DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Emergency Medical Services, Trauma Center, Comprehensive Stroke Center, Primary Stroke Center and Acute Stroke Ready Hospital Code

2) Code Citation: 77 Ill. Adm. Code 515

3)

Section Numbers:	Proposed Actions:
515.100	Amendment
515.125	Amendment
515.150	Amendment
515.190	Amendment
515.210	Amendment
515.220	Amendment
515.310	Amendment
515.320	Amendment
515.330	Amendment
515.350	Amendment
515.360	Amendment
515.380	Amendment
515.390	Amendment
515.420	Amendment
515.450	Amendment
515.455	Amendment
515.460	Amendment
515.500	Amendment
515.510	Amendment
515.520	Amendment
515.530	Amendment
515.540	Amendment
515.550	Amendment
515.560	Amendment
515.570	Amendment
515.580	Amendment
515.590	Amendment
515.600	Amendment
515.610	Amendment
515.630	Amendment
515.640	Amendment
515.700	Amendment
515.710	Amendment
515.715	Amendment

515.725	Amendment
515.730	Amendment
515.740	Amendment
515.750	Amendment
515.760	Amendment
515.810	Amendment
515.825	Amendment
515.830	Amendment
515.860	Amendment
515.920	Amendment
515.930	Amendment
515.935	Amendment
515.940	Amendment
515.945	Amendment
515.950	Amendment
515.955	Amendment
515.960	Amendment
515.963	Amendment
515.965	Amendment
515.970	Amendment
515.975	Amendment
515.980	Amendment
515.985	Amendment
515.990	Amendment
515.995	Amendment
515.1000	Amendment
515.3000	Amendment
515.Appendix D	Amendment
515.Appendix E	Amendment

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

5) A Complete Description of the Subjects and Issues Involved: The proposed rulemaking seeks to implement P.A. 96-1469, P.A. 98-0973, P.A. 99-0319 and P.A. 99-0661. P.A. 96-1469 granted authority to the Department to adopt minimum standards for critical care providers via administrative rulemaking; P.A. 980973 adopted comprehensive new national EMS education standards for three separate classes of EMS licensees and creates one new category of EMS provider (AEMT); P.A. 99-0319 changed the name of the advance directive form from DNR/POLST to POLST; and P.A. 99-0661 amended several definitions.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: All EMS service providers, universities, colleges and hospital based EMS personnel, as defined in the amended rules, will be required to update their EMS personnel curriculum and policies to meet the new educational national standards.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this rulemaking within 45 days after the publication of the issue of the *Illinois Register* to:

Elizabeth Paton
Assistant General Counsel
Division of Legal Services
Illinois Department of Public Health
535 W. Jefferson St., 5th floor
Springfield, Illinois 62761

(271) 782-2043
dph.rules@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: All EMS service providers who employ EMS personnel, as defined in the proposed amended rule, will need to change the nomenclature of their EMT's. The proposed amendments also bring the Part into alignment with current medical

standards of practice as well as aligning State and EMS System business practices with the Part.

B) Reporting, bookkeeping or other procedures required for compliance: All EMS service providers will need to change any documentation to the new nomenclature and update their educational material to the new national standards.

C) Types of professional skills necessary for compliance: All EMS service providers will need to bring their staff in alignment with the new national educational standards.

14) Regulatory Agenda on which this rulemaking was summarized: January 2017

The full text of the Proposed Amendments begins on the next page:

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

PART 515
EMERGENCY MEDICAL SERVICES, TRAUMA CENTER,
COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER
AND ACUTE STROKE READY HOSPITAL CODE

SUBPART A: GENERAL PROVISIONS

Section

SUBPART B: EMS REGIONS

Section

SUBPART C: EMS SYSTEMS
Section

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

515.APPENDIX J Credentials of Emergency Department Physicians Level I and Level II Pediatric Trauma Centers
515.APPENDIX K Application for Facility Recognition for Emergency Department with Pediatrics Capabilities
515.APPENDIX L Pediatric Equipment Recommendations for Emergency Departments
515.APPENDIX M Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline
515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application
515.APPENDIX O Pediatric Critical Care Center Plan
515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35 Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6, 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208, effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15, 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683, effective June 25, 2013; amended at 37 Ill. Reg. 18883, effective November 12, 2013; amended at 37 Ill. Reg. 19610, effective November 20, 2013; amended at 38 Ill. Reg. 9053, effective April 9, 2014; amended at 38 Ill. Reg. 16304, effective July 18, 2014; amended at 39 Ill. Reg. 13075,

effective September 8, 2015; amended at 40 Ill. Reg. 8274, effective June 3, 2016; amended at 40 Ill. Reg. 10006, effective July 11, 2016; amended at 42 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 515.100 Definitions

Act – the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

Acute Stroke-Ready Hospital or ASRH – a hospital that has been designated by the Department as meeting the criteria for providing emergent stroke care. Designation may be provided after a hospital has been certified or through application and designation as an Acute Stroke-Ready Hospital. (Section 3.116 of the Act)

Advanced Emergency Medical Technician or A-EMT − a person who has successfully completed a course in basic and limited advanced emergency medical care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part, and practices within an Intermediate or Advanced Life Support EMS System. (Section 3.50(b-5) of the Act)

Advanced Life Support Services or ALS Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the National EMS Education Standards relating to Advanced Life Support and any modifications to that curriculum or those standards specified in this Part. (Section 3.10(a) of the Act)

Aeromedical Crew Member or Watercraft Crew Member or Off-road Specialized Emergency Medical Services Vehicle (SEMSV) Crew Member – an individual, other than an EMS pilot, who has been approved by an SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program.

Alternate EMS Medical Director or Alternate EMS MD – the physician who is designated by the Resource Hospital to direct the ALS/Advanced/ILS/BLS operations in the absence of the EMS Medical Director.

Alternate Response Vehicle – ambulance assist vehicles and non-transport vehicles as defined in Section 515.825.

Ambulance – any publicly or privately owned on-road vehicle that is specifically designed, constructed or modified and equipped for, and is intended to be used for, and is maintained or operated for, the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such individuals. (Section 3.85 of the Act)

Ambulance Service Provider and Vehicle Service Provider Upgrades – Rural Population – a practice that allows an ambulance, alternate response vehicle, specialized emergency medical services vehicle or vehicle service provider that serves a population of 7,500 or fewer to upgrade the level of service of the provider vehicle using pre-approved System personnel and equipment.

Ambulance Service Provider – any individual, group of individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

Applicant – an individual or entity applying for a Department-issued license or certification.

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting education programs nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprehensive emergency department with 24-hour physician coverage. It shall have a functioning Intensive Care Unit or a Cardiac Care Unit.

Associate Hospital EMS Coordinator – the Paramedic or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the EMS System, in accordance with the Department-approved EMS System Program Plan.

Associate Hospital EMS Medical Director – the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the EMS System, in accordance with the Department-approved EMS System Program Plan.

Basic Emergency Department – a classification of a hospital emergency department where at least one physician is available in the emergency department at all times; physician specialists are available in minutes; and ancillary services, including laboratory, x-ray and pharmacy, are

staffed or are "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Basic Life Support or BLS Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes medical monitoring, clinical observation, airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in the National EMS Education Standards relating to Basic Life Support and any modifications to that curriculum or standards specified in this Part. (Section 3.10(c) of the Act)

Board Eligible in Emergency Medicine – completion of a residency in Emergency Medicine in a program approved by the Residency Review Committee for Emergency Medicine or the Council on Postdoctoral Training (COPT) for the American Osteopathic Association (AOA).

Continuing Education or CE – Ongoing emergency medical education after licensure that is designated to maintain, update or upgrade medical knowledge and skills.

Certified Registered Nurse Anesthetist or CRNA – a licensed Registered Professional Nurse who has had additional education beyond the Registered Professional Nurse requirements at a school/program accredited by the National Council on Accreditation; who has passed the certifying exam given by the National Council on Certification; and who, by participating in 40 hours of continuing education every two years, has been recertified by the National Council on Recertification.

Child Abuse and Neglect – see the definitions of "abused child" and "neglected child" in Section 3 of the Abused and Neglected Child Reporting Act.

Child Life Specialist – A person whose primary role is to minimize the adverse effects of children's experiences by facilitating coping and the psychosocial adjustment of children and their families through the continuum of care.

Clinical Observation – ongoing observation of a patient's condition by a licensed health care professional utilizing a medical skill set while continuing assessment and care. (Section 3.5 of the Act)

Comprehensive Emergency Department – a classification of a hospital emergency department where at least one licensed physician is available in the emergency department at all times; physician specialists shall be available in minutes; ancillary services, including laboratory and x-ray, are staffed at all times; and the pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Comprehensive Stroke Center or CSC – a hospital that has been certified and has been designated as a Comprehensive Stroke Center under Subpart K. (Section 3.116 of the Act)

CPR for Healthcare Providers – a course in cardiopulmonary resuscitation that meets or exceeds the American Heart Association course "BLS for Healthcare Providers".

Critical Care Transport or CCT or Specialty Care Transport or SCT – pre-hospital or inter-hospital transportation of a critically injured or ill patient by a vehicle service provider, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the Paramedic. When medically indicated for a patient, as determined by a physician licensed to practice medicine in all of its branches, an Advanced Practice Nurse , or a physician assistant, in compliance with subsections (b) and (c) of Section 3.155 of the Act.(Section 3.10(f-5).

Department or IDPH – the Illinois Department of Public Health. (Section 3.5 of the Act)

Director – the Director of the Illinois Department of Public Health or his/her designee. (Section 3.5 of the Act)

Door-to-_____ − The time from patient arrival at the health care facility until the specified result, procedure or intervention occurs.

Dysrhythmia – a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

Electrocardiogram or EKG – a single lead graphic recording of the electrical activity of the heart by a series of deflections that represent certain components of the cardiac cycle.

Emergency – a medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Communications Registered Nurse or ECRN – a Registered Professional Nurse licensed under the Nurse Practice Act who has successfully completed supplemental education in accordance with this Part and who is approved by an EMS Medical Director to monitor telecommunications from and give voice orders to EMS System personnel, under the authority of the EMS Medical Director and in accordance with System protocols. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Emergency Department Approved for Pediatrics or EDAP – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.4000 of this Part as being capable of providing optimal emergency department care to pediatric patients 24 hours per day.

Emergency Medical Dispatch Priority Reference System or EMDPRS – an EMS System's organized approach to the receipt, management and disposition of a request for emergency medical services.

Emergency Medical Dispatcher or EMD – a person who has successfully completed a training course in emergency medical dispatching in accordance with this Part, who accepts calls from the public for emergency medical services and dispatches designated emergency medical services personnel and vehicles. (Section 3.70 of the Act)

Emergency Medical Responder or EMR (AKA First Responder) – a person who has successfully completed a course of instruction for the Emergency Medical Responder as approved by the Department, who provides Emergency Medical Responder services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the National EMS Educational Standards for Emergency Medical Responders as modified by the Department.

Emergency Medical Responder Services – a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the Emergency Medical Responder (EMR) curriculum of the National EMS Education standards and any modifications to that curriculum (standards) specified in this Part. (Section 3.10(d) of the Act)

Emergency Medical Services Personnel or EMS Personnel – persons licensed as an Emergency Medical Responder (EMR) (First Responder), Emergency Medical Dispatcher (EMD), Emergency Medical Technician (EMT), Emergency Medical Technician-Intermediate (EMT-I), Advanced Emergency Medical Technician (A-EMT), Paramedic, Emergency Communications Registered Nurse (ECRN), or Pre-Hospital Registered Nurse (PHRN). (Section 3.5 or the Act)

Emergency Medical Services System or EMS System or System – an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System Program Plan submitted to and approved by the Department, and pursuant to the EMS Region Plan adopted for the EMS Region in which the System is located. (Section 3.20(a) of the Act)

Emergency Medical Services System Survey – a questionnaire that provides data to the Department for the purpose of compiling annual reports.

Emergency Medical Technician or EMT (AKA EMT-B) – a person who has successfully completed a course in basic life support as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an EMS System. (Section 3.50(a) of the Act)

Emergency Medical Technician-Coal Miner – for purposes of the Coal Mine Medical Emergencies Act, an EMT, A-EMT, EMT-I or Paramedic who has received additional education emphasizing extrication from a coal mine.

Emergency Medical Technician-Intermediate or EMT-I – a person who has successfully completed a course in intermediate life support as approved by the Department, is currently licensed by the Department in accordance with the standards prescribed in this Part and practices within an Intermediate or Advanced Life Support EMS System. (Section 3.50(b) of the Act)

Emergent Stroke Care – emergency medical care that includes diagnosis and emergency medical treatment of suspected or known acute stroke patients. (Section 3.116 of the Act)

Emergent Stroke Ready Hospital – a hospital that has been designated by the Department as meeting the criteria for providing emergent stroke care as set forth in the Act and Section 515.5060. (Section 3.116 of the Act)

EMS – emergency medical services.

EMS Administrative Director – the administrator, appointed by the Resource Hospital in consultation with the EMS Medical Director, in accordance with this Part, responsible for the administration of the EMS System. (Section 3.35 of the Act)

EMSC – Emergency Medical Services for Children.

EMS Lead Instructor or LI – a person who has successfully completed a course of education as approved by the Department in this Part, and who is currently approved by the Department to coordinate or teach education, training and continuing education courses, in accordance with this Part. (Section 3.65(a) of the Act)

EMS Medical Director or EMS MD – the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

EMS Regional Plan – a plan established by the EMS Medical Director's Committee in accordance with Section 3.30 of the Act.

EMS System Coordinator – an individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System program.

EMS System Program Plan – the document prepared by the Resource Hospital and approved by the Department that describes the EMS System program and directs the program's operation.

Fixed-Wing Aircraft – an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

Full-Time – on duty a minimum of 36 hours a week.

Half-Duplex Communications – a radio or device that transmits and receives signals in only one direction at a time.

Health Care Facility – a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed. It does not include "pre-hospital emergency care settings" that utilize EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle, as defined in the Act and this Part. (Section 3.5 of the Act)

Helicopter or Rotorcraft – an aircraft that is capable of vertical take offs and landings, including maintaining a hover.

Helicopter Shopping − the practice of calling various operators until a helicopter emergency medical services (HEMS) operator agrees to take a flight assignment, without sharing with subsequent operators that the previously called operators declined the flight, or the reasons why the flight was declined.

Hospital – has the meaning ascribed to that term in Section 3 of the Hospital Licensing Act. (Section 3.5 of the Act)

Hospitalist – a physician who primarily provides unit-based/in-hospital services.

In-Field Service Level Upgrade – a practice that allows the delivery of advanced care from a lower level service provider by a licensed higher level of care ambulance, alternate response

vehicle, or specialized emergency medical services vehicle according to a pre-approved written plan approved by the local EMS Medical Director.

Instrument Flight Rules or IFR – the operation of an aircraft in weather minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

Instrument Meteorological Conditions or IMC – meteorological conditions expressed in terms of visibility, distance from clouds and ceiling, which require Instrument Flight Rules.

Intermediate Life Support Services or ILS Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes basic life support care plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support national curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Level I Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2030 to provide optimal care to trauma patients and to provide all essential services in-house, 24 hours per day.

Level II Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2040 to provide optimal care to trauma patients, to provide some essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day.

Licensee – an individual or entity to which the Department has issued a license.

Limited Operation Vehicle – a vehicle which is licensed by the Department to provide basic, intermediate or advanced life support emergency or non-emergency medical services that are exclusively limited to specific events or locales. (Section 3.85 of the Act)

Local System Review Board – a group established by the Resource Hospital to hear appeals from EMS Personnel or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

Medical Monitoring – the performance of medical tests and physical exams to evaluate an individual's on-going exposure to a factor that could negatively impact that person's health. This includes close surveillance or supervision of patient's liable to suffer deterioration in physical or mental health and checks of various parameters such as pulse rate, temperature, respiration rate,

the condition of the pupils, the level of consciousness and awareness, the degree of appreciation of pain, and blood gas concentrations such as oxygen and carbon dioxide. (Section 3.5 of the Act)

Mobile Radio – a two-way radio installed in an EMS vehicle, which may not be readily removed.

Morbidity – a negative outcome that is the result of the original medical or trauma condition or treatment rendered or omitted.

911 – an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone or mobile device to obtain emergency services, including police, fire, medical ambulance and rescue.

Non-emergency Medical Care – medical care, clinical observation, or medical monitoring rendered to patients whose conditions do not meet the Act's definition of emergency, before or during transportation of such patients to or from health care facilities visited for the purpose of obtaining medical or health care services that are not emergency in nature, using a vehicle regulated by the Act and this Part. (Section 3.10(g) of the Act)

Nurse Practitioner – a person who is licensed as a Nurse Practitioner under the Nurse Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Off-Road Specialized Emergency Medical Services Vehicle or Off-Road SEMSV or Off-Road SEMS Vehicle – a motorized cart, golf cart, all-terrain vehicle (ATV), or amphibious vehicle that is not intended for use on public roads.

Paramedic or EMT-P – a person who has successfully completed a course in advanced life support care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)

Participating Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital.

Pediatric Critical Care Center or PCCC – a hospital participating in an approved EMS System and designated by the Department as being capable of providing optimal critical and specialty care services to pediatric patients, and of providing all essential services either in-house or readily available 24 hours per day.

Pediatric Patient – patient from birth through 15 years of age.

Physician – any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Physician Assistant – a person who is licensed under the Physician Assistant Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Pilot or EMS Pilot – a pilot certified by the Federal Aviation Administration who has been approved by an SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program.

Practitioner Order for Life-Sustaining Treatment on POLST or Do Not Resuscitate or DNR – an authorized practitioner order that reflects an individual's wishes about receiving cardiopulmonary resuscitation (CPR) and life-sustaining treatments, including medical interventions and artificially administered nutrition.

Pre-Hospital Care – those medical services rendered to patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to healthcare facilities. (Section 3.10(e) of the Act)

Pre-Hospital Care Participants – Any EMS Personnel, Ambulance Service Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS Administrative Director, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN, Resource Hospital, Emergency Dispatch Center or physician serving on an ambulance or non-transport vehicle or giving voice orders for an EMS System and who are subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Pre-Hospital Registered Nurse or PHRN – a Registered Professional Nurse, with an unencumbered Registered Nurse license in the state in which he or she practices who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric

programs, the professional shall have an unencumbered license in the state in which he or she practices.

Primary Stroke Center or PSC – a hospital that has been certified by a Department-approved, nationally recognized certifying body and designated as a Primary Stroke Center by the Department. (Section 3.116 of the Act)

Provisional EMR – a person who is at least 16 years of age, who has successfully completed a course of instruction for emergency medical responders as prescribed by the Department and passed the exam, and who functions within an approved EMS System pursuant to Section 515.715.

Regional EMS Advisory Committee – a committee formed within an Emergency Medical Services Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one individual from each level of license provided by the Act, one Pre-Hospital Registered Nurse practicing within the Region, and one Registered Professional Nurse currently practicing in an emergency department within the Region. Of the two administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee. (Section 3.25 of the Act)

Regional EMS Coordinator – the designee of the Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

Regional EMS Medical Directors Committee – a group comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For regions that include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis. (Section 3.25 of the Act)

Regional Stroke Advisory Subcommittee – a subcommittee formed within each Regional EMS Advisory Committee to advise the Director and the Region's EMS Medical Directors Committee on the triage, treatment, and transport of possible acute stroke patients and to select the Region's representative to the State Stroke Advisory Subcommittee. (Section 3.116 of the Act) The composition of the Subcommittee shall be as set forth in Section 3.116 of the Act.

Regional Trauma Advisory Committee – a committee formed within an Emergency Medical Services Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each trauma center within the Region, one EMS Medical Director from a Resource Hospital within the Region, one EMS System Coordinator from another Resource Hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each trauma center within the Region, one EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, or PHRN representing the highest level of EMS Personnel practicing within the Region, one emergency physician and one Trauma Nurse Specialist currently practicing in a trauma center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN – a person who is licensed as an RN under the Nurse Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.

Resource Hospital – the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire program, including the clinical aspects, operations and education programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

Rural Ambulance Service Provider – an ambulance service provider licensed under the Act that serves a rural population of 7,500 or fewer inhabitants. (Section 3.87(a) of the Act)

Rural In-Field Service Level Upgrade – a practice that allows the delivery of advanced care for a lower level service provider that serves a rural population of 7,500 or fewer inhabitants, through use of EMS System approved EMS personnel.

Rural Vehicle Service Provider – an entity that serves a rural population of 7,500 or fewer inhabitants and is licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act, this Part and an operational plan approved by the entity's

EMS System, utilizing at least an ambulance, alternate response vehicle as defined by the Department in this Part, or specialized emergency medical services vehicle. (Section 3.87(a) of the Act)

Screening – a preliminary procedure or assessment, such as a test or examination, to detect the most characteristic sign or signs of a disorder or condition that may require further investigation (for example, assessing for potential abuse or neglect through interview responses and behavioral/physical symptom clues).

SEMSV Medical Control Point or Medical Control Point – the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

SEMSV Medical Director or Medical Director – the physician appointed by the SEMSV Program who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part.

SEMSV Program or Specialized Emergency Medical Services Vehicle Program – a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, using specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

Special-Use Vehicle – any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated solely for, the emergency or non-emergency transportation of a specific medical class or category of persons who are sick, injured, wounded or otherwise incapacitated or helpless (e.g., high-risk obstetrical patients, neonatal patients). (Section 3.85 of the Act)

Specialized Emergency Medical Services Vehicle or SEMSV – a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads. (Section 3.85 of the Act) "Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (i.e., in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is used for the emergency transportation of the sick or injured;

The vehicle is advertised as a vehicle for the emergency transportation of the sick or injured;

The vehicle is owned, registered or licensed in another state and is used on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

Standby Emergency Department – a classification of a hospital emergency department where at least one of the Registered Nurses on duty in the hospital is available for emergency services at all times, and a licensed physician is "on-call" to the emergency department at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Standby Emergency Department Approved for Pediatrics or SEDP – a hospital participating in an approved EMS System and designated by the Department, pursuant to Section 515.4010, as being capable of providing optimal standby emergency department care to pediatric patients and to have transfer agreements and transfer mechanisms in place when more definitive pediatric care is needed.

State EMS Advisory Council – a group that advises the Department on the administration of the Act and this Part whose members are appointed in accordance with Section 3.200 of the Act.

Stretcher Van – a vehicle used by a licensed stretcher van provider to transport non-emergency passengers in accordance with the Act and this Part.

Stretcher Van Provider – an entity licensed by the Department to provide non-emergency transportation of passengers on a stretcher in compliance with the Act and this Part, utilizing stretcher vans. (Section 3.86 of the Act)

Stroke Network – a voluntary association of hospitals, including a hospital with a board eligible or board certified neurosurgeon or neurologist, that may, among other activities, share stroke protocols; provide medical consultations on possible or known acute stroke patients or on inter-facility transfers of possible or known acute stroke patients; or provide education specific to improving acute stroke care. Participating hospitals in a stroke network may be in-state or out-of-state.

Substantial Compliance – meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Substantial Failure – the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Sustained Hypotension – two systolic blood pressures of 90 mmHg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mmHg five minutes apart.

System Participation Suspension – the suspension from participation within an EMS System of an individual or individual provider, as specifically ordered by that System's EMS Medical Director.

Telecommunications Equipment – a communication system capable of transmitting and receiving voice and electrocardiogram (EKG) signals.

Telemetry – the transmission of data through a communication system to a receiving station for recording, interpretation and analysis.

Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Trauma Category I – a classification of trauma patients in accordance with Appendix C and Appendix F.

Trauma Category II – a classification of trauma patients in accordance with Appendix C and Appendix F.

Trauma Center – a hospital which: within designated capabilities provides optimal care to trauma patients; participates in an approved EMS System; and is duly designated pursuant to the provisions of the Act. (Section 3.90 of the Act)

Trauma Center Medical Director or Trauma Center MD – the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of patient care and trauma services at the Trauma Center. He or she must have 24-hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

Trauma Center Medical Directors Committee – a group composed of the Region's Trauma Center Medical Directors. (Section 3.25 of the Act)

Trauma Coordinator – a Registered Nurse working in conjunction with the Trauma Medical Director. The Trauma Coordinator is responsible for the organization of service and systems necessary for a multidisciplinary approach throughout the continuum of trauma care.

Trauma Nurse Specialist or TNS – a Registered Professional Nurse licensed under the Nurse Practice Act who has successfully completed supplemental education and testing requirements as prescribed by the Department, and is licensed in accordance with this Part. (Section 3.75 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.

Trauma Nurse Specialist Course Coordinator or TNSCC – a Registered Nurse appointed by the Chief Executive Officer of a hospital designated as a TNS education site, who meets the requirements of Section 515.750.

Trauma Service – an identified hospital surgical service in a Level I or Level II Trauma Center functioning under a designated trauma director in accordance with Sections 515.2030(c) and 515.2040(c).

