discipline, correct faulty operating practices within the system, and report any violations of system discipline to the regional EMS Consultant for appropriate action.
- (h) The RMCC shall cooperate with radio repair services during their performance of maintenance on EMS radio equipment.
- (i) The RMCC shall maintain a current and accurate index of Federal Communications Commission (FCC) assigned call signs and commercial telephone numbers of all regional ambulance services and medical facilities participating in the EMS radio communications system and shall assure adherence to applicable Tennessee statutes and rules and regulations of the FCC on the part of all regional participants. All local EMS agencies and participants shall notify the RMCC of any changes of radio call signs and telephone numbers.
- (j) The RMCC shall maintain a constant status of emergency readiness, assuring that all employees are knowledgeable of the procedures for emergency operation and are familiar with the operation, capability and limitation of equipment. Centers maintaining controlled entrance to their facilities will provide the regional EMS Consultant with a personal method of access, and will immediately notify that Consultant on learning of an occurrence of a natural or man-made disaster or mass casualty incident that may tax the resources within the region.
- (k) Only one RMCC shall be designated in each region.
- (3) EMS Telecommunications Equipment Inventory - An inventory of emergency medical services telecommunications equipment shall be maintained under the supervision of the chief official of each emergency medical services entity controlling the use of the equipment.
- (a) Upon receipt of a complaint or upon reasonable belief that a violation of Tennessee Code Annotated Title 68, Chapter 140 Part 2 or these rules is or was occurring, each emergency medical services entity shall allow access to identified representatives of the Division of Emergency Medical Services to inspect and verify the status of emergency medical services telecommunications equipment.

(Rule 1200-12-01-.08, continued)

- (b) The inventory of emergency medical services telecommunications equipment shall include all electronic equipment utilizing radio frequencies to render emergency medical service activity and any communications device requiring licensure by the Federal Communications Commission and used for emergency medical communications.
  - (c) The inventory will be kept current and will include the items described in (b), above, by quantity, manufacturer, model number, frequency(s), and noun description. In addition, for transmitting equipment, the radio frequency power presented to the antenna will be given. At the option of the controlling entity, other identifying marks such as serial numbers may be listed for inventory and loss control.
- (4) EMS Telecommunications Operating Techniques - All emergency medical services entities participating in the Tennessee EMS Telecommunications System shall conform to the radio operation techniques approved by the Division of Emergency Medical Services.
- (5) EMS Telecommunications System Access - Access to the statewide emergency medical services telecommunications system, including the use of selective signals or tones, shall comply with technical specifications developed or approved by the Division of Emergency Medical Services, and correspond to the procedures outlined in the State EMS Telecommunications Plan. Emergency medical service entities in the statewide network shall meet the following requirements:
- (a) Each ambulance permitted to transact business in the State of Tennessee and each emergency ambulance dispatching center shall have two-way radio capability with the following devices and frequencies as addressed in either part 1 or part 2 of this rule.
    - 1. A Very High Frequency radio on the frequency of 155.205 MHz with approved equipment utilizing Digital coded squelch of 205, not later than six months following the effective date of this rule.
      - (i) Each entity shall have a valid radio station license or letter providing frequency use agreement from a radio station license issued by the Federal Communications Commission (FCC) for all transmitting equipment on the frequency used; or,
      - (ii) Those services having a FCC license for mobile operation only on 155.205 MHz shall have a written agreement with a nearby service operating a properly licensed base station on this frequency, such agreement extending cooperative communications to radio equipped vehicles of the service.
      - (iii) The frequency 155.205 MHz shall be used for ambulance mutual aid activities.
    - 2. Those counties with a population of more than 250,000 people according to the 2000 U.S. Census and that rely upon an 800 MHz radio system for public safety communications may apply to use an alternative communications system to accomplish the objectives of this rule, as detailed in paragraphs (a),(b), and (c). The alternative must provide for ambulance to ambulance and ambulance to hospital communications for the affected Tennessee licensed ambulances when operating outside their primary base of operations.
      - (i) Communications equipment or techniques proposed as an alternative for VHF radio requirements identified by this rule shall be determined by the Division of Emergency Medical Services on a case by case basis. The

(Rule 1200-12-01-.08, continued)

Division may review alternative methods by requiring a demonstration of such equipment and procedures at any time to determine whether the alternative process is adequate.

- (ii) Communications equipment or techniques proposed as an alternative for such VHF radio requirements for EMS systems interoperability must be accompanied by all of the following:
  - (I) A realistic assessment of the range, coverage, and efficiency of those procedures and devices which are proposed;
  - (II) The availability of alternatives and the time necessary to deploy such alternatives; and
  - (III) The cost analysis for deployment of resources outside of the jurisdiction of the primary ambulance service provider for a seventy-two hour period, and statement that such deployment would not affect the capabilities within the primary jurisdiction to provide public safety interoperability.
- (b) Each emergency ambulance operated by an emergency medical service entity licensed to transact business in the State of Tennessee shall have mobile two-way radio capability on the frequency 155.295 MHz utilizing Digital coded squelch of 155, with approved equipment for on-scene interoperability and communications among health agencies and emergency medical services providers. Radio modifications for this frequency shall be required not later than six months following the effective date of this rule. All future paging activity on 155.295 MHz within the State of Tennessee shall be prohibited.
- (c) Each emergency ambulance operated by an emergency medical service entity licensed to transact business in the State of Tennessee shall have two-way radio capability on the frequency 155.340 MHz with approved equipment. The entity shall have a valid radio station license issued by the FCC (MOBILE ONLY) for all transmitting equipment on this frequency. The entity shall have a written agreement with an adjacent, or nearby, hospital operating a properly licensed base station on this frequency, such agreement extending cooperative communications to radio equipped vehicles of the entity. The ambulance crew shall use this frequency (155.340 MHz) as the primary patient information frequency in the absence of Ultra High Frequency (UHF) or 800 MHz capability between the ambulance and the medical facility.
- (d) Each licensed hospital within the State of Tennessee which maintains an emergency room and offers the facilities of this department to the general public shall have a two-way radio base station access capability on the EMS radio frequency(s) of 155.340 MHz and such other frequencies within the predominant service area of the hospital or identified in the approved Regional Frequency Use Plan. The primary service area is defined as a radius of not more than thirty (30) miles from the transmitting antenna site. The accessing control point for the base station shall be located in, or adjacent to, the emergency department of the hospital. When participating in an ultra high frequency system (MED channels), the hospital must retain a radio for responding to calls on 155.340 MHz. This frequency (155.340 MHz) is intended and dedicated as a two-way voice channel between the emergency medical technician, ambulance, and the hospital emergency department physician or authorized nurse. All paging activity on 155.340 MHz shall be prohibited.
- (e) Licensed hospitals within the State of Tennessee may, at their option, license the use of frequency 155.280 MHz. This frequency may be used by the hospital to converse with

(Rule 1200-12-01-.08, continued)

adjacent hospitals during routine or emergency situations, and may be further licensed for mobile operation and other medical purposes, as approved within the Regional EMS Communications Plan and the EMS Communications Manager.

- (f) Audible tones will be restricted to actual emergency radio transmissions alerting EMS or rescue personnel or in accordance with the approved Regional Frequency Use and State EMS Telecommunications Plans. Use of audible tones of more than two seconds preceding, during or following routine EMS radio transmission on these frequencies is prohibited.
- (g) The Tennessee Emergency Medical Services State EMS Communications Plan will guide technical specifications and approval of equipment. The plan will be revised, as appropriate, to reflect improvement in technology and systems design. Responsibility for development, implementation, and revision of the plan is delegated to the Director, Division of Emergency Medical Services.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-202, 68-140-203, 68-140-204, 68-140-205, 68-140-206, 68-140-207, 68-140-208, 68-140-502, 68-140-504, 68-140-505, and 68-140-513. **Administrative History:** Original rules filed February 8, 1983; effective May 16, 1983. Amendment filed April 8, 1987; effective May 23, 1987. Amendment filed May 27, 1988; effective July 11, 1988. Amendment filed March 7, 1989; effective April 21, 1989. Amendment filed August 11, 1993; effective October 25, 1993. Amendment filed January 7, 1997; effective March 23, 1997. Amendment filed June 1, 2007; effective August 15, 2007.

**1200-12-01-.09 GROUND INVALID VEHICLE STANDARDS.** All invalid vehicles operating in the State of Tennessee shall meet the following standards.

- (1) The invalid vehicle shall be used only for the transport of an "invalid". "Invalid" shall mean a person whose physical impairments render it impractical to use regular common carrier taxi service and who does not require provision of medical attention prior to or during transport.
- (2) To preclude substitution of services or the negligent or adverse delivery of medical transportation, after January 1, 1987 no ambulance service shall be authorized permits for invalid vehicles.
- (3) Vehicles permitted for invalid transfer shall not display or use markings, flashing lights, sirens, or other devices which might resemble an emergency vehicle.
  - (a) The word **AMBULANCE** or the term **AMBULANCE SERVICE** shall not appear on the vehicle, nor shall these terms be used to identify the nature of service or used in any service advertisement.
  - (b) All advertising and vehicles used for invalid transfer shall display in a conspicuous manner a placard, visible from the exterior, or a notice on advertisements as follows:  

INVALID TRANSPORT - THIS SERVICE DOES NOT PROVIDE MEDICAL CARE
- (4) Vehicles permitted for invalid transfer shall meet the following design requirements:
  - (a) At least two doors shall allow access to the passenger compartment one at the rear for stretcher loading, and one at the side capable of evacuating a stretcher patient. Door latches shall allow operation from the interior and exterior.
  - (b) The invalid vehicle shall provide the following minimal dimensions:
    - 1. Interior height: 42 inches, floor to ceiling,

(Rule 1200-12-01-.09, continued)

2. Interior width: 48 inches, measured fifteen (15) inches above the floor,
  3. Interior passenger compartment length of 92 inches, measured fifteen (15) inches from floor, from rear door to divider or driver seat back.
- (5) Each invalid vehicle shall conform to sanitation requirements, mechanical and safety standards, and requirements for insurance as specified under rules 1200-12-01-.01, 1200-12-01-.02, and 1200-12-01-.07.
- (6) Operations and records for invalid transport shall be maintained as follows:
- (a) Employee records for all drivers and attendant personnel. Each person transported shall be accompanied in the patient compartment.
  - (b) Run records showing the name, location and destination for each person transported, and personnel completing transfer, identifying the date, time, and vehicle utilized.
  - (c) Records on the registration and maintenance of all invalid vehicles.
  - (d) All records detailed herein shall be made available to the duly authorized representative of the department.
- (7) Invalid vehicles shall be equipped as follows:
- (a) Each vehicle shall have a crash stable device for securing the stretcher.
  - (b) Each vehicle shall have a wheeled stretcher adjustable to a semi-sitting position, with at least two patient safety restraining straps.
  - (c) Each vehicle shall have a blanket and pillow, and clean linen shall be used for each person transported.
  - (d) Each vehicle shall provide a bedpan, urinal, basin, tissues and towels as needed for personal hygiene during transport.

**Authority:** T.C.A. §§4-5-202, 68-39-504, and 68-39-507. **Administrative History:** Original rule filed February 8, 1983; effective May 16, 1983. Amendment filed April 8, 1987; effective May 23, 1987.

**1200-12-01-10 AMBULANCE DRIVER QUALIFICATIONS.** The following rules are promulgated to establish minimal qualifications for operators or drivers of ambulances operated by ambulance services licensed by the Tennessee Department of Health:

- (1) The vehicle operator or driver shall possess such special class licenses and endorsements as are required for ambulance by the Tennessee Department of Safety or the individual's state of residence.
- (2) No person who is under the age of nineteen (19) years shall drive any ambulance or invalid vehicle authorized for operation in Tennessee, and each ambulance driver shall have at least three years of licensed driver or operator experience.
- (3) Reserved.
- (4) This rule shall not prohibit the operation of an ambulance by an individual during extraordinary circumstances during which both ambulance personnel must be engaged in patient care or are otherwise incapacitated.

