

SIERRA-SACRAMENTO VALLEY EMS AGENCY

STATE LAW AND REGULATION SECTION I

SUBJECT: INDEX

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101 Health and Safety Code, Division 2.5

102 California Code of Regulations, Title 22, Division 9

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State of California
California Emergency
Medical Services Law

Health & Safety Code Division 2.5
Statutes in Effect as of January 1, 2013

Emergency Medical Services Authority
Health and Human Services Agency





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The attached compilation of EMS Statutes (Division 2.5 of the Health and Safety Code) has been updated for your convenience to include changes made during the first half of the 2011-12 Legislative Session. Although every effort has been made to ensure that this document is accurate and complete, no guarantee is being made or implied.

HEALTH AND SAFETY CODE

DIVISION 2.5

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HEALTH AND SAFETY CODE DIVISION 2.5. EMERGENCY MEDICAL SERVICES

[Except where noted, Division 2.5 was created by SB 125 (Ch. 1260); 1980]
[Originally, the heading "Part 1" followed the heading for Division 2.5 and a number of the sections in Division 2.5 referred to "this part". Because there was no Part 2, the "Part 1" heading was deleted and all references to "this part" were changed to "this division" in a number of sections, by SB 2451 (Ch. 248): 1986. This change will not be noted for each section.]

CHAPTER 1. GENERAL PROVISIONS

1797. This division shall be known and may be cited as the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act.

1797.1. The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services.

[The name of the EMS Authority was technically changed from the Emergency Medical Service Authority to the Emergency Medical Services Authority in Section 1797.1 and in other sections of Division 2.5 by SB 595 (Ch. 1246; statutes of 1983) in order to be consistent with other code sections and with accepted usage. This change will not be noted for each affected section.]

1797.2. It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible.

1797.3. The provisions of this division do not preclude the adoption of additional training standards for EMT-II and EMT-P personnel by local EMS agencies, consistent with standards adopted pursuant to Sections 1797.171, 1797.172, and 1797.214.
[Amended by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.4. Any reference in any provision of law to mobile intensive care paramedics subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid certificates under this division as an EMT-I, EMT-II, or EMT-P. Any reference in any provision of law to mobile intensive care nurses subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid

authorization under this division as an MICN. [Original Sec. 1797.4 repealed by SB 595 (Ch. 1246) 1983. New Sec. 1797.4 added by AB 1119 (Ch. 260) 1988.]

1797.5. It is the intent of the Legislature to promote the development, accessibility, and provision of emergency medical services to the people of the State of California.

Further, it is the policy of the State of California that people shall be encouraged and trained to assist others at the scene of a medical emergency. Local governments, agencies, and other organizations shall be encouraged to offer training in cardiopulmonary resuscitation and lifesaving first aid techniques so that people may be adequately trained, prepared, and encouraged to assist others immediately. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1750.]

1797.6. (a) It is the policy of the State of California to ensure the provision of effective and efficient emergency medical care. The Legislature finds and declares that achieving this policy has been hindered by the confusion and concern in the 58 counties resulting from the United States Supreme Court's holding in *Community Communications Company, Inc. v. City of Boulder, Colorado*, 455 U.S. 40, 70 L. Ed.2d 810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust laws.

(b) It is the intent of the Legislature in enacting this section and Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state direction and supervision over emergency medical services as will provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this division. [Added by AB 3153 (Ch. 1349) 1984.]

1797.7. (a) The Legislature finds and declares that the ability of some prehospital emergency medical care personnel to move from the jurisdiction of one local EMS agency which issued certification and authorization to the jurisdiction of another local EMS agency which utilizes the same level of emergency medical care personnel will be unreasonably hindered if those personnel are required to be retested and recertified by each local EMS agency.

(b) It is the intent of the Legislature in enacting this section and Section 1797.185 to ensure that EMT-P personnel who have met state competency standards for their basic scope of practice, as defined in Chapter 4 (commencing with Section 100135) of Division 9 of Title 22 of the California Code of Regulations, and are currently certified are recognized statewide without having to repeat testing or certification for that same basic scope of practice.

(c) It is the intent of the Legislature that local EMS agencies may require prehospital emergency medical care personnel who were certified in another jurisdiction to be oriented to the local EMS system and receive training and demonstrate competency in any optional skills for which they have not received accreditation. It is also the intent of the Legislature that no individual who possesses a valid California EMT-P certificate shall be prevented from beginning working within the standard statewide scope of practice of an EMT-P if he or she is accompanied by an EMT-P who is currently certified in California and is accredited by the local EMS agency. It is further the intent of the Legislature that the local EMS agency provide, or arrange for the provision of, training

and accreditation testing in local EMS operational policies and procedures and any optional skills utilized in the local EMS system within 30 days of application for accreditation as an EMT-P by the local EMS agency.