Unit Identifier – a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

Vehicle Service Provider – an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act and this Part and an operational plan approved by its EMS Systems, utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV). (Section 3.85(a) of the Act)

Watercraft – a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.125 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:

1) Private and professional association standards:

A) Glasgow Coma Scale
Champion HR, Sacco WJ, Carnazzo AJ et al.:

CritCare Med 9(9): 672-676 (1981)

B) Revised Trauma Score, 1999
from Resources for the Optimal Care of the Injured Patient
American College of Surgeons
633 North Saint Clair Street
Chicago IL 60611-3211

C) Abbreviated Injury Score, 2005
American Association for the Advancement
of Automotive Medicine
Des Plaines IL 60008

D) Injury Severity Score
Baker SP, O'Neil B, Hadon W et al.:
Journal of Trauma 14: 187-196 (1974)

E) International Classification of Diseases,
9th Revision, Clinical Modification (ICD-9-CM)
Alphabetic Index to External Causes of Injury (E-Codes),
Second Printing (2010)
World Health Organization, Geneva, Switzerland and
National Center for Health Statistics
Published by Edwards Brothers, Inc. Ann Arbor MI

F) Resources for Optimal Care of the Injured Patient (2006)
American College of Surgeons
633 North Saint Clair Street
Chicago IL 60611-3211

G) Pediatric Advanced Life Support (PALS) (2011)
American Heart Association National Center
7272 Greenville Center
Dallas TX 75231

H) Advanced Cardiovascular Life Support (ACLS) Provider Manual (2010)
American Heart Association National Center
7272 Greenville Center
Dallas TX 75231

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Pediatric Education for Prehospital Professionals (PEPP) Third Edition Provider Manual (2015)
American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village IL 60007

J) International Trauma Life Support (ITLS) 8th Edition Provider Manual
ITLS-International Trauma Life Support
3000 Woodcreek Drive, Suite 200
Downers Grove IL 60515

K) Prehospital Trauma Life Support (PHTLS) 8th Edition Providers Manual
National Association of Emergency Medical Technicians (NAEMT)
P.O. Box 1400
Clinton MS 39060-1400

L) National Registry of Emergency Medical Technicians (NREMT) (2015): A nationally recognized corporation that certifies EMS Personnel: https://www.nremt.org/nremt/about/apply_for_assess_exam.asp

M) National Registry of Emergency Medical Technicians (NREMT) Cognitive Exam Retest Policy (2015): https://www.nremt.org/ nremt/about/policyCognitiveExamRetest. asp

N) National EMS Scope of Practice Model (2007): National Highway Traffic Safety Administration (NHTSA): http://www.ems.gov/ education/EMSScope.pdf

O) National Association of EMS State Officials (NASEMSO), National Model EMS Clinical Guidelines (2014): https:// www.nasemso.org/Projects/ModelEMSClinicalGuidelines/index.asp

P) National Guidelines for Educating EMS Instructors (2002), National Association of EMS Educators (NAEMSE): http:// naemse.org/?page=LVL1InstructorCourse

2) Federal government publications:

A) Federal Specifications for Ambulance, KKK-A-1822F (August 2007), United States General Services Administration, Specifications Section, 2200 Crystal Drive, Suite 1006, Arlington VA 22202

B) National Emergency Medical Services Education Standards: National Highway Traffic Safety Administration (NHSTA) DOT HS 811 077A; (2009):http://www.ems.gov/pdf/811077c.pdf

C) National Highway Traffic Safety Administration (NHSTA): National Emergency Medical Services Education Standards (2009): http://www.ems.gov/pdf/811077a.pdf

D) United States Department of Transportation, Emergency Medical Dispatcher: National Standard Curriculum (1996), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington DC 20402

E) The Federal Aviation Administration Type Certificate Data Sheet for a particular aircraft required crew can be found at http://www.faa.gov/aircfraft/

F) The Aeronautical Information Manual, Chapter 10 (2014, US Department of Transportation): https://www.faa.gov/air_traffic/ publications/media/aim_basic_4-03-14.pdf

3) Federal regulations:

A) 47 CFR 90 (October 15, 2012) − Private Land Mobile Radio Services

B) Air Taxi Operations and Commercial Operators (14 CFR 135 (January 1, 2009), Subparts A, Sections 135.1 through 135.43; B, Sections 135.61 through 135.125; C, Sections 135.141 through 135.185; D, Sections 135.201 through 135.229; E, Sections 135.241 through 135.247; F, Section 135.261; J, Sections 135.411 through 135.443)

C) 42 CFR 2A (October 1, 2009) − Confidentiality of Alcohol and Drug Abuse Patient Records

b) The following statutes and State regulations are referenced in this Part:

1) Federal statutes:

Federal Aviation Act of 1958, Sections 307 and 308 (P.L. 85-726, 72 USC 731)

2) State of Illinois statutes:

A) Hospital Emergency Services Act [210 ILCS 80]

B) Hospital Licensing Act [210 ILCS 85]

C) Medical Practice Act of 1987 [225 ILCS 60]

D) Nurse Practice Act [225 ILCS 65]

E) Medical Studies Act [735 ILCS 5/8-2101]

F) Emergency Telephone System Act [50 ILCS 750]

G) Boat Registration and Safety Act [625 ILCS 45]

H) Open Meetings Act [5 ILCS 120]

I) Illinois Administrative Procedure Act [5 ILCS 100]

J) Head and Spinal Cord Injury Act [410 ILCS 515]

K) Freedom of Information Act [5 ILCS 140]

L) State Records Act [5 ILCS 160]

M) Coal Mine Medical Emergencies Act [410 ILCS 15]

N) Abused and Neglected Child Reporting Act [325 ILCS 5]

O) Illinois Grant Funds Recovery Act [30 ILCS 705]

3) State of Illinois regulations:

A) Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

B) Hospital Licensing Requirements (77 Ill. Adm. Code 250)

C) Aviation Safety (92 Ill. Adm. Code 14.790, 14.792, 14.795)

c) National Emergency Medical Services Information System (NEMSIS) Version 3 Prehospital Dataset, January 28, 2016, available at: http://www.dph.illinois.gov/sites/default/files/resources/Illinois-NEMSIS-v3-Datset-012816.pdf

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.150 Waiver Provisions

a) The Department may grant a waiver to any provision of the Act or this Part for a specified period of time determined appropriate by the Department. The Department may grant a waiver when it can be demonstrated that there will be no reduction in standards of medical care as determined by the EMS MD or the Department. (Section 3.185 of the Act) Waivers shall be valid only for the length of time determined by the Department (see subsection (f)). For either a single or multiple waiver request, the burden of proof as to the factual basis supporting any waiver shall be on the applicant.

b) Any entity may apply in writing to the Department for a waiver to specific requirements or standards for which it considers compliance to be a hardship. (Section 3.185 of the Act) The application shall contain the following information:

1) The applicant's name, address, and license number (if applicable);

2) The Section of the Act or this Part for which the waiver is being sought;

3) An explanation of why the applicant considers compliance with the Section to be a unique hardship, including:

A) A description of how the applicant has attempted to comply with the Section;

B) The reasons for non-compliance; and

C) A detailed plan for achieving compliance. The detailed plan shall include specific timetables;

4) The period of time for which the waiver is being sought;

5) An explanation of how the waiver will not reduce the quality of medical care established by the Act and this Part; and

6) If the applicant is a System Participant, the applicant's EMS MD shall state in writing whether he or she recommends or opposes the application for waiver, the reason for the recommendation or opposition, and how the waiver will or will not reduce the quality of medical care established by the Act and this Part. The applicant shall submit the EMS MD's statements along with the application for waiver. If the EMS MD does not provide written statements within

30 days after the applicant's request, the EMS MD will be determined to be in support of the application, and the application may be submitted to the Department.

c) An EMS MD may apply to the Department for a waiver on behalf of a System Participant by submitting an application that contains all of the information required by subsection (b), along with a statement signed by the System Participant requesting or authorizing the EMS MD to make the application.

d) The Department will grant the requested waiver if it finds the following:

1) The waiver will not reduce the quality of medical care established by the Act and this Part;

2) Full compliance with the statutory or regulatory requirement at issue is or would be a unique hardship on the applicant;

3) For EMS Personnel seeking a waiver to extend a relicensure date in order to complete relicensure requirements:

A) The EMS Personnel has previously received no more than one extension since his or her last relicensure; and

B) The EMS Personnel has not established a pattern of seeking extensions (e.g., waivers sought based on the same type of hardship in two or more previous license periods);

4) For an applicant other than EMS Personnel:

A) The applicant has previously received no more than one waiver of the same statutory or regulatory requirement during the current license or designation period;

B) The applicant has not established a pattern of seeking waivers of the same statutory or regulatory requirement during previous license or designation period; and

C) The Department finds that the hardship preventing compliance with the particular statutory or regulatory requirement is unique and not of an ongoing nature;

5) For a hospital requesting a waiver to participate in a System other than that in which the hospital is geographically located:

A) Documentation that transfer patterns support the request; and

B) Historic patterns of patient referrals support the request.

e) When granting a waiver, the Department will specify the statutory or regulatory requirement that is being waived, any alternate requirement that the waiver applicant shall meet, and any procedures or timetable that the waiver applicant shall follow to achieve compliance with the waived requirement.

f) The Department will determine the length of any waiver that it grants, based on the nature and extent of the hardship and will consider the medical needs of the community or areas in which the waiver applicant functions.

g) The Department will grant a waiver of Section 515.830(a)(1) for a vehicle that changes ownership if the vehicle meets the requirements of the U.S. General Services Administration's "Specifications for Ambulance" (KKK-A-1822D or KKK-A-1822E).

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.190 Felony Convictions

a) Applicants and licensees convicted of an Illinois Class X, Class 1 or Class 2 felony or an out-of-state equivalent offense shall be subject to adverse licensure actions under Section 3.50(d)(8) of the Act. In determining whether an applicant or licensee has been convicted of an out-of-state equivalent offense under Section 3.50(d)(8)(H) of the Act, the Department shall look to the essential elements of the out-of-state offense to determine whether that conviction is substantially equivalent to an Illinois Class X, Class 1 or Class 2 felony. The fact that the out-of-state offense may be named or classified differently by another state, territory or country shall not be considered in determining whether the out-of-state offense is equivalent. The controlling factor shall be whether the essential elements of the out-of-state offense are substantially equivalent to the essential elements of an Illinois Class X, Class 1 or Class 2 felony (Section 3.50(d) of the Act).

b) All applicants for any license, permit or certification under the Act shall fully disclose any and all felony convictions in writing to the Department at the time of initial application or renewal. Failure to disclose all felony convictions on an application submitted to the Department shall be grounds for license denial or revocation.

c) All licensees and certificate and permit holders under the Act shall report all new felony convictions to the Department within seven days after conviction. Convictions shall be reported by means of a letter to the Department.

d) For applicants with a Class X, Class 1 or Class 2 felony or an out-of-state equivalent offense (Section 3.50(d) of the Act), the Department shall have the authority to require that the applicant sign an authorization permitting the Department to obtain a criminal history report from the Illinois State Police or other law enforcement agency at the applicant's cost. The failure or refusal of any felony applicant to provide the authorization and fee required by the applicable law enforcement agency shall be grounds for denial of licensure, including renewal.

e) In deciding whether to issue any license to a person with a felony conviction under Section 3.50(d) of the Act, the Department shall consider the degree to which the applicant's criminal history suggests that the applicant may present a risk to patients. Factors to be considered shall include, but not be limited to:

1) The length of time since the conviction and the severity of the penalty imposed;

2) Whether the conviction involved theft, deception or infliction of intentional, unjustified harm to others;

3) Whether there are repeat or multiple convictions or whether the convictions suggest a particular pattern of overall disregard for the safety or property of others;

4) Whether the conviction suggests a propensity that may pose a threat to the public in stressful situations commonly confronted by EMS providers and EMRs;

5) The degree to which the applicant provided full, complete and accurate information upon written request of the Department; and

6) Other unusual facts and circumstances that strongly suggest that the applicant should not be granted a license.

f) The Department may request and the applicant shall provide all additional information relevant to the applicant's history and the factors listed in subsection (e). The Department shall deny any application when the applicant fails or refuses to provide additional relevant information requested by the Department, including, but not limited to, providing the written authorization and fee for a police criminal background check.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART B: EMS REGIONS

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.220 EMS Regional Plan Content

a) The EMS Medical Directors Committee portion of the Regional Plan shall address at least the following (Section 3.30(a) of the Act):

1) Protocols for inter-System/inter-Region patient transports, including protocols for pediatric patients and pediatric patients with special health care needs, identifying the conditions of emergency patients that may not be transported to the different levels of emergency department, based on the emergency department classifications and relevant Regional considerations (e.g., transport times and distances);

2) Regional standing medical orders;

3) Patient transfer patterns, including criteria for determining whether a patient needs the specialized service of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;

4) Protocols for resolving regional or inter-System conflict;

5) An EMS disaster preparedness plan which includes the actions and responsibilities of all EMS participants within the Region for care and transport of both the adult and pediatric population;

6) Regional standardization of CE requirements;

7) Regional standardization of Do Not Resuscitate (DNR) and Practitioner Orders for Life-Sustaining Treatment (POLST) policies, and protocols for power of attorney for health care;

8) Protocols for disbursement of Department grants (Section 3.30(a)(1-8) of the Act);

9) Protocols for the triage, treatment, and transport of possible acute stroke patients developed jointly with the Regional Stroke Advisory Subcommittee (Section 3.30(a)(9) of the Act). Regional Stroke Data will be considered as it becomes available regarding development of stroke transport protocols;

10) Regional standing medical orders shall include the administration of opioid antagonists. (Section 3.30(a)(10) of the Act);

11) Protocols for stroke screening;

12) Development of protocols to improve and integrate EMS for children (or EMSC) into the current delivery of emergency services within the Region; and

13) Development of a policy in regard to incidents involving school buses, which shall include, but not be limited to:

A) Assessment of the incident, including mechanism and extent of damage to the vehicle;

B) Passenger assessment/extent of injuries;

C) A provision for transporting all children with special healthcare needs and those with communication difficulties;

D) Age specific issues; and

E) Use of a release form for non-transports.

b) The Trauma Center Medical Directors or Trauma Center Medical Directors Committee portion of the Regional Plan shall address at least the following:

1) The identification of regional trauma centers and identification of trauma centers that specialize in pediatrics;

2) Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional considerations (e.g., transport times and distances);

3) Regional trauma standing medical orders;

4) Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal (These policies must include the criteria of Appendix C.);

5) The identification of which types of patients can be cared for by Level I and Level II Trauma Centers;

6) Criteria for inter-hospital transfer of trauma patients, including the transfer of pediatric patients;

7) The treatment of trauma patients in each trauma center within the Region;

8) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients. (Section 3.30(b)(1-9) of the Act)

A) This shall include but not be limited to all cases that have been deemed potentially preventable or preventable in the trauma center review using Resources for Optimal Care of the Injured Patient. This review should exclude trauma patients who were dead on arrival.

B) In addition, the review shall include all patients who were transferred more than two hours after time of arrival at the initial institution and who meet one or more of the following criteria at the receiving trauma center:

i) Admitted to an intensive care unit;

ii) Admitted to a bed with telemetry monitoring;

iii) Went directly to the operating room;

iv) Went to the operating room from the emergency department;

v) Discharged to a rehabilitation or skilled care facility;

vi) Died following arrival.

C) The Region shall include a review of morbidity/audit filters that have been determined by the Region.

D) Cumulative regional reports will be made available upon request from the Department; and

9) The establishment of a regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, that shall perform periodic medical audits of each

trauma center's trauma services, and forward tabulated data from those reviews to the Department. (Section 3.30(b)(9) of the Act)

c) The Regional Stroke Advisory Subcommittee portion of the Region Plan shall address at least the following:

1) The identification of Comprehensive Stroke Centers, Primary Stroke Centers, Acute Stroke-Ready Hospitals and Emergent Stroke Ready Hospitals and their incorporation in the Region Plan and the System Program Plan;

2) In conjunction with the EMS Medical Directors, development of protocols for identifying and transporting acute stroke patients to the nearest appropriate facility capable of providing acute stroke care. These protocols shall be consistent with individual System bypass or diversion protocols and protocols for patient choice;

3) Regional stroke transport protocols recommended by the Regional Stroke Advisory Subcommittee and approved by the EMS Medical Directors Committee; and

4) With the EMS Medical Directors, joint development of acute stroke patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, along with protocols for the bypassing of, or diversion to, any hospital, that are consistent with individual inter-system bypass or diversion protocols and protocols for patient choice or refusal.

d) The Director shall coordinate with and assist the EMS System Medical Directors and Regional Stroke Advisory Subcommittee within each EMS Region to establish protocols related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible acute stroke patients to the most appropriate Comprehensive Stroke Center, Primary Stroke Center or Acute Stroke-Ready Hospital, unless circumstances warrant otherwise. (Section 3.118.5(f) of the Act)

e) The Region's EMS Medical Directors and Trauma Center Medical Directors Committees shall appoint any subcommittees that they deem necessary to address specific issues concerning Region activities. (Section 3.30(c) of the Act)

f) Internal Disaster Plans

1) Each System hospital shall submit an internal disaster plan to the EMS Medical Directors Committee and the Trauma Center Medical Directors Committee.

2) The hospital internal disaster plan shall be coordinated with, or a part of, the hospital's overall disaster plan.

3) The plan shall be coordinated with local and State disaster plans.

4) The hospital internal disaster plan shall be developed by a hospital committee and shall at a minimum:

A) Identify the authority to implement the internal disaster plan, including the chain of command and how notification shall be made throughout the hospital;

B) Identify the critical operational elements required in the hospital in an internal disaster;

C) If the facility needs to go on bypass or resource limitation status, identify the person responsible for notification and the persons both outside and within the hospital who should be notified;

D) Identify a person or group responsible for ensuring that needed resources and supplies are available;

E) Identify a person to communicate with representatives from other agencies, organizations, and the EMS System;

F) Identify a person who is responsible for procuring all supplies required to manage the facility and return the facility to the pre incident status;

G) Identify the plan and procedure for educating facility employees on their role and responsibilities during the disaster;

H) Designate a media spokesperson;

I) Establish a method for resource coordination between departments and individuals to address management of staff, patients and patient flow patterns;

J) Designate a person (safety officer) with responsibility for establishing safety policies to include, but not be limited to, decontamination operations, safety zones, site safety plans, evacuation parameters, and traffic patterns;

K) Designate a location where personnel, not actually committed to the incident, will report for assignments, as needed (i.e., a staging area);

L) Include notification procedures to EMS Systems, area ambulances, both public and private, and police and fire authorities of the type of incident that caused the hospital to implement its internal disaster plan and of any special instructions, e.g., use of a different driveway or entrance;

M) Establish a designated form of communication, both internal and external, to maintain two-way communication (e.g., Mobile Emergency Communications of Illinois (MERCI), ham radio, walkie talkies);

N) Include a policy to call in additional nursing staff when an identified staffing shortage exists;

O) Include the policy developed pursuant to Section 515.315(f);

P) Include contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to a power failure (Section 3.30 of the Act); and

Q) Address biological and chemical incidents and the availability of decontamination.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART C: EMS SYSTEMS

Section 515.310 Approval and Renewal of EMS Systems

a) All applicants for EMS System approval shall submit to the Department one copy of a written EMS System Program Plan in a format approved by the Department that complies with Section 515.330 and is authorized by the EMS MD.

1) The Plan shall clearly identify any portion or item that is not expected to be fully operational by the date of Department approval, and shall specify the expected date for full operation of such portion or item, which shall not exceed one year after Department approval has been issued.

2) The Department will expect all portions of the proposed Plan to be fully operational upon Department approval unless otherwise identified pursuant to this Section.

b) The Department will review a submitted Program Plan and notify the applicant of any corrections that must be submitted in order to complete the Plan. The Department will also require the applicant to submit a formal waiver request for any item or portion identified as having a delayed operational date, if the Department finds that:

1) The item or length of operational delay has not previously been authorized by the Department for other EMS Systems;

2) The delay would appear to prevent the System from operating in substantial compliance with the Act or this Part upon approval; or

3) The delay would appear potentially to reduce the quality of medical/EMS care established by the Act and this Part.

c) The Department will conduct an on-site inspection of the applicant Resource Hospital within 90 days after a Program Plan has been accepted as complete.

d) The Department will issue a letter of approval to the applicant EMS System if the inspection indicates compliance with the approved Program Plan, the Act and this Part. The letter will indicate the level or levels of service that the System is authorized to provide (CCT, ALS, ILS, BLS).

e) A System approval shall be valid for a period of four years, except as allowed in subsection (l).

f) A System seeking renewal of approval shall submit a written request to the Department at least 90 days prior to its renewal date. The request shall include any proposed revisions to the Program Plan and updates of all letters of commitment required by Section 515.330.

g) The Department will review the request for renewal and notify the System of any corrections that must be submitted to complete the update of the Program Plan.

h) The Department will conduct an on-site renewal inspection of the Resource Hospital during each four-year approval period, and will conduct additional inspections of any System hospital or vehicle provider as necessary to ensure compliance with the Program Plan, the Act and this Part.

i) The Department will issue a letter of renewal approval to the EMS System if the Program Plan is complete, the inspection indicated substantial compliance with the approved Program Plan, the Act and this Part, and there is no Department legal action pending against the System. The letter will indicate the level or levels of service that the System is authorized to provide (CCT, ALS, ILS, BLS).

j) An approved EMS System shall amend its Program Plan by submitting to the Department the portion or Section in which the change is proposed, along with a letter authorized by the EMS MD that describes the reason or reasons for the change. The amendment shall not be implemented until approval has been granted by the Department.

k) Changes in any of the following shall be considered modifications of a System Program Plan requiring submission of a proposed amendment:

1) EMS MD;

2) Resource, Associate or Participating Hospital, or their specific roles;

3) System service area;

4) Written standing orders and policies;

5) Method or methods of providing EMS services;

6) Additional vehicle service providers, or changes in their levels of service, specific roles or response areas;

7) Access and dispatch procedures and mechanisms;

8) Communications plan;

9) Equipment and drug requirements;

10) Education, continuing education and/or examination requirements;

11) Quality assurance policies;

12) Data collection and evaluation policies;

13) Override or bypass/diversion policies;

14) Disciplinary or suspension policies or procedures.

l) All EMS Systems shall submit to the Department a revised Program Plan that conforms to the requirements of this Part. The Department will approve Program Plans that meet the requirements of this Part and will establish renewal dates for EMS System approval.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.320 Scope of EMS Service

a) All BLS, ILS), and ALS services, and CCT, as defined in the Act, shall be provided through EMS Systems. An individual System shall operate at one or more of those levels of service, as specified in its Program Plan and the Department's letter of approval, using vehicles licensed by the Department pursuant to the Act and this Part.

b) All pre-hospital, inter-hospital and non-emergency medical care, as defined in the Act, shall be provided through EMS Systems, using the levels of Department licensed or approved personnel required by the Act and this Part.

c) An EMS System shall designate a Resource Hospital, which shall have the authority and responsibility for the System, through the EMS MD, as described in the Act, this Part and the System Program Plan.

d) All other hospitals that are located within the geographic boundaries of a System and that have standby, basic or comprehensive level emergency departments must function in that System as either an Associate Hospital or Participating Hospital and follow all System policies specified in the System Program Plan, including, but not limited to, the replacement of drugs and equipment used by providers who have delivered patients to their emergency departments. (Section 3.20(b) of the Act)

1) All hospitals shall be formally affiliated with a System. A hospital may have a secondary affiliation with another System or may request a waiver to participate in a System other than that in which the hospital is geographically located. (See Section 515.150(d)(5).)

2) Every System Hospital shall identify the level of its emergency department services in its letter of commitment, which is part of the EMS System Program Plan to be submitted to the Department.

3) An "Associate Hospital" shall provide the same clinical and communications services as the Resource Hospital, but shall not have the primary responsibility for personnel education and System operations. It shall have a basic or comprehensive emergency department with 24-hour physician coverage and a functioning intensive care and/or cardiac care unit.

4) All "Participating Hospitals" shall maintain ambulance to hospital communications capabilities that, at a minimum, include MERCI radio and comply with the Resource Hospital's communication plan.

5) All System Hospitals shall agree to replace medical supplies and provide for equipment exchange for System vehicles.

6) All Resource and Associate Hospitals monitoring telecommunications from EMS field personnel shall provide voice orders by the EMS MD, a physician appointed by the EMS MD, or an ECRN.