(Rule 1200-12-1-.10, continued)

**Authority:** T.C.A. §§4-5-202, 68-39-504, and 68-39-507. **Administrative History:** Original rule filed November 30, 1984; effective February 12, 1985. Amendment filed September 18, 1986; effective December 29, 1986. Amendment filed September 24, 1990; effective November 8, 1990.

**1200-12-01-.11 AMBULANCE SERVICE OPERATIONS AND PROCEDURES.** To establish operating standards for ambulances and emergency medical services.

- (1) Each service provider shall assure that safety belts are maintained in good working condition, and that all ambulance personnel, patients, and passengers utilize seat restraints at all times the vehicle is in motion, except as necessary to attend a patient within the patient compartment.
  - (a) All vehicle operators, crew personnel, or passengers within the driver's compartment or forward passenger seats shall be secured by a device in compliance with appropriate federal motor vehicle safety standards (49 C.F.R. 571) for restraints, anchorages and mechanisms.
  - (b) Children under four years of age shall be transported in the front passenger compartment only when the child is appropriately secured in a child passenger restraint system, meeting state and federal motor vehicle safety standards. (T.C.A. §55-9-214)
  - (c) Patients shall be secured to stretchers, except as may be necessary to facilitate treatment.
- (2) Each ambulance service shall report any accident or incident resulting in bodily harm to a person, including an agent or employee, or property damage which is in excess of \$200, that results from the operation of the ambulance. Such report shall be made in writing to the Division of Emergency Medical Services within ten (10) days of occurrence, including any copies of the Tennessee officer's accident report, and shall be in addition to other reports mandated by law or insurance regulations.
- (3) The Division of Emergency Medical Services may deny issuance or renewal of licenses or permits for any of the following:
  - (a) Incomplete or incorrect information on applications for licenses or permits.
  - (b) Unsatisfactory inspections or safety deficiencies on more than 25% of the vehicles operated by a service.
  - (c) Failure to list and record all personnel employed or serving as vehicle operators or emergency care personnel and to record personnel serving on each call or request.
  - (d) Failure to furnish or maintain accurate verification of insurance coverage.
  - (e) Change in ownership.
- (4) Each ambulance service shall submit an annual report of its operations and may include financial information for statistical compilation. Such information shall be submitted in the manner and upon such forms as may be provided for such purposes by the Division of Emergency Medical Services.
- (5) Ambulance Dispatch Procedures.

(Rule 1200-12-01-.11, continued)

Ambulance services classified above minimum standards shall process all emergency calls through a designated dispatcher. Whether employed by the service or obtained by cooperative agreement, dispatchers of emergency medical services shall conform to the following standards:

- (a) From a listing of staffed ambulances, the dispatcher will assign an available unit within two minutes of receipt of an emergency call. or refer the call by mutual aid agreement, except as provided under T.C.A. §68-39-516.
  - (b) Reserved
  - (c) Class A - Advanced Life Support Services shall respond first response units to any priority call, including automobile accidents or cardio-respiratory emergencies, where unit arrival can be anticipated to exceed eight minutes, and where such units are organized and can demonstrate capabilities to render more rapid assistance.
- (6) Smoking or any other use of a tobacco product within ten (10) feet of an ambulance is prohibited.
- (7) Repealed

**Authority:** T.C.A. §§4-5-201, 4-5-202, 68-39-501, 68-39-504, 68-39-505, 68-39-508, 68-39-509, 68-140-504, 68-140-505, 68-140-509, and 68-140-521. **Administrative History:** Original rule filed November 30, 1984; effective February 12, 1985. Amendment filed April 8, 1987; effective May 23, 1987. Amendment filed June 30, 1987; effective August 14, 1987. Amendment filed June 28, 1988; effective August 12, 1988. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed June 5, 1998; effective August 19, 1998. Amendment filed September 22, 1998; effective December 6, 1998. Amendment filed October 15, 2002; effective December 29, 2002.

#### **1200-12-01-.12 AUTHORIZATION OF EMERGENCY MEDICAL TECHNICIAN INSTRUCTOR/COORDINATORS.**

- (1) EMS Program Director/Administrator shall mean an individual responsible for the overall coordination of all EMS Programs. The individual shall act as a liaison between faculty, the sponsoring agency, students, the local medical community, and the Division of Emergency Medical Services. The individual is also responsible for the recruitment and continued development of faculty to meet the needs of the institution. The minimum qualifications for EMS Program Director/Administrator shall include:
  - (a) Professional requirements
    1. Bachelor's degree required from a regionally accredited college/university.
    2. The program director must be licensed in Tennessee as an EMT-Paramedic, registered nurse, or physician.
    3. Professional license must be free from history of revocation, denial or suspension.
    4. Licensed emergency care experience shall include a minimum of three years practice.
    5. Administrative experience shall include a minimum of two (2) years in EMS educational administration.

(Rule 1200-12-01-.12, continued)

6. Current endorsement in a Board approved trauma, cardiac, and pediatric course at the provider level.
- (b) Authorization Renewal shall be contingent upon:
1. Assisting with at least forty-five (45) hours of advanced EMS instruction on an annual basis.
  2. Maintaining current credentials for the course content.
  3. Attendance at annual Instructor/Coordinator Conference as required by the Division of Emergency Medical Services.
- (c) Denial of Reauthorization or Revocation of Authorization - The authorization of an EMS Program Director/Administrator may be removed or denied by the Director for the following reasons:
1. Two or more instances of failure to cover the prescribed course curriculum or failure to conduct the course in accordance with the practices prescribed by the Board and the Division.
  2. Failure to complete and submit required documentation for all students.
  3. A lapsed, revoked, suspended or expired license.
  4. Any violation of Tennessee Code Annotated, Title 68, Chapter 140 or any rule promulgated by the Board.
- (2) EMT-Paramedic Instructor/Coordinator shall mean an employee responsible for the delivery of instruction in accredited Paramedic Programs. The individual shall be knowledgeable in all aspects of prehospital care, capable of applying techniques and modalities of adult education, and of managing resources and resource personnel. The minimum qualifications for EMT-Paramedic Instructor/Coordinator shall include:
- (a) Professional requirements
1. Associate degree from a regionally accredited institution.
  2. Currently licensed as a Tennessee EMT-Paramedic, registered nurse, or physician.
  3. Professional license must be free from history of revocation, denial or suspension.
  4. Licensed emergency care experience shall include a minimum of two years practice.
  5. Administrative experience shall include a minimum of two (2) years in EMS educational administration or greater than three hundred (300) hours of EMS instruction.
  6. Current endorsement in a Board approved trauma, cardiac, and pediatric course at the provider level.
- (b) Authorization Renewal shall be contingent upon:

(Rule 1200-12-01-.12, continued)

Assisting with at least one hundred (100) hours of advanced EMS instruction on an annual basis.

1. Maintaining current Tennessee licensure as an Emergency Medical Technician-Paramedic, registered nurse, or physician.
2. Maintaining current CPR instructor endorsement.
3. Attendance at annual EMT Instructor/Coordinators conference as required by the Division of Emergency Medical Services.

(c) Denial of Reauthorization or Revocation of Authorization - The authorization of an EMT-Paramedic Instructor/Coordinator may be removed or denied by the Director for the following reasons:

1. Two or more instances of failure to cover the prescribed course curriculum or failure to conduct the course in accordance with the practices prescribed by the Board and the Division.
2. Failure to complete, and submit as required, all required documentation for all students in each class.
3. A lapsed, revoked, suspended or expired license.
4. Any violation of Tennessee Code Annotated, Title 68, Chapter 140 or any rule promulgated by the Board.

(3) EMT Paramedic Instructor Assistant shall mean an individual capable of teaching the application of practical skills to include: assisting the faculty in the delivery of instruction, evaluating student performance of skills, maintenance of equipment, and coordinating with the faculty or Instructor/Coordinator to maintain adequate levels of needed equipment. The minimum qualifications for an EMT-Paramedic Instructor assistant shall include:

(a) Professional requirements

1. Currently licensed as a Tennessee EMT-Paramedic, registered nurse, or physician without a history of revocation, denial or suspension of licensure.
2. Licensed experience with a minimum of two years practicing advanced life support in the pre-hospital or emergency department environment.
3. Minimum of two years experience in EMS education administration or greater than seventy-five (75) hours of EMS instruction.
4. Current endorsement in an EMS Board approved trauma, cardiac and pediatric course as an instructor.
5. Completion of an EMS Board approved instructors' assistant course.

(b) Authorization Renewal shall be contingent upon:

1. Assisting with at least forty-five (45) hours of advanced EMS instruction on an annual basis.
2. Maintaining current Tennessee licensure as an Emergency Medical Technician-Paramedic, Registered Nurse or Physician.

(Rule 1200-12-01-.12, continued)

3. Current endorsement in an EMS Board approved trauma, cardiac and pediatric course as an instructor.
  4. Attendance at annual Instructor update as required by the Division of Emergency Medical Services.
- (c) Denial of Reauthorization or Revocation of Authorization - The authorization of an EMT Paramedic Instructor Assistant may be removed or denied by the Director for the following reasons:
1. Two or more instances of failure to cover the prescribed course curriculum or failure to conduct the course in accordance with the practices prescribed by the Board and the Division.
  2. Failure to complete, and submit required documentation for all students.
  3. A lapsed, revoked, suspended or expired license.
  4. Any violation of Tennessee Code Annotated, Title 68, Chapter 140 or any rule promulgated by the Board.
- (4) EMT-Basic Instructor/Coordinator shall mean an individual responsible for the overall coordination of the EMT-Basic Program. The individual shall act as a liaison between faculty, the sponsoring agency, students, the local medical community and the Division of Emergency Medical Services. The individual is also responsible for the delivery of didactic material, demonstration of the psychomotor skills, verification of skill proficiency, and the recruitment and continued development of faculty to meet the needs of the institution. The minimum qualifications for the EMT -Basic Instructor Coordinator shall include:
- (a) Professional requirements
1. Associate degree from a regionally accredited institution.
  2. Currently licensed as a Tennessee EMT-Paramedic, without history of revocation, denial, or suspension of licensure.
  3. Experience. Pre-Hospital: Minimum of two years practicing in the pre-hospital environment or one hundred fifty (150) hours of EMS instruction acceptable to the Board. Administrative: Minimum of one year in EMS educational administration.
  4. Completion of an EMS Board approved Instructors' course.
  5. The provisions of subparagraph (a) shall not apply to any EMT – Basis Instructor/Coordinator authorized by the Division prior to July 1, 2001.
- (b) Authorization Renewal shall be contingent upon:
1. Assisting with at least seventy-five (75) hours instruction (EMT-Basic or EMT-IV or EMT-I or EMT-P) on an annual basis.
  2. Maintaining current Tennessee licensure as an Emergency Medical Technician-Paramedic.
  3. Maintaining current CPR instructor endorsement.