(d) It is the intent of the Legislature that subdivisions (a), (b) and (c) not be construed to hinder the ability of local EMS agencies to maintain medical control within their EMS system in accordance with the requirements of this division. [Added by AB 3057 (Ch. 312) 1986. Amended by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.8. (a) For purposes of this section, the following definitions apply:

(1) "EMT-I" means any person who has training and a valid certificate as prescribed by Section 1797.80.

(2) "EMT certifying authority" means the medical director of the local emergency medical services agency.

(b) Any county may, at the discretion of the county or regional medical director of emergency medical services, develop a program to certify an EMT-I to administer naloxone hydrochloride by means other than intravenous injection.

(c) Any county that chooses to implement a program to certify an EMT-I to administer naloxone hydrochloride, as specified in subdivision (b), shall approve and administer a training and testing program leading to certification consistent with guidelines established by the state Emergency Medical Services Authority.

(d) On or before July 1, 2003, the state Emergency Medical Services Authority shall develop guidelines relating to the county certification programs authorized pursuant to subdivision (b).

(e) An EMT-I may be authorized by the EMT certifying authority to administer naloxone hydrochloride by means other than intravenous injection only if the EMT-I has completed training and passed an examination administered or approved by the EMT certifying authority in the area.

(f) This section shall be operative only until the operative date of regulations that revise the regulations set forth in Chapter 3 (commencing with Section 100101) of Division 9 of Title 22 of the California Code of Regulations and that authorize an EMT-I to receive EMT-II training in administering naloxone hydrochloride without having to complete the entire EMT-II certification course. [Added by SB 1695 (Ch. 678) 2002]

1797.9. (a) This division shall not be construed to regulate or authorize state or local regulation of any nonmedical aspects of the following:

(1) Public aircraft certification or configuration.

(2) Public aircraft maintenance procedures and documentation.

(3) Piloting techniques and methods of piloting public aircraft.

(4) Public aircraft crewmember qualifications.

(5) Pilot certification or qualifications for public aircraft.

(b) For purposes of this section, "public aircraft" has the same meaning as in Section 1.1 of Title 14 of the Code of Federal Regulations. [Added by SB 1141 (Ch. 288) 2008.]

CHAPTER 2. DEFINITIONS

1797.50. Unless the context otherwise requires, the definitions contained in this chapter shall govern the provisions of this division.

1797.52. "Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.53. "Alternative base station" means a facility or service operated and directly supervised by, or directly supervised by, a physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel, which has been approved by the medical director of the local EMS agency to provide medical direction to advanced life support or limited advanced life support personnel responding to a medical emergency as part of the local EMS system, when no qualified hospital is available to provide that medical direction. [Added by AB 3269 (Ch. 1390) 1988.]

1797.54. "Authority" means the Emergency Medical Services Authority established by this division.

1797.56. "Authorized registered nurse," "mobile intensive care nurse," or "MICN" means a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been authorized by the medical director of the local EMS agency as qualified to provide prehospital advanced life support or to issue instructions to prehospital emergency medical care personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a registered nurse or mobile intensive care nurse as otherwise provided by law. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.58. "Base hospital" means one of a limited number of hospitals which, upon designation by the local EMS agency and upon the completion of a written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system and prehospital care system assigned to it by the local EMS agency. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.59. "Base hospital physician" or "BHP" means a physician and surgeon who is currently licensed in California, who is assigned to the emergency department of a base

hospital, and who has been trained to issue advice and instructions to prehospital emergency medical care personnel consistent with statewide guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a physician and surgeon as otherwise provided by law. [Added by SB 1124 (Ch. 1391) 1984.]

1797.60. "Basic life support" means emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available.

1797.61. (a) "Certificate" or "license" means a specific document issued to an individual denoting competence in the named area of prehospital service.

(b) "Certificate status" or "license status" means the active, expired, denied, suspended, revoked, or placed on probation designation applied to a certificate or license issued pursuant to this division.

[Added by AB 2917 (Ch. 274) 2008.]

1797.62. "Certifying entity" means a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT-I personnel that is approved pursuant to the standards developed pursuant to Section 1797.109, or the medical director of a local EMS agency. [Repealed and added by AB 2917 (Ch. 274) 2008.]

1797.63. "Certifying examination" or "examination for certification" means an examination designated by the authority for a specific level of prehospital emergency medical care personnel that must be satisfactorily passed prior to certification or recertification at the specific level and may include any examination or examinations designated by the authority, including, but not limited to, any of the following options determined appropriate by the authority:

(a) An examination developed either by the authority or under the auspices of the authority or approved by the authority and administered by the authority or any entity designated by the authority to administer the examination.

(b) An examination developed and administered by the National Registry of Emergency Medical Technicians.

(c) An examination developed, administered, or approved by a certifying agency pursuant to standards adopted by the authority for the certification examination. [Added by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989, technically, as two identical sections with the same number. SB 2510 (Ch. 216) 1990, repealed the duplicate as part of a general code cleanup.]