7) All System Hospitals shall allow the Department, EMS MD and EMS System Coordinator access to all records, equipment, vehicles and personnel during their activities evaluating the Act and this Part.

e) The Resource Hospital shall appoint an EMS MD. The EMS MD for an ILS or ALS or CCT level EMS System shall be a physician licensed to practice medicine in all of its branches in Illinois, and shall be certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, and, for a BLS level EMS System, the EMS MD shall be a physician licensed to practice medicine in all of its branches in Illinois, with regular and frequent involvement in pre-hospital emergency medical services. In addition, all EMS MDs shall:

1) Have experience on an EMS vehicle at the highest level available within the System, or make provision to gain such experience within 12 months prior to the date responsibility for the System is assumed or within 90 days after assuming the position;

2) Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS Personnel within the System; and

3) Have or make provision to gain experience instructing students at a level similar to that of the levels of EMS Personnel within the System; and

4) For ILS and ALS EMS MDs, successfully complete a Department-approved EMS MD's Course. (Section 3.20(c)(1 through 6) of the Act)

f) The EMS MD shall appoint an alternate EMS MD and establish a written protocol addressing the functions to be carried out in his or her absence. (Section 3.35(b) of the Act)

g) An EMS System utilizing SEMSVs shall appoint and approve SEMSV Medical Directors to manage and direct the use of SEMSVs and their personnel within the System. He or she shall be a physician who has met at least the following qualifications:

1) One or more of the following:

A) Certified by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) through the American Osteopathic Association (AOA);

B) Completion of a residency in emergency or osteopathic emergency medicine as prescribed by one of the Boards listed in subsection (g)(1)(A); or

C) Completion of a 12-month internship followed by 60 months plus 7,000 hours of hospital based emergency or osteopathic emergency medicine (2,800 of the 7,000 hours must be completed within one 24-month period), and documentation of 50 hours of related continuing education for each complete year of practice; and

2) Completion of advanced cardiac life support and advanced trauma life support courses;

3) For aircraft programs, completion of education covering inflight treatment modalities, altitude physiology, and infection; and

4) For watercraft programs, completion of education covering diving accident physiology and treatment and drowning in cold, warm, fresh and salt water.

h) The Resource Hospital shall appoint a full-time EMS System Coordinator, who shall be responsible for coordinating the educational and functional aspects of the System, as described in the Program Plan. He or she shall be an RN or Paramedic licensed in the State of Illinois, and meet at least the following qualifications:

1) Be educated and knowledgeable in all principles of the National EMS Education Standards;

2) Have a diverse background in emergency care. For EMS Systems with CCT program plans, the System Coordinator shall have knowledge of or obtain education regarding critical care standards within six months; and

3) Within one year after being appointed, complete in-field observation and/or participation on at least 10 ambulance runs at the highest level of service provided by the System.

i) The Resource Hospital shall appoint an EMS Administrative Director, who shall be responsible for administrative leadership of the System as described in the Program Plan.

j) To avoid any conflict of interest, the EMS MD, EMS System Coordinator and EMS Administrative Director shall notify the Department in writing of any association with an ambulance service provider through employment, contract, ownership, or otherwise specifying how he or she is answerable to or directed by the ambulance service provider concerning any matter falling within the scope of the Act or this Part. The Department shall review and address potential or actual conflicts of interest on a case-by-case basis.

k) The Resource Hospital must identify the EMS System in the facility's budget, with sufficient funds to support the EMS MD, EMS Administrative Director, EMS System Coordinator, and support staff and to provide for the operation of the EMS System.

l) All EMS Resource Hospitals shall obtain recognition as an SEDP, EDAP or PCCC. All Illinois hospitals are encouraged to obtain and maintain SEDP or EDAP status.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.330 EMS System Program Plan

An EMS System Program Plan shall contain the following information:

a) The name, address and fax number of the Resource Hospital;

b) The names and resumes of the following persons:

1) The EMS MD;

2) The Alternate EMS MD;

3) The EMS Administrative Director;

4) The EMS System Coordinator;

c) The name, address and fax number of each Associate or Participating Hospital (see subsection (i));

d) The name and address of each ambulance provider participating within the EMS System;

e) A map of the EMS System's service area indicating the location of all hospitals and ambulance providers participating in the System;

f) Current letters of commitment from the following persons at the Resource Hospital that describe the commitment of the writer and his or her office to the development and ongoing operation of the EMS System, and that state the writer's understanding of and commitment to any necessary changes, such as emergency department staffing and educational requirements:

1) The Chief Executive Officer of the hospital;

2) The Chief of the Medical Staff; and

3) The Director of the Nursing Services;

g) A letter of commitment from the EMS MD that describes the EMS MD's agreement to:

1) Be responsible for the ongoing education of all System personnel, including didactic and clinical experience;

2) Develop and authorize written standing orders (treatment protocols, standard operating procedures) and certify that all involved personnel will be knowledgeable and competent in emergency care;

3) Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;

4) Develop or approve one or more patient care reports covering all types of patient care responses performed by System providers;

5) Ensure that the Department has access to all records, equipment and vehicles under the authority of the EMS MD during any Department inspection, investigation or site survey;

6) Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;

7) Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;

8) Direct the applicant to the IDPH EMS website for access to an independent renewal form for EMS Personnel within the System who have not been recommended for relicensure by the EMS MD; and

9) Be responsible for compliance with the provisions of Sections 515.400 and 515.410;

h) A description of the method of providing EMS services, which includes:

1) Single vehicle response and transport;

2) Dual vehicle response;

3) Level of first response vehicle;

4) Level of transport vehicle;

5) A policy that describes in-field service level upgrade, using advanced level EMS vehicle service providers;

6) A policy that describes ambulance service provider and vehicle service provider upgrade – rural population (optional);

7) Use of mutual aid agreements; and

8) Informing the caller requesting an emergency vehicle of the estimated time of arrival when this information is requested by the caller;

i) A letter of commitment from each Associate Hospital, Participating Hospital or Veterans Health Administration facility within the System that includes the following:

1) Signed statements by the hospital's Chief Executive Officer, Chief of the Medical Staff and Director of the Nursing Service describing their commitments to the standards and procedures of the System;

2) A description of how the hospital will relate to the EMS System Resource Hospital, its involvement in the ongoing planning and development of the program, and its use of the education and continuing education aspects of the program;

3) Only at an Associate Hospital, a commitment to meet the System's educational standards for ECRNs;

4) An agreement to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System or other EMS System whose ambulances transport to them;

5) An agreement to use the standard treatment orders as established by the Resource Hospital;

6) An agreement to follow the operational policies and protocols of the System;

7) A description of the level of participation in the education and continuing education of EMS Personnel;

8) An agreement to collect and provide relevant data as determined by the Resource Hospital;

9) A description of the hospital's data collection and reporting methods and the personnel responsible for maintaining all data;

10) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;

11) If the hospital is a participant in another System, a description of how it will interact within both Systems and how it will ensure that communications interference as a result of this dual participation will be minimized; and

12) The names and resumes of the Associate Hospital EMS MD and Associate Hospital EMS Coordinator;

j) A letter of commitment from each ambulance provider participating within the System that indicates compliance with Section 515.810;

k) Descriptions and documentation of each communications requirement provided in Section 515.400;

l) The Program Plan shall consist of the EMS System Manual, which shall be made accessible to all System Participants and shall include the following Sections:

1) Education

A) Curricula and standards for all education programs for EMS Personnel offered or authorized within the System shall be consistent with national EMS education standards, including any necessary transitional or bridge education to align System personnel with the current national EMS education standards.

B) Education, testing and credentialing requirements for ECRN and PHRN.

C) Continuing education for EMS Personnel, including:

i) System requirements (hours, types of content, etc.);

ii) A plan for measurement of ongoing competency for all System Participants (i.e., quality assurance);

iii) Requirements for approval of academic course work;

iv) Didactic programs offered by the System;

v) Clinical opportunities available within the System; and

vi) Recordkeeping requirements for participants, which must be maintained at the Resource Hospital.

D) Renewal Protocols

i) System examination requirements for EMS Personnel;

ii) Procedures for approval and the renewal of EMS Personnel;

iii) Requirements for submission of transaction cards for EMS Personnel meeting renewal requirements; and

iv) Department renewal application forms for EMS Personnel who have not met renewal requirements according to System records.

E) System Participant education and information, including:

i) Distribution of System Manual amendments;

ii) In-services for policy and protocol changes;

iii) Methods for communicating updates on System and regional activities, and other matters of medical, legal and/or professional interest; and

iv) Locations of library/resource materials, forms, schedules, etc.

F) A plan that describes how Emergency Medical dispatch agencies and EMRs participate within the EMS System Program Plan (see Sections 515.710 and 515.725).

G) A System may require that up to one-half of the continuing education hours that are required toward relicensure, as determined by the Department, be earned through attendance at System-required courses.

H) A didactic continuing education offering or course that has received a State site code or has been approved by other Department-approved national accrediting bodies shall be accepted by the System, subject only to the requirements of subsection (l)(1)(C).

2) Drugs and Equipment

A) A list of all drugs and equipment required for each type of System vehicle;

B) Procedures for obtaining replacements at System hospitals; and

C) Policies for appropriate storage and security of medications.

3) Personnel Requirements for EMS Personnel

A) Minimum staffing for each type and level of vehicle; and

B) Guidelines for EMS Personnel patient interaction.

4) EMS Protocols, including medical-legal policies, but not limited to:

A) The Regional Standing Medical Orders;

B) Administrative, Legal and EMS Protocols and Guidelines(Appendix D).

5) Communications standards and protocols, including:

A) The information contained in the System Program Plan relating to the requirements of Sections 515.410(a)(1), (2), (3) and (4) and 515.390(b) and (c);

B) Protocols ensuring that physician direction and voice orders to EMS vehicle personnel and other hospitals participating in the System are provided from the operational control point of the Resource or Associate Hospital;

C) Protocols ensuring that the voice orders via radio and using telemetry shall be given by or under the direction of the EMS MD or the EMS MD's designee, who shall be either an ECRN or physician; and

D) Protocols defining when an ECRN should contact a physician.

6) Quality improvement measures for both adult and pediatric patient care shall be performed on a quarterly basis and be available upon Department request; ambulance operation and System educational activities, including, but not limited to, monitoring educational activities to ensure that the instructions and materials are consistent with national EMS education standards for EMTs and Section 3.50 of the Act; unannounced inspections of pre-hospital services; and peer review.

7) Data collection and evaluation methods that include:

A) The process that will facilitate problem identification, evaluation and monitoring in reference to patient care and/or reporting discrepancies from hospital and pre-hospital providers;

B) A copy of the pre-hospital reporting form; and

C) A sample of the information and data to be reported to the Department summarizing System activity (see Section 515.350).

8) Operational policies that delineate the respective roles and responsibilities of all providers in the System regarding the provision of emergency service, including policies identified in Appendix D.

9) Each EMS System shall develop an administrative policy that provides the IDPH Division of EMS and Highway Safety and its State

Regional EMS Coordinator with notification the next business day when an Illinois licensed EMS crew member is killed in the line of duty.

10) The responsibilities of the EMS MD.

11) The responsibilities of the Alternate EMS MD.

12) The responsibilities of the EMS Administrative Director.

13) The responsibilities of the EMS System Coordinator, as designated by the EMS MD and Resource Hospital, including, but not limited to, data evaluation, quality management, complaint investigation, supervision of all didactic education, clinical and field experiences, and physician and nurse education as required by Section 515.320(h);

m) Written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, which provide that a person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal. (Section 3.20(c)(5) of the Act) The bypass status policy shall include criteria to address how the hospital will manage pre-hospital patients with life threatening conditions within the hospital's then-current capabilities while the hospital is on bypass status. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:

1) There are no critical or monitored beds available in the hospital; or

2) An internal disaster occurs in the hospital;

n) Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes;

o) Each hospital shall have a policy addressing peak census procedures, such as the model policy developed by the Department.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.350 Data Collection and Submission

a) A patient care run report shall be completed by each Illinois-licensed transport vehicle service provider for every inter-hospital transport and pre-hospital emergency call, regardless of the ultimate outcome or disposition of the call.

1) One patient care report shall be provided (paper or electronic) to the receiving hospital emergency department or health care facility before leaving this facility.

2) Each EMS System shall designate or approve the patient care report to be used by all of its transport vehicle providers. The report shall contain the minimum requirements listed in Appendix E.

b) All non-transport vehicle providers shall document all medical care provided and shall submit the documentation to the EMS System within 24 hours. The EMS System shall review all medical care provided by non-transport vehicles and shall provide a report to the Department upon request.

c) The transport vehicle provider shall submit patient care report data to the EMS System. When an EMS System is unable to import data from one or more providers, those providers may, with EMS System approval, submit their patient care report data directly to the Department. The Department will make the patient care report data available to the EMS System upon request. Every EMS System and EMS provider approved to submit data directly shall electronically submit all patient care report data to the Department by the 15th day of each month. The monthly report shall contain the previous month's patient care report data. Third party software shall be validated by the Department to ensure compatibility with the Department's data specifications. Third party software shall not be used until the Department's validation is complete.
(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.360 Approval of Additional Drugs and Equipment

a) All drugs and equipment, other than those covered by the national EMS education standards, as modified by the Department, for each level of licensure, must be approved by the Department in accordance with subsections (b), (c) and (d) before being used in a System.

b) To apply for approval to add drugs and/or equipment, the EMS MD shall submit to the Department documentation covering the following:

1) The education program for all additional psychomotor skills and the number of continuing education hours;

2) A curriculum for each additional drug, psychomotor skill, equipment or device, which includes at least the following (as applicable):

A) Objectives;

B) Methods and materials;

C) Content, which shall include, but not be limited to, usage, complications, adverse reactions, and equipment maintenance and use;

D) Evidence-based standards and guidelines relevant to the proposal ; and

E) Evaluation of learning; and

3) New written standing orders.

c) Upon receipt of the application from the System, the Director or his or her designee shall either approve the drug or equipment, approve the drug or equipment on a conditional basis, or disapprove the drug or equipment. The Director's or designee's decision shall be based on a review and evaluation of the documentation submitted under subsection (b); the application of technical and medical knowledge and expertise; consideration of relevant literature and published studies on the subject; and whether the drug or equipment has been reviewed or tested in the field. The Director may seek the recommendations of medical specialists or other professional consultants to determine whether to approve or disapprove the specific drug or drugs or equipment.

d) The Director or designee shall consider whether the drugs and equipment may be used safely and with proper education by the pre-hospital care provider and shall disapprove any drugs or equipment that he or she finds are generally unsafe or dangerous in the pre-hospital care setting.

e) When a drug or equipment is approved on a conditional basis, the System shall submit to the Department, on a quarterly basis (January 1, April 1, July 1 and October 1) the following information:

1) Indications for use;

2) Number of times used;

3) Number and types of complications that occurred;

4) Outcome of patient after use of drug or equipment; and

5) Description of follow-up actions taken by the System on each case in which complications occurred.

f) When a death or complication that results in a deterioration of a patient's condition occurs, involving a drug or equipment approved on a conditional basis, the System shall notify the Department within three business days, followed by a written report of the situation submitted to the Department within 10 business days.

g) Failure of the System to submit the information required under subsection (e) shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis. Failure of the System to notify the Department as required under subsection (f) shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis.

h) The Director or designee shall evaluate the information submitted under subsection (e) and any notification required under subsection (f). The Department will notify the System that a drug or equipment is disapproved and may no longer be performed on a conditional basis when the evaluation of the information submitted pursuant to this subsection (h) indicates that the safety of the drug or equipment has not been established for use in the pre-hospital setting.

i) An EMS MD shall not approve EMS Personnel to use new drugs or equipment unless that individual has completed the Department- and System-approved education program and examination, and has demonstrated the required knowledge and skill to use that intervention safely and effectively.

j) An EMS MD shall not be required to provide education on new interventions to EMS Personnel who will not be using the new interventions.

k) The Department may share best practice models with proven efficacy with the EMS System EMS MDs.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.380 Do Not Resuscitate (DNR) and Practitioner Orders for Life-Sustaining Treatment (POLST) Policy

a) A System shall adopt a Regional standardized DNR and POLST policy for use by System personnel. The policy shall be implemented only after it has been reviewed and approved by the Department, in accordance with the requirements of this Section. For purposes of this Section, DNR refers to the withholding of cardiopulmonary resuscitation (CPR) and cardiocerebral resuscitation (CCR); electrical therapy to include pacing, cardioversion and defibrillation; invasive airway management and manually or mechanically assisted ventilations, unless otherwise stated on the IDPH Uniform POLST Advance Directive. POLST refers to the recording of a person's desires for life-sustaining treatment and palliative care.

b) The policy shall include, but not be limited to, specific procedures and protocols for cardiac arrest/DNR situations arising in long-term care facilities, with hospice and home care patients, and with patients who arrest during inter-hospital transfers or transportation to or from home.

c) The policy shall include specific procedures and protocols for withholding CPR and CCR in situations where explicit signs of biological death are present (e.g., decapitation, rigor mortis without profound hypothermia, profound dependent lividity), or the patient has been declared dead by a coroner/medical examiner or the patient's physician. The policy shall include recording such information on the patient care report.

d) The policy shall include specific procedures and protocols for a person's desire for life-sustaining treatment and palliative care.

e) For situations not covered by subsection (c), the policy shall require that resuscitative procedures be followed unless a valid IDPH Uniform POLST advance directive is present.

f) The Department of Public Health Uniform POLST form, or a copy of that form, shall be honored. (Section 3.57 of the Act) Systems shall also have a policy in place concerning recognition of other DNR and POLST advance directives. The information required on the Department Uniform POLST advance directive includes, but is not limited to, the following items:

1) Name of the patient;

2) Name and signature of authorized practitioner;

3) Effective date;

4) The phrase "Do Not Resuscitate" or "Practitioner Orders for Life-Sustaining Treatment" or both;

5) Evidence of consent:

A) signature of patient;

B) signature of legal guardian;

C) signature of durable power of attorney for health care agent; or

D) signature of surrogate decision-maker.

g) A living will by itself cannot be recognized by pre-hospital care providers.

h) Revocation of a written DNR or POLST Advance Directive shall be made only in one or more of the following ways:

1) The advance directive is physically destroyed by the authorized practitioner who signed the advance directive or by the person who gave written consent to the advance directive; or

2) The advance directive is verbally rescinded by the authorized practitioner who signed the advance directive or by the person who gave written consent to the advance directive, the word "VOID" is written in large letters across the front of the advance directive, and the advance directive is signed and dated by the authorized practitioner who signed the advance directive or by the person who gave written consent to the advance directive.

i) A System's DNR and POLST policy shall require System personnel to make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid DNR or POLST advance directive.

j) The policy shall describe the roles of the on-line medical control physician and ECRN in DNR or POLST situations.

k) The policy shall state which System EMS Personnel are authorized to respond to a valid DNR or POLST advance directive (Paramedic, PHRN, A-EMT, EMT-I, EMT, EMR).

l) The policy shall cross-reference the System's coroner/medical examiner notification policy.

m) The policy shall describe the System's program for educating System personnel concerning the DNR or POLST policy.

n) The policy shall identify the quality assurance measures specific to this policy, including the methods and periods of review.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.390 Minimum Standards for Continuing Operation

a) The Resource Hospital and all System Participants shall comply with the terms of the EMS System Program Plan, the System Manual, their respective letters of commitment, and any applicable provisions of the Act or this Part.

b) All System EMS personnel, provider agencies and licensed vehicle owners are responsible for and shall maintain current certifications, licenses and approvals.

c) In accordance with Section 515.160, the Department may suspend, revoke or refuse to issue or renew the approval of any EMS System when its findings show that the System is in violation of one or more of the requirements of the Act and this Part.

1) Suspension, revocation or refusal to renew shall be preceded by notice and an opportunity for a hearing served upon the EMS MD by certified mail, personal service or confirmed facsimile.

2) The notice shall set forth the reasons for the proposed suspension or revocation and shall afford the EMS MD 15 days from the date of receipt to make a written request for an administrative hearing. The EMS MD's failure to file a written request for a hearing within 15 days shall be considered a waiver of the System's right to a hearing on the proposed suspension, revocation or refusal.

3) All hearings shall be conducted in accordance with the Department's Rules of Practice and Procedure for Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.420 System Participation Suspensions

a) An EMS MD may suspend from participation within the System any EMS Personnel, EMS Lead Instructor (LI), individual, individual provider or other participant considered not to

be meeting the requirements of the Program Plan of that approved EMS System. (Section 3.40(a) of the Act)

b) Except as allowed in subsection (l), the EMS MD shall provide the individual, individual provider or other participant with a written explanation of the reason for the suspension; the terms, length and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.

c) Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.

d) The Resource Hospital shall designate the local System review board, for the purpose of providing a hearing to any individual or entity participating within the System who is suspended from participation by the EMS MD. (Section 3.40(e) of the Act) The review board will consist of at least three members, one of whom is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. The EMS MD shall prepare and post, in a 24-hour accessible location at the Resource Hospital, the System Review Board List.

e) The hearing shall commence as soon as possible, but at least within 21 days after receipt of a written request. The EMS MD shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing and the local System review board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the local System review board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the Act and this Part. (Section 3.40(e) of the Act)

f) The local System review board shall state in writing its decision to affirm, modify or reverse the suspension order. That decision shall be sent via certified mail or personal service to the EMS MD and the individual, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing.

g) The EMS MD shall notify the Department, in writing, within five business days after the Board's decision to either uphold, modify or reverse the EMS MD's suspension of an individual, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.

h) If the local System review board affirms or modifies the EMS MD's suspension order, the individual, individual provider or other participant shall have the opportunity for a review of the local board's decision of the State EMS Disciplinary Review Board. (Section 3.40(b)(1) of the Act)

i) If the local System review board reverses or modifies the EMS MD's suspension order, the EMS MD shall have the opportunity for review of the local board's decision by the State EMS Disciplinary Review Board. (Section 3.40(b)(2) of the Act)

j) Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the local board's decision or the EMS MD's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed. (Section 3.45(h) of the Act)

k) An EMS MD may immediately suspend an EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, PHRN, LI, or other individual or entity if he or she finds that the continuation in practice by the individual or entity would constitute an imminent danger to the public. The suspended individual or entity shall be issued an immediate verbal notification, followed by a written suspension order by the EMS MD that states the length, terms and basis for the suspension. (Section 3.40(c) of the Act)

1) Within 24 hours following the commencement of the suspension, the EMS MD shall deliver to the Department, by messenger, telefax, or other Department-approved electronic communication, a copy of the suspension order and copies of any written materials that relate to the EMS MD's decision to suspend the individual or entity.

2) Within 24 hours following the commencement of the suspension, the suspended individual or entity may deliver to the Department, by messenger, telefax, or other Department-approved electronic communication, a written response to the suspension order and copies of any written materials that the individual or entity feels are appropriate.

3) Within 24 hours following receipt of the EMS MD's suspension order or the individual's or entity's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending an opportunity for a hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS MD, who shall immediately notify the suspended individual or entity. The suspension shall remain in effect during this period of review by the Director or the Director's designee. (Section 3.40(c) of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.450 Complaints

a) For the purposes of this Section, "complaint" means a report of an alleged violation of the Act or this Part by any System Participants or providers covered under the Act, or members of the public. Complaints shall be defined as problems related to the care and treatment of a patient.

b) A person who believes that the Act or this Part may have been violated may submit a complaint by means of a telephone call, letter, fax, or in person. An oral complaint will be reduced to writing by the Department. The complainant is requested to supply the following information concerning the allegation:

1) Date and time or shift of occurrence;

2) Names of the patient, EMS Personnel, entities, family members, and other persons involved;

3) Relationship of the complainant to the patient or to the provider;

4) Condition and status of the patient;

5) Details of the situation; and

6) The name of the facility where the patient was taken.

c) All complaints shall be submitted to the Department's Central Complaint Registry or to the EMS MD. Complaints received by the EMS MD or Trauma Center MD shall be forwarded to the Department's Central Complaint Registry within five working days after receipt of the complaint. The substance of the complaint shall be provided in writing to the System participant or provider no earlier than at the commencement of an on-site investigation pursuant to subsection (e).

d) The Department and the EMS MD or Trauma Center MD shall not disclose the name of the complainant unless the complainant consents in writing to the disclosure.

e) The Department may conduct a joint investigation with the EMS MD, EMS Coordinator or Trauma Center MD if a death or serious injury has occurred or there is imminent risk of death

or serious injury, or if the complaint alleges action or conditions that could result in a denial, non-renewal, suspension, or revocation of licensure or designation. If the complaint alleges a violation by the EMS MD, EMS Coordinator or Trauma Center MD, the Department shall conduct the investigation. If the complaint alleges a violation that would not result in licensure or designation action, the Department shall forward the complaint to the EMS MD or Trauma Center MD for review and investigation. The EMS MD or Trauma Center MD may request the Department's assistance at any time during an investigation. In the case of a complaint between EMS Systems, the Department will be involved as mediator or lead investigator.

f) The EMS MD or Trauma Center Director shall forward the results of the investigation and any disciplinary action resulting from a complaint to the Department. Documentation of the investigation shall be retained at the hospital in accordance with EMS System improvement policies and shall be available to the Department upon request. The investigation file shall be considered privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101].

g) Based on the information submitted by the complainant and the results of the investigation conducted in accordance with subsection (e), the Department will determine whether the Act or this Part is being or has been violated. The Department will review and consider any information submitted by the System participant or provider in response to an investigation.

h) The Department will have final authority in the disposition of a complaint. Complaints shall be classified as "violation", "no violation", or "undetermined".

i) The Department will inform the complainant and the System Participant or provider of the complaint results (i.e., whether the complaint was found to be a violation, no violation, or undetermined) within 20 days after its determination.

j) The EMS System shall have a policy in place requiring compliance with this Section.

k) An EMS System Participantparticipant or provider who is dissatisfied with the determination or investigation by the Department may request reconsideration by the Department.

l) The investigative files of the EMS System and the Department shall be privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101], except that the Department and the involved EMS System may share information. The Department's final determination shall be public information subject to FOIA.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.455 Intra- and Inter-System Dispute Resolution

a) If the Director determines that a dispute exists between an EMS System, Vehicle Service Provider, Advisory Committee, hospital, or EMS MD or between any combination of any elements of these entities and the dispute causes an imminent threat to the availability or quality of emergency pre-hospital care within the State, then the Director or designee shall have the authority to resolve those disputes, if one party to the dispute requests the Director's intervention in writing. If the Director receives and approves such a request, then each entity's duly authorized representative shall be given the opportunity to submit written arguments and evidence in support of any potential resolution. The Director or designee shall have the authority to hear oral arguments and testimony based upon the written submissions. Any decision by the Director or designee shall be issued in writing and state the basis for the decision, which shall be final and binding upon all parties to the dispute. The Director or designee will endeavor to issue a written decision within 30 days after receipt of all written submissions and verbal testimony, if verbal testimony is permitted.

b) This dispute resolution procedure shall not be available to any EMS Personnel or a member of the public. This procedure shall not be applicable to any EMS System Suspension, Local Board of Review, action by the State EMS Disciplinary Review Board or the Department.

c) The Department's Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) shall govern all proceedings.

d) All final administrative decisions of the Department hereunder shall be subject to judicial review pursuant to the provisions of the Administrative Review Law [35 ILCS 5/Art. III] . (Section 3.145 of the Act) A decision by the Director in accordance with this Section shall be considered an administrative review decision under Section 3.145 of the Act and shall be subject to judicial review.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.460 Fees

a) The following fees shall be submitted to the Department at the time of application for examination, initial licensure, licensure renewal, duplicate license, or reciprocity:

1) EMT licensure: $45

2) EMT renewal: $20

3) EMT examination: $20

4) A-EMT or EMT-I licensure: $45

5) A-EMT or EMT-I renewal: $30

6) A-EMT or EMT-I examination: $30

7) Paramedic licensure: $60

8) Paramedic renewal: $40

9) Paramedic examination: $40

10) Trauma Nurse Specialist licensure: $50

11) Trauma Nurse Specialist renewal: $25

12) Trauma Nurse Specialist examination: $25 (see Section 515.750(f))

13) Emergency Communications Registered Nurse licensure: $55

14) Emergency Communications Registered Nurse renewal: $20

15) Emergency Medical Dispatcher licensure: $30

16) Emergency Medical Dispatcher renewal: $20

17) Pre-Hospital RN licensure: $30

18) Pre-Hospital RN renewal: $20

19) Lead Instructor licensure: $40

20) Lead Instructor renewal: $20

21) EMR licensure: $55

22) EMR renewal: $20

23) Duplicate license: $10

24) Reciprocity application processing fee: $50

25) Fees for a reciprocity license or reinstatement of a license will be equal to the amount of the initial license fee.