(Rule 1200-12-01-.12, continued)

4. Attendance at annual EMT Instructor/Coordinators conference as required by the Division of Emergency Medical Services.
- (c) Denial of Reauthorization or Revocation of Authorization - The authorization of an EMT Basic-Instructor/Coordinator may be removed or denied by the Director for the following reasons:
1. Two or more instances of failure to cover the prescribed course curriculum or failure to conduct the course in accordance with the practices prescribed by the Board and the Division.
  2. Failure to complete and submit, as required, all required documentation for all students in each class.
  3. A lapsed, revoked, suspended, or expired license.
  4. Any violation of Tennessee Code Annotated, Title 68, Chapter 140 or any rule promulgated by the Board.
- (5) EMT Instructor Assistant shall mean an individual capable of teaching the application of practical skills including assisting the faculty in the delivery of instruction, evaluating student performance of skills, maintenance of equipment, and coordinating with the faculty or Instructor/Coordinator to maintain adequate levels of needed equipment. The minimum qualifications for an EMT Instructor Assistant shall include:
- (a) Professional requirements.
1. Currently licensed as a Tennessee EMT-Basic, without history of revocation, denial, or suspension of licensure.
  2. Licensed experience shall include a minimum of one year practicing in the pre-hospital environment in Tennessee.
  3. Must document at least seventy-five (75) hours of EMS instruction acceptable to the Board.
- (b) Authorization Renewal shall be contingent upon:
1. Document at least forty-five (45) hours of EMT instruction on an annual basis and acceptable to the Board.
  2. Maintaining current Tennessee licensure as an Emergency Medical Technician-Basic.
  3. Maintaining current CPR instructor endorsement.
  4. Completion of an EMS Board approved Instructors' course.
  5. Attendance at an annual Instructor update as mandated by the Division of Emergency Medical Services.
- (c) Denial of Reauthorization or Revocation of Authorization - The authorization of an EMT Instructor Assistant may be removed or denied by the Director for the following reasons:

(Rule 1200-12-01-.12, continued)

1. Two or more instances of failure to cover the prescribed course curriculum or failure to conduct the course in accordance with the practices prescribed by the Board and the Division.
2. Failure to complete and submit, as required, all required documentation for all students in each class.
3. A lapsed, revoked, suspended, or expired license.
4. Any violation of Tennessee Code Annotated Title 68, Chapter 140, or any rule promulgated by the Board.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-39-504, 68-39-505, 68-39-504, 68-39-508, 68-140-504, 68-140-505, 68-140-508, 68-140-509, and 68-140-518. **Administrative History:** Original rule filed November 30, 1984; effective February 12, 1985. Amendment filed April 8, 1987; effective May 23, 1987. Repeal and new rule filed January 4, 2005; effective March 20, 2005. Amendment filed September 21, 2007; effective December 5, 2007.

### 1200-12-01-.13 EMT AND EMT PARAMEDIC TRAINING PROGRAMS.

- (1) Definitions. Within this Rule, the following terms shall apply:
  - (a) Accreditation: Means the process of training program approval used to assure compliance with the requirements of the Tennessee Emergency Medical Services Board and the policies of Division of Emergency Medical Services.
  - (b) Accredited Program: Means a training program approved by the Tennessee Emergency Medical Services Board.
  - (c) Contract or Agreement: Means a written agreement between the school and the cooperating agency.
- (2) Basic Emergency Medical Technician Training Programs. All programs offered by institutions or entities desiring to qualify applicants for EMT certification shall conform to standards approved by the Tennessee Emergency Medical Services Board, and such rules as shall be promulgated by the department.
  - (a) Purpose of Accreditation
    1. To ensure the safe practice of the Emergency Medical Technician (EMT) by setting standards for programs preparing the practitioner.
    2. To ensure graduates of accredited schools eligibility for admission to the certification examinations.
  - (b) Accreditation shall be considered in accordance with the following criteria:
    1. Initial accreditation is granted a new program that has not been in operation long enough to complete its first class but demonstrates its eligibility for full accreditation. The program shall be reviewed after one year or when the first students complete the program.
    2. Full accreditation is granted a program that has met the requirements that are set forth by the Board and the policies of the Division of EMS. The accreditation will be for a period of two years.

(Rule 1200-12-01-.13, continued)

3. Conditional accreditation may be accorded a program which has failed to maintain minimum standards and has been notified that it must meet the requirements within a specified time period.
  4. Accreditation shall be denied for cause or may be revoked or conditioned for failure to comply with the standards established by the Board.
  5. Renewal of Accreditation. Renewal shall be based on recommendations of the staff to the Board utilizing surveys and site visits, conferences, review of documentation, instructor-student ratio, instructor qualifications, and related evidence of continuing compliance with the regulations of the Board and policies of the Division. If deficiencies are not corrected within the specified time, and until such action is approved by the board, the facility shall not convene a subsequent class.
- (c) Philosophy, Purpose, Capabilities, and Organization
1. Philosophy and Purpose. The institution seeking initial and continuing accreditation of an EMT Training Program shall have written statements of the educational philosophy and purpose of the program.
  2. Capabilities:
    - (i) The institution sponsoring an EMT training program shall be an accredited post-secondary educational institution or other entity which meets comparable standards for education in this field.
    - (ii) The institution shall maintain liaison with a hospital which is capable of supporting EMT clinical training.
    - (iii) The institution shall ensure the financial support, equipment, facilities, and leadership which will provide for a sound educational program.
    - (iv) The institution shall ensure student competency in knowledge and experience and shall endorse participants for eligibility to complete the certification examinations.
  3. Organization
    - (i) The institution shall demonstrate effective organization and shall be administered in ways conducive to the management of the program.
    - (ii) An authorized Instructor/Coordinator (I/C) shall supervise the overall organization and administration of the program.
    - (iii) An accurate, comprehensive record system shall be maintained for all phases of the program and shall be available for inspection during survey visits.
    - (iv) When the institution coordinates courses or facilities with other institutions or agencies, a written agreement of mutual policies covering all major aspects of the cooperative relationships shall be negotiated by administrative authorities of each institution.
    - (v) Reserved.

(Rule 1200-12-01-.13, continued)

- (vi) Reserved.
- (d) Faculty. The faculty may include qualified physicians, registered nurses, EMTs, Paramedics, or other licensed practitioners to assist in the instruction of the course.
  - 1. Reserved.
  - 2. Reserved.
- (e) Medical Advisor/Director
  - 1. Each program shall have a licensed physician who serves as the medical advisor.
  - 2. Reserved.
  - 3. Reserved.
- (f) An authorized Instructor/Coordinator (I/C) shall provide overall direction and coordination of the planning, organization, administration, periodic review, continued development, funding and effectiveness of the program. Among the functions to be maintained are the processing of student applications; the selection of students; the scheduling of classes and assignment of faculty; the coordination of examination and evaluation of students; the preparation of assessment materials; the development and availability of required equipment and materials for each class; the maintaining of an adequate inventory of training equipment, including audiovisual resources, the provision for counseling services to students on an individual and a group basis; the establishment of liaison between students, program staff, the sponsoring institution and its affiliates; information about the program to interested individuals and organizations; the preparation of the program budget, and, as appropriate, assistance in class instruction.
- (g) Students Admission and Conduct
  - 1. Selection and Admission. Selection and admission practices for entrance into an EMT training program shall be based on the following criteria:
    - (i) Meet the admission requirements of the educational institution.
    - (ii) Possess a high school diploma or general education equivalent.
    - (iii) Show that he is in good physical and mental health and that he possesses no physical handicaps or disabilities which would impede his ability to fulfill the functions and responsibilities of an EMT.

A physical examination form must be completed by a physician who has examined the individual within the past six months and who possesses adequate knowledge of EMT's responsibilities such as lifting, dexterity, observations, verbal communications, and hearing, with a favorable report of physical health sufficient to perform as an EMT.

If there are any limitations in the individual ability to perform adequately, he must submit additional documentation from the appropriate professional evaluator which could clearly indicate his abilities to perform adequately. (i.e.)

(Rule 1200-12-01-.13, continued)

- (I) Speech impairment-Speech Pathologist
  - (II) Hearing impairment-Audiologist
  - (III) Physical Handicap or Disability-Orthopedist or Registered Physical Therapist
  - (IV) Vision-Ophthalmologist
2. Student Identification - Reserved.
  3. Transfer and Readmission of Students. A student may be readmitted and accepted through transfer to a program if such readmission and/or transfer admission is within the established entrance policies and standards of the institution and the Department and that provisions are made for each such student to meet the requirements for course completion and qualify for the state certification examination.
  4. Dismissal. Students shall be subject to dismissal for cause.
  5. Reserved.
- (h) Educational Facilities
1. Classrooms, Laboratories, Offices. Each institution shall provide adequate teaching facilities and laboratories in the school and the clinical areas sufficient for instruction. Separate office space for faculty should be provided.
  2. Clinical Facilities. The clinical facilities shall be selected on the basis of adequacy for student learning experiencing and proximity to the training program.
- (i) Curriculum Organization and Review
1. Curriculum organization. The EMT curriculum shall conform to the National Standard Curriculum, Emergency Medical Technician: Basic, as published August, 1994, or the successor publication applicable on the date of course enrollment. The curriculum shall include such modifications as are approved by the board within the scope of practice recognized in Rule 1200-12-01-.04. Copies of the applicable version of the curriculum are available at cost upon request from the Division office.
  2. The program shall consist of three components; didactic, practical instruction, and clinical experience.
  3. Textbooks shall be approved by the Board.
  4. Major Curriculum Change. Any major curriculum change must be presented in writing subject to department and Board approval.
- (j) Curriculum Review A copy of the complete curriculum, statements of course objectives, copies of course outlines, class schedules, schedules of supervised clinical experience, and teaching plans shall be on file and available for review and inspection by an authorized representative of the Department with other information as follows:
1. Evidence of student competency in achieving the performance for educational objectives of the program shall be kept on file.

(Rule 1200-12-01-.13, continued)

2. Procedures for evaluation of teaching effectiveness and instruction shall be established by the program
- (k) Only students from Tennessee accredited programs or having completed an equivalent curriculum in other states shall be eligible for state certification.
- (3) Extended Skills Training Programs for Emergency Medical Technicians. All programs offered by an entity desiring to qualify applicants in extended skills approved under rule 1200-12-01-.04(3) shall conform to standards approved by the Board as follows:
  - (a) An entity seeking to provide extended skills programs shall file a written request with the Division of EMS at least 30 days prior to the scheduling of training.
    1. Each entity shall assure sufficient supervised practice, equipment, and experience for the clinical skill.
    2. Each entity shall have a medical director who is a licensed physician, and whose affiliation is confirmed in writing.
    3. Clinical affiliations shall be established and confirmed in writing.
  - (b) Instructors may be physicians, registered nurses, EMT-paramedics or other licensed practitioners confirmed by the Division's authorized representative.
  - (c) Educational facilities shall meet the standards set forth under paragraph (2),
  - (d) Clinical facilities shall be selected on the basis of adequacy for student learning training program.
  - (e) Each program shall follow the curriculum approved by the Board for the skill area, as published by the Division of Emergency Medical Services, including but not necessarily limited to, the following areas:
    1. Administration of epinephrine for anaphylaxis, bronchodilators for respiratory distress, aspirin for chest pain and nitroglycerine lingual or sublingual for suspected cardiac conditions subject to medical control.
    2. Use of approved airway procedures.
    3. Venipuncture and the administration of intravenous fluids without admixtures.;
    4. Performing defibrillation or transcutaneous external pacing in a pulseless, nonbreathing patient using an automated-mode device.
  - (f) Each course shall prepare students for examination which shall fulfill criteria as established under rule 1200-12-01-.04(1)(f).
- (4) Emergency Medical Technician-Paramedic Training Programs.
  - (a) All programs offered by facilities, institutions, agencies, or agencies, desiring to qualify applicants for EMT-P certification shall conform to the standards published by the U.S. Department of Transportation, the standards approved by the Tennessee Emergency Medical Services Board, and such rules as shall be promulgated by the Department.
    1. Purpose of Accreditation

(Rule 1200-12-01-.13, continued)

