



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director

Reza Vaezazizi, M.D., Medical Director

DATE: August 28, 2009

TO: Fire Chiefs
Ambulance CEO'S

FROM: Virginia Hastings
Executive Director

SUBJECT: SPECIALTY PROGRAMS AND OPTIONAL SCOPE PROGRAMS

To acknowledge and inventory all the valuable resources found in the ICEMA Region, I am requesting all providers to assist us by updating our records of specialty programs. We are asking you to provide ICEMA with a current list of previously approved specialty programs, along with the date each was approved by ICEMA.

- Bike Medics
- Swat Medics
- River/Boat Medics
- Other

In addition, we ask that you provide us with a list of EMT optional scope programs. Examples would be:

- Combitube programs
- Automatic External Defibrillator (AEDs)

Effective September 1st, 2009 any new requests to provide a specialty program or optional scope program will require the completion of the attached application for Specialty or EMT I Optional Scope Program.

Please submit this information no later than September 15, 2009. If you have any questions, please contact Sherri Shimshy, RN at SShimshy@cao.sbcounty.gov or (909) 388-5816.

VH/SS/jch

c: Reza Vaezazizi MD, Medical Director
Paramedic Coordinators



INLAND COUNTIES EMERGENCY MEDICAL AGENCY

Serving San Bernardino, Inyo, and Mono Counties

**515 N ARROWHEAD AVENUE
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825**

**SPECIALTY OR EMT-I OPTIONAL SCOPE
PROGRAM APPLICATION**

I. PROVIDER INFORMATION

A. **Provider Name:** _____

B. **Address** _____
Number & Street City State Zip

II. ADMINISTRATION

A. **Name of proposed Program Medical Director:** _____

Phone Number: _____ **Email:** _____

B. **Name of proposed Program Coordinator:** _____

Phone Number: _____ **Email:** _____ **Title**

III. PROGRAM DETAILS

SUBMIT THE FOLLOWING FOR PROGRAM REVIEW:

- Completed original application
- Copy of proposed program which shall include:
 - Demonstration of Need for program approval
 - Description when the program will operate (special events, 24/7)
 - Description how employees will be trained and provide a list of those employees. ICEMA must be notified in the event of any changes
 - Does program require deviations from the Standard Drug and Equipment List? Provide detailed list and how equipment will be transported and stored
 - Overview of the quality assurance/quality improvement program and process for reporting
 - Description of how the program will interface with the EMS system and 9-1-1
 - Description of how the program will be implemented

Additional information may be requested after program is reviewed

Completed by _____
(Please print)

Date

Signature: _____

ICEMA Use Only

Date letter received: _____

All requirements verified: _____

Approved by: _____ Date: _____