26) License status verification documentation for out-of-state or organizational requests: $25

27) License renewal late fee during lapse period: $50

b) An EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN or PHRN who is a member of the Illinois National Guard or an Illinois State Trooper or who exclusively serves as a volunteer for units of local government with a population base of less than 5,000 or as a volunteer for a not-for-profit organization that serves a service area with a population base of less than 5,000 in this State may submit an application to the Department for a waiver of the fees for the EMS Personnel examination, licensure and license renewal on a form prescribed by the Department. (Section 3.50(d-5) of the Act) The fee waiver application shall be submitted to the Department and approved prior to examination, licensure or renewal. No fees will be refunded.

c) Fees shall be paid on-line or by certified check or money order made payable to the Department. Personal checks or cash will not be accepted.

d) If a candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.

e) All fees submitted for licensure examinations are not refundable.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section 515.500 EMS System Education Program-Emergency Medical Technician

a) An EMS education program shall only be conducted by an EMS System or an academic institution under the direction of the EMS System.

b) Applications for pre-approval of EMS education programs shall be filed with the Department on forms prescribed by the Department. The applications shall contain, at a minimum:

1) Name of the applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of the EMS MD and EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program, including course schedule;

6) Goals, objectives and course outline;

7) Methods, materials and text books;

8) Content and time consistent with the national EMS education standards and additional course curricula required by the Department. Initial or modified course syllabi shall be approved by the Department;

9) Description of the clinical and field requirements;

10) Description of evaluation tools (student, clinical units, faculty and programs); and

11) Requirements for successful completion.

c) Applications for pre-approval, including a copy of the course schedule and syllabus, shall be submitted no less than 60 days before the first scheduled class.

1) Initial or revised education programs require full submission of all curriculum related educational documents for Department pre-approval (see Section 515.520(b)(1 through 11)).

2) Education programs previously approved by the Department without changes to curricula or content require submission of the course schedule and syllabus only.

d) The EMS MD shall attest on the application form that the education program will be conducted according to the national EMS education standards, including modifications required by the Department. The course hours shall include, at a minimum, 125 hours of didactic

education and 25 hours of clinical experience, which includes hospital or alternate health care facility and field internship experience. The clinical experience shall include minimum patient care contacts, competency evaluation, and measurement, as defined in the standards and approved by the EMS MD.

e) The EMS MD and the EMS System Coordinator, in cooperation with the educational institution, shall be responsible for oversight, quality assurance and outcome measurement for the EMT education program.

f) The Lead Instructor for the course shall be responsible for ensuring that no EMT course begins until after the Department issues its formal, written pre-approval, which shall be in the form of a numeric site code.

g) The Lead Instructor for the course shall be responsible for ensuring that all materials presented to EMT students conform to all curriculum requirements of both the Department and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both the Department and the EMS System shall not be taught or presented. All LIs for courses shall be approved by the EMS MD.

h) Any change in the EMT program's EMS MD, EMS System Coordinator or Lead Instructor, or change in the minimum approved program, shall require an amendment to be filed with the Department by the EMS System.

i) Before a candidate is accepted into the program, documentation shall be submitted that a BLS EMS System vehicle will be available to accommodate field internship needs.

j) Each EMS Lead Instructor shall verify a student's qualification to take a Department-approved licensure examination upon the successful completion of the education program and shall submit a student roster on a form approved by the Department. The EMS MD or designee may approve students through an on-line verification system.

k) EMT candidates may test for licensure through the Illinois State examination or the NREMT examination. For EMT candidates who have completed and passed components of the program, and passed the NREMT examination, the EMS MD shall submit to the Department an electronic transaction provided by the Department. No electronic transaction form is necessary for candidates taking the State licensing examination.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.510 Advanced Emergency Medical Technician and Emergency Medical Technician-Intermediate Education

a) An A-EMT or EMT-I course shall be conducted only by an EMS System or an academic institution whose curriculum has been approved by the EMS System.

b) Applications for pre-approval of A-EMT or EMT-I education programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum:.

1) Name of the applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of EMS MD and EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program, including course schedule;

6) Goals, objectives and course outline;

7) Methods, materials and text books;

8) Content and time consistent with the national EMS education standards and additional course curricula required by the Department. Initial or modified course syllabi shall be approved by the Department;

9) Description of the clinical and field requirements;

10) Description of evaluation tools (student, clinical units, faculty and programs); and

11) Requirements for successful completion.

c) Applications for pre-approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days before the first scheduled class.

1) Initial or revised education programs require full submission of all curriculum related educational documents for Department pre-approval (see Section 515.520(b)(1) through (11)).

2) Education programs previously approved by the Department without changes to curricula or content require submission of the course schedule and syllabus only.

d) The EMS MD shall attest on the application form that the A-EMT or EMT-I education program shall be conducted according to the national EMS education standards for an A-EMT, including modifications required by the Department. The course hours shall minimally include 200 hours of didactic education and at least 150 hours of clinical experience. Clinical experience shall include hospital, alternate care facility, and field internship experience, including minimum patient care contacts, competency evaluation and measurement, as defined in the standards and approved by the EMS MD.

e) Oversight, quality assurance and outcome measurement for the A-EMT and EMT-I education program shall be the responsibility of the EMS MD and the EMS System Coordinator, with cooperation of the educational institution.

f) The Lead Instructor shall be responsible for ensuring that no A-EMT or EMT-I course begins before the Department issues its formal written pre-approval, which will be in the form of a numeric site code.

g) The Lead Instructor for the course shall be responsible for ensuring that all materials presented to A-EMT or EMT-I students conform to all curriculum requirements of both the Department and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both the Department and the EMS System shall not be taught or presented. All LIs for courses must be approved by the EMS MD.

h) Any change in the A-EMT or EMT-I program's EMS MD, EMS System Coordinator or Lead Instructor, or change in the minimum approved program, requires an amendment to be filed with the Department.

i) A candidate for an A-EMT or EMT-I education program shall have a current Illinois EMT license. All program participants shall maintain their qualifying license throughout completion of the program and successful completion of the licensure examination.

j) Before a candidate is accepted into the program, documentation shall be submitted that an ILS or ALS EMS System vehicle will be available to accommodate field internship needs.

k) Each education program shall verify a student's qualification to attempt a Department-approved licensure examination upon the successful completion of the education program and shall submit a student roster on a form approved by the Department. The EMS MD or designee may approve students through an on-line verification system.

l) A-EMT and EMT-I candidates who have completed and passed all components of the program may test for licensure through the Illinois State examination. No electronic transaction form is necessary for candidates taking the State licensing examination. An A-EMT candidate may choose to test with the NREMT examination. For candidates successfully passing the NREMT examination and applying for Illinois licensure, the EMS MD shall submit to the Department an electronic transaction form provided by the Department.

m) All approved programs shall maintain course and student records, for a minimum of seven years, in compliance with affiliated academic institution requirements as applicable. The course and student records shall be made available to the EMS System or Department upon demand.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.520 Paramedic Education

a) A Paramedic course shall be conducted only by an EMS System or an academic institution whose curriculum has been approved by the EMS System.

b) Applications for pre-approval of Paramedic education programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum:

1) Name of the applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of EMS MD and EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program, including course schedule;

6) Goals, objectives and course outline;

7) Methods, materials and text books;

8) Content and time, consistent with the national EMS education standards and additional course curricula required by the Department. Initial or modified course syllabi shall be approved by the Department;

9) Description of the clinical and field requirements;

10) Description of evaluation tools (student, clinical units, faculty and programs); and

11) Requirements for successful completion.

c) Applications for pre-approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days before the first scheduled class.

1) Initial or revised education programs require full submission of all curriculum related educational documents for Department pre-approval (see Section 515.520(b)(1 through 11)).

2) Education programs previously approved by the Department without changes to curricula or content will require submission of the course schedule and syllabus only.

d) The EMS MD of the EMS System shall attest on the application form that the education program will be conducted according to the national EMS education standards, including all modifications required by the Department. The course hours shall minimally include 500 hours of didactic education and 500 hours of clinical experience, which includes hospitals plus alternate care facilities and field internship experience, including minimum patient care contacts and competency evaluation and measurement as defined in the standards and approved by the EMS MD. .

e) Oversight, quality assurance and outcome measurement for the Paramedic education program shall be the responsibility of the EMS MD and the EMS System Coordinator, with cooperation of the educational institution.

f) The Lead Instructor for the course shall be responsible for ensuring that no Paramedic class begins until after the Department issues its formal written pre-approval, which shall be in the form of a numeric site code.

g) The Lead Instructor for the course shall be responsible for ensuring that all materials presented to Paramedic students conform to all curriculum requirements of both the Department and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both the Department and the EMS System shall not be taught or presented. All LIs for courses must be approved by the EMS MD.

h) Any change in the Paramedic program's EMS MD, EMS System Coordinator or Lead Instructor, or change in the minimum approved program, shall require an amendment to be filed with the Department.

i) A candidate for a Paramedic education program shall have a current Illinois EMT, A-EMT or EMT-I license. All program participants shall maintain their qualifying license throughout completion of the program and successful completion of the licensure examination.

j) Before a candidate is accepted into the program, documentation shall be submitted that an ALS or CCT EMS System vehicle will be available to accommodate field internship needs.

k) Each education program shall verify a student's qualification to attempt a Department-approved licensure examination upon the successful completion of the education program and shall submit a student roster on a form approved by the Department. The EMS MD or designee may approve students through an on-line verification system.

l) Paramedic candidates may test for licensure through the Illinois State examination or the NREMT examination (NREMT requires successful completion from an accredited academic institution recognized by NREMT). For Paramedic candidates who have completed and passed all components of the program, and passed the NREMT examination, and who are applying for Illinois licensure, the EMS MD shall submit to the Department an electronic transaction form provided by the Department. No electronic transaction form is required for candidates taking the State licensure examination.

m) All approved programs shall maintain course and student records for seven years, in compliance with the affiliated academic institution requirements as applicable. The course and student records shall be made available to the EMS System or Department upon request.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.530 EMT, A-EMT, EMT-I and Paramedic Testing

a) All candidates shall hold a high school diploma or high school equivalency certificate and be 18 years of age or older to be licensed. Candidates who meet all of the requirements of this Part may test after attaining 17 years of age and may apply for licensure upon attaining 18 years of age.

b) After completion of an approved education program and a recommendation to test by the EMS MD or designee, candidates shall take a written licensure examination. Candidates shall

have the choice of taking either the NREMT written and psychomotor examination or the Department's examination if eligible and available. The Department's written examinations shall be based on the national EMS education standards and practice analysis and are equivalent to the NREMT written examinations as modified by the Department.

c) Candidates qualifying for licensure examinations may register for examinations through either the State of Illinois testing vendor or the NREMT. Application information may be found at the Department's website (http://www. continentaltesting.net/) or the NREMT website (https://www.nremt.org/nremt/ about/apply_for_assess_exam.asp). All candidates for licensure examinations shall be approved by the EMS System. Candidates shall register to take a licensure examination within 90 days after course completion, including all clinical and field requirements.

d) A failure rate per course of 30 percent or greater on the licensure examination will subject the particular education program to review by the EMS System or the Department.

e) Candidates shall have three attempts to pass the licensure examination within 12 months after initial authorizations to test. Candidates who fail all three initial examination attempts shall take a refresher course in alignment with the NREMT Cognitive Examination Retest policy. Candidates shall be granted up to three additional licensure examination attempts only upon EMS MD authorization.

f) When a candidate elects to take the State examination or the NREMT examination, the candidate shall pass that particular testing procedure or exhaust all three test attempts with the initial testing agency. Any candidate may request a waiver from the Department to change the examination testing venue after three unsuccessful testing attempts.

g) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in the forfeiture of the examination fee.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.540 EMT, A-EMT, EMT-I and Paramedic Licensure

a) To be licensed by the Department as an EMT, A-EMT, EMT-I or Paramedic, an individual must pass either the NREMT examination or the Department's licensure examination based on a final composite score of 70.

b) Upon successful completion of the NREMT written and psychomotor examinations, the applicant shall apply to the Department through the affiliated EMS System, using forms specified by the Department. The application will include demographic information, social

security number, child support statement, felony conviction statement, and applicable fees, and will require EMS System authorization. Upon successful completion of the State examination, the applicant will be required to pay the applicable fees (see Section 515.460(a)).

c) An EMS license will specify the level of licensure, i.e., EMT, A-EMT, EMT-I or Paramedic, and will be effective for a period of four years.

d) An EMT, A-EMT, EMT-I or Paramedic shall notify the Department within 30 days after any change in name or address. Notification may be in person or by mail, phone, fax or electronic mail. Addresses may be changed through the Department's on-line system. Name and gender changes require certified copies of court orders, i.e., marriage license or court documents.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.550 Scope of Practice − Licensed EMT and Paramedic

a) Any person currently licensed as an EMT, EMT-I, A-EMT or Paramedic may only perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in this Part, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System. The Director may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not to exceed 180 days. (Section 3.55(a) of the Act)

b) EMS Personnel who have successfully completed a Department-approved course in automated external defibrillator operation and who are functioning within a Department-approved EMS System may use an automated external defibrillator according to the standards of performance and conduct prescribed by the Department in this Part, and the requirements of the EMS System in which they practice, as contained in the approved Program Plan for that System. (Section 3.55(a-5) of the Act)

c) An EMT, EMT-I, A-EMT or Paramedic who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine with him or her as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System. (Section 3.55 (a-7) of the Act)

d) An EMR, EMT, EMT-I, A-EMT or Paramedic may only practice as an EMR, EMT, EMT-I, A-EMT or Paramedic or utilize his or her EMR, EMT, EMT-I, A-EMT or Paramedic license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction of the EMS MD. For purposes of this

Section, a "pre-hospital emergency care setting" may include a location, that is not a health care facility, which utilizes EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMT, EMT-I, A-EMT or Paramedic's level of care, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS MD.

e) This does not prohibit an EMR, EMT, EMT-I, A-EMT or Paramedic from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS MD. This also does not prohibit an EMT, EMT-I, A-EMT or Paramedic from seeking credentials other than his or her EMT, EMT-I, A-EMT or Paramedic license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer. (Section 3.55(b) of the Act)

f) A student enrolled in a Department-approved EMS Personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the System and the Department, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified RN or a qualified EMS Personnel, only when authorized by the EMS MD. (Section 3.55(d) of the Act)

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.560 EMT Continuing Education

a) Continuing education classes, seminars, clinical time, workshops or other types of programs shall be approved by the Department before being offered to EMTs. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1) Name of applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of the EMS MD and the EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program (submit course schedule);

6) Goals and objectives;

7) Methods and materials, text books, and resources, when applicable;

8) Content consistent with the national EMS education standards;

9) Description of evaluation instruments; and

10) Requirements for successful completion, when applicable.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the national EMS education standards, as modified by the Department. Upon approval, the Department will issue a site code to the course, seminar, workshop or program.

c) An EMS System may apply to the Department for a single System site code to cover CE activities conducted or approved by the System for System EMTs when an urgent education need arises that requires immediate attention or when other appropriate education opportunities present outside of the scheduled approved offerings. Activities conducted under the System site code shall not require individual approval by the Department. The single System site code is not intended to replace the routine CE pre-approvals required by this Section and Sections 515.570 and 515.580.

d) An EMT functioning within an EMS System shall submit written proof of CE attendance to the EMS System Coordinator pursuant to System policy. An EMT not functioning within an EMS System shall submit written proof of CE attendance to the Department Regional EMS Coordinator upon licensure renewal request..

e) The EMS MD or designee of the EMS System of the EMT's primary affiliation or Department's designee for independent EMTs shall verify whether specific CE hours meet requirements for educational credit towards active status or renewal purposes outlined in Section 515.590(a)(2)(B).

f) An EMS System that requires clinical CE shall specify in the System Program Plan the number of hours required and the manner in which those hours shall be earned, submitted and verified.

g) An EMT shall maintain copies of all documentation concerning CE programs that he or she has completed for a period of not less than four years.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.570 A-EMT and EMT-I Continuing Education

a) Continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to A-EMTs or EMT-Is. An application for approval shall be submitted to the Department by an EMS MD, on a form prescribed and furnished by the Department, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1) Name of applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of the EMS MD and the EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program (submit course schedule);

6) Goals and objectives;

7) Methods and materials, text books, and resources, when applicable;

8) Content consistent with the national EMS education standards;

9) Description of evaluation instruments; and

10) Requirements for successful completion, when applicable.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the national EMS education standards for an A-EMT, as modified by the Department. Upon approval, the Department will issue a site code to the course, seminar or program.

c) An EMS System may apply to the Department for a single System site code to cover CEactivities conducted or approved by the System for System A-EMTs and EMT-Is when an urgent education need arises that requires immediate attention or when other appropriate education opportunities present outside of the scheduled approved offerings. Activities conducted under the System site code shall not require individual approval by the Department.

The single System site code is not intended to replace the routine CE pre-approvals required by this Section and Sections 515.560 and 515.580.

d) A-EMTs and EMT-Is functioning within an EMS System shall submit written proof of CE attendance to the EMS System Coordinator pursuant to System policy. A-EMTs and EMT-Is not functioning within an EMS System shall submit written proof of CE attendance to the Department Regional EMS Coordinator upon licensure renewal request.

e) The EMS MD or designee of the EMS System of the A-EMT's or EMT-I's primary affiliation or the Department's designee for independent A-EMTs or EMT-Is shall verify whether specific CE hours meet criteria for educational credit towards active status or renewal purposes as required by Section 515.590(a)(2)(B).

f) An EMS System that requires clinical CE shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

g) A-EMTs and EMT-Is shall maintain copies of all documentation concerning CE programs or activities that they have completed for a period of not less than four years.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.580 Paramedic Continuing Education

a) Continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to Paramedics. An application for approval shall be submitted to the Department by an EMS Medical Director, on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1) Name of applicant, agency and address;

2) Lead Instructor's name, license number, address and contact information;

3) Name and signature of the EMS MD and the EMS System Coordinator;

4) Type of education program;

5) Dates, times and location of the education program (submit course schedule);

6) Goals and objectives;

7) Methods and materials, text books, and resources, when applicable;

8) Content consistent with the national EMS education standards;

9) Description of evaluation instruments; and

10) Requirements for successful completion, when applicable.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the national EMS education standards, as modified by the Department. Upon approval, the Department will issue a site code to the course, seminar or program.

c) An EMS System may apply to the Department for a single System site code to cover CE activities conducted or approved by the System solely for System Paramedics when an urgent education need arises that requires immediate attention or when other appropriate education opportunities present outside of the scheduled approved offerings. Activities conducted under the System site code shall not require individual approval by the Department. The single System site code is not intended to replace routine CE pre-approvals required by this Section and Sections 515.560 and 515.570.

d) A Paramedic functioning within an EMS System shall submit written proof of CE attendance to the EMS System Coordinator pursuant to System policy. A Paramedic not functioning within an EMS System shall submit written proof of CE attendance to the Department Regional EMS Coordinator upon licensure renewal request.

e) The EMS MD or designee of the EMS System Paramedic's primary affiliation shall verify whether specific CE hours meet the criteria for educational credit towards active status or renewal purposes required by Section 515.590(a)(2)(B).

f) An EMS System that requires clinical CE shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

g) A Paramedic shall maintain copies of all documentation concerning CE programs or activities that he or she has completed for a period of not less than four years.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.590 EMS Personnel License Renewals

a) To be relicensed:

1) The licensee shall file an application for renewal, either written or on-line, with the Department, using the format prescribed by the Department, at least 30 days prior to the license expiration date. Incomplete license applications submitted to the Department less than 30 days before the expiration may not be processed by the expiration date and may be subject to a late fee.

A) In addition to completion of the renewal application and payment of the renewal fee, a licensee who functions within an EMS System shall submit documentation of completion of CE requirements to his or her EMS System of primary affiliation at least 30 days before the expiration of his or her license. A licensee who does not function within an EMS System, and who seeks independent renewal, shall submit documentation of completion of CE requirements to the Department at least 30 days before the expiration of his or her license.

B) A licensee who has not been recommended for relicensure by the EMS MD shall independently submit an application for renewal to the Department. The EMS MD shall provide a written statement stating the reason for the denial of relicensure to the licensee and the Department. The application for independent renewal may be found on the Department's website: http://dph.illinois.gov/sites/ default/files/forms/emsindependentrenewal-040317.pdf.

2) The EMS MD or designee shall provide an electronic authorization to the Department regarding completion of the following minimum requirements:

A) Paramedics and PHRNs shall have a minimum of 100 approved CE hours. A-EMTs and EMT-Is shall have a minimum of 80 approved CE hours. EMTs shall have a minimum of 60 approved CE hours.

B) CE hours shall consist of EMS System-approved in-services, Department-recognized college health care courses, online CE courses, seminars and workshops, addressing both adult and pediatric care. The System shall define in the Program Plan the number of CE hours to be accrued for relicensure. No more than 20 percent of those hours may be in the same subject.

C) Any System CE requirements for EMS Personnel approved to operate an automated external defibrillator shall be included in the required CE hours.

D) The licensee shall have a current CPR for Healthcare Providers card that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

b) The license of EMS Personnel who has failed to file a completed application for renewal on time shall be invalid on the day following the expiration date shown on the license. EMS Personnel shall not function on an expired license.

c) At any time prior to the expiration of the current license, an EMT, A-EMT, EMT-I or Paramedic may downgrade to EMT or EMR status for the remainder of the license period. The EMT, A-EMT, EMT-I or Paramedic shall make this request in writing to the EMS MD of his or her System of primary affiliation along with a signed renewal notice and his or her original EMS license and duplicate license fee. The EMS MD or designee shall verify that the license is current with CE hours and forward the approved applications to the Department. To relicense at the EMT or EMR level, the individual must meet the relicensure requirements for that downgraded level.

d) EMS Personnel who have downgraded to EMT, A-EMT or EMT-I status may subsequently upgrade to his or her original level of licensure held at the time of the downgrade upon the recommendation of an EMS MD who has verified that the individual's knowledge and psychomotor skills are at the level of the licensure being requested. The individual shall complete any education or testing deemed necessary by the EMS MD for resuming A-EMT, EMT-I or Paramedic activities and submit a duplicate license fee. EMS Personnel cannot upgrade from the EMR level.

e) EMS Personnel whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees (see Section 515.460), including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and no disciplinary actions are pending against the EMS Personnel, the Department will relicense the EMS Personnel.

f) EMS Personnel whose licenses have expired for a period of more than 60 days shall be required to reapply for licensure, complete the education program, pass a Department-approved licensure examination, and pay the fees as required for initial licensure (see Section 515.460). Within 36 months after expiration of a license, an individual may quality for reinstatement under Section 515.640.

g) The Department shall require the licensee to certify on the renewal application form, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. (Section 10-65(c) of the Illinois Administrative Procedure Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.600 EMS Personnel Inactive Status

a) Prior to the expiration of the current license, EMS Personnel may request to be placed on inactive status on a form prescribed by the Department available on the Department's website: http://dph.illinois.gov/sites/default/files/forms/ems-inactive-request-062116.pdf. The application shall contain the following information:

1) Name of individual and contact information;

2) Applicant's current original license;

3) Level of licensure;

4) License number;

5) Circumstances requiring inactive status; and

6) Confirmation from the EMS MD of the System of primary affiliation or the Department for independent licensees that relicensure requirements have been met by the date of the application for inactive status.

b) The Department will review requests for inactive status. The Department will notify the EMS MD in writing of its decision based on subsection (a).

c) For EMS Personnel to return to active status, the EMS MD shall make application to the Department on a form prescribed by the Department available on the Department's website: http://dph.illinois.gov/sites/ default/files/forms/ems-reactivation-request-061416.pdf. The EMS MD shall confirm that the applicant has been examined (physically and mentally) and found capable of functioning within the EMS System; that the applicant's knowledge and psychomotor skills are at the active EMT level for that individual's license; and that the applicant has completed any education and evaluation deemed necessary by the EMS MD and approved by the Department. If the inactive status was based on a disability, the EMS MD shall also verify that the applicant can perform all critical functions of the requested license level.

d) During inactive status, the individual shall not perform at the level of any EMS provider.

e) EMS Personnel whose inactive status period exceeds 48 months shall pass a Department-approved licensure examination for the requested level of license upon recommendation of an EMS MD.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.610 EMT, A-EMT, EMT-I and Paramedic Reciprocity

a) An EMT, A-EMT, EMT-I or Paramedic licensed or certified in another state, territory or jurisdiction of the United States who seeks licensure in Illinois may apply to the Department for licensure by reciprocity on a form prescribed by the Department available on the Department's website: http://dph.illinois.gov/sites/ default/files/forms/emsreciprocityapplication.pdf.

b) The reciprocity application shall contain the following information:

1) Verifiable proof of current state, territory or jurisdiction licensure or certification, or current registration with NREMT;

2) A written statement of satisfactory completion of an education program that meets or exceeds the requirements of the Department as set forth in this Subpart;

3) A letter of recommendation from the EMS MD of the EMS System in the state, territory or jurisdiction from which the individual is licensed. The letter should include a statement that the applicant is currently in good standing and up to date with CE hours; and

4) A current CPR for Healthcare Providers card that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

c) The Department will review requests for reciprocity to determine compliance with the applicable provisions of this Part. CE hours from the state of current licensure will be prorated based on the expiration date of the current license.

d) Individuals who meet the requirements for licensure by reciprocity will be State licensed consistent with the expiration date of their current license but not to exceed a period of four years.

e) Following licensure by reciprocity, the individual must comply with the requirements of this Part for relicensure.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.630 Evaluation and Recognition of Military Experience and Education

a) In prescribing licensure testing requirements for honorably discharged members of the armed forces of the United States under this Part, the Department shall ensure that a candidate's military emergency medical training, emergency medical curriculum completed, and clinical experience, as described in this Section, are recognized. (Section 3.50(d)(2) of the Act)

b) The Department will review applications for EMS Personnel licensure from honorably discharged members of the armed forces of the United States with military emergency medical training.

c) The Department will provide application forms. Applications shall be filed with the Department within one year after military discharge and shall contain the following:

1) Documentation that the application is being filed within one year after military discharge;

2) Proof of successful completion of military emergency medical training;

3) A detailed description of the emergency medical curriculum completed, including official documentation demonstrating basic coursework and curriculum; and

4) A detailed description and official documentation of the applicant's clinical experience.

d) The Department may request additional and clarifying information and supporting documentation, if necessary, to verify the information provided in subsection (c).

e) The Department shall evaluate the application, including the applicant's training and experience, consistent with the standards set forth under Section 3.10(a), (b), (c) or (d) of the Act and this Part, to determine if the applicant qualifies for the licensure level for which the applicant has applied.

f) If the application clearly demonstrates that the training and experience meets the standards of subsection (e), the Department shall offer the applicant the opportunity to successfully complete a Department-approved EMS Personnel examination for the level of license for which the applicant is qualified, in accordance with Section 515.530.

g) Upon the applicant's passage of an examination and having paid all required fees, as set forth in Sections 515.530 and 515.460, the Department shall issue a license that shall be subject

to all provisions of the Act and this Part that are otherwise applicable to the class of EMS Personnel license issued, as set forth in Section 515.590. (Section 3.50(d)(2.5) of the Act)

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.640 Reinstatement

a) An Illinois licensed EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN or PHRN whose license has been expired for less than 36 consecutive months may apply for reinstatement by the Department. (Section 3.50(d)(5) of the Act)

b) Reinstatement shall require all of the following:

1) The applicant shall submit satisfactory proof of completion of continuing medical education and clinical requirements in accordance with the following:

A) Continuing education in accordance with Sections 515.560, 515.565, 515.570, 515.580, 515.710, 515.715, 515.725, 515.730 and 515.740 .