- (i) To insure the safe practice of Emergency Medical Technician Paramedic (EMT-P) by setting standards for program preparing the practitioner.
  - (ii) To insure graduates of accredited schools eligibility for admission to the certification examinations.
- 2. Accreditation shall be categorized, and awarded or revoked in accordance with the following criteria:
  - (i) Initial accreditation is granted a new program that has not been in operation long enough to graduate its first class but demonstrates its eligibility for full accreditation. The program shall be reviewed for consideration for full accreditation after one year or when the first students graduate.
  - (ii) Full accreditation will be granted for a two (2) year period a program that has met the requirements that are set forth by the Board and the policies of the Division of EMS.
  - (iii) Conditional accreditation may be accorded a program which has failed to maintain the standards and has been notified that it must meet the requirements within a specified time period, or upon demonstration of compliance.
  - (iv) Accreditation shall be denied for cause or may be revoked or conditioned for failure to comply with standards established by the Board.
  - (v) Renewal of Accreditation - Renewal shall be based on recommendations of the staff to the Board based upon survey and site visits, conferences, review of clinical experiences and documentation, instructor student ratio, instructor qualifications, and related evidence of continuing compliance with the Regulations of the Board. If deficiencies are not corrected within the specified time, and until such action is approved by the Board, the facility shall not convene a subsequent class.
  - (vi) Renewal by Committee on Allied Health Education and Accreditation (CAHEA) - Full or Conditional renewal shall be granted to all programs fulfilling requirements of the Joint Review Committee on Educational Programs for the EMT-Paramedic, which equal or exceed Tennessee standards.
  - (vii) Programs desiring to cease training activities shall notify the Director of EMS in writing.
- (b) Requirements for Accreditation.
  - 1. Sponsorship
    - (i) The institution sponsoring an EMT-Paramedic training program shall be an accredited post-secondary educational institution, such as a university, senior college, community college, technical school, or an appropriately accredited medical institution with adequate resources and dedication to educational endeavors.

(Rule 1200-12-01-.13, continued)

- (ii) An accredited program shall be affiliated with a licensed medical facility or hospital which is capable of supporting EMT-Paramedic education and training with sufficient supervised practice and experience.
  - (iii) The educational institution must provide the financial support, facilities, and leadership which will provide for a sound educational program, and appropriate services to faculty and students.
  - (iv) The educational institution shall maintain an overall student competency in knowledge and experience and endorse participants for eligibility to complete the certification examinations.
2. Curriculum
- (i) Program Goals and Objectives
    - (I) There shall be a written statement of program goals and program objectives consistent with and responsive to the demonstrated needs and expectations of the various communities it serves.
    - (II) Statements of goals and objectives shall provide the basis for program planning, implementation, and evaluation.
    - (III) An advisory commission shall be designated and charged with assisting program and sponsoring institutional personnel in formulating appropriate goals and standards, monitoring needs and expectations, and ensuring program responsiveness to change.
  - (ii) Minimum Expectations
    - (I) The goals and objectives must include, but need not be limited to providing assurance that graduates demonstrate entry-level competencies, as periodically defined by nationally accepted standards of practitioner roles and functions.
    - (II) The curriculum shall follow planned outlines and appropriately integrate lecture, laboratory, clinical, and field experience sequenced to assure efficient learning and opportunity for every student. Content and support courses shall include basic theoretical and scientific knowledge reflective of state of the art patient care.
    - (III) The curriculum shall meet or exceed the educational objectives and competencies as adopted in the United States Department of Transportation. EMT-Paramedic National Standard Curriculum.
3. Resources
- (i) Administration
    - (I) Program Director
      - I. The program shall have a full time program director, whose primary responsibility and full time commitment is to the educational program at all times when a program is functioning.

(Rule 1200-12-01-.13, continued)

- II. The program director shall have appropriate training and experience to fulfill the role as program director.
- III. The program director shall be responsible for the organization, administration, periodic review, development and effectiveness of the educational program.

(II) Medical Director

- I. The program shall have in appointed medical director who is a licensed physician with experience and current knowledge of emergency care of acutely, ill and traumatized patients. This individual must be familiar with base station operation including communication with, and direction of, pre-hospital emergency units. The medical director must be knowledgeable of the administrative problems effecting education for EMT-Paramedic programs and be knowledgeable of tile legislative issues regarding educational programs for the pre-hospital provider.
- II. The medical director must review and approve the educational content of the program curriculum. The medical director must review and approve the content and quality of tile medical instruction and supervision delivered by the facility The medical director shall assure that each student is appropriately assessed to assure that they are making adequate progress toward the completion for the educational program. The medical director will attest that each student has achieved the desired level of competence prior to graduation.

(III) Instructional Faculty

- I. The faculty shall be qualified through academic preparation., training, and experience to teach tile courses or topics to which they are assigned in the curriculum.
- II. Individual proficiency and qualifications for faculty members shall be demonstrated in a personal curriculum Vitae, oil file with the Program Director.
- III. The number of faculty instructors shall be sufficient to provide instruction and supervision for each period of the program or field experience.

(IV) Finances

- I. Financial resources adequate for the continued operation of the educational program shall be provided for each class of students enrolled.
- II. There shall be a distinct budget with an accounting of financial resources required and income generated by the program.

(V) Facilities

- I. Instructional resources

(Rule 1200-12-01-.13, continued)

- A. Classrooms, laboratories and administrative offices shall be provided with sufficient space to accommodate the number of students matriculating in the program and the supporting faculty.
- B. Library resources, related to the curriculum, shall be readily accessible to students and shall include current EMS and medical periodicals, scientific books, audiovisual and self-instructional resources, and other references.
- C. Sufficient supplies and equipment to be used in the provision of instruction shall be available and consistent with the needs of the curriculum and adequate for the students enrolled.

(VI) Clinical Resources

- I. Clinical affiliations shall be established and confirmed in written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision.
- II. Students shall have access to patients who present common problems encountered in the delivery of advanced emergency care in adequate numbers and in distribution by sex and age.
- III. Students shall be assigned in clinical settings where experiences are educationally efficient and effective in achieving the program's objectives. These areas shall include, but not be limited to, the operating room, recovery room, delivery room, pediatrics, and emergency department.
- IV. Supervision in the clinical setting shall be provided by program instructors or hospital personnel, such as nurses or physicians, if they have been approved by the program to function in such roles. The ratio of students to instructors in the clinical facilities shall be adequate to assure effective learning.

(VII) Field Internship

- I. The field internship of the program shall occur within an emergency medical system which demonstrates medical accountability. The student must be under direct supervision of preceptors who are designated by the program and who are physicians, nurses, or paramedics. The program will assure that there is appropriate, objective evaluation of student progress in acquiring the desired competencies developed through this experience. The experience shall occur on an intensive care vehicle within an EMS system that has the capability of voice telecommunications with on line medical direction and is equipped with equipment and drugs necessary for advanced life support.

(Rule 1200-12-01-.13, continued)

- II. The majority of the field internship experience shall occur following the completion of the didactic and clinical phases of the program. It must be structured to assure that by the completion of this portion of the program, each student will achieve the desired competencies of the curriculum. Adequate manpower must be available within the EMS system to assure that the assigned student is never a substitute for paid personnel or a required team member.

#### 4. Program Records

##### (i) Student Records

- (I) There shall be a transcript of high school graduation or graduate equivalent (GED) in each student's file.
- (II) There shall be medical evidence that the protection of students and the public from injury or the transmission of communicable diseases is assured for each student.
- (III) There shall be a record of class and practice participation and evidence of competencies attained throughout the education and training program for each student.
- (IV) There shall be copies of examinations and assessments of the student development and attainment of competencies on file.
- (V) There shall be sufficient information to document each student's satisfactory completion of all didactic, clinical, and field requirements.
- (VI) The records maintained by the institution shall be complete whether or not a student is successful in completing the prescribed course of instruction.

##### (ii) Academic Records

- (I) There shall be a descriptive synopsis of the current curriculum on file.
- (II) There shall be a statement of course objectives, copies of course outlines, class and laboratory schedules, clinical and field internship experience schedules, and teaching plans on file.

#### 5. Students

- (i) Disclosure - Accurate information regarding program requirements, tuition and fees, prerequisites, institutional and programmatic policies, procedures, and supportive services shall be available to all prospective students and provided to all enrolled students.

##### (ii) Counseling

Academic - Counseling services shall be accessible to all students for student academic counseling and learning assistance.

(Rule 1200-12-01-.13, continued)

- (iii) Placement - Guidance and placement services shall be available to all new graduates of the program.
- (iv) Identification - Students shall be clearly identified by name plate, uniform, or other apparent means to distinguish them from graduate emergency medical services personnel, other health professionals, workers, and students.
- (v) Admission/Readmission/Transfer
  - (I) Admission, readmission, or transfer of students shall be made in accordance with clearly defined and published practices of the institution which shall be non-discriminatory with respect to race, color, creed, sex, age, handicaps, or national origin. Specific academic, health related and/or technical requirements for admission shall also be clearly defined and published.
  - (II) The individual must be currently certified as Emergency Medical Technician in the State of Tennessee or be state eligible.
  - (III) The individual must show that he is in good physical and mental health and is able to fulfill the functions and responsibilities of a Paramedic.
  - (IV) If there are any limitations in the individual's ability to perform adequately, he must submit additional documentation from the appropriate professional evaluator which could clearly indicate his abilities to perform adequately. (i.e.)
    - I. Speech impairment Speech Pathologist
    - II. Hearing impairment Audiologist
    - III. Physical Handicap or Disability - Orthopedist or Registered Physical Therapist.
    - IV. Vision - Ophthalmologist
  - (V) The individual must take the Academic Assessment Placement Program (AAPP) Examination or an examination acceptable to the Board to determine academic eligibility into the program unless he meets the requirements through ACT scores or accumulated college credits.
  - (VI) The individual must be evaluated using the scale approved by the Division. Each requirement will receive a score of 1-5 depending on the quality of achievement with 5 being the highest and 1 being the lowest. Applicants selected shall receive an overall rating of 2.5 and above. The following areas of assessment are to be tabulated:
    - I. EMT Knowledge: The applicant shall take the Basic EMT Certification Examination and shall be ranked based on his score:
      - 1 = 80-82%
      - 2 = 83-86%

(Rule 1200-12-01-.13, continued)

3 = 87-91%  
 4 = 92-96%  
 5 = 97-100%

- II. Psychological Profile: The applicant shall take the required psychological examinations which must include at least the Minnesota Multiple Personality Index (MMPI). The individual is given an overall score of 1-5 based on these examinations.
- III. Interview: The applicant shall be interviewed by a committee of at least four (4) individuals, and a representative from the Division of Emergency Medical Services. These members shall be selected from an educator, a registered nurse, a physician, a Paramedic, a psychologist, and an ambulance service director.

The applicant will be evaluated on his EMS related experience, level of maturity and motivation, level of knowledge, communication ability, and poise.

- (VII) Insurance - The applicants accepted must subscribe to a malpractice program with minimal coverage of \$1,000,000 which will extend for the entire length of the training program.

## 6. Evaluation

### (i) Student Evaluation

- (I) Purpose and Frequency - Evaluation of students shall be conducted on a recurrent basis and with sufficient frequency to provide both the student and program faculty with valid and timely indicators of the student's progress toward and achievement of the competencies and objectives stated in the curriculum.
- (II) Methods - The methods used to evaluate students shall verify, the achievement of the objectives stated in the curriculum. Evaluation methods, including direct assessment of student competencies in patient care environments, shall be appropriate in design to assure valid assessments of competency. Evaluation methods must be consistent with the competencies and objectives being tested. Methods of assessment shall be carefully designed and constructed to appropriately measure stated objectives. Methods used to evaluate clinical and field skills and behaviors shall be consistent with stated performance expectations and designed to assess competency attainment.