1797.64. "Commission" means the Commission on Emergency Medical Services created pursuant to the provisions of Section 1799.

1797.66. "Competency based curriculum" means a curriculum in which specific objectives are defined for each of the separate skills taught in training programs with

integrated didactic and practical instruction and successful completion of an examination demonstrating mastery of every skill.

1797.665. [Added by SB 595 (Ch. 1246) 1983. Repealed by AB 3269 (Ch. 1390) 1988.]

1797.67. "Designated facility" means a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority. [Added by SB 595 (Ch. 1246) 1983.]

1797.68. "Director" means the Director of the Emergency Medical Services Authority.

1797.70. "Emergency" means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency.

1797.72. "Emergency medical services" means the services utilized in responding to a medical emergency.

1797.74. "Emergency medical services area" or "EMS area" means the geographical area within the jurisdiction of the designated local EMS agency. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.76. "Emergency medical services plan" means a plan for the delivery of emergency medical services consistent with state guidelines addressing the components listed in Section 1797.103.

1797.78. "Emergency medical services system" or "system" means a specially organized arrangement which provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions.

1797.80. "Emergency Medical Technician-I" or "EMT-I" means an individual trained in all facets of basic life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part. This definition shall include, but not be limited to, EMT-I (FS) and EMT-I-A.

1797.82. "Emergency Medical Technician-II," "EMT-II," "Advanced Emergency Medical Technician," or "Advanced EMT" means an EMT-I with additional training in limited advanced life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part. [Amended by SB 997 (Ch. 275) 2008.]

1797.84. "Emergency Medical Technician-Paramedic," "EMT-P," "paramedic" or "mobile intensive care paramedic" means an individual whose scope of practice to provide advanced life support is according to standards prescribed by this division and

who has a valid certificate issued pursuant to this division. [Amended by SB 595 (Ch. 1246) 1983.]

1797.85. "Exclusive operating area" means an EMS area or subarea defined by the emergency medical services plan for which a local EMS agency, upon the recommendation of a county, restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. [Added by AB 3153 (Ch. 1349) 1984.]

1797.86. "Health systems agency" means a health systems agency as defined in subsection (a) of Section 300(1)-1 of Title 42 of the United States Code.

1797.88. "Hospital" means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of-state acute care hospital which substantially meets the requirements of Chapter 2 (commencing with Section 1250) of Division 2, as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located. [Amended by SB 1791 (Ch. 1162) 1986.]

1797.90. "Medical control" means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798).

1797.92. "Limited advanced life support" means special service designed to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support and are those procedures specified pursuant to Section 1797.171.

1797.94. "Local EMS agency" means the agency, department, or office having primary responsibility for administration of emergency medical services in a county and which is designated pursuant to Chapter 4 (commencing with Section 1797.200).

1797.97. "Poison control center" or "PCC" means a hospital-based facility or other facility which, as a minimum, provides information and advice regarding the management of individuals who have or may have ingested or otherwise been exposed to poisonous or possibly toxic substances, and which has been designated by the Emergency Medical Services Authority according to the standards prescribed by this division. [Added by SB 1124 (Ch. 1391) 1984. Amended by AB 580 (Ch. 972) 1987.]

CHAPTER 2.5 THE MADDY EMERGENCY MEDICAL SERVICES FUND

[Added by SB 12 (Ch. 1240) 1987.]

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund in an amount that does not exceed the actual administrative costs or 10 percent of the amount of the fund, whichever amount is lower.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic, comprehensive, or standby emergency services pursuant to paragraph (3) or (5) of subdivision (f) of Section 1797.98e up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held

and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

(e) Of the money deposited into the fund pursuant to Section 76000.5 of the Government Code, 15 percent shall be utilized to provide funding for all pediatric trauma centers throughout the county, both publicly and privately owned and operated. The expenditure of money shall be limited to reimbursement to physicians and surgeons, and to hospitals for patients who do not make payment for emergency care services in hospitals up to the point of stabilization, or to hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment. Local emergency medical services (EMS) agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures. Counties that do not maintain a pediatric trauma center shall utilize the money deposited into the fund pursuant to Section 76000.5 of the Government Code to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children. Funds spent for the purposes of this section, shall be known as Richie's Fund. This subdivision shall remain in effect only until January 1, 2014, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2014, deletes or extends that date.

(f) Costs of administering money deposited into the fund pursuant to Section 76000.5 of the Government Code shall be reimbursed from the money collected in an amount that does not the actual administrative costs or 10 percent of the money collected, whichever amount is lower. This subdivision shall remain in effect only until January 1, 2014, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2014, deletes or extends that date.

[Amended by SB 612 (Ch. 945) 1988; SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; SB 1683 (Ch. 1143) 1994; AB 2021 (Ch. 58) 1998; SB 476 (Ch. 707) 2003; SB 941 (Ch. 671) 2005, and SB 1773 (Ch. 841) 2006; SB 1236 (Ch. 