B) EMS Personnel education in accordance with Sections 515.500, 515.505, 515.510, 515.520, 515.710, 515.715, 515.725, 515.730 and 515.740.

2) The applicant shall submit a positive recommendation in writing from an Illinois EMS MD attesting to the applicant's clinical qualifications for retesting. The EMS MD shall verify that the applicant has demonstrated competency of all skills at the level of EMS Personnel license to be reinstated.

3) The applicant shall pass a Department-approved test for the level of EMS Personnel license sought to be reinstated, in accordance with Section 515.530. (Section 3.50(d)(5) of the Act)

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section 515.700 EMS Lead Instructor

a) All education, training and CE courses for EMT, EMT-I, A-EMT, Paramedic, PHRN, ECRN, EMR and EMD shall be coordinated by at least one approved Illinois EMS Lead Instructor. A program that includes education, training or CE for more than one type of EMS Personnel may use one EMS LI to coordinate the program. A single EMS LI may simultaneously coordinate more than one program or course. (Section 3.65(b)(5) of the Act)

b) To be eligible for an Illinois EMS LI license, the applicant shall meet at least the following minimum experience and education requirements and shall provide a written recommendation from the EMS MD of the primary EMS System affiliation:

1) A current Illinois license as an EMT, EMT-I, A-EMT, Paramedic, RN or physician;

2) A minimum of four years of experience in EMS or emergency care;

3) At least two years of documented teaching experience;

4) Documented EMS classroom teaching experience with a recommendation for LI licensure by an EMS MD or licensed LI;

5) Documented successful completion of the Illinois EMS Instructor Education Course or equivalent to the National Standard Curriculum for EMS Instructors as approved by the Department.

c) Upon successful course completion, the applicant may apply to the Department through the affiliated EMS System using the child support form available on the Department's website (http://dph.illinois.gov/sites/default/files/forms/ems-renewal-notice.pdf) and an application form provided by the local EMS System. The application will include demographic information, social security number, child support statement, felony conviction statement, applicable fees, and EMS System authorization.

d) All EMS LIs shall attend a Department-approved review course whenever revisions are made to the national EMS education standards.

e) Relicensure Application

1) To apply for relicensure, the EMS LI shall submit the following to the Department at least 60 days, but not more than 90 days, prior to the LI's license expiration:

A) A letter of support or electronic authorization from an EMS MD indicating that the EMS LI has satisfactorily coordinated programs for the EMS System at any time during the four-year period;

B) Documentation of at least 40 hours of continuing education, of which 20 hours shall be related to the development, delivery and evaluation of education programs; and

C) Documentation of attendance at a Department-approved national EMS education standards update course, if applicable, in accordance with subsection (d).

2) The EMS LI shall file a written or electronic application for renewal with the Department no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the expiration may not be processed by the expiration date and will be subject to a late fee once the license has expired.

A) In addition to submission of the renewal application and renewal fee, an LI functioning within an EMS System shall submit documentation of completion of all CE requirements of the EMS System or primary affiliation no less than 30 days before the expiration of his or her license.

B) An LI who has not been recommended for relicensure shall be provided with a written statement from the EMS MD stating the reason for the withholding of the endorsement.

C) The license of an LI who has failed to complete the renewal application requirements for the EMS System and the Department shall be invalid on the expiration of the license. An individual shall not function as an EMS LI on an expired license.

D) An LI whose license has expired may, within 60 days after the expiration of the license, submit all relicensure requirements and submit the fees required by Section 575.460, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending or sustained disciplinary actions against the LI, the Department will relicense the LI.

f) The Department will, in accordance with Section 515.160, suspend, revoke or refuse to issue or renew the approval of an EMS Lead Instructor, after an opportunity for a hearing, when findings show one or more of the following:

1) The EMS LI has failed to conduct a course in accordance with the curriculum prescribed by the Act and this Part and the System sponsoring the course; or

2) The EMS LI has failed to comply with protocols prescribed by this Part and the System sponsoring the course. (Section 3.65(b)(7) of the Act)

g) The EMS LI shall be responsible for the following:

1) Ensuring that no EMS education course begins until after the Department issues its formal written pre-approval, which shall be in the form of a numeric site approval code; and

2) Ensuring that all materials presented to participants comply with the national EMS education standards, as modified by the Department, and are approved by the EMS System and the Department. Methods of assessment or intervention that are not approved byboth the EMS System and the Department shall not be presented.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.710 Emergency Medical Dispatcher

a) EMD Licensure

1) To apply for licensure as an EMD, the individual shall request that the EMS System submit the following to the Department:

A) A completed electronic transaction form recommending initial licensure as an EMD; and

B) Documentation of successful completion of a training course in emergency medical dispatching that meets or exceeds the national curriculum of the United States Department of Transportation for EMS Dispatchers or its equivalent. (Section 3.70(a) of the Act)

2) Reciprocity shall be granted to an individual who is licensed as an EMD in another state and who meets the requirements of this Section.

3) An individual who is certified or recertified by a national certification agency shall be licensed as an EMD if he or she meets the requirements of this Section.

4) The license shall be valid for a period of four years.

5) A licensed EMD shall notify the Department within 30 days after any changes in name or address. Notification may be in person or by mail, phone, fax or electronic mail. Addresses may be changed through the Department's online system. Name and gender changes require legal documents, i.e., marriage license or court documents.

6) A person may not represent himself or herself, nor may an agency or business represent an agent or employee of that agency or business, as an EMD unless licensed by the Department as an EMD. (Section 3.70(b)(11) of the Act)

b) EMD Protocols

1) The EMD shall use the Department-approved emergency medical dispatch priority reference system (EMDPRS) protocol selected for use by his or her agency and approved by the EMS MD. Prearrival support instructions shall be provided in a non-discriminatory manner and shall be provided in accordance with the EMDPRS established by the EMS MD of the EMS System in which the EMD operates. (Section 3.70(a) of the Act)

2) EMD protocols shall include:

A) Complaint-related question sets that query the caller in a standardized manner;

B) Pre-arrival instructions associated with all question sets;

C) Dispatch determinants consistent with the design and configuration of the EMS System and the severity of the event as determined by the question sets; and

D) Post-dispatch instructions with all question sets.

3) If the dispatcher operates under the authority of an Emergency Telephone System Board established under the Emergency Telephone System Act, the protocols shall be established by the Board in consultation with the EMS MD. (Section 3.70(a) of the Act)

4) The EMD shall provide prearrival instructions in compliance with protocols selected and approved by the System's EMS MD and approved by the Department. (Section 3.70(b) of the Act)

5) The Department and the EMS MD shall approve EMDPRS protocols that meet or exceed the requirements of subsection (b)(2) and the National Highway Traffic Safety Administration (NHTSA) Emergency Medical Dispatch: National Standard Curriculum (1996); available from the U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954; no later editions or amendments are included.

c) EMD Relicensure

1) To apply for relicensure, the EMD shall submit the following to the Department no less than 30 days before the licensure expiration date:

A) An approval signed by the EMS MD recommending recertification;

B) Proof of completion of at least 12 hours annually of medical dispatch CE.

2) The EMD shall file a written or electronic application for renewal with the Department no less than 30 days before the license expiration data. Incomplete license applications submitted less than 30 days before the expiration of the license may not be processed by the expiration date and will be subject to a late fee.

3) An EMD whose license has expired may, within 60 days after the license expiration date, complete all relicensure requirements, and submit relicensure fees (see Section 515.460), including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met and there are no pending or sustained disciplinary action against the EMD, the Department will relicense the EMD.

4) An EMD who has not been recommended for relicensure by the EMS MD shall independently submit to the Department an application for recertification. The EMS MD shall provide the EMD with a copy of the appropriate form to be completed.

d) EMD Education Program

1) Department-approved emergency medical dispatch training programs shall be conducted in accordance with the standards of the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum or equivalent. (Section 3.70(b)(9) of the Act)

2) Applications for approval of EMD education programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, the name of the applicant, agency and address, type of education program, Lead Instructor's name and address, and dates of the education program.

3) Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class. A description of the text book being used and passing score for the course shall be included with the application. The application shall be made on a form provided by the Department and will include, but not be limited to, the following:

A) Name of applicant, agency and address:

B) Lead Instructor's name, license number, address and contact information;

C) Name and signature of the EMS MD and the EMS System Coordinator;

D) Type of education program;

E) Dates, times and location of the education program (submit course schedule);

F) Goals, objectives and course outline;

G) Methods, materials and text books;

H) Content and time consistent with the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum and additional course curricula required by the Department. Initial or modified course syllabi shall be approved by the Department;

I) Description of evaluation instruments (student, clinical units, faculty and programs); and

J) Requirements for successful completion, when applicable.

4) All education, training, and CE courses for EMD shall be coordinated by at least one approved EMS Lead Instructor. (Section 3.65(b)(5) of the Act) The EMS LI shall be approved by the Department based on the requirements of Section 515.700.

5) EMD training programs shall be conducted by instructors licensed by the Department as an EMT, EMT-I, A-EMT or Paramedic who:

A) are, at a minimum, licensed as emergency medical dispatchers;

B) have completed a Department-approved course on methods of instruction;

C) have previous experience in a medical dispatch agency; and

D) have demonstrated experience as an EMS instructor. (Section 3.70(b)(14) of the Act)

6) Any change in the EMD education program's EMS LI shall require that an amendment to the application be filed with the Department.

7) Questions for all quizzes and tests to be given during the EMD education program shall be prepared by the EMS LI and available for review by the Department upon the Department's request.

8) All approved programs shall maintain course and student records for seven years. The records shall be made available to the Department for review upon request.

e) Emergency Medical Dispatch Agency Certification

1) To apply for certification as an emergency medical dispatch agency, the person, organization or government agency that operates an emergency medical dispatch agency shall submit the following to the Department:

A) A completed emergency medical dispatch agency certification form that includes name and address;

B) Documentation of the use on every request for medical assistance of an emergency medical dispatch priority reference system (EMDPRS) that complies with this Section and is approved by the EMS MD (Section 3.70(b)(10) of the Act); and

C) Documentation of the establishment of a continuous quality improvement (CQI) program under the approval and supervision of the EMS MD. (Section 3.70(b)(10) of the Act) The CQI program shall include, at a minimum, the following:

i) A quality assistance review process used by the agency to identify EMD compliance with the protocol;

ii) Random case review;

iii) Regular feedback of performance results to all EMDs;

iv) Availability of CQI reports to the Department upon request; and

v) Compliance with the confidentiality provisions of the Medical Studies Act.

2) A person, organization, or government agency shall not represent itself as an emergency medical dispatch agency unless the person, organization, or government agency is certified by the Department as an emergency medical dispatch agency. (Section 3.70(b)(12) of the Act)

f) Emergency Medical Dispatch Agency Recertification
To apply for recertification, the emergency medical dispatch agency shall submit an application to the Department at least 30 days prior to the certification expiration date. The application shall document continued compliance with subsection (e).

g) Revocation or Suspension of EMD or Emergency Medical Dispatch Agency Certification

1) The EMS MD shall report to the Department whenever an action has taken place that may require the revocation or suspension of a license issued by the Department. (Section 3.70(b)(4) of the Act)

2) Revocation or suspension of an EMD license or emergency medical dispatch agency certification shall be in accordance with Section 515.165.

h) Waiver of Emergency Medical Dispatch Requirements

1) The Department may modify or waive emergency medical dispatch requirements based on:

A) The scope and frequency of dispatch activities and the dispatcher's access to training; or

B) Whether the previously attended dispatcher training program merits automatic relicensure for the dispatcher. (Section 3.70(b)(15) of the Act)

2) The following individuals are exempt from the requirements of this Section:

A) Public safety dispatchers who only transfer calls to another answering point that is responsible for dispatching of fire or EMS Personnel;

B) Dispatchers for volunteer or rural ambulance companies providing only one level of care, whose dispatchers are employed by the ambulance service and are not performing call triage, answering 911 calls or providing pre-arrival instructions.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.715 Provisional Licensure for Emergency Medical Responders

a) A person under the age of 18 shall not be issued an EMR license. A person between the ages of 16 and 18 who has successfully completed a Department-approved EMR course may apply to the Department for a provisional EMR license. Upon satisfaction of all other applicable

requirements, the Department will issue a provisional license, subject to the following limitations:

1) A person with a provisional license shall not use his or her provisional license except when affiliated with a recognized Illinois EMS System and with the written authorization of that System's EMS MD;

2) A provisional licensee shall not be placed in a position of primary response to emergencies by any licensee of the Department, unless the assignment satisfies all other provisions of this Part;

3) A provisional licensee shall function as an EMR only while under the direct, personal and continuous supervision of at least one other non-provisional EMR, EMT, A-EMT, EMT-I, Paramedic or PHRN licensed at or above the level of the provider's license. Nothing in this Part shall preclude a provisionally licensed EMR from providing nationally recognized basic first aid when not participating as part of the emergency medical response of his or her affiliated agency;

4) A provisional licensee shall not be involved in the transport of a patient unless he or she is under the direct, personal and continuous supervision of at least two other non-provisional EMRs, EMTs, A-EMTs, EMT-Is, Paramedics or PHRNs licensed at or above the level of the transport provider's license. A provisional licensee shall not be used to satisfy the staffing requirements of this Part;

5) A provisional licensee shall not operate, drive or maneuver a Department licensed transport vehicle, rescue vehicle or non-transport agency owned vehicle in connection with an emergency response or the transportation of any patient; and

6) A provisional licensee will be recognized by the Department as an unrestricted EMR upon turning 18 years of age as required in Section 515.725.

b) The EMS provider agency and the supervising licensee shall be jointly responsible for assuring that no provisional licensee violates rules applicable to the provisional licensee and shall jointly report, in writing, the nature and details of any violations of this Section to the EMS MD within 48 hours after the occurrence. A failure to make written reports as required shall be grounds for disciplinary action as authorized by this Part.

c) Violation of provisions applicable to provisional licensees shall be grounds for any form of disciplinary action authorized by this Part, up to and including license suspension and revocation.

d) Applicants for Provisional EMR shall verify compliance with Section 10-65(c) of the Illinois Administrative Procedure Act and Section 515.620 of this Part on a form prescribed by the Department.

e) The Provisional EMR license fee is the same fee prescribed in the schedule for EMRs (see Section 575.460). The license fee shall be in effect for four years.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.725 Emergency Medical Responder

a) An EMR education program shall be pre-approved by the Department and conducted only by an EMS System or a community college under the direction of the EMS System.

b) Applications for approval of EMR education programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS MD and EMS System Coordinator.

c) Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class.

d) The EMS MD of the EMS System shall attest on the application form that the education program will be conducted according to the national EMS education standards. The EMR education program shall include all components of the national EMS education standards, including all modifications required by the Department. The course hours shall minimally include 52 hours of didactic education.

e) The EMR education program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the education program and shall be approved by the Department based on requirements of Section 515.700.

f) The EMS MD shall electronically submit to the Department approval for licensure for an EMR candidate who is at least 18 years of age and has completed and passed all components of the education program, has passed the final examination, and has paid the appropriate initial licensure fee (see Section 515.460). The initial licensure fee may be waived pursuant to Section 515.460(c).

g) All approved programs shall maintain course and student records for seven years, which shall be made available to the Department upon request.

h) CE classes, seminars, workshops, or other types of programs shall be approved by the Department before being offered to EMR candidates. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department at least 60 days prior to the scheduled event.

i) Approval will be granted provided that the application is complete and the content of the program is based on topics or materials from the national EMS education standards for the EMR.

j) EMRs shall be responsible for submitting written proof of CE attendance to the EMS System Coordinator or, for independent renewals, to the Department Regional EMS Coordinator. The EMS System Coordinator or Department Regional EMS Coordinator shall verify whether specific CE hours submitted by the EMR qualify for renewal.

k) EMRs shall maintain copies of all documentation concerning CE programs that he or she has completed.

l) To renew an EMR license, the applicant shall submit the following to the Department at least 60 days, but no more than 90 days, before the license expiration. The renewal licensure fee may be waived pursuant to Section 515.460(c).

1) The submission of an electronic transaction by the EMS MD will satisfy the renewal application requirement for an EMR who has been recommended for re-licensure by the EMS MD.

2) The licensee shall file a written or electronic application for renewal with the Department no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the license expiration may not be processed by the expiration date and will be subject to a late fee.

3) EMRs whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the EMR, the Department will relicense the EMR.

4) An EMR who has not been recommended for relicensure by the EMS MD shall independently submit to the Department an application for renewal. The EMS MD shall provide the EMR with a copy of the application form.

m) A written recommendation signed by the EMS MD shall be provided to the Department regarding completion of the following requirements:

1) 24 hours of CE every four years. The System shall define in the EMS Program Plan the number of CE hours to be accrued each year for re-licensure; and

2) The licensee shall have a current CPR for Healthcare Providers card that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

n) EMRs whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or in the form of a certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the EMR, the Department will relicense the EMR.

o) EMRs who are not affiliated with an EMS System shall have equipment immediately available to provide the standard of care established by the national EMS education standards for the EMR.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.730 Pre-Hospital Registered Nurse

a) To be licensed as a PHRN, an individual shall:

1) Be an RN in accordance with the Nurse Practice Act;

2) Complete an education curriculum formulated by an EMS System and approved by the Department, which consists of at least 40 hours of classroom and psychomotor education and measurement of competency equivalent to the entry level Paramedic program; and practical education, including, but not limited to, advanced airway techniques, ambulance operations, extrication, telecommunications, and pre-hospital cardiac and trauma care of both the adult and pediatric population (Section 3.80(c)(1)(A) of the Act);

3) Complete a minimum of 10 ALS runs supervised by a licensed physician, an approved PHRN or a Paramedic, only as authorized by the EMS MD; and

4) New applicants completing course work after January 1, 2018 shall successfully pass the State of Illinois Paramedic licensure examination as the PHRN cognitive competency examination; and

5) The EMS MD shall electronically submit to the Department, using the Department's Electronic Transaction Form, making a recommendation for licensure for a PHRN candidate who has completed and passed all components of the PHRN education program and passed the final examination. The application will include demographic information, social security number, child support statement, felony conviction statement, and applicable fees and shall require EMS System authorization.

b) To apply for a four year renewal, the PHRN shall comply with Section 515.590.

c) Inactive Status

1) Prior to the expiration of the current license, a PHRN may request to be placed on inactive status as outlined in Section 515.600. The request shall be made in writing to the EMS MD.

2) A PHRN who wants to restore his or her license to active status shall follow the requirements set forth in Section 515.600.

3) If the PHRN inactive status period exceeds 48 months, the licensee shall redemonstrate competencies and successfully pass the State Paramedic examination.

4) The EMS MD shall notify the Department in writing of a PHRN's approval, reapproval, or granting or denying of inactive status within 10 days after any change in a PHRN's approval status.

e) A PHRN shall notify the Department within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax, or electronic mail. Addresses may be changed through the Department's online system: https://emslicensing.dph.illinois.gov/Clients/ILDOHEMS/Private/AddressChange/AddressLogin.aspx. Names and gender changes require legal documents, i.e., marriage license or court documents.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.740 Emergency Communications Registered Nurse

a) To be licensed as an ECRN, an individual shall:

1) Be an RN in accordance with the Nurse Practice Act;

2) Complete an education curriculum formulated by an EMS System and approved by the Department, which consists of at least 40 hours of classroom and practical education for both the adult and pediatric population, including telecommunications, System standing medical orders, and the procedures and protocols established by the EMS MD (Section 3.80(c)(1)(B) of the Act);

3) Complete eight hours of field experience supervised by a Paramedic, only as authorized by the EMS MD.

b) The EMS MD shall electronically submit to the Department, using the Department's Electronic Transaction Form, a recommendation for licensure for an ECRN candidate who has completed and passed all components of the education program and passed the final examination. The application will include demographic information, social security number, child support statement, felony conviction statement, applicable fees, and EMS System authorization.

c) To apply for a four year renewal:

1) The ECRN shall submit proof of the following no less than 60 days, but not more than 90 days, before the license expiration:

A) Is an RN with an unencumbered license in the state in which he or she practices; and

B) Has completed 32 hours of continuing education in a four-year period.

2) The ECRN shall submit a written or electronic application for renewal with the Department no less than 30 days before the license expiration. Incomplete license applications submitted less than 30 days before the expiration may not be processed by the expiration date and shall be subject to a late fee.

3) An ECRN whose license has expired may, within 60 days after the license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or by a certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the ECRN, the Department will relicense the ECRN.

d) Inactive Status

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Prior to the expiration of the current ECRN license, the ECRN may request to be placed on inactive status. The request shall be made in writing to the EMS MD and shall contain the following information:

A) Name of individual;

B) Date of approval;

C) Circumstances requiring inactive status;

D) A statement that recertification requirements have been met by the date of the application for inactive status.

2) The EMS MD shall review and grant or deny requests for inactive status.

3) For the ECRN to return to active status, the EMS MD shall document that the ECRN has been examined (physically and mentally) and found capable of functioning within the EMS System, that the ECRN's knowledge and clinical skills are at the active ECRN level, and that the ECRN has completed any refresher education deemed necessary by the EMS System. If the inactive status was based on a temporary disability, the EMS System shall also verify that the disability has ceased.

4) During inactive status, the individual shall not function as an ECRN at any level.

5) The EMS MD shall notify the Department in writing of the ECRN's approval, reapproval or granting or denying inactive status within 10 days after any change in an ECRN's approval status.

e) An ECRN shall notify the Department within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax or electronic mail. Addresses may be changed through the Department's online system: https://emslicensing.dph.illinois.gov/Clients/ILDOHEMS/Private/AddressChange/AddressLogin.aspx. Name and gender changes require legal documents, i.e., marriage license or court documents.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.750 Trauma Nurse Specialist

a) TNS Education Sites

1) TNS courses shall be conducted only at hospitals that have been designated by the Department as TNS education sites.

2) The Department shall designate TNS education sites based upon regional needs, the educational capabilities of interested hospitals to provide advanced trauma education to nurses, and participation in an EMS System.

3) The TNS Program Plan (see Section 515.760) shall serve as a standard TNS program plan. The Department will approve program plans based on compliance with Section 515.760.

4) The Chief Executive Officer of the hospital designated as a TNS education site shall appoint, and endorse in writing to the Department, a TNSCC to plan, coordinate, implement and evaluate the TNS course and TNS program activities, who meets the following requirements:

A) Is an RN with an unencumbered license in the state in which he or she practices;

B) Is employed by the TNS education site;

C) Has at least three years of experience as an RN in an emergency department or critical care setting in a trauma center;

D) Holds a certificate of TNS course completion issued by the Department as provided in this Section; and

E) Has a minimum of 50 hours of teaching experience in emergency/critical care nursing courses.

b) The TNSCC shall admit to the TNS course only those individuals who have met the following requirements:

1) Are currently licensed as an RN in the state in which they are practicing, as verified by the submission of a photocopy of the official license showing the license number and expiration date; and

2) Have at least 1500 hours of clinical care experience in an emergency department or critical care unit (preferred) as an RN, with successful completion of a unit orientation.

c) The TNS course shall reflect evidence-based content as created by the TNSCC and approved by the Department as being in compliance with the TNS program (see Section 515.760).

d) Testing

1) A standardized practical examination shall be administered. The practical examination shall include an assessment station at which the student will evaluate and stabilize a simulated critically injured trauma patient.

A) The student shall have a maximum of 10 minutes to evaluate and stabilize the patient.

B) The TNSCC shall develop the passing criteria, which shall be included in the program plan developed in accordance with Section 515.760.

C) A student shall be given three attempts to successfully complete the practical examination.

2) A student who has successfully completed course requirements per procedure and paid all fees shall be eligible to take the final written examination. The TNSCC shall develop the final examination and shall provide the examination to the Department. The TNSCC shall develop passing criteria, which shall be included in the Program Plan developed in accordance with Section 515.760.

A) A student shall be given three attempts to successfully complete the final written examination.

B) The candidate shall successfully achieve a passing score on the State examination within 12 months after completing the education program.

3) Examination Application

A) Candidates for the TNS examination shall apply to take the examination using the Department form. Information is available on the Department's website: http://www.continentaltesting.net/ProfDetail.aspx?Entity=5&ProfID=73.

B) A roster of examination candidates from each TNS education site is created by the TNSCC who approves the candidate's application and is submitted to the Department.

C) The candidate shall submit a fee for each written examination attempt (see Section 515.460).

e) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in forfeiture of the examination fee.

f) If a candidate does not achieve a passing grade on the written examination, the fee for the re-test is the same as for initial examination.

g) All fees submitted for licensure examination are nonrefundable.

h) Testing Option − Challenge
Any individual who has met the admission requirements provided in subsection (b) has the option of taking the TNS practical examination and final examination without having completed the didactic sessions (referred to as "challenging" the examination). The individual shall file a request to challenge the examination with the TNS education site at least 30 days prior to the scheduled practical examination. Candidates who elect to challenge the examination will have only one attempt to successfully complete the written and practical examinations to demonstrate proficiency.

i) Licensure as a TNS

1) The Department will license a student or candidate after the student or candidate has achieved a passing score on the final written and practical examinations and has paid any required fees (see Section 515.460).

2) Licensure is effective for four years.

j) TNS Relicensure

1) A TNS may be relicensed by either submitting approved trauma-specific CE or taking the current TNS final written examination as provided in this Section.