### (ii) Program Evaluation

- (I) Purpose and Frequency - The program shall periodically assess its effectiveness in achieving its stated goals and objectives. The results of this evaluation must be reflected in the review and timely revision of the program.
- (II) Methods - Program evaluation methods shall emphasize gathering and analyzing data on the effectiveness of the program in

(Rule 1200-12-01-.13, continued)

developing competencies consistent with the stated program goals and objectives.

- (III) Changes - Any major curriculum or program changes must be presented to the department in writing and will be subject to department and Board approval.

7. Administering Accreditation

- (i) Program Responsibilities - The accreditation process is initiated with the written request of an official representative of the institution.
- (I) A comprehensive report of the program shall be included with this request. This report shall substantiate compliance with the accreditation standards.
- (II) An agreement to a site visit by the review team within 90 days shall be included in the request.
- (ii) Division Responsibilities - Staff will determine the readiness of the program to determine if the process should be initiated.
- (I) After review of the written report, the staff will determine whether and when a site visit shall be made.
- I. The program will be notified and given the opportunity to correct any deficiencies.
- II. The division will schedule the site visit date and the appointments.
- (II) Following the site visit, a written report will be issued to the institution citing deficiencies, if any, and the status of accreditation.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, 68-140-506, 68-140-508, and 68-140-509.  
**Administrative History:** Original rule filed November 30, 1985; effective February 12, 1985. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed January 17, 1989; effective March 3, 1989. Amendment filed September 24, 1990; effective November 8, 1990. Amendment filed October 22, 1993; effective January 5, 1994. Amendment filed August 5, 1996; effective October 19, 1996.

**1200-12-01-.14 CATEGORIES FOR AMBULANCE SERVICE AND MOBILE PRE-HOSPITAL EMERGENCY CARE.** The following rules are promulgated to establish minimal standards and categorical capabilities for ambulance services licensed in Tennessee and to govern emergency medical services provided to a patient.

- (1) Definitions - as used in this rule, the following definitions shall apply:
- (a) "Advanced Life Support" shall mean the treatment of life-threatening medical emergencies by authorized emergency medical technician-paramedics under medical control, pursuant to the rules of the department, or the provision of such treatment by other qualified and licensed medical or nursing personnel.
- (b) "Basic Life Support" shall mean the treatment of life-threatening medical emergencies by an emergency medical technician or other qualified and licensed medical and nursing personnel qualified through the use of such techniques as patient assessment

(Rule 1200-12-01-.14, continued)

basic cardiopulmonary resuscitation, splinting, obstetrical assistance, bandaging, administration of oxygen, application of pneumatic antishock trousers, and other techniques described in the Basic Emergency Medical Technician curriculum or otherwise approved by the Board, pursuant to the rules of the department.

- (c) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function; or, serious dysfunction of any body organ or part.
- (d) "Emergency Run" means a response "to the perceived need for immediate medical care in order to prevent loss of life or aggravation of illness or injury".
- (e) "Extended Life Support" shall mean the treatment of life-threatening medical emergencies by emergency medical technicians, qualified pursuant to the rules of the department, performing under medical control, to include airway retention with an esophageal obturator airway; venipuncture, administration and maintenance of intravenous fluids, and such other procedures as may be approved pursuant to the rules of the department and may include such advanced life support as shall be provided by emergency medical technician-paramedics or other qualified and licensed medical and nursing personnel operating pursuant to the rules of the department.
- (f) "Medical Director" shall mean a physician licensed to practice in the State of Tennessee, contracted by an ambulance service to provide medical supervision and assure the provision of quality emergency medical care by the agents of the service.
- (g) "Minimum Standards" shall mean the minimum essential requirements for ambulance and emergency medical services established by law, regulation of the department, and such prevailing standards or practices as may be cited within the State.
- (h) "Primary Provider" or primary service shall mean the EMS provider within a service area who has contracted or been recognized by the local government to provide the initial response to scene emergencies.
- (i) "Occasional use" shall mean the isolated, unplanned use of a vehicle for patient transfer which is not maintained by an ambulance service, when such use is likely to expedite care for the patient.
- (j) "Rescue operation" shall mean the use of specialized equipment and procedures to free persons from confinement entrapment, impingement or the search for and removal or transportation of persons from locations inaccessible to conventional means of vehicle travel.
- (k) "Rescue vehicle" shall mean a vehicle operated by an association, squad, service, department, or any other persons equipped to provide extrication, fire suppression, or specialized services, and not maintained with fixed litters for the transport of patients, in accordance with T. C.A. §68-39-516(3).
- (l) "Service Area" shall mean the political and geographical area with a population that can be expected to use the services offered by a specific provider.
- (m) "Special Ambulance Service" shall mean a service restricting emergency operations to scheduled events or, serving as a relief organizations under the constraint of the main purveyor or governmental Emergency Medical Services provider within a service area.

(Rule 1200-12-01-.14, continued)

(2) Classification of Services - The following classes of service shall be recognized by the Department in licensing or authorization of ambulance and/or emergency medical services:

(a) Ambulance Services

1. Class A - Advanced Life Support Ambulance Services shall conduct operations of ambulances to provide capabilities for advanced life support or special critical care on ninety-five percent (95%) of emergency runs within their service area, staffed to provide twenty-four hour service. All ambulances shall be equipped at a minimum as a basic life support unit. Staffed ambulances shall be equipped to provide advanced life support.
2. Class B - Extended Life Support Ambulance Services shall conduct operations of ambulances to provide capabilities for extended life support on ninety-five percent (95%) of emergency runs within their service area, staffed to provide twenty-four hour service. All ambulances shall be equipped as a minimum as a basic life support unit.
3. Class C - Basic Life Support Ambulance Services shall conduct operations of ambulances to provide capabilities for basic life support on ninety-five percent (95%) of emergency runs within their service area, staffed to provide twenty-four hour service. All ambulances shall be equipped as a minimum as a basic life support unit.
4. Class D - Minimum Standard Ambulance Services shall conduct operations in compliance with minimum standards for ambulance services, staffed to provide twenty-four hour service. All ambulances shall be equipped as a minimum as a basic life support unit.
5. Special Ambulance Services - shall conduct operations only upon a preplanned schedule or as a secondary resource when services classified under 1 through 4, as designated above, are unable to provide service; but shall otherwise comply with all minimum standards as set forth in statute or rule. All ambulances shall be equipped as a minimum as a basic life support unit.
6. Air Ambulance Services - shall constitute a separate class of service for operation under standards established in Rule 1200-12-01-.05.

(b) Conditional Ambulance Services - Upon issuance of a new service license or finding of deficiencies services may be placed in a conditional license category for up to one year from the date of deficiency or issuance.

(c) Advanced Life Support/Non-Transport Service - Services providing Advanced Life Support response to the public without association as a First Responder to a licensed ambulance service shall be licensed by, the Department as a separate entity.

1. Advanced Life Support/Non-Transport services shall remit a license fee and fees for each specialty vehicle in the same manner as provided for ambulance services in Rule 1200-12-01-.06.
2. ALS/Non-Transport services shall demonstrate compliance for insurance coverage as required in Rule 1200-12-01-.07.
3. Mechanical safety of specialty vehicles used for ALS/Non-Transport shall be demonstrated in the same manner as prescribed for ambulance in Rule 1200-12-

(Rule 1200-12-01-.14, continued)

- 01-.02(n) except that such forms shall not be submitted to the Division, but shall be retained at the service for inspection by a representative of the Department.
4. ALS/Non-Transport services shall demonstrate compliance with operational and procedural requirements; destination guidelines and referral for transportation, and records as provided in Rules 1200-12-01-.11 and 1200-12-01-.15.
  5. Each service shall provide sufficient coverage with an Emergency Medical Technician and Emergency Medical Technician-Paramedic as provided in (3)(b).
- (3) Personnel. As classified in (1) above, each ambulance or emergency medical service shall insure compliance by assigning persons qualified to perform the following functions:
- (a) Medical Director - Each service classified or otherwise providing advanced or extended life support shall retain a medical director to maintain quality control of the care provided, whose functions shall include the following:
    1. Quality Assurance of patient care, including development of protocols, standing orders, training, policies, and procedures; and approval of medications and techniques permitted for field use by service personnel in accordance with regulations of the department; quality assurance of field performance as may be provided by direct observation, field instruction, inservice training or other means including, but not limited to:
      - (i) Ambulance Run Report Review
      - (ii) Review of field communications tapes
      - (iii) Post-run interviews and case conferences
      - (iv) Critiques of simulated or actual patient presentations
      - (v) Investigation of complaints or incident reports
    2. The Medical Director shall serve as medical authority for the ambulance service, to perform liaison with the medical community, medical facilities, and governmental entities.
    3. The Medical Director may have disciplinary authority sufficient to oversee quality control as deemed appropriate by the Administrative Director of the Ambulance Service and retain other responsibilities as may be negotiated by agreement with the service.
  - (b) Advanced Life Support Service Personnel - Each service classified for advanced life support shall provide sufficient coverage with a crew comprised of an Emergency Medical Technician and Emergency Medical Technician-Paramedic on ninety-five percent (95%) of all emergency runs staffed to provide twenty-four hour service.
  - (c) Extended Life Support Service Personnel - Each service classified for extended life support shall provide sufficient coverage with a crew comprised of two Emergency Medical Technicians on ninety-five percent (95%) of all emergency runs; one of the Emergency Medical Technicians shall hold extended skills certification for Esophageal Airway and Intravenous Therapy, or shall be certified as an EMT-Paramedic; the service shall be staffed to provide twenty-four hour service.
  - (d) Basic Life Support Service Personnel - Each service classified for basic life support shall provide sufficient coverage with a crew comprised of two Emergency Medical Technicians on ninety-five percent (95%) of all emergency runs, staffed to provide twenty-four hour service.

(Rule 1200-12-01-.14, continued)

- (e) Reserved for future use.
- (4) Each service shall require and document continuing education of at least twelve (12) hours for seventy-five percent (75%) of emergency care personnel. In-service training shall be conducted as ordered by the Medical Director for new procedures or remedial instructions.
- (5) No service shall be required to comply with revised classification standards of paragraph (3)(b), (c) and (d); and paragraph (4) until January 1, 1992.
- (6) Each service shall be issued permits identifying the county in which ambulances or response units are based. Records for such operations may be maintained at a central operating base by the service owner but shall be maintained to detail all activities on a county specific basis.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, 68-140-506, and 68-140-507. **Administrative History:** Original rule filed November 30, 1984; effective February 12, 1985. Amendment filed March 22, 1985; effective April 21, 1985. Amendment filed June 30, 1987; effective August 14, 1987. Amendment filed September 23, 1991; effective November 7, 1991. Amendment filed October 22, 1993; effective January 5, 1994. Amendment filed March 7, 1994; effective May 21, 1994. Amendment filed January 7, 1997; effective March 23, 1997.

**1200-12-01-.15 AMBULANCE SERVICE RECORDS.** Each ambulance service and invalid vehicle operator, licensed or permitted by the Tennessee Department of Health and Environment shall maintain records that include, but are not limited to, the following information:

- (1) Employee or Membership
  - (a) Employee or membership records, indicating the driver's license type and number, emergency medical technician certification number, training or expiration date of CPR certification, and physical examination date. Such records shall detail status of EMS Telecommunication training, Defensive Driving Courses or equivalent, and Emergency Vehicle Operations Courses. At the time of license renewal, a record of emergency care personnel and vehicle operators on a form furnished by the department (or its equivalent) shall accompany the license renewal application.
  - (b) Time cards or sheets, call rosters, or shift schedules that accurately reflect the availability of ambulance service personnel. These records may be managed in accord with requirements for wage and hours compliance or other applicable labor laws, but shall be maintained by all services, whether non-profit, volunteer, governmental, or proprietary, indicating the date and crews assigned for each staffed ambulance.
  - (c) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily function; or, serious dysfunction of any body organ or part.
- (2) Dispatch and Run Records shall be provided for every call to which an ambulance responds or when a patient is evaluated, treated, or transported; including information in accordance with the following requirements:
  - (a) A dispatch log shall be maintained to record the assignment of all units, including the date, the time the call is received, time and unit dispatched, time of arrival on scene, time of arrival at the destination, and time available for return to service. The dispatch log will specify responding or attending personnel by name and level of licensure, and cross-reference any ambulance run report number. Calls will be logged to reflect immediate emergency or non-emergency response or scheduled transfers.

(Rule 1200-12-01-.15, continued)

Compliance may be demonstrated by a single log, or such combination of records that can confirm the required information. Ambulance dispatch logs will be retained for a period of at least ten (10) years.

- (b) Ambulance service run reports shall be filed with the Division of Emergency Medical Services to include all information in required data fields and such other information as may be detailed in the Board approved prehospital care data set. This information shall be transmitted in an approved format using Tennessee subset schema definitions (XSD) in Extensible Markup Language (XML) in compliance with information systems procedures adopted by the State of Tennessee. Each service shall submit reports, either web based or via compiled form, to the Division of Emergency Medical Services within sixty (60) days. Notices shall be sent to the service within fifteen (15) days for non-compliance or citing deficiencies in the reported data elements or required information.
  - (c) For each patient transported to a hospital emergency department or transferred between medical facilities, emergency medical services personnel shall submit a report to the emergency department or hospital personnel in a written or electronic format or method approved by the Division or the Board. This report shall provide brief information identifying the patient by name (if known), age, and gender; the location from which the patient was transported; the approximate times of the medical incident, initiation of transport, and arrival at the hospital; the chief complaint or description of the illness or injuries, with appropriate notation of vital signs and patient condition; and shall describe the care and treatment provided at the scene or during transport. This report shall identify the name(s) and professional license level of the attending personnel, ambulance unit, and ambulance service. The receiving facility should receive any records or copies of physicians' orders for scope of treatment (POST) that may accompany the patient. Should circumstances or other emergencies preclude the submission of the report at the time of arrival at the emergency department, the report shall be submitted in not less than twenty-four hours from time of transport. If circumstances or other emergencies preclude the submission of the report at the time of arrival at the emergency department, the attending personnel must give a verbal report of above information to receiving personnel at health care facility with that individual signing for receipt of verbal report before attending personnel leave the health care facility. This report, while classified as confidential, shall be deemed as an essential element for continuity of care.
- (3) Vehicle and Equipment Records - Records regarding the acquisition and maintenance of all vehicles and equipment shall be retained by each service, which shall include the following:
- (a) Registration and title certificates or notarized copies of such documents for each vehicle.
  - (b) Maintenance records shall be maintained on each vehicle, detailing all mechanical work.
  - (c) Copies of orders, invoices or other documents asserting title or ownership of medical equipment, including contracts or agreements pertaining to state-issued equipment consigned to the service.
- (4) Ambulance equipment inventory - An ambulance equipment inventory shall be recorded not less than every three (3) days for each vehicle reflecting an accurate status of patient care equipment, safety devices, and supplies. Each service shall adopt forms or procedures appropriate to this purpose which shall be available for inspection reflecting status of a period of at least three (3) months.

(Rule 1200-12-01-.15, continued)

- (5) Each ambulance service shall maintain a file of FCC-related records in accordance with 47 C.F.R., Part 90.443. Such records shall include that of any transmitter maintenance, base or mobile, which affects frequency, modulation or power output tolerance of the transmitter, and those periodic reports of inspection of antenna support structures which are required to be illuminated.
- (6) All records detailed herein shall be made available when requested for inspection by a duly authorized representative of the department.

**Authority:** T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 68-140-502, 68-140-504, 68-140-505, 68-140-508, 68-140-509, and 68-140-519. **Administrative History:** Original rule filed November 30, 1984; effective February 12, 1985. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed August 11, 1993; effective October 25, 1993. Amendment filed October 21, 1993; effective January 4, 1994. Amendment filed June 5, 1998; effective August 19, 1998. Amendment filed December 16, 2005; effective March 1, 2006.

**1200-12-01-.16 EMERGENCY MEDICAL FIRST RESPONDERS.** Shall be regulated according to the following standards:

- (1) Definitions- The terms used in this rule shall be defined as follows:
  - (a) First Responder - means a person who has completed required training and who participates in an organized program of mobile pre-hospital emergency medical care.
  - (b) First Responder Certification - means successful participation and completion of the First Responder Course.
  - (c) First Responder Course - means instruction in basic knowledge and skills necessary to provide emergency medical care to the sick and injured to individuals who may respond before licensed Basic or Advanced Life Support units arrive.
  - (d) First Responder Service - shall mean a service providing capabilities for mobile pre-hospital emergency medical care using emergency medical response vehicles.
- (2) Operation of First Responder Services. A licensed ambulance service classified as a primary provider shall coordinate first response services within its service area. If the primary provider is a contracted ambulance service, the county or local government may designate a representative who shall coordinate first responder services within the service area of its jurisdiction. First responder services shall meet the following standards for participation in the community EMS system. To participate in the community EMS system, each First Responder Service shall:
  - (a) Be a state-chartered or legally recognized organization or service sanctioned to perform emergency management, public safety, fire fighting, rescue, ambulance, or medical functions.
  - (b) Provide a member on each response who is certified as a First Responder, Emergency Medical Technician, or EMT- Paramedic in Tennessee.
    1. Personnel may provide the following additional procedures with devices and supplies consigned under medical direction:
      - (i) First Responders and Emergency Medical Technicians trained in an appropriate program authorized by the Division may perform defibrillation in a pulseless, nonbreathing patient with an automated mode device.

(Rule 1200-12-01-.16, continued)

- (ii) Emergency Medical Technicians - I.V. and EMT-Paramedics may administer:
    - (I) Intravenous fluids with appropriate administration devices.
    - (II) Airway retention with Board approved airway procedures.
  - (iii) EMT-Paramedics and advanced life support personnel trained and authorized in accordance with these rules may perform skills or procedures as adopted in Rule 1200-12-01-.04(3).
  - (iv) First Responders and Emergency Medical Technicians participating in a recognized first responder organization within the community EMS system may, upon completion of the approved training, periodic review training, and concurrent quality assurance of the local EMS system Medical Director, utilize a dual-lumen airway device (such as the Combitube or Pharyngeal Tracheal Lumen airway) that has been approved by the EMS Board.
2. Such procedures shall be consistent with protocols or standing orders as established by the ambulance service medical director.
  3. Services shall provide at least six (6) hours of annual in-service training to all EMS First Responder personnel, in a plan and with instructors approved by the medical director.
- (c) Provide services twenty-four (24) hours a day, seven (7) days a week, and notify the primary service and dispatching agent of any time period in which the service is not available or staffed for emergency medical response.
- (d) Provide minimum equipment and supplies and such other equipment and supplies as shall be mutually adopted under the agreement with the primary ambulance service and medical director. The following minimum equipment shall be provided:
1. Emergency Medical Care (Jump) Kit containing:
    - (i) Dressings and bandaging supplies, with adhesive tape, bandaids, sterile 4" gauze pads, sterile ABD pads, 3" or wider gauze roller bandages, bandage shears, occlusive dressing materials, at least four triangular bandages, and burn sheets.
    - (ii) Patient assessment and protective supplies including a flashlight, disposable gloves, antibacterial wipes or solution with tissues, trash bags, an adult blood pressure cuff with manometer and a stethoscope.
  2. Resuscitative devices including oral airways in at least five sizes; a pocket mask; suction device capable of 12 inches vacuum with suction tips for oropharyngeal suction; and, an oxygen administration unit, capable of 2 to 15 liters per minute flow rate with a minimum 150 liter supply.
  3. Splints for upper and lower extremities.
  4. Patient handling equipment including a blanket and appropriate semi-rigid extrication collars.

(Rule 1200-12-01-.16, continued)

- (e) Develop and maintain a memorandum of understanding or agreement of coordination within the service area with the primary provider of emergency ambulance services. If the primary provider is a contracted ambulance service, said agreement shall be developed and maintained with the designated representative of the county or local government. Such agreement will provide for policies and procedures for the following:
  - 1. Personnel and staffing, including a roster of response personnel and approved procedures for such personnel, and the crew component operational for emergency medical response.
  - 2. Designation of vehicles to be operated as prehospital emergency response vehicles, including unit identifiers and station or location from which vehicles will be operated.
  - 3. Nature of calls for which first response services will be dispatched, and dispatch and notification procedures that assure resources are simultaneously dispatched and that ambulance dispatch is not deferred or delayed.
  - 4. Radio communications and procedures between medical response vehicles and emergency ambulance services.
  - 5. On-scene coordination, scene control and responsibilities of the individuals in attendance by level of training.
  - 6. Medical direction and protocols and/or standing orders under the authority of the ambulance service medical director.
  - 7. Exchange and recovery of required minimum equipment and supplies and additional items adopted for local use.
  - 8. Exchange of patient information, records and reports, and quality assurance procedures.
  - 9. Terms of the agreement including effective dates and provisions for termination or amendment.
- (f) First response services shall maintain professional liability insurance providing indemnity to emergency care personnel and the organization. Each first response service shall maintain the minimum liability coverage which are set forth in T.C.A. § 29-20-403.
- (3) First Responder Course Coordinators/Instructors Authorization - Each course shall be supervised by an instructor who shall meet qualifications and perform duties as follows:
  - (a) Must be certified in Tennessee as an emergency medical technician or EMT-Paramedic and nominated by the Regional EMS Consultant.
  - (b) Must be certified as a Cardiopulmonary Resuscitation Instructor.
  - (c) Must have at least one (1) year experience in pre-hospital care or equivalent preparation and participate in emergency care training each year.
  - (d) Shall be responsible for training, course administration and testing of students according to applicable procedures established by the Division of Emergency Medical Services, stipulating that the instructor shall:

(Rule 1200-12-01-.16, continued)

1. Conduct training with First Responder texts and course outlines approved by the Board.
  2. Maintain and impart knowledge of Emergency Medical Services laws and emergency care standards and requirements for First Responders, evidenced by completion of the First Responder examination with a score of 90% or higher.
  3. Maintain accurate attendance and class records and assure that class size does not exceed twenty-five (25) students per instructor.
  4. Schedule lessons and instruct the majority of the course hours in the curriculum approved by the Board.
  5. Request exams and process records in a timely manner according to administrative policies established by the Division of Emergency Medical Services.
  6. Obtain course evaluation materials and submit to the Regional EMS Consultant.
- (4) Training facilities shall be scheduled by the instructor and approved by the Regional EMS Consultant based upon criteria which assure:
- (a) Adequate lighting and ventilation.
  - (b) Adequate seating, restroom, and break facilities.
  - (c) Audio-Visual instructional aids, supplies and equipment for skills training.
  - (d) Minimal distractions from radios, scanners, traffic noises, or operational interference.
- (5) Denial of approval for training or instructor qualification shall result from failure to schedule the course, to obtain approved facilities, or to conduct training in accordance with course requirements, or poor student performance.
- (6) Certification for First Responders shall be issued for a period not to exceed two years, based upon satisfactory completion of the following:
- (a) An application for certification shall be completed, signed, and submitted by any person desiring First Responder Certification upon a form adopted for this purpose.
  - (b) Prior to certification, each instructor shall submit documentation that each applicant:
    1. shall be at least eighteen (18) years of age.
    2. shall be able to read, write, and speak the English language.
    3. is currently certified in Basic Cardiopulmonary Resuscitation.
    4. has attended all classes in training, with one allowable absence.
    5. has completed practical skills evaluation.
    6. has performed satisfactorily on all in-class examinations.
  - (c) Applicant's score of 70 percent or higher must be obtained on the written examination.