2) A TNS may apply for relicensure by submitting the following to a TNSCC at least 40 days, but no more than 90 days, prior to license expiration:

A) Documentation of 64 hours of approved trauma-specific CE/activities for nursing or CME acquired over four years, using the TNS CE Summary Submission form. CE approval will be granted, provided that the application is complete and the content of the program educational activity is based on topics listed in the TNS program in place at the time the CE is acquired;

B) Completed Child Support form supplied by the Department; and

C) Relicensure fee (see Section 515.460).

3) The TNS final written examination is an alternative option for relicensure. A total of three attempts are allowed for the relicensure candidate to achieve a successful examination score prior to the lapse date. The process used in subsection (d)(3) is used for the application, assignment to an examination site, and fee submission.

4) The candidate applying for license renewal is responsible for his/her record keeping and timely submission of CE documentation.

5) The license of a TNS who has failed to file an application for recertification or an application for an extension prior to the lapse date shall terminate on the day following the expiration date shown on the certificate.

k) Inactive Status

1) Prior to the expiration of the current license, a TNS may request to be placed on inactive status. The request shall be in writing, on a form prescribed by the Department, and shall contain the following information:

A) Name of individual;

B) Date of certification;

C) Circumstances requiring inactive status; and

D) A statement that relicensure requirements have been met by the date of the application for inactive status. CE hours shall be current at the prorated rate of 1.3 hours per month for the current licensure period.

2) The Department will review requests for inactive status. The Department will notify the individual TNS in writing of its decision based on subsection (k)(1).

3) To return to active status, the TNS shall apply in writing within 36 months after being placed on inactive status. The application shall include a current unencumbered RN license and a fee (see Section 515.460).

4) Inactive status is valid for only 36 months. If status is not reactivated, the individual shall successfully complete the examination or retake the course (see subsection (h)).

5) During inactive status, the individual shall not function as a TNS.

l) A TNS whose license has expired may, within 60 days after expiration, submit all relicensure material required by this Section and a fee (see Section 515.460), in the form of an organization's payment, a certified check, or a money order (cash or personal check will not be accepted). If the application for license renewal meets the requirements of this Section and there is no disciplinary action pending against the TNS, the Department will renew the TNS license.

m) A TNS shall notify the Department within 30 days after any change in name or address. Notification may be in person or by mail, phone, fax or electronic mail. Addresses may be changed through the Department's online system: https://emslicensing.dph.illinois.gov/Clients/ILDOHEMS/Private/AddressChange/AddressLogin.aspx. Name and gender changes require legal documents, i.e., marriage licenses or court documents.

n) The Department shall have the authority and responsibility to suspend, revoke or renew the license of a TNS, after an opportunity for hearing by the Department, if findings show that the TNS has failed to maintain proficiency in the level of skills for which the TNS is licensed or has failed to comply with relicensure requirements. (Section 3.75(b)(8) of the Act) Hearings shall be conducted in accordance with Practice and Procedure in Administrative Hearings.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.760 Trauma Nurse Specialist Program Plan

A TNS program plan shall contain the following information:

a) The name, address and fax number of the TNS site hospital;

b) The names and resumes of the TNSCCs;

c) Current letters of commitment from the following persons at the TNS site hospital that describe the commitment of the writer and his or her office to the development and ongoing operation of the TNS program and that state the writer's understanding of and commitment to TNS program staffing and educational requirements:

1) The Chief Executive Officer of the hospital; and

2) The administrative representative responsible for the TNS program;

d) A letter of commitment from the above administrator that describes the TNS site's agreement to:

1) Be responsible for providing initial TNS education and CE based on region needs, including coordinating didactic and clinical experiences;

2) Provide travel and meeting time and expenses; clerical support including access to a computer with word processing and data base management capabilities; audiovisual equipment; printing; and education aides;

3) Ensure that the Department has access to all TNS program records under the authority of the TNS site during any Department inspection, investigation or site survey;

4) Notify the Department of any known changes in TNS personnel;

5) Be responsible for the total management of the TNS program at that site and collaborative management of the TNS program with all TNSCCs and the Department;

6) Ensure that a copy of the application for renewal (a form supplied by the Department) is provided to every TNS within the region (in collaboration with TNSCCs); and

7) Be responsible for compliance with the provisions of Section 515.750.

e) The TNS program manual maintained at each TNS site shall include the following:

1) Education

A) Content and curricula of the TNS educational or certification program including:

i) Entrance and completion requirements;

ii) Program schedules;

iii) Goals and objectives;

iv) Subject areas;

v) Didactic requirements, including skills laboratories;

vi) Clinical requirements;

vii) Testing formats.

B) CE for TNSs, including:

i) Relicensure requirements (hours, types of programs, etc.);

ii) Site program for TNS participants: types of activities covered (e.g., trauma case review, morbidity and mortality conferences, grand rounds, etc.);

iii) Requirements for approval of academic course work;

iv) Didactic programs offered by the site;

v) Clinical opportunities available within the region;

vi) Record-keeping requirements for the individual.

C) Renewal Protocols

i) Examination requirements for TNSs;

ii) Procedures for renewal of TNSs;

iii) Submission of transaction cards for TNSs meeting renewal requirements;

iv) Providing Department renewal application forms to TNSs who have not met renewal requirements according to region records.

D) TNS education and information, including:

i) Distribution of policy and protocol changes;

ii) Methods for communicating updates on site and regional activities, and other matters of medical, legal and/or professional interest;

iii) Locations of resource materials, forms, schedules, etc.

2) Quality improvement measures should be performed on a semiannual basis and be available upon Department request.

3) Any procedures regarding disciplinary or suspension decisions and the review of those decisions that the site has elected to follow in addition to those required by the Act.

4) The responsibilities of the TNSCC, as designated by the Department, including:

A) Curriculum development and maintenance;

B) Creation and maintenance of the program policies and procedures;

C) Planning, organizing, implementing and evaluating the TNS course at that site;

D) Planning, organizing, implementing and evaluating CE offerings in their regions;

E) Maintenance of a TNS database within the region to facilitate TNS relicensure;

F) Archive TNS education records, including: curriculum, handouts, and participant information for minimum of 7 years;

G) Attend not less than 75 percent of bimonthly scheduled meetings.

5) All TNS sites in existence upon adoption of this Section shall submit to the Department a revised program plan that conforms to requirements of this Part. The Department will approve program plans that meet the requirements of this Part.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.810 EMS Vehicle System Participation

For each EMS vehicle participating within the System, the following documentation shall be provided:

a) A list of the following:

1) The year, model, make and vehicle identification number;

2) The license plate number;

3) The Department license number;

4) The base location address; and

5) The level of service (advanced, intermediate or basic);

b) A description of the vehicle's role in providing advanced life support, intermediate life support, basic life support and patient transport services within the System;

c) Definitions of the primary, secondary and outlying areas of response for each EMS vehicle used within the System;

d) A map or maps indicating the base locations of each EMS vehicle, the primary, secondary and outlying areas of response for each EMS vehicle, the population base of each service area and the square mileage of each service area;

e) A commitment to optimum response times up to six minutes in primary coverage areas, six to 15 minutes in secondary coverage areas, and 15 to 20 minutes in outlying coverage areas;

f) A commitment to 24-hour coverage;

g) A commitment that within one year after Department approval of a new or upgraded vehicle service, each ambulance at the scene of an emergency and during transport of emergency patients to and between hospitals will be staffed in accordance with the requirements of Section 515.830(f)(1) and (2);

h) Copies of written mutual aid agreements with other providers and a description of the provider's own back-up system, which detail how adequate coverage will be ensured when an EMS vehicle is responding to a call and a simultaneous call is received for service within that vehicle's coverage area;

i) A statement that emergency services that an EMS vehicle is authorized to provide shall not be denied on the basis of the patient's inability to pay for such services;

j) An agreement to file an appropriate EMS run sheet or form for each emergency call, as required by the System;

k) An agreement to maintain the equipment required by Section 515.830 and by the System in working order at all times, and to carry the medication as required by the System;

l) An agreement to notify the EMS MD of any changes in personnel providing pre-hospital care in the System in accordance with the policies in the System manual;

m) A copy of its current FCC licenses;

n) A description of the mechanism and specific procedures used to access and dispatch the EMS vehicles within their respective service areas;

o) A list of all personnel who will provide care, their license numbers, expiration dates and levels of licensure (EMT, EMT-I, A-EMT, Paramedic), and their PHRN or physician;

p) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;

q) An agreement to allow the EMS MD or designee access to all records, equipment and vehicles relating to the System during any inspection or investigation by the EMS MD or designee to determine compliance with the System program plan;

r) Documentation that its communications capabilities meet the requirements of Section 515.410;

s) Documentation that each EMS vehicle participating in the System complies with the vehicle design, equipment and extrication criteria as provided in Section 515.830(a)(1) and (b); and

t) An agreement to follow the approved EMS policies and protocols of the System.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.825 Alternate Response Vehicle

a) Ambulance Assistance Vehicles

Ambulance assistance vehicles are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. Ambulance assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by this Section. Ambulance assistance vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available. The agency shall identify ambulance

assistance vehicles as a program plan amendment outlining the type and level of response that is planned. The ambulance assistance vehicle shall not transport or be a primary response vehicle but a supplementary vehicle to support EMS services. The ambulance assistance vehicle shall be dispatched only if needed. Ambulance assistance vehicles shall be classified as either:

1) Advanced ambulance assistance vehicles shall be staffed with a minimum of one Paramedic, PHRN or physician and shall have all of the required equipment;

2) Intermediate ambulance assistance vehicles shall be staffed with a minimum of one EMT, EMT-I, A-EMT, Paramedic, PHRN or physician and shall have all of the required equipment;

3) Basic ambulance assistance vehicles shall be staffed with a minimum of one EMT, EMT-I, A-EMT, Paramedic, PHRN or physician and shall have all of the required equipment; or

4) First Responder assistance vehicles shall be staffed with a minimum of one EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN or physician and shall have all of the required equipment.

b) Non-Transport Vehicles
Non-Transport Vehicles are dispatched prior to dispatch of a transporting ambulance and include ambulances and fire engines that contain the staff and equipment required by this Section. The vehicle service provider shall identify non-transport vehicles as a program plan amendment outlining the type and level of response that is planned. Non-transport vehicles shall be staffed 24 hours per day, every day of the year.

1) ALS Non-Transport Vehicles shall have a minimum of either one System authorized Paramedic or one PHRN and one additional System authorized A-EMT, EMT-I, EMT or physician, and shall have all of the required equipment.

2) ILS Non-Transport Vehicles shall have a minimum of either one System authorized A-EMT, EMT-I, Paramedic or PHRN and one additional System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician and shall have the required equipment.

3) BLS Non-Transport vehicles shall be staffed by one System authorized EMT, A-EMT, EMT-I, Paramedic or physician on all responses and shall have all of the required equipment.

c) Equipment Requirements
Each vehicle used as an alternate response vehicle shall meet the following equipment requirements, as determined by the Department by an inspection.

1) Functional portable oxygen cylinder, with a capacity of not less than 350 liters

2) Dial flowmeter/regulator for 15 liters per minute

3) Delivery tubes

4) Adult, child and infant masks

5) Adult squeeze bag and valve, with adult and child masks

6) Child squeeze bag and valve, with child, infant and newborn size masks

7) Airways, oropharyngeal − adult, child and infant (sizes 00-5)

8) Airways, nasopharyngeal with lubrication (sizes 12-30F)

9) Manually operated suction device

10) Triangular bandages or slings

11) Roller bandages, self-adhering (4" by 5 yds)

12) Trauma dressings

13) Sterile gauze pads (4" by 4")

14) Vaseline gauze (3" by 8")

15) Bandage shears

16) Adhesive tape rolls

17) Blanket

18) Long backboard (if required by the EMS System protocols)

19) Cervical collars − adult, child and infant

20) Extremity splints − adult/child, long/short

21) Adult/child/infant blood pressure cuffs and gauge

22) Stethoscope

23) Burn sheet, individually wrapped

24) Sterile saline or water solution (1,000ml), plastic bottles or bags

25) Obstetrical kit, sterile − minimum one, pre-packaged with instruments, bulb syringe and cord clamps

26) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

27) Cold packs

28) EMS run reports

29) Nonporous disposable gloves

30) Personal protective equipment (PPE), including gowns, eye/nose/mouth protection or face shields

31) Flashlight

32) Equipment to allow reliable communications with hospital

33) ILS/ALS System-approved equipment

A) Drug box

B) Airway equipment, including laryngoscope and assorted blades

C) Monitor/defibrillator, equipped with pediatric size defibrillation pads or paddles

34) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care

35) Automated external defibrillator (AED) that includes pediatric capabilities

e) Registration of Non-transport Provider Agencies

Each non-transport provider shall complete and submit to the Department either the EMS non-transport provider application or EMS non-transport application for an existing transport provider, available on the Department's website: http://dph.illinois.gov/topics-services/emergency-preparedness-response/ems/prov-vehLic.

f) Inspection of Non-transport EMS Providers

The Department will schedule initial inspections. Thereafter, non-transport ambulance assist providers shall perform annual self-inspections, using forms provided by the Department, and shall submit the form to the EMS System for submission to the Department upon completion of the inspection. The Department will perform inspections randomly or as the result of a complaint.

g) Issuance and Renewal of License

Upon payment of the appropriate fee, qualifying non-transport providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual Non-Transport Vehicles. Providers shall inform the EMS System and the Department of any modifications to the application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.830 Ambulance Licensing Requirements

a) Vehicle Design

1) Each new vehicle used as an ambulance shall comply with the criteria established by the Federal Specifications for Ambulance, KKK-A-1822F, United States General Services Administration, with the exception of Section 3.16.2, Color, Paint and Finish.

2) A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, as long as the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred. (Section 3.85(b)(8) of the Act)

3) The following requirements listed in Specification KKK-A-1822F shall be considered mandatory in Illinois even though they are listed as optional in that publication:

A) 3.7.7.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item 7).

B) 3.8.5.2 Patient compartment checkout lights will be provided (see 3.15.3 item 9).

C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).

D) 3.15.4M3 Electric clock with sweep second hand will be provided.

b) Equipment Requirements – Basic Life Support Vehicles Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

1) Stretchers, Cots, and Litters

A) Primary Patient Cot
Shall meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822F.

B) Secondary Patient Stretcher
Shall meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822F.

2) Oxygen, Portable
Shall meet the operational requirements of section 3.12.2 of KKK-A-1822-F.

3) Suction, Portable

A) Shall meet the operational requirements of section 3.12.4 of KKK-A-1822F.

B) A manually operated suction device is acceptable if approved by the Department.

4) Medical Equipment

A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask, and child size bag-valve-mask ventilation unit with child, infant and newborn size transparent masks

B) Lower-extremity traction splint, adult and pediatric sizes

C) Blood pressure cuff, one each, adult, child and infant sizes and gauge

D) Stethoscopes, two per vehicle

E) Pneumatic counterpressure trouser kit, adult size, optional

F) Long spine board with three sets of torso straps, 72" x 16" minimum

G) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional

H) Airway, oropharyngeal – adult, child, and infant, sizes 0-5

I) Airway, nasopharyngeal with lubrication, sizes 14-34F

J) Two adult and two pediatric sized non-rebreather oxygen masks per vehicle

K) Two infant partial re-breather oxygen masks per vehicle

L) Three nasal cannulas, adult and child size, per vehicle

M) Bandage shears, one per vehicle

N) Extremity splints, adult, two long and short per vehicle

O) Extremity splints, pediatric, two long and short per vehicle

P) Rigid cervical collars – one pediatric, small, medium, and large sizes or adjustable size collars per vehicle. Shall be made of rigid material to minimize flexion, extension, and lateral rotation of the head and cervical spine when spine injury is suspected

Q) Patient restraints, arm and leg, sets

R) Pulse oximeter with pediatric and adult probes

S) AED or defibrillator that includes pediatric capability

5) Medical Supplies

A) Trauma dressing – six per vehicle

B) Sterile gauze pads – 20 per vehicle, 4 inches by 4 inches

C) Bandages, soft roller, self-adhering type, 10 per vehicle, 4 inches by 5 yards

D) Vaseline gauze – two per vehicle, 3 inches by 8 inches

E) Adhesive tape rolls – two per vehicle

F) Triangular bandages or slings – five per vehicle

G) Burn sheets – two per vehicle, clean, individually wrapped

H) Sterile solution (normal saline) – four per vehicle, 500 cc or two per vehicle, 1,000 cc plastic bottles or bags

I) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

J) Obstetrical kit, sterile – minimum one, pre-packaged with instruments and bulb syringe

K) Cold packs, three per vehicle

L) Hot packs, three per vehicle, optional

M) Emesis basin – one per vehicle

N) Drinking water – one quart, in non-breakable container; sterile water may be substituted

O) Ambulance emergency run reports – 10 per vehicle, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515.Appendix E or electronic documentation with paper backup

P) Pillows – two per vehicle, for ambulance cot

Q) Pillowcases – two per vehicle, for ambulance cot

R) Sheets – two per vehicle, for ambulance cot

S) Blankets – two per vehicle, for ambulance cot

T) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care

U) Urinal

V) Bedpan

W) Remains bag, optional

X) Nonporous disposable gloves

Y) Impermeable red biohazard-labeled isolation bag

Z) Face protection through any combination of masks and eye protection and field shields

AA) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall have a thumb suction control port

BB) Child and infant or convertible car seats

CC) Current equipment/drug dosage sizing tape or pediatric equipment/drug age/weight chart

DD) Flashlight, two per vehicle, for patient assessment

EE) Current Illinois Department of Transportation Safety Inspection sticker in accordance with Section 13-101 of the Illinois Vehicle Code

FF) Illinois Poison Center telephone number

GG) Department of Public Health Central Complaint Registry telephone number posted where visible to the patient

HH) Medical Grade Oxygen

II) Ten disaster triage tags

JJ) State-approved Mass Casualty Incident (MCI) triage algorithms (START/JumpSTART)

c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS MD in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These

vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

d) Equipment Requirements – Rescue and/or Extrication
The following equipment shall be carried on the ambulance, unless the ambulance is routinely accompanied by a rescue vehicle:

1) Wrecking bar, 24"

2) Goggles for eye safety

3) Flashlight – one per vehicle, portable, battery operated

4) Fire Extinguisher – two per vehicle, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment

e) Equipment Requirements – Communications Capability
Each ambulance shall have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400.

f) Equipment Requirements – Epinephrine
An EMT, EMT-I, A-EMT or Paramedic who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) with him or her in the ambulance or drug box as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System within the context of the EMS System plan. (Section 3.55(a-7) of the Act)

g) Personnel Requirements

1) Each Basic Life Support ambulance shall be staffed by a minimum of one System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician on all responses.

2) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one System authorized A-EMT, EMT-I, Paramedic or PHRN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician on all responses.

3) Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one System authorized Paramedic or PHRN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician on all responses.

h) Alternate Rural Staffing Authorization

1) A Vehicle Service Provider that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers, paid-on-call personnel or a combination to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMS Personnel licensed at or above the level at which the vehicle is licensed, plus one EMR when two licensed EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs or physicians are not available to respond. (Section 3.85(b)(3) of the Act)

2) The EMS Personnel licensed at or above the level at which the ambulance is licensed shall be the primary patient care provider in route to the health care facility.

3) The Vehicle Service Provider shall obtain the prior written approval for alternate rural staffing from the EMS MD. The EMS MD shall submit to the Department a request for an amendment to the existing EMS System plan that clearly demonstrates the need for alternate rural staffing in accordance with subsection (h)(4) and that the alternate rural staffing will not reduce the quality of medical care established by the Act and this Part.

4) A Vehicle Service Provider requesting alternate rural staffing authorization shall clearly demonstrate all of the following:

A) That it has undertaken extensive efforts to recruit and educatelicensed EMTs, A-EMTs, EMT-Is, Paramedics, or PHRNs;

B) That, despite its exhaustive efforts, licensed EMTs, A-EMTs, EMT-Is, Paramedics or PHRNs are not available; and

C) That, without alternate rural staffing authorization, the rural or semi-rural population of 10,000 or fewer inhabitants served will be unable to meet staffing requirements as specified in subsection (g).

5) The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates not to exceed 48 months. The EMS MD shall re-evaluate subsequent requests for authorization for compliance with subsections (h)(4)(A) through (C). Subsequent requests for authorization shall be submitted to the Department for approval in accordance with this Section.

6) Alternate rural staffing authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate rural staffing authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate rural staffing authorization presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing.

7) Vehicle Service Providers that cannot meet the alternate rural staffing authorization requirements of this Section may apply through the EMS MD to the Department for a staffing waiver pursuant to Section 515.150.

i) Alternate Response Authorization

1) A Vehicle Service Provider that exclusively uses volunteers or paid-on-call personnel or a combination to provide patient care who are not required to be stationed with the vehicle may apply to the Department for alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed by at least one licensed EMT, A-EMT, EMT-I, Paramedic, PHRN or physician.

2) A Vehicle Service Provider operating under alternate response authorization shall ensure that a second licensed EMS Personnel is on scene or in route to the emergency response location.

3) The Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with fewer than two EMTs, Paramedics or PHRNs or a physician or a combination, at least one of whom shall be licensed at or above the level of the license for the vehicle, unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h).

4) Alternate response authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization presents an immediate threat to the health or safety of the public. After summary suspension, the licensee shall have the opportunity for an expedited hearing (see Section 515.180).

j) Alternate Response Authorization – Secondary Response Vehicles

1) A Vehicle Service Provider that uses volunteers or paid-on-call personnel or a combination to provide patient care, and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one System authorized licensed EMT, A-EMT, EMT-I, PHRN or physician.

2) A Vehicle Service Provider operating under the alternate response authorization shall ensure that a second System authorized licensed EMT, A-EMT, EMT-I, Paramedic, PHRN or physician is on the scene or in route to the emergency response location, unless the Vehicle Service Provider is approved for alternate rural staffing authorization, in which case the second individual may be an EMR or First Responder.

3) The Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported without at least one EMT who is licensed at or above the level of ambulance, plus at least one of the following: EMT, Paramedic, PHRN or physician, unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h).

4) Alternate response authorization for secondary response vehicles may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization for secondary response vehicles may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization for secondary vehicles presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing (see Section 515.180).

k) Operational Requirements

1) An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the Act and this Part.

2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required in this subsection (k), each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS

vehicle can be used to provide coverage at either an ALS, ILS or BLS level, and the coverage shall meet the requirements of this Section.

A) At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

i) A current roster shall also be submitted that lists the System authorized EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date and telephone number, and shall state whether the person is scheduled to be on site or on call.

ii) An actual or proposed four-week staffing schedule shall also be submitted that covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

B) Licensees shall obtain the EMS MD's approval of their vehicles' hours of operation prior to submitting an application to the Department. An EMS MD may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

C) A Vehicle Service Provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day. (See Section 515.800(j).)

3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Appendix E.

4) A Vehicle Service Provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.

5) A Vehicle Service Provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h).)

6) A Vehicle Service Provider shall not operate its ambulance at a level exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support),

unless the vehicle is operated pursuant to an EMS System-approved in-field service level upgrade or ambulance service upgrades – rural population.

7) The Department will inspect ambulances each year. If the Vehicle Service Provider has no violations of this Section that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it, the Department will inspect the Vehicle Service Provider's ambulances in alternate years, and the Vehicle Service Provider may, with the Department's prior approval, self-inspect its ambulances in the other years. The Vehicle Service Provider shall use the Department's inspection form for self-inspection. Nothing contained in this subsection (k)(7) shall prevent the Department from conducting unannounced inspections.

l) A licensee may use a replacement vehicle for up to 10 days without a Department inspection, provided that the EMS System and the Department are notified of the use of the vehicle by the second working day.

m) Patients, individuals who accompany a patient, and EMS Personnel may not smoke while inside an ambulance or SEMSV. The Department of Public Health shall impose a civil penalty on an individual who violates this subsection (m) in the amount of $100. (Section 3.155(h) of the Act)

n) Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.860 Critical Care Transport

a) Critical care transport may be provided by:

1) Department-approved critical care transport providers, not owned or operated by a hospital, utilizing EMT-Paramedics with additional training, nurses, or other qualified health professionals; or

2) Hospitals, when utilizing any vehicle service provider or any hospital-owned or operated vehicle service provider. Nothing in the Act requires a hospital to use, or to be, a Department-approved critical care transport provider when transporting patients, including those critically injured or ill. Nothing in the Act shall restrict or prohibit a hospital from providing, or arranging for, the medically appropriate transport of any patient, as determined by a physician licensed to

practice medicine in all of its branches, an Advanced Practice Nurse, or a physician assistant. (Section 3.10(f-5) of the Act)

b) All critical care transport providers must function within a Department-approved EMS System. Nothing in this Part shall restrict a hospital's ability to furnish personnel, equipment, and medical supplies to any vehicle service provider, including a critical care transport provider. (Section 3.10(g-5) of the Act)

c) For the purposes of this Section, "expanded scope of practice" includes the accepted national curriculum plus additional education, experience and equipment (see Section 515.360) as approved by the Department pursuant to Section 3.55 of the Act. Tier I transports are considered "expanded scope of practice".

d) For the purposes of this Section, CCT plans are defined in three tiers of care. Tier II and Tier III are considered Critical Care Transports.

e) Tier I

Tier I provides a level of care for patients who require care beyond the Department-approved Paramedic scope of practice, up to but not including the requirements of Tiers II and III. Tier I transport includes the use of a ventilator, the use of infusion pumps with administration of medication drips, and maintenance of chest tubes.

1) Personnel Staffing and Licensure

A) Licensure:

i) Licensed Illinois Paramedic or PHRN;

ii) Scope of practice more comprehensive than the national EMS scope of practice model approved by the Department in accordance with the EMS System plan (see Sections 515.310 and 515.330); and

iii) Approved to practice by the Department in accordance with the EMS System plan.

B) Minimum Staffing:

i) System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN as driver; and

ii) System authorized expanded scope of practice Paramedic, PHRN or physician who shall remain with the patient at all times.

2) Education, Certification and Experience

A) Initial Education: Documentation of initial education and demonstrated competencies of expanded scope of practice knowledge and skills as required by Tier I Level of Care and approved by the Department in accordance with the EMS System plan.

B) CE Requirements:

i) Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed; and

ii) The EMS vehicle service provider shall maintain documentation of competencies and provide documentation to the EMS Resource Hospital upon request.

C) Certifications − Tier I personnel shall maintain all of the following renewable certifications and credentials in active status:

i) Advanced Cardiac Life Support (ACLS);

ii) Pediatric Education for Pre-Hospital Professionals (PEPP) or Pediatric Advance Life Support (PALS);

iii) International Trauma Life Support (ITLS) or Pre-Hospital Trauma Life Support (PHTLS); and

iv) Any additional educational course work or certifications required by the EMS MD.

D) Experience:

i) Minimum of one year of experience functioning in the field at an ALS level or as a physician in an emergency department; and

ii) Documentation of education and demonstrated competencies of expanded scope of practice knowledge and skills required for Tier I Level of Care, approved by the Department and included in the EMS System plan.

3) Medical Equipment and Supplies

A) Ventilator; and

B) Infusion pumps.

4) Vehicle Standards
Any vehicle used for providing expanded scope of practice care shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs –General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for expanded scope of practice transport shall be equipped with an onboard alternating current (AC) supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

5) Treatment and Transport Protocols shall address the following:

A) EMS MD or designee present at established Medical Control;

B) Communication points for contacting System authorized Medical Control and a written Expanded Scope of Practice Standard;

C) Written operating procedures and protocols signed by the EMS MD and approved for use by the Department in accordance with the System plan; and

D) Use of a ventilator, infusion pumps with administration of medication drips, and maintenance of chest tubes.

6) Quality Assurance Program

A) The Tier I transport provider shall develop a written Quality Assurance (QA) plan approved by the EMS System and the Department in accordance with subsection (e)(6)(D). The provider shall provide quarterly QA reports to the assigned EMS Resource Hospitals for the first 12 months of operation.

B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.

C) An EMS MD or a SEMSV shall oversee the QA program.

D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:

i) Review of transferring physician orders and evidence of compliance with those orders;

ii) Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;

iii) Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;

iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;

v) Review of any Medical Control contact for further direction;

vi) Documentation that any unusual occurrences were promptly communicated to the EMS System; and

vii) A root cause analysis of any event or care inconsistent with standards. The EMS System educator shall assess and carry out a corrective action plan.

E) The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

f) Tier II

Tier II provides a level of care for patients who require care beyond the Department-approved national EMS scope of practice model and expanded scope of practice ALS (Paramedic) transport program, and who require formal advanced education for ALS Paramedic staff. Tier II transport includes the use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines; accessing central lines; medication-assisted intubation; patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

1) Personnel Staffing and Licensure

A) Licensure − Licensed Illinois Paramedic or PHRN:

i) Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier I Level as approved by the Department; and

ii) Approved to practice by the EMS System and the Department in accordance with the EMS System plan.

B) Minimum Staffing:

i) System authorized Paramedic or PHRN; and

ii) System authorized Paramedic, PHRN or physician who is critical care prepared and who shall remain with the patient at all times.

2) Education, Certification and Experience

A) Initial Advanced Formal Education:

i) At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education based on nationally recognized program models; and

ii) Demonstrated competencies, as documented by the EMS MD or SEMSV MD and approved by the Department.

B) CE Requirements:

i) The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;

ii) The following current credentials, as a minimum, shall be maintained: ACLS, PEPP or PALS, ITLS or PHTLS;

iii) A minimum of 40 hours of critical care level education shall be completed every four years;

iv) The EMS provider shall maintain documentation of compliance with subsections (f)(2)(B)(i) through (iii) and shall provide documentation to the EMS Resource Hospital upon request; and

v) Nationally recognized critical care certifications shall be maintained and renewed based on national recertification criteria.

C) Experience − Minimum of two years experience functioning in the field at an ALS level for Paramedics and PHRNsand one year experience in an emergency department for physicians.

3) Medical Equipment and Supplies

A) Ventilator; and

B) Infusion pumps.

4) Vehicle Standards
Any vehicle used for providing critical care transport shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

5) Treatment and Transport Protocols shall address the following:

A) EMS MD or designee present at established Medical Control communication points and a written Expanded Scope of Practice Standard Operating Procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;

B) The use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines, accessing central lines, and medication-assisted intubation; and

C) Patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

6) Quality Assurance Program

A) The Tier II transport provider shall develop a written QA plan approved by the EMS System and the Department in accordance with subsection (f)(6)(D). The participating provider

shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.

B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.

C) An EMS MD or SEMSV MD shall oversee the QA program.

D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:

i) Review of transferring physician orders and evidence of compliance with those orders;

ii) Documentation of vital signs and frequency, and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;

iii) Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;

iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;

v) Review of any Medical Control contact for further direction;

vi) Documentation that unusual occurrences were promptly communicated to the EMS System; and

vii) A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.

E) The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

g) Tier III

Tier III provides the highest level of ground transport care for patients who require nursing level treatment modalities and interventions.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Minimum Personnel Staffing and Licensure

A) EMT, A-EMT, EMT-I or Paramedic (as driver); and

B) Two critical care prepared providers, who shall remain with the patient at all times:

i) Paramedic or PHRN; and

ii) RN or PHRN.

2) Education, Certification, and Experience: Paramedic or PHRN

A) Initial Advanced Formal Education

i) Approval to practice by EMS System and the Department in accordance with the EMS program plan;

ii) At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education nationally recognized program models;

iii) Demonstrated competencies, as documented by EMS MD and SEMSV MD and approved by the Department; and

iv) Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier II level as approved by the Department.

B) CE Requirements

i) The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;

ii) The following valid credentials, at a minimum, shall be maintained: ACLS, PEPPO or PALS, ITLS or PHTLS;

iii) A minimum of 40 hours of critical care level CE shall be completed every four years;

iv) The EMS provider shall maintain documentation of compliance with subsection (g)(2)(B)(i) and shall provide documentation to the EMS Resource Hospital upon request; and

v) Nationally recognized critical certifications shall be maintained and renewed based on national recertification criteria.

C) Experience

i) Minimum of two years experience functioning in the field at an ALS Level;

ii) Documented demonstrated competencies; and

iii) Completion of annual competencies of expanded scope knowledge, equipment and procedures.

3) Education, Certification and Experience − Registered Nurse:

A) CE Requirements

i) A minimum of 48 hours of critical care level education shall be completed every four years;

ii) The EMS provider shall maintain documentation of compliance with subsection (g)(3)(A)(i) and shall provide documentation to the EMS Resource Hospital upon request; and

iii) Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed.

B) Certifications
Tier III personnel shall maintain the following valid critical care certifications and credentials:

i) ACLS;

ii) PALS, PEPP or ENPC;

iii) ITLS, PHTLS, TNCC or TNS; and

iv) ECRN or equivalent.

C) Advanced Certifications Preferred but not Required

i) Certified Emergency Nurse (CEN);

ii) Critical Care Registered Nurse (CCRN);

iii) Critical Care Emergency Medical Technician-Paramedic (CCEMT-P);

iv) Certified Registered Flight Nurse (CFRN); and

v) Certified Transport Registered Nurse (CTRN).

D) Experience

i) Two years of experience with demonstrated competency in a critical care setting; and

ii) Documented demonstrated EMT System competencies.

4) Medical Equipment and Supplies

Tier III transport requires nursing level treatment modalities and interventions as agreed upon by the sending physician and the accepting physician at the receiving facility. If either physician is not available for consult, the EMS MD or SEMSV MD or designee shall direct care.

5) Vehicular Standards

Any vehicle used for providing CCT shall comply, at a minimum, with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

6) Treatment and Transport Protocols shall address the following:

A) Paramedic or PHRN: EMS MD or designee present at established Medical Control communication points and written Critical Care Standard Operating procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;

B) Registered Nurse: The provider's EMS MD or SEMSV Critical Care MD may establish standing medical orders for nursing personnel, or the RN may be approved to accept orders from the sending physician or receiving physician.

7) Quality Assurance Program

A) The Tier III transport provider shall have a written QA plan approved by the EMS System and the Department, in accordance with subsection (g)(7)(D). The provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.

B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.

C) An EMS MD or SEMSV MD shall oversee the QA program.

D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:

i) Review of transferring physician orders and evidence of compliance with those orders;

ii) Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;

iii) Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status or changes in neurological examination, and evidence that interventions were appropriate for those events;

iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;

v) Review of any medical control contact for further direction;

vi) Prompt communication of unusual occurrences to the EMS System;

vii) A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.

E) The QA plan will be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

h) The Department will approve vehicle service providers for CCT when the provider demonstrates compliance with an approved EMS System's CCT program plan for Tier II or Tier III transports. Only Department-approved agencies may advertise as CCT providers.

i) The Department will suspend a vehicle service provider's approval for critical care transport if any part of the provider's QA plan is not followed or if a situation exists that poses a threat to the public health and safety. The Department will provide a notice of suspension of CCT approval and an opportunity for hearing. If the vehicle service provider does not respond to the notice within 10 days after receipt, approval will be revoked.

j) The Director may summarily suspend any licensed provider's authorization to perform CCT under this Part if the Director or designee determines that continued CCT by the provider poses an imminent threat to the health or safety of the public. Any order for suspension will be in writing and effective immediately upon service of the provider or its lawful agent. Any provider served with an order of suspension shall immediately cease accepting all CCT cases and shall have the right to request a hearing if a written request is delivered to the Department within 15 days after receipt of the order of suspension. If a timely request is delivered to the Department, then the Department will endeavor to schedule a hearing in an expedited manor, taking into account equity and the need for evidence and live witnesses at the hearing. The Department is authorized to seek injunctive relief in the circuit court if the Director's order is violated.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section 515.920 SEMSV Program Licensure Requirements for All Vehicles

a) The SEMSV Program shall be part of a Department-approved EMS System.

b) The SEMSV Program shall meet and comply with all State and federal requirements governing the specific vehicles employed in the program. (See Section 515.930, 515.945 or 515.970.)

c) The SEMSV Program shall comply with this Part during its hours of operation. The SEMSV Program shall operate 24 hours per day, every day of the year, in accordance with weather conditions, except when the service is committed to another medical emergency request, or is unavailable due to maintenance requirements.

d) The SEMSV Program shall provide pre-hospital emergency services within its service area on a per-need basis without regard to the patient's ability to pay for the service.

e) The SEMSV Program shall be supervised and managed by a Medical Director, who shall be a physician who has met at least the following requirements:

1) Educational experience in those areas of medicine that are commensurate with the mission statement of the medical service (e.g., trauma, pediatric, neonatal, obstetrics) or utilize specialty physicians as consultants when appropriate;

2) Valid certification and experience in Advanced Cardiac Life Support (ACLS), such as the American Heart Association's ACLS course or equivalent education;

3) Valid certification and experience in Pediatric Advanced Life Support (PALS), such as the American Heart Association PALS course or PEPP/American Academy of Pediatrics Advanced Pediatric Life Support Course or equivalent education;

4) Valid certification and experience in Advanced Trauma Life Support (ATLS), such as the American College of Surgeons' ATLS course or equivalent education;

5) In programs using air vehicles, documentation, such as certificates or proof of completion in course work designed to bring about:

A) Experience and knowledge in in-flight treatment modalities;

B) Experience and knowledge in altitude physiology;

C) Experience and knowledge in infection control as it relates to airborne and intra-facility transportation; and

D) Experience and knowledge in stress management techniques;

6) In programs using watercraft, documentation, such as certificates of completion in course work designed to bring about:

A) Experience and knowledge in treating persons suffering from submersion incidents (cold, warm, fresh and salt water); and

B) Experience and knowledge in diving accident physiology and treatment.

7) In programs using air vehicles, the SESMV MD shall be knowledgeable and involved in the establishment of flight safety and weather-related parameters.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.930 Helicopter and Fixed-Wing Aircraft Requirements

In addition to the requirements specified in Sections 515.900 and 515.920, an SEMSV Program using helicopters or fixed-wing aircraft shall submit a program plan that includes the following:

a) Documentation of the SEMSV MD's credentials as required by Section 515.920(e), and a statement signed by the MD containing his or her commitment to the following duties and responsibilities:

1) Supervising and managing the program;

2) Supervising and evaluating the quality of patient care provided by the aeromedical crew;

3) Developing written treatment protocols and standard operating procedures to be used by the aeromedical crew during flight;

4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer;

5) Providing periodic review, at least monthly, of patient care provided by the aeromedical crew;

6) Providing for the CE of the aeromedical team (see Section 515.940(a)(2));

7) Providing medical advice and expertise on the use, need and special requirements of aeromedical transfer;

8) Submitting documentation assuring the qualifications of the aeromedical crew;

9) Notifying the Department when the primary SEMSV is unavailable in excess of 24 hours, stating the reason for unavailability, the expected date of return to service, and the provisions made, if any, for replacement vehicles;

10) Assuring appropriate staffing of the SEMSV, with a minimum of one EMS pilot and one aeromedical crew member for BLS missions. There shall be two aeromedical crew members for ALS and CCT, one of which must be an RN or physician with completion of education required by Section 515.940. Two EMS pilots shall be used for fixed-wing aircraft or helicopters when required by the Federal Aviation Administration (FAA) requiring that staffing. Additional

aeromedical personnel may be required at the discretion of the SEMSV MD. The SEMSV MD shall provide the Department with a list of all approved pilots and aeromedical crew members, and shall update the list whenever a change in those personnel is made;

b) The SEMSV MD's list of required medical equipment and drugs for use on the aircraft (see Section 515.950);

c) The SEMSV MD's treatment protocols and standard operating procedures;

d) The curriculum and requirements for orientation and education (see Section 515.940(a)(2), (3) and (4)), including mandatory CE for all aeromedical crew members consisting of at least 16 hours in specialized aeromedical transportation topics, eight hours of which may include quality assurance reviews; operational safety standards; and weather related parameters;

e) A description of the communications system accessing the aeromedical dispatch center, the medical control point, receiving and referring agencies (see Section 515.960);

f) A description and map of the service area for each vehicle;

g) A description of the EMS System's method of providing emergency medical services using the SEMSV Program; and

h) The identification number and description of all vehicles used in the program.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.935 EMS Pilot Specifications

a) Approval for EMS System participation for a pilot shall be valid for a period of one year and may be renewed by the SEMSV MD if the pilot has completed renewal education, which shall include, but is not limited to, the requirements of subsections (b)(1) and (5)(A) through (H) or subsections (c)(1) and (3)(A) through (F).

1) For helicopter programs only:

A) Four EMS pilots per helicopter, excluding relief support, shall be dedicated to the SEMSV Program. Temporary staffing by three full-time pilots is permitted for no more than six months while finding and educating a replacement pilot.

B) An EMS pilot assigned to SEMSV duty shall be physically present at the aircraft base to assure timely response.

C) An EMS pilot assigned to SEMSV duty shall be provided with work space to carry out assigned duties. If duty time exceeds 12 continuous hours, separate sleeping quarters shall be provided to assure physical rest.

2) For fixed-wing programs only: One EMS pilot per aircraft who will respond within one-half hour from the receipt of the request.

b) Each EMS pilot assigned to a helicopter shall be approved for participation in an EMS System by the EMS MD and shall meet the following requirements:

1) Compliance with subparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135).

2) A minimum of 2000 flight hours with a minimum of 1500 rotorcraft flight hours and the following stipulations:

A) Factory school or equivalent (ground and flight);

B) A minimum of 1000 hours as the pilot in command (PIC) in a rotorcraft;

C) 100 flight hours at night, unaided; and

D) A minimum of 500 hours of turbine time.

3) A minimum of five hours day/night area flight orientation, of which two hours must be at night, and, in the judgment of the SEMSV MD, special terrain flight orientation.

4) Instrument Flight Rules (IFR) certification by the Federal Aviation Administration (IFR Currency is recommended).

5) Documentation of completion of education that includes, but is not limited to, the following:

A) Judgment and decision making;

B) Local routine operating procedures, including day and night operations;

C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery;

D) Regional area weather phenomena;

E) Area terrain hazards;

F) Scene procedures;

G) EMS System and SEMSV Program communications requirements;

H) Orientation to each hospital/pre-hospital health care system affiliated with the SEMSV Program; and

I) Crew resource management education.

c) Each pilot assigned to a fixed-wing aircraft shall be approved by the EMS MD for participation in an EMS System and shall meet the following requirements:

1) Compliance with subparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135);

2) The pilot shall have a minimum of 2000 flight hours; a minimum of 1000 flight hours as PIC in a fixed wing aircraft; 100 night flight hours and 25 hours in the specific make and model of aircraft before flying as the PIC on patient missions; or completion of a commercially established education program for the specific make and model air craft and the successful completion of the check ride;

3) Provide documentation of completion of education that includes, but is not limited to, the following:

A) Judgment and decision making;

B) Local routine operating procedures, including day and night operations;

C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery;

D) Regional area weather phenomena;

E) Area terrain hazards;

F) EMS System and SEMSV Program communications requirements; and

G) Crew resource management education.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.940 Aeromedical Crew Member Education Requirements

a) Except as provided for by subsection (b), each aeromedical crew member assigned to a helicopter or fixed-wing aircraft shall be approved by the SEMSV MD and shall meet the following requirements:

1) Be a Paramedic, RN or a physician.

2) Each crew member shall be current in, or obtain within six months of hire:

A) Advanced Cardiac Life Support (ACLS);

B) Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support (ITLS);

C) Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC) or Pediatric Education for Prehospital Professionals (PEPP) Advanced;

D) TNS or Trauma Nurse Core Course (TNCC);

E) Neonatal Resuscitation Program (NRP) or an equivalent as approved by the EMS MD.

3) Initial education program requirements for full-time and part-time critical care and ALS providers. Each critical care and ALS provider shall successfully complete a comprehensive education program or show proof of recent experience, education and competency in the categories listed in subsections (a)(3)(A) and (B) prior to assuming independent responsibility.

A) Didactic Component − Shall be specified and appropriate for the mission statement and scope of the medical transport service:

i) Advanced airway management;

ii) Altitude physiology/stressors of flight if involved in rotor wing or fixed wing operations;

iii) Anatomy, physiology and assessment for adult, pediatric and neonatal patients;

iv) Aviation − aircraft orientation/safety and in-flight procedures/general aircraft safety, including depressurization procedures for fixed wing (as appropriate). Ambulance orientation/safety and procedures as appropriate;

v) Cardiac emergencies and advanced cardiac critical care;

vi) Hemodynamic monitoring, pacemakers, implantable cardiac defibrillator (ICD), intra-aortic balloon pump, and central lines, pulmonary artery and arterial catheters;

vii) Multiple patient incidents;

viii) EMS radio communications;

ix) Environmental emergencies;

x) Hazardous materials recognition and response (all hazards recognition and response);

xi) High risk obstetric emergencies (bleeding, medical, and trauma);

xii) Infectious disease prevention, mitigation and treatment;

xiii) Metabolic/endocrine emergencies;

xiv) Multi-trauma (chest, abdomen, facial);

xv) Neonatal emergencies (respiratory distress, surgical, cardiac);

xvi) Oxygen therapy in the medical transport environment − mechanical ventilation and respiratory physiology for adult, pediatric and neonatal patients as appropriate to the mission statement and scope of care of the medical transport service;

xvii) Pediatric medical emergencies;

xviii) Pediatric trauma;

xix) Pharmacology;

xx) Quality Management − didactic education that supports the medical transport service mission statement and scope of care (e.g., adult, pediatric, neonatal);

xxi) Respiratory emergencies;

xxii) Scene management/rescue/extrication (rotor wing and ground ambulance);

xxiii) Stress recognition and management;

xxiv) Survival education;

xxv) Record keeping;

xxvi) Thermal, chemical, inhalation, radiation and electrical burns;

xxvii) Legal aspects; and

xxviii) Toxicology.

B) Clinical Component − clinical experiences shall include, but not be limited to, the following (experiences shall be specific and appropriate for the mission statement and scope of care of the medical transport service):

i) Critical care;

ii) Emergency care;

iii) Invasive procedures or simulations equivalent for practicing invasive procedures;

iv) Neonatal intensive care;

v) Obstetrics − five deliveries;

vi) Pediatric critical care;

vii) Pre-hospital care, for rotor wing programs only; and

viii) Tracheal intubations − 10 performed on live patients either in the field or in the hospital setting when in the presence of and under the direct supervision of a licensed physician or

Certified Registered Nurse Anesthetist (CRNA); or performed on cadavers or a human patient simulator (HPS) while under direct supervision; or when in the presence of and under the direct and immediate supervision of the EMS MD or SEMSV MD or designee.

4) CE /staff development shall be provided and documented for all full-time and part-time critical care and ALS providers. These shall be specific and appropriate for the mission statement and scope of care of the medical transport service.

A) Didactic CE shall include:

i) Aviation − safety issues (if involved in rotor wing or fixed wing operations);

ii) Requirements of this Part regarding ground and air transport;

iii) Altitude physiology/stressors of flight (if involved in both rotor wing and fixed wing operations);

iv) Critical care courses;

v) Emergency care courses;

vi) Hazardous materials recognition and response;

vii) Infection control;

viii) Stress recognition and management;

ix) Survival education; and

x) Equipment reviews consistent with program scope and mission.

B) Clinical and laboratory CE shall include:

i) Emergency/trauma care;

ii) Critical care (adult, pediatric, neonatal);

iii) Invasive procedure labs;

iv) Labor and delivery;

v) Pre-hospital experience, for rotor wing programs only;

vi) Skills maintenance program documented to comply with number of skills required in a set period of time according to policy of the medical transport service (i.e., endotracheal intubations, chest tubes);

vii) No fewer than five successful intubations per year are required for each Critical Care or ALS provider. These intubations may be on live patients, either in the field or in the hospital setting, when in the presence of and under the direct supervision of a licensed physician or CRNA; or cadavers or HPS while under direct supervision; or when in the presence of and under the direct and immediate supervision of the EMS MD or SEMSV MD. Success rates for all live intubations are documented and monitored through the quality management process; and

viii) Live, HPS or cadaver intubation experience within the following age ranges if served by the air medical/ground inter-facility service: birth to 28 days; 28 days to 12 months; 12 months to 2 years; 2 years to 8 years; and 8 years and older.

5) Yearly completion of the CE requirements as described in Section 515.930(d).

b) In addition to at least one aeromedical crew member for BLS who has met the requirements of subsection (a), and two aeromedical crew members, one of whom must be an RN or licensed physician, for ALS or CCT missions who have met the requirements of subsection (a), the EMS MD or SEMSV MD may approve and assign additional crew members to a helicopter or fixed-wing aircraft. The additional crew members shall meet the following requirements:

1) Provide documentation of completion of education that includes, but is not limited to, the following:

A) General patient care in-flight;

B) Aircraft emergencies;

C) Flight safety;

D) EMS System and SEMSV Program communications;

E) Use of all patient care equipment and

F) Rescue and survival techniques.

2) Yearly completion of the CE requirements as described in Section 515.930(d).

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.945 Aircraft Vehicle Specifications and Operation

a) All vehicles shall meet the requirements of subparts A, B, C, and D of Air Taxi Operations and Commercial Operators (14 CFR 135).

b) All vehicles shall have communication equipment to permit both internal crew and air-to-ground exchange of information between individuals and agencies, including at least those involved in SEMSV medical control within the EMS System, the flight operations center, air traffic control and law enforcement agencies. Helicopters must be able to communicate with law enforcement agencies, EMS providers, fire agencies, and referring and receiving facilities.

c) Rotor wing vehicles shall be equipped with a Medical Emergency Radio Communications for Illinois (MERCI) radio.

d) All vehicles shall be designed to allow the loading and unloading of the patient without rotating the patient more than 30 degrees along the longitudinal axis or 45 degrees along the lateral axis.

e) All vehicles shall be climate controlled to prevent temperature extremes that would adversely affect patient care in the judgment of the EMS MD or SEMSV MD.

f) All vehicles shall have interior lighting to permit patient care to be given and patient status to be monitored without interfering with the pilot's vision.

g) All vehicles shall carry survival equipment including but not limited to:

1) Two sources of heat or fire;

2) Two forms of signaling device;

3) Equipment to provide shelter: blanket, nylon cord and adhesive tape;

4) Knife; and

5) Food and water supply.

h) All patients shall be restrained to the helicopter or fixed-wing aircraft litter to assure the safety of the patient and crew.

i) For helicopter programs:

1) Each rotorcraft shall be powered by at least one turbine engine. There shall be at least one dedicated turbine powered rotorcraft.

2) Each vehicle shall be staffed with at least one EMS pilot and at least one aeromedical crew member for BLS missions. There shall be two aeromedical crew members for ALS and CCT, one of whom shall be an RN or licensed physician.

3) Each vehicle shall be equipped with flight reference instruments to allow recovery from inadvertent Instrument Flight Rules (IFR) situations.

4) Each vehicle shall be equipped with a searchlight pivoting at least 180 degrees horizontal and 90 degrees vertical, controlled by the pilot without removing hands from the flight controls. The searchlight shall be at least 400,000 candlepower, mounted and operated in accordance with requirements of the Federal Aviation Administration (14 CFR 135).

5) The cockpit shall be isolated by a protective barrier to minimize in-flight distraction or interference.

6) All medical equipment, supplies and personnel shall be secured or restrained.

7) All equipment, litters/stretchers and seating shall be arranged so as not to block rapid egress by personnel or patient from the aircraft and shall be affixed or secured in racks or compartments approved by the Federal Aviation Administration (14 CFR 135) or by straps.

j) For fixed-wing aircraft programs:

1) All single engine fixed-wing aircraft shall be powered by a turbine engine. There shall be at least one dedicated fixed-wing aircraft.

2) Each vehicle shall be staffed with at least one EMS pilot and at least one aeromedical crew member for BLS missions. There shall be two aeromedical crew members for ALS and CCT.

3) The aircraft shall be IFR equipped and certified.