(Rule 1200-12-01-.16, continued)

1. Applicants who fail to pass the written examination shall be eligible to reapply for examination for a period up to one year from the original course ending date.
  2. Fees for examination and certification must be submitted if authorized pursuant to Rule 1200-12-01- .06.
- (d) First Responder certification may be renewed upon filing an application, possession of a current Cardiopulmonary Resuscitation card verifying successful completion of a basic life support course which includes automatic external defibrillation for health care professionals, and verification of one of the following:
1. Successful completion of refresher training course of at least sixteen (16) hours meeting the refresher course curriculum approved by the board; or
  2. Satisfactory completion of the examination as established in paragraph (6)(c); or
  3. Completion of ten (10) continuing education hours in the following areas:
    - (i) Preparatory: one (1) hour consisting of:
      - (I) EMS systems
      - (II) Well being of the first responder
      - (III) Legal and ethical issues
      - (IV) Human body
      - (V) Lifting and moving patients
    - (ii) Airway: two (2) hours
    - (iii) Patient assessment: two (2) hours
    - (iv) Circulation: one (1) hour
    - (v) Illness and injury: two (2) hours
      - (I) Medical: one (1) hour
      - (III) Trauma: one (1) hour
    - (vi) Children and childbirth: one (1) hour
    - (vii) Rescue and EMS operations: one (1) hour.
- (e) Those persons who fail to timely renew certification as provided by law are subject to the following:
1. Late renewal within sixty (60) days or less from the expiration of certification will require payment of a twenty-five dollar (\$25.00) reinstatement fee, and in addition to CPR certification, either the examination required by part (6)(d)2 or the refresher course required by part (6)(d)1.
  2. Reinstatement of certification sought to be renewed more than sixty (60) days after expiration of certification will require payment of a twenty-five (\$25.00)

(Rule 1200-12-01-.16, continued)

reinstatement fee and in addition to CPR certification, successful completion of both the refresher course and the examination as required in parts (6)(d) 1 and 2.

- (7) Official response shall be performed only as assigned upon the specific policy guidelines of the coordinating dispatch agency responsible for dispatching emergency ambulances and/or an emergency (911) communications district. No emergency medical first responder or emergency medical response vehicle shall be authorized to make an unofficial response on the basis of information obtained by monitoring a radio frequency of a law enforcement ambulance service, fire department, rescue squad, or public safety agency.

**Authority:** §§4-5-202, 4-5-204, 68-140-504, 68-140-504(1) and (2), 68-140-506, 68-140-506(c), 68-140-507, 68-140-508, 68-140-508(a) & (b), and 68-140-517. **Administrative History:** Original rule filed March 25, 1987; effective May 9, 1987. Amendment filed March 7, 1989; effective April 21, 1989. Amendment filed March 7, 1994; effective May 21, 1994. Amendment filed January 9, 1997; effective March 25, 1997. Amendment filed November 16, 2005; effective January 30, 2006. Amendment filed December 16, 2005; effective March 1, 2006.

**1200-12-01-.17 UNETHICAL PRACTICES AND CONDUCT.** Emergency medical services and emergency medical services personnel shall be subject to discipline or may be denied authorization for unethical practices or conduct which includes but shall not be limited to the following:

- (1) Engaging in acts of dishonesty which relate to the practice of emergency medical care.
- (2) Failing to report to appropriate personnel facts known to the individual regarding incompetent, unethical, or illegal practice of any other emergency medical services personnel.
- (3) Failing to take appropriate action in safeguarding the patient from incompetent health care practices of emergency medical services personnel.
- (4) Violating confidentiality of information or knowledge concerning the patient, except when required to do so by a court of law or authorized regulatory agency.
- (5) Engaging in the delivery of emergency medical services on a revoked, suspended, expired, or inactive license, or beyond the scope of a modified or conditioned license.
- (6) Accepting and performing, or attempting to perform, professional responsibilities which the licensee knows, or has reason to know, he is not competent to perform.
- (7) Delegating, assisting, or advising a person to perform professional responsibilities or procedures when the licensee knows, or has reason to know, that such person is not qualified by training, experience, or license to perform such procedures.
- (8) Failing to provide supervision of students in a clinical experience or field internship.
- (9) Exercising influence on a patient in such a manner as to exploit the patient for financial gain of the licensee or a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs.
- (10) Disseminating any written materials within an emergency medical services relationship, including those of a religious or political nature, which do not pertain to patient care, insurance reimbursement, support or follow-up services.
- (11) Exercising influence within an emergency medical services relationship for the purposes of engaging a patient in any sexual activity, or indecently exposing oneself to a patient.

(Rule 1200-12-01-.17, continued)

- (12) Willfully failing to file a report or record required by state or federal law, or willfully impeding or obstructing such filing, or inducing another person or licensee to do so.
- (13) Providing false information to regulatory officials in inspection reports regarding defective or faulty equipment, or willfully concealing known deficiencies during an inspection.
- (14) Misrepresentation of the level of services provided and/or false or misleading advertising.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-502, 68-140-504, 68-140-505, 68-140-506, 68-140-507, 68-140-508, 68-140-509, and 68-140-511. **Administrative History:** Original rule filed June 5, 1998; effective August 19, 1998.

#### **1200-12-01-.18 EMERGENCY MEDICAL DISPATCHER STANDARDS.**

- (1) Definitions - The terms used in this rule shall be defined as follows:
  - (a) Department - The Tennessee Department of Health, Division of Emergency Medical Services.
  - (b) Emergency Medical Dispatcher (EMD) - An individual certified by the Department as having successfully completed a Department-approved Emergency Medical Dispatch Course.
  - (c) Emergency Medical Dispatch Priority Reference System (EMDPRS) - A Department-approved protocol system used by a dispatch agency to dispatch aid to medical emergencies which must include:
    - 1. Systemized caller interrogation questions;
    - 2. Systemized pre-arrival instructions; and
    - 3. Protocols matching the dispatcher's evaluation of injury or illness severity with vehicle response mode and configuration.
  - (d) Medical Director - A person approved by the Department who assumes medical leadership for the provision of emergency medical services, including basic and/or advanced life support, and/or medical dispatch services in the dispatch agency's geographical area.
  - (e) Pre-Arrival Instructions - Telephone-rendered, medically approved, written instructions given by trained EMDs through callers which help to provide aid to the victim and control of the situation prior to the arrival of pre-hospital personnel. The dispatcher shall adhere to the written wording as closely as possible.
  - (f) Vehicle Response Mode - The use of emergency driving techniques, such as red-light and siren, versus routine driving response.
  - (g) Vehicle Response Configuration - The specific vehicle(s) of varied types, capabilities, and numbers responding to render assistance in a particular emergency situation.
- (2) Requisites for providing Medical Dispatch Service
  - (a) Any dispatching entity receiving and dispatching calls for emergency medical services which provides pre-arrival medical care instructions may require persons assigned to handle such calls to be certified as emergency medical dispatchers as defined in

(Rule 1200-12-01-.18, continued)

T.C.A. §68-140-502. All such dispatching entities shall have medically approved dispatch protocols.

- (b) The Department shall assist local dispatch agencies in implementing an Emergency Medical Dispatch Priority Reference System by:
    - 1. Providing medical direction; and
    - 2. Providing technical assistance; and
    - 3. Identifying an approved standard Emergency Medical Dispatch Priority Reference System which must include at a minimum caller interrogation questions, pre-arrival instructions, and vehicle response mode/ configuration protocols as defined by these Rules.
  - (c) The EMDPRS including its questions, instructions, and protocols, shall be used exactly as approved by the Department.
  - (d) Dispatch agencies shall provide for medical dispatch quality assurance by initiating an ongoing medical call review procedure and a quality assurance program as established by the agency's Medical Director.
- (3) Emergency Medical Dispatcher Curriculum
- (a) All Emergency Medical Dispatch training program curricula shall be approved by the Department based on an approved checklist of required basic components and elements as approved by the EMS Board.
  - (b) Any curriculum submitted for approval shall conform to the guidelines of the National Association of EMS Physician's (Position Paper on Emergency Medical Dispatching) and ASTM F 1258-90 (Standard Practice for Emergency Medical Dispatch) and/or its successor standards as a minimum.
  - (c) The length of the course shall be a minimum of 24 hours.
- (4) Personnel Standards
- (a) Certification - The Department shall develop, establish, or approve an Emergency Medical Dispatch certification and re-certification program. To be initially certified as an EMD, an individual shall:
    - 1. Successfully complete a Department approved EMD Course; and
    - 2. Maintain proficiency in cardiopulmonary resuscitation for basic life support procedures; and
    - 3. Successfully pass either the Department written examination or an exam given through an approved dispatch organization that has pre-qualified for testing reciprocity; or submit proof of having successfully certified as an EMD through an approved medical dispatch organization that has pre-qualified for certification reciprocity.
    - 4. An applicant shall cause to be submitted to the administrative office of the Division of Emergency Medical Services, directly from the vendor identified in the Division's certification application materials, the result of a criminal background check.

(Rule 1200-12-01-.18, continued)

- (b) Recertification - Recertification is required every two (2) years to maintain Department certification. To recertify an EMD shall:
    - 1. Submit to the Department a completed application form provided by the Department; and
    - 2. Maintain proficiency in cardiopulmonary resuscitation for basic life support procedures; and
    - 3. Meet one of the following:
      - (i) Complete ten hours or 1.0 continuing education unit (CEU) of Department-approved continuing medical dispatch education or in-service during the 2-year recertification period; or
      - (ii) Successfully complete either the Department's EMD written examination or an examination given through an approved medical dispatch organization that has qualified for recertification testing reciprocity; or
      - (iii) Submit proof of having successfully recertified as an EMD through an approved medical dispatch organization that has qualified for recertification reciprocity
  - (c) Reciprocal certification - Reciprocity for applicants certified outside Tennessee may be granted by the Department based on the following considerations:
    - 1. Applicants shall provide to the Department with a current copy of their Emergency Medical Dispatcher certification; and
    - 2. Applicants shall provide to the Department proof that the certifying course meets the standards established by the Department or shall provide the Department the curriculum; and
    - 3. Applicants shall successfully complete the Department written examination; and
    - 4. Applicants shall meet all Department certification requirements demonstrating proof that the applicant has certified in a State having current certification reciprocity with the Department.
  - (d) Certification and Recertification for the Handicapped - These rules shall not preclude any physically handicapped individual from certifying or recertifying who can demonstrate proficiency in verbally describing the treatment methods outlined in the Department approved EMD course and/or CPR course to a caller.
  - (e) Lapsed certification - Individuals who permit their certification to lapse may be recertified by completion of the recertification requirement.
  - (f) Instructor Standards - Instructors who teach Emergency Medical Dispatchers shall meet training and certification standards established by the Department.
- (5) Proscribed Acts for Emergency Medical Dispatchers - The Department may refuse to issue a certification or recertification, or suspend or revoke a certification for any of the causes listed in T.C.A. §68-140-511.

(Rule 1200-12-01-.18, continued)

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-203, 68-140-204, 68-140-502, 68-140-504, 68-140-505, 68-140-506, 68-140-508, 68-140-511, 68-140-513, and 68-140-525. **Administrative History:** Original rule filed January 7, 1997; effective March 23, 1997. Amendment filed April 13, 2006; effective June 27, 2006.

#### 1200-12-01-.19 AUTOMATED EXTERNAL DEFIBRILLATOR PROGRAMS.

- (1) Each entity shall submit a written notice to the local primary emergency medical services provider or emergency communications district that provides the following information:
  - (a) the name of the entity, the owner of the AED, and a contact person and an alternate with telephone numbers, and mailing address of the placement facility;
  - (b) the street location and site within the facility where the AED shall be placed, means to access the AED, hours during the day when the AED may be available, and whether the AED may be used off-site;
  - (c) description of the AED by manufacturer and model;
  - (d) listing of the area emergency medical services and contact information for the EMS agency and emergency communications district;
  - (e) the name and contact information of the physician supervising the AED placement; and,
  - (f) how the use of the AED is coordinated with the local EMS system.
- (2) Each entity shall maintain and submit a copy of a written AED plan to the local primary emergency medical services provider or emergency communications district that includes:
  - (a) designation of the training programs adopted by the entity to prepare expected users;
  - (b) a list of individuals appropriately trained and authorized;
  - (c) a plan of action for proper use of the AED;
  - (d) registration with local emergency medical services with acknowledgement by their representatives of the AED placement, plan, and program;
  - (e) description of how the AED program coordinates with EMS and the dispatching entity;
  - (f) maintenance and testing procedures necessary to maintain the device, as well as sample forms to document proper maintenance; and,
  - (g) reports that shall be made of AED use along with other records to be maintained by the program.
- (3) Each entity shall complete a report of the use of an AED and submit a copy to the responding EMS agency and the supervising physician to document the following:
  - (a) time of use or deployment of the device;
  - (b) the model of AED used;
  - (c) names of the AED responders;

(Rule 1200-12-01-.19, continued)

- (d) patient information, when known, to include name, age, race, and gender of the patient;
  - (e) condition of the patient upon arrival of AED responders and resuscitative actions taken;
  - (f) condition of the patient upon arrival of EMS; and,
  - (g) patient outcome.
- (4) Each placement of an AED shall be supervised and endorsed by a physician with an unrestricted license to practice medicine or osteopathy in Tennessee.
- (5) Each automated external defibrillator shall comply with the provisions of T.C.A. § 68-140-710 and shall perform the following capabilities:
- (a) analyze heart rhythm and deliver electrical impulses (countershocks) for at least thirty (30) minutes after deployment;
  - (b) deliver visual or audible warnings of low battery power;
  - (c) provide an audible or visual warning of loose connections of the electrodes; and
  - (d) incorporate an internal event record providing the time of activation, times of rhythm analysis, and times of delivery of countershocks.
- (6) The following training programs in cardiopulmonary resuscitation and AED use are consistent with the scientific guidelines of the American Heart Association and have been approved by the Tennessee Emergency Medical Services Board.
- (a) Heartsaver AED and Basic Life Support for Healthcare Professional CPR and AED Courses of the American Heart Association
  - (b) Advanced Cardiac Life Support Course of the American Heart Association (for Healthcare professionals in conjunction with Basic Life Support for Healthcare Providers)
  - (c) Workplace First Aid and Safety; Adult CPR/AED Training Course of the American Red Cross
  - (d) AED Training Course of the American Red Cross (in conjunction with Adult and Professional Rescuer CPR courses)
  - (e) AED Course of the National Safety Council (in conjunction with AHA, NSC, or ARC Adult CPR Courses)
  - (f) Heartsaver FACTS Course of the National Safety Council or American Heart Association;
  - (g) Medic First Aid family of programs for Basic Life Support for Professionals and AED Training by EMP International, Inc.
  - (h) American Safety and Health Institute programs for Basic CPR and AED education and training.
  - (i) Coyne First Aid CPR and AED training program.

**Authority:** T.C.A. §§4-5-202, 68-140-504, 68-140-505, and 68-140-705. **Administrative History:** Original rule filed January 24, 2002; effective April 9, 2002. Amendment filed August 15, 2005; effective October 29, 2005.

**1200-12-01-.20 TRAINING FOR EMERGENCY MEDICAL SERVICES FOR CHILDREN.** Training programs for emergency medical care for children shall be provided as follows

- (1) Within twenty-four (24) months of the effective date of this rule, each EMT-Paramedic shall demonstrate capability of recognizing and managing overt shock and respiratory failures and stabilizing pediatric trauma patients, including recognition and stabilization of problems that may lead to shock and respiratory failure in children. Successful completion of courses, such as the Pediatric Education for Prehospital Professionals, EMS-C/Pediatric Advanced Life Support (American Heart Association courses), or Emergency Nursing Pediatric Courses, can be utilized to demonstrate this clinical capability.
- (2) Each service shall ensure that licensed EMS personnel employed by the service receive a minimum of one and one half (1.5) hours of pediatric emergency medical care refresher training each year. Attendance in courses or subjects from the Pediatric Education for Prehospital Professionals, EMS-C/Pediatric Advanced Life Support, Neonatal Resuscitation Program (American Heart Association courses), Emergency Nursing Pediatric Courses, or other programs approved by the board may be credited to fulfill this requirement. Such in-service shall follow and shall be in addition to the initial completion of a pediatric emergency care training program by EMT- Paramedics, or by other EMS personnel appropriate to their level of licensure.
- (3) All accredited EMT and EMT-Paramedic training programs shall offer and provide pediatric emergency care training, including courses in pediatric advanced life support and trauma care. Such programs shall be offered subject to demand and enrollment, but at least annually.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-140-504, 68-140-509, and 68-140-521. **Administrative History:** Original rule filed November 15, 2002; effective January 29, 2003.

**1200-12-01-.21 DESTINATION DETERMINATION.** Sick or injured persons who are in need of transport to a health care facility by a ground or air ambulance requiring licensure by the State of Tennessee should be transported according to these destination rules.

- (1) Trauma patients - The goal of the pre-hospital component of the trauma system and destination guidelines is to minimize injury through safe and rapid transport of the injured patient. The patient should be taken directly to the center most appropriately equipped and staffed to handle the patient's injury as defined by the region's trauma system. These destinations should be clearly identified and understood by regional prehospital personnel and should be determined by triage protocols or by direct medical direction. Ambulances should bypass those facilities not identified by the region's trauma system as appropriate destinations, even if they are closest to the incident.
- (2) Beginning no later than six (6) months after the designation of a trauma center in any region, persons in that region, who are in need of transport who have been involved in a traumatic incident and who are suffering from trauma or a traumatic injury as a result thereof as determined by triage at the scene, should be transported according to the following rules.
  - (a) Adult (greater than or equal to fifteen (15) years of age) and Pediatric (less than fifteen (15) years of age) Trauma Patients will be triaged and transported according to the flow chart labeled "Field Triage Decision Scheme" in "Resources For Optimal Care of the Injured Patient: 1999," or any successor publication. The Pediatric Trauma Score shall be used as published in "Basic Trauma Life Support for Paramedics and Other

(Rule 1200-12-01-.21, continued)

Advanced EMS Providers," Fourth Edition, 2000. Copies of the charts are available from the Division.

1. Step One and Step Two patients should go to a Level 1 Trauma Center or Comprehensive Regional Pediatric Center (CRPC), either initially or after stabilization at another facility. EMS field personnel may initiate air ambulance response.
  2. Step One or Step Two pediatric patients should be transported to a Comprehensive Regional Pediatric Center (CRPC) or to an adult Level 1 Trauma Center if no CRPC is available. Local Destination Guidelines should assure that in regions with two CRPC's or one CRPC and another facility with Level 1 Adult Trauma capability, that seriously injured children are cared for in the facility most appropriate for their injuries.
  3. For pediatric patients, a Pediatric Trauma Score of less than or equal to 8 ( $\leq 8$ ) will be considered as a cutoff level for Step One patients.
  4. Local or Regional Trauma Medical Control may establish criteria to allow for non-transport of clearly uninjured patients.
  5. Trauma Medical Control will determine patient destinations within thirty (30) minutes by ground transport of a Level 1 Trauma Center or CRPC.
- (b) Exceptions apply in the following circumstances:
1. For ground ambulances, when transport to a Level I Trauma Center will exceed thirty (30) minutes, Trauma Medical Control will determine the patient's destination. If Trauma Medical Control is not available, the patient should be transported to the closest appropriate medical facility.
  2. For air ambulances, Step One patients will be transported to the most rapidly accessible Level I Trauma Center, taking safety and operational issues into consideration. Step Two, Three, and Four patients will be transported to a Level I Trauma Center as determined by the air ambulance's Medical Control. The Flight Crew will make determination of patient status on arrival of the air ambulance.
  3. Air ambulances will not transport chemical or radiation contaminated patients prior to decontamination.
  4. If the Trauma Center chosen as the patient's destination is overloaded and cannot treat the patient, Trauma Medical Control shall determine the patient's destination. If Trauma Medical Control is not available, the patient's destination shall be determined pursuant to regional or local destination guidelines.
  5. A transport may be diverted from the original destination:
    - (i) if a patient's condition becomes unmanageable or exceeds the capabilities of the transporting unit; or
    - (ii) if Trauma Medical Control deems that transport to a Level I Trauma Center is not necessary.

(Rule 1200-12-01-.21, continued)

- (c) Utilization of any of the exceptions listed above should prompt review of that transport by the quality improvement process and the medical director of the individual EMS providers.
  - (d) Trauma Medical Control can be accomplished by a Trauma or Emergency Physician on duty at a designated Trauma Center or by protocols established in conjunction with a Regional Level I Trauma Center.
- (3) Pediatric Medical Emergency - Pediatric patients represent a unique patient population with special care requirements in illness and injury. Tennessee has a comprehensive destination system for emergency care facilities in regards to pediatric patients where there are variable levels of available care, as defined in Rule 1200-08-30-.01.
- (a) There are circumstances in pediatric emergency care as determined by local medical control where it would be appropriate to bypass a basic or a primary care facility for a general or comprehensive regional pediatric center.
    - 1. Examples of such circumstances include, but are not limited to the following
      - (i) On-going seizures
      - (ii) A poorly responsive infant or lethargic child
      - (iii) Cardiac arrest
      - (iv) Significant toxic ingestion history
      - (v) Progressive respiratory distress (cyanosis)
      - (vi) Massive gastrointestinal (GI) bleed
      - (vii) Life threatening dysrhythmias
      - (viii) Compromised airway
      - (ix) Signs or symptoms of shock
      - (x) Severe respiratory distress
      - (xi) Respiratory arrest
      - (xii) Febrile infant less than two months of age.
    - 2. Pediatric medical emergency transport may be diverted from the original destination if the patient's condition becomes unmanageable or exceeds the capability of the transporting unit, in which case the patient should be treated at the closest facility.
    - 3. Pediatric medical emergency air ambulance transports must go to a Comprehensive Regional Pediatric Center.
  - (b) Pediatric trauma patients should be taken to trauma facilities as provided in paragraph (2).

(Rule 1200-12-01-.21, continued)

- (4) Any patient who does not qualify for transport to a Trauma Center or a Comprehensive Regional Pediatric Center should be transported to the most appropriate facility in accordance with regional or local destination guidelines.
- (5) Adults or children with specialized healthcare needs beyond those already addressed should have their destination determined by Medical or Trauma Control, by regional or local guidelines, or by previous arrangement on the part of patient (or his/her family or physician).
- (6) A transport may be refused or an alternate destination requested. If so, non-transport of the patient, or transport of the patient to an alternate destination shall not violate this rule and shall not constitute refusal of care.

**Authority:** T.C.A. §§4-5-202, 68-140-504, 68-140-505, 68-140-509, and 68-140-521. **Administrative**

**History:** Original rule filed October 15, 2002; effective December 29, 2002.