4) All equipment, litters/stretchers and seating shall be arranged so as not to block rapid egress by personnel or patient from the aircraft and shall be affixed or secured in approved racks or compartments or by strap restraint.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.950 Aircraft Medical Equipment and Drugs

a) Each helicopter or fixed-wing aircraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV MD.

b) The SEMSV MD shall submit for approval to the Department a list of medical equipment and drugs to be taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route. This shall include, but not be limited to:

1) Cardiac monitor with extra battery;

2) Defibrillator that is adjustable for all age groups;

3) External pacemaker;

4) Advanced airway equipment, including, but not limited to, laryngoscope and tracheal intubation supplies for all age ranges;

5) Mechanical ventilator available;

6) Two suction sources; one must be portable;

7) Pulse oximeter; central and peripheral sensors, adult and pediatric;

8) End tidal CO2 − quantitative wave form capnography;

9) Automatic blood pressure monitor;

10) Doppler with dual capacity to obtain fetal heart tones as well as systolic blood pressure;

11) Invasive pressure monitor;

12) Intravenous pumps with adjustable rates for appropriate age groups;

13) Two sources of oxygen; one must be portable;

14) A stretcher that is large enough to carry the 95th percentile adult, full length in supine position, and that is rigid enough to support effective cardiopulmonary resuscitation and has the capability of raising the head 30°;

15) Electrical power source provided by an inverter or appropriate power source of sufficient output to meet the requirements of the complete specialized equipment package without compromising the operation of any electrical aircraft equipment;

16) If the patient weighs less than 60 lbs. (27 kg.), an appropriate (for height and weight) restraint device shall be used, which shall be secured by a devise approved by the Federal Aviation Administration (14 CFR 135);

17) An isolette if the service mission profile includes neonate transports; and

18) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care of the SEMSV.

c) The Department's approval shall be based on, but not limited to:

1) Length of time of the mission;

2) Possible environmental or weather hazards;

3) Number of individuals served; and

4) Medical condition of individuals served.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.955 Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs

a) For helicopter programs:

1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).

2) One certified airframe and power plant (A & P) mechanic with two years experience for each helicopter shall be available and dedicated to the program 24 hours per day.

3) Mechanics shall have completed factory-approved education for the makes and models of aircraft used in the SEMSV Program.

4) Back-up maintenance support shall be available when the primary mechanic is unavailable or during times of extensive maintenance needs.

5) Hangar facilities shall be available for major maintenance activities, as specified in manufacturer's requirements. These facilities need not be located at the base of operations.

6) Progressive maintenance on aircraft used by the SEMSV Program is recommended, including routine daily inspections, as required by the aircraft manufacturer.

b) For fixed-wing aircraft programs:

1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).

2) Mechanics shall be certified A & P with two years experience, and shall have completed education for the make and model of aircraft used by the SEMSV Program.

3) Hangar facilities shall be available for major maintenance activities as specified in manufacturer's requirements.

4) Progressive maintenance on aircraft used by the SEMSV Program is recommended, including routine daily inspections, as required by the aircraft manufacturer.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.960 Aircraft Communications and Dispatch Center

a) The SEMSV Program shall have a designated person assigned and available 24 hours per day every day of the year to receive and dispatch all requests for aeromedical services. For fixed-wing aircraft programs, a telephone answering service may be used.

b) Education of the designated person shall be commensurate with the scope of responsibility of the communications center and pertinent to the air medical service, including:

1) Knowledge of EMS roles and responsibilities of the various levels of education;

2) Knowledge of Federal Aviation Administration and Federal Communications Commission regulations;

3) General safety rules, emergency procedures and flight following procedures;

4) Navigation techniques/terminology and understanding weather interpretation;

5) Types of radio frequency bands used;

6) Stress recognition and management;

7) Medical terminology and obtaining patient information;

8) Assistance with all hazards response and recognition procedure using appropriate reference materials; and

9) Crew resource management.

c) The dispatch center shall have at least one dedicated telephone number for the SEMSV Program.

d) A pre-arranged emergency plan shall be in place to cover situations in which an aircraft is overdue, radio communication cannot be established, or an aircraft location cannot be verified.

e) A back-up power source shall be available for all communications equipment used at the SEMSV medical control point.

f) The dispatch center shall have a system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings shall be kept for 30 days.

g) In addition, for helicopter programs:

1) The dispatch center shall have the capability to communicate with the aircraft pilot and aeromedical crew for nonmedical purposes on a separate designated frequency.

2) Continuous flight following every 15 minutes shall be maintained and documented.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.963 Flight Program Safety Standards

For rotor-wing and fixed-wing programs:

a) Flight crews shall wear the following protective clothing:

1) Reflective material or striping on uniforms during night operations;

2) Flame-retardant clothing;

3) Flight helmets for all rotorcraft crews, including specialty teams; and

4) Boots or sturdy footwear for on-scene operations.

b) Safety and Environment

1) Oxygen storage shall be 10 feet from any heat source and 20 feet from any open flame.

2) All crews shall carry a photo ID with first and last names while on duty.

3) Family members or other passengers who accompany patients shall be identified and listed in the communications center.

4) A policy shall address the security of the aircraft and physical environment (i.e., hangar, fuel farm), including:

A) Security of the aircraft or ambulance if left unattended on a helipad, hospital ramp or unsecured airport or parking lot;

B) Education for pilots, mechanics and medical personnel to recognize signs of aircraft tampering; and

C) A plan to address aircraft or ambulance tampering.

c) Completion of all of the following educational components shall be documented for each of the flight medical personnel:

1) General aircraft safety:

A) Aircraft evacuation procedures (exits and emergency release mechanisms), including emergency shutdown − engines, radios, fuel switches, and electrical and oxygen shutdown;

B) Aviation terminology and communication procedures, including knowledge of emergency communications and knowledge of emergency communications frequency;

C) In-flight and ground fire suppression procedures (use of fire extinguishers);

D) In-flight emergency and emergency landing procedures (i.e., position, oxygen, securing equipment);

E) Safety in and around the aircraft, including national aviation regulations pertinent to medical team members, landing zone personnel when possible, patients, and lay individuals;

F) Specific capabilities, limitations and safety measures for each aircraft used, including specific education for backup or occasionally used aircraft;

G) Use of emergency locator transmitter (ELT); and

H) All ground support ambulances used for fixed wing operations shall meet minimal State ambulance licensing requirements located in Section 515.830.

2) Ground operations rotor wing (RW)

A) Landing site policies consistent with Federal Aviation Administration Helicopter Emergency Medical Services (HEMS) requirements;

B) Patient loading and unloading – policy for rapid loading/unloading procedures;

C) Refueling policy for normal and emergency situations;

D) Hazardous materials recognition, response and training policy consistent with 2014 Aeronautical Information Manual, Chapter 10 (2014, US Department of Transportation);

E) Highway scene safety management policy that demonstrates coordination with local emergency response personnel;

F) Survival education/techniques/equipment that are pertinent to the environment/geographic coverage area of the medical service based on the program risk assessment;

G) Smoke in the cockpit/cabin, firefighting in the cockpit/cabin; and

H) Emergency evacuation of crew and patients.

d) A planned and structured safety program shall be provided to public safety/law enforcement agencies and hospital personnel who interface with the medical service that includes:

1) Identifying, designating and preparing an appropriate landing zone (LZ).

2) Personal safety in and around the helicopter for all ground personnel.

3) Procedures for day/night operations, conducted by the medical team, specific to the aircraft, including:

A) High and low reconnaissance;

B) Two-way communications between helicopter and ground personnel to identify approach and departure obstacles and wind direction;

C) Approach and departure path selection; and

D) Procedures for the pilot to ensure safety during ground operations in an LZ with or without engines running.

4) Crash recovery procedures specific to the aircraft make and model shall minimally include:

A) Location of fuel tanks;

B) Oxygen shut-offs in cockpit and cabin;

C) Emergency egress procedures;

D) Aircraft batteries; and

E) Emergency shut-down procedures.

5) Education regarding "helicopter shopping" shall be included.

6) Records shall be kept of initial and recurrent safety education of pre-hospital, referring and receiving ground support personnel.

e) The program shall maintain a safety management system that is proactive in identifying risks and eliminating injuries to personnel and patients and damage to equipment.

f) Special requirements for night operations; SEMSV rotorcraft programs shall incorporate use of night vision goggles (NVG) and shall be compliant by December 31, 2018:

1) Pilot required; and

2) Medical crew recommended.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.965 Watercraft Requirements

In addition to the requirements specified in Sections 515.900 and 515.920, an SEMSV Program using watercraft shall submit a program plan that includes the following:

a) Documentation of the EMS MD's or SEMSV MD's credentials as required by Section 515.920(e), and a statement signed by the EMS MD or SEMSV MD committing to the following duties and responsibilities:

1) Supervising and managing of the program;

2) Supervising and evaluating the quality of patient care provided by the watercraft crew;

3) Developing written treatment protocols and standard operating procedures to be used by the watercraft crew during vehicle operation;

4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer;

5) Providing periodic review, at least quarterly, of patient care provided by the watercraft crew;

6) Providing medical advice/expertise on the use, need and special requirements of watercraft transfer;

7) Submitting documentation assuring the qualifications of the watercraft crew;

8) Assuring appropriate staffing of the SEMSV:

A) Each watercraft crew member assigned to a watercraft shall be approved by the EMS MD or SEMSV MD, who shall provide the Department with a list of all approved crew members and watercraft operators and update the list whenever a change in such personnel is made.

B) For ALS operations, the watercraft shall be staffed by a crew of at least one Paramedic, RN or physician, and one other EMT, A-EMT, EMT-I, Paramedic, RN or physician, in addition to the watercraft operator.

C) For BLS operations, the watercraft shall be staffed by a crew of at least two of the following: EMT, A-EMT, EMT-I, Paramedic, RN or physician, one of whom may also be the watercraft operator.

D) Except as provided for by subsection (a)(8)(E) of this Section, each watercraft crew member shall document, appropriate to their scope of practice, completion of education that includes, but is not limited, to the following:

i) Advanced life support;

ii) Cardiac support;

iii) Traumatic emergencies;

iv) Pediatric emergencies;

v) Psychiatric emergencies;

vi) Crisis intervention;

vii) Infection control;

viii) Advanced airway management techniques;

ix) Environmental emergencies;

x) Radio or other EMS communications;

xi) Rescue and survival techniques;

xii) Record keeping;

xiii) Legal aspects;

xiv) Certification in Advanced Life Saving by the American Red Cross; and

xv) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act [625 ILCS 45].

E) In addition to at least two watercraft crew members who have met the requirements of subsections (a)(8)(B) through (D), the EMS MD or SEMSV MD may approve and assign additional watercraft crew members to a watercraft. Such additional watercraft crew members shall document the completion of training that includes but is not limited to the following:

i) General patient care;

ii) Watercraft emergencies;

iii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act;

iv) EMS System and SEMSV Program communications;

v) Use of all patient care equipment;

vi) Rescue and survival techniques; and

vii) Certification in Advanced Life Saving by the American Red Cross.

F) Watercraft operators shall be at least 21 years of age and shall meet the following requirements:

i) Certification in Advanced Life Saving by the American Red Cross; and

ii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act;

b) The EMS MD's or the SEMSV MD's list of required medical equipment and drugs for use on the watercraft (see Section 515.975);

c) The EMS MD's or the SEMSV MD's standing orders (treatment protocols, standard operating procedures);

d) A description of the communications system linking the watercraft with the SEMSV medical control point;

e) A description of the EMS System's method of providing emergency medical services using the SEMSV Program;

f) A description and map of the service area for each vehicle; and

g) The identification number and description of all vehicles used in the program.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.970 Watercraft Vehicle Specifications and Operation

a) All watercraft shall meet the requirements of Article IV of the Boat Registration and Safety Act.

b) All watercraft shall carry equipment including but not limited to the following:

1) One anchor with line attached that is three times the maximum depth of water in the areas of usual operation;

2) Two docking fenders;

3) Two mooring lines;

4) Self or mechanical bailer;

5) Search light with a minimum of 200,000 candle power;

6) Swim harness attached to 75 feet of tethering line;

7) Waterproof flashlight capable of operating for more than two hours;

8) Basic tool kit, to include at least:

A) Wrench, 12 inch with adjustable open end;

B) Screw driver, 12 inch with straight blade;

C) Locking pliers, minimum length, 10 inches;

9) One life jacket for each member of the watercraft crew and two extra adult life jackets (Type I, II or III);

10) Two child life jackets (Type I or II);

11) Any watercraft 16 feet or more in length, except a canoe or kayak, shall have a least one Type IV (throwable) U.S. Coast Guard approved personal floatation device (PFD) or its equivalent on board, in addition to the PFDs required in subsections (b)(9) and (10);

12) Knife, 6-inch blade, with sheath;

13) Boat hook, extendable to at least 10 feet;

14) A locking mechanism to secure a stretcher or litter below the gunwale level;

15) Lanyard or engine cut-off device;

16) Lights (operational between the hours of sunset and sunrise);

17) Mufflers;

18) Whistle or electric or air powered horn;

19) Fire extinguisher;

20) Carburetor arrestors (except for outboard motors);

21) Ventilators (except for open boats);

22) Battery covers to prevent accidental shorting;

23) For watercraft operating on Lake Michigan:

A) A VHF/FM marine radio with at least 25 watts of power;

B) Navigational charts for service area and navigational aids, including compass or Global Positioning System (GPS);

C) Speed capability of 20 knots per hour;

D) Visual distress signal; and

E) Sealing of marine heads.

c) All watercraft shall have communication equipment to assure exchange of information between individuals and agencies, including at least those involved at the SEMSV medical control point within the EMS System, and law enforcement agencies.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.975 Watercraft Medical Equipment and Drugs

a) Each watercraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it will be responding, as specified by the EMS MD or the SEMSV MD.

b) Opioid antagonist, including, but not limited to, Naloxone, appropriate for the licensed level of care of the SEMSV.

c) For ALS operations, the EMD MD or the SEMSV MD shall submit for approval a list of supplies available for each mission used. The EMS MD or the SEMSV MD shall decide on the medical equipment and drugs taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

d) The Department's approval shall be based on, but not limited to:

1) length of time of the mission;

2) possible environmental or weather hazards;

3) number of individuals served; and

4) medical condition of individuals served.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.980 Watercraft Communications and Dispatch Center

a) The SEMSV Program shall have a designated dispatch center assigned and available 24 hours per day every day of the year to receive and dispatch all requests for watercraft services.

b) The communications and dispatch center shall have the ability to communicate with the watercraft for nonmedical purposes through approved telecommunications or on a separate designated radio frequency.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.985 Off-Road SEMSV Requirements

In addition to the requirements specified in Sections 515.900 and 515.920, an SEMSV Program utilizing off-road SEMSV vehicles shall submit a program plan that includes the following:

a) Documentation of the EMS MD's or the SEMSV MD's credentials as required by Section 515.920(e), and a statement signed by the EMS MD or the SEMSV MD containing his or her commitment to the following duties and responsibilities:

1) The supervision and management of the program;

2) Supervising and evaluating the quality of patient care provided by the off-road SEMSV crew;

3) Providing medical advice and expertise on the use, need and special requirements of off-road SEMSV transfer;

4) Submitting documentation assuring the qualifications of the off-road SEMSV crew; and

5) Assuring appropriate staffing of the off-road SEMS vehicle:

A) For ALS operations, the vehicle shall be staffed by a minimum of one Paramedic, RN or physician and one other EMT, A-EMT, EMT-I, Paramedic, RN or physician, one of whom may also be the driver of the off-road SEMSV; and

B) For BLS operations, the vehicle shall be staffed by a minimum of two of the following: EMTs, A-EMTs, EMT-Is, Paramedics, RNs or physicians, one of whom may also be the driver of the off-road SEMSV;

b) The EMS MD's or the SEMSV MD's list of required medical equipment and drugs for use on the off-road SEMSV (see Section 515.995 of this Part);

c) The EMS MD's or the SEMSV MD's standing orders (treatment protocols, standard operating procedures);

d) A description of the communications system linking the off-road SEMSV with the SEMSV medical control point;

e) A description and map of the service area for each vehicle;

f) The identification number and description of all vehicles used in the program;

g) An agreement/contract with a licensed ground provider for transportation of patients; and

h) A description of the EMS System's method of providing emergency medical services using the SEMSV Program.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.990 Off-Road Vehicle Specifications and Operation

a) The off-road SEMSV shall have sufficient space for the vehicle operator, a patient in a supine position, and personnel rendering medical care alongside the patient.

b) Each vehicle shall have a locking mechanism to secure the patient transport litter/stretcher to the off-road SEMSV.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 515.995 Off-Road Medical Equipment and Drugs

a) Each off-road SEMSV shall be equipped with medical equipment and drugs for the various types of missions to which it will be responding, as specified by the EMS MD or the SEMSV MD.

b) Opioid antagonist, including, but not limited to, Naloxone, appropriate for the licensed level of care of the SEMSV.

c) For ALS operations, the EMS MD or the SEMSV MD shall submit for approval a list of supplies available for each mission. The SEMSV MD shall decide what medical equipment and drugs are taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.1000 Off-Road Communications and Dispatch Center

a) The SEMSV Program shall have a designated dispatch center assigned and available 24 hours per day every day of the year to receive and dispatch all requests for off-road SEMSV services.

b) The communications and dispatch center shall have the ability to communicate with the off-road SEMSV for nonmedical purposes through approved telecommunications or on a separate designated radio frequency.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

SUBPART I: EMS ASSISTANCE FUND

Section 515.3000 EMS Assistance Fund Administration

a) All licensing, testing and certification fees authorized by the Act, excluding ambulance licensure fees, within the EMS Assistance Fund shall be used by the Department for administration, oversight, and enforcement of activities authorized under the Act. (Section 3.220(b-5) of the Act)

b) All other moneys within the EMS Assistance Fund shall be distributed by the Department to the EMS Regions for disbursement in accordance with protocols established in the EMS

Region Plans, for the purposes of organization, development and improvement of Emergency Medical Services Systems, including but not limited to training of personnel and acquisition, modification and maintenance of necessary supplies, equipment and vehicles. (Section 3.220(c) of the Act)

c) Award of Funds

1) Any Illinois licensed and based EMS provider agency that provides EMS service within the State of Illinois may apply for funds through the Regional EMS Advisory Committee.

A) Application shall be made using a process prescribed and provided by the Department.

B) Applicants shall provide evidence of financial planning, to include but not be limited to: equipment replacement plans, budgeting plans, and fundraising plans.

C) Applicants shall submit a copy of their current provider license.

D) To be eligible for any grant, the EMS provider agency shall be in compliance with pre-hospital reporting requirements (see Section 515.350).

2) Programs, services and equipment funded by the EMS Assistance Fund shall comply with the Act, this Part and the EMS Regional Plan in which the applicant participates.

3) The award of funds shall be based upon demonstrated need and one or more of the following:

A) Establishment of a new EMS agency, program or service where needed to improve emergency medical services available in an area;

B) Expansion or improvement of an existing EMS agency, program or service;

C) Replacement of equipment that is unserviceable or procurement of new equipment; and

D) Establishment, expansion or improvement of EMS education and training programs including the adult and pediatric population.

4) All purchases and education shall occur during the fiscal year in which the grant is awarded.

5) The grant cycle runs from July 1 through June 30 of each year.

6) Grant recipients shall complete and return documentation as prescribed by the Department (e.g., grant application, Reimbursement Certification Form or Internal Revenue Service W-9 Form).

7) Grantees receiving grant funds are required to permit the Department, the Auditor General, and the Attorney General to inspect and audit any books, records or papers related to the program, project, equipment or use for which the EMS Assistance Grant funds were provided.

8) All funds remaining at the end of the period of time in which grant funds are available for expenditure (June 30 of the fiscal year in which the grant was awarded) shall be returned to the State within 45 days.

9) All grants shall be subject to all requirements and limitations imposed by Illinois law, including, without limitation, the Illinois Grant Funds Recovery Act.

d) Emergency Grant Awards

1) The Regional EMS Advisory Committee may recommend that the Department issue emergency grant awards. Emergency grant awards shall not exceed 10 percent of the total funds available in a year.

2) Applications shall be made in accordance with subsections (c)(1) and (2).

3) The award of funds shall be based on the demonstrated needs arising from a natural or man-made disaster.

e) Amount of Grant Award

1) The amount of the grant award shall be based on the amount requested by the applicant, the recommendation of the Regional EMS Advisory Committee, the Department's review of the application, and the amount available in the Fund for distribution. The amount awarded shall not exceed the amount requested by the applicant.

2) The applicant shall provide adequate information to substantiate the requested amount or any hardship claim.

f) Modification of a Grant Agreement

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Any change in the use of grant funds from that specified in the approved grant agreement will be permitted only by written modification of the grant agreement. The grantee may request modification of the grant agreement by submitting in writing to the Department the reasons and circumstances necessitating the request.

2) The grant award shall be suspended and all disbursements of funds held in situations including, but not limited to:

A) Failure to comply with the Act and this Part;

B) Failure to follow the EMS Region Plan in which the grantee participates; and

C) Violation of the terms of the grant agreement.

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.APPENDIX D Administrative, Legal and EMS Protocols and Guidelines

Administrative, Legal and EMS Protocols and Guidelines shall include, but not be limited to the following:

1) Administrative and Legal:

- Patient disposition/selection of receiving facility
- Patient choice and refusal regarding treatment, transport or destination
- Patient abandonment
- Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST)/Advance Directives/Health Care Power of Attorney (POA) status
- When and how to notify a coroner or medical examiner
- Appropriate interaction with law enforcement on the scene
- The duty to perform all services without unlawful discrimination
- Patient confidentiality and release of information/Health Insurance Portability and Accountability Act (HIPAA)
- Appropriate interaction with an independent physician/nurse on the scene
- Offering immediate and adequate information regarding services available to victims of abuse, for any person suspected to be a victim of domestic abuse
- Mandated reporting policy
- Relinquished newborn
- Consent for treatment of minors

- A policy that addresses the EMS System Participant safety, disinfection of EMS vehicles and equipment, and assessment, treatment, transport and follow-up of patients with suspected or diagnosed infectious diseases
- Significant or high risk occupational exposure of EMS System Participants to an infectious disease, including notification to the designated infection control officer of the EMS provider agency following exposure
- A policy concerning the use of latex-free supplies
- Medical records documentation and reporting policy
- Incident reporting/equipment malfunction/sentinel event reporting
- Crisis response and medical surge policy/multiple patient incidents
- Professional ethical standards and behavioral expectations
- Any procedures regarding disciplinary or suspension decisions and the review of those decisions that the System has elected to follow in addition to those required by the Act
- Resource Hospital overrides (situations in which Associate Hospital orders are overruled by the Resource Hospital)
- Protocols for ILS and ALS personnel to assess the condition of a patient being initially treated in the field by BLS personnel, for the purpose of determining whether a higher level of care is warranted and transfer of care of the patient to the ILS or ALS personnel is appropriate; the protocols shall include a requirement that neither the assessment nor the transfer of care can be initiated if it appears to jeopardize the patient's condition, and shall require that the activities of the System personnel be under the immediate direction of the EMS MD or designee
- Any System policies regarding abuse of controlled substances or conviction of a felony crime by EMS Personnel, whether on or off duty

2) EMS Standing Medical Orders/Standard Operating Guidelines/Procedures

- Cardiovascular:
  - Adult and Pediatric Syncope and Pre-syncope
  - Chest Pain/Acute Coronary Syndrome (ACS)/ST-segment Elevation Myocardial Infarction (STEMI)
  - Tachycardia with a Pulse
  - Bradycardia with a Pulse
  - Health Failure/Pulmonary Edema/Cardiogenic Shock

- Resuscitation:
  - Cardiac Arrest (VF/VT/Asystole/PEA)
  - Adult Post-ROSC (Return of Spontaneous Circulation) Care
  - Determination of Death/Withholding or Termination of Resuscitative Efforts

- Respiratory:

- Airway/Ventilatory Management
- Acute Respiratory Conditions
- Chronic Respiratory Conditions

- Medical:
- Agitated or Violent Patient/Behavioral Emergency; Use of Restraints
- Anaphylaxis and Allergic Reaction
- Altered Mental Status
- Hypoglycemia/Hyperglycemia
- Pain Management
- Seizures
- Shock
- Suspected Stroke/Transient Ischemic Attack
- Nausea/Vomiting
- Functional Needs/Special Needs Populations

- Pediatric Specific Guidelines:
- Apparent Life Threatening Event (ALTE)
- Pediatric Respiratory Distress (Bronchiolitis)
- Pediatric Respiratory Distress (Croup, Epiglottitis)
- Neonatal Resuscitation
- EMSC Medical Treatment Protocol at a minimum

- GI/GU/Gyne:
- Childbirth/Complicated and Uncomplicated Delivery
- Newborn Care
- OB Complications/All Trimesters
- Obstetrical/Gynecological Conditions

- Trauma:
- General Trauma Assessment/Management
- Blast Injuries
- Head/Facial/Neck Injury
- Thoracic
- Abdominal/Pelvic
- Musculoskeletal Trauma/External Hemorrhage Management
- Acute Spine Trauma and Selective Spine Precautions
- Conducted Electrical Weapon (e.g., TASER)
- Blunt, Penetrating and Perforating Injuries

- Environmental:
  - Hyperthermia/Heat Exposure
  - Hypothermia/Cold Exposure
  - Submersion Incidents
  - SCUBA Injury/Accidents
  - Altitude Illness

- Burns:
  - Electrical
  - Lightening/Lightening Strike Injury
  - Radiation Exposure
  - Thermal
  - Chemical
  - Inhalation

- Toxins:
  - Bites and Envenomation
  - Poisoning/Overdose Universal Care
  - Acetylcholinesterase Inhibitors (Carbamates, Nerve Agents, Organophosphates) Exposure
  - Stimulant Poisoning/Overdose
  - Central Nervous System Depressant Poisoning/Overdose
  - Cyanide Exposure
  - Hallucinogenic
  - Beta Blocker Poisoning
  - Calcium Channel Blocker Poisoning/Overdose
  - Carbon Monoxide/Smoke Inhalation
  - Biological Agents

(Source: Amended at 42 Ill. Reg. _____, effective _____)

Section 515.APPENDIX E Minimum Prescribed Data Elements

Submit all data elements as listed in the Illinois Department of Public Health, Division of EMS and Highway Safety, National Emergency Medical Services Information System (NEMSIS) Prehospital Dataset.
(Source: Amended at 42 Ill. Reg. _____, effective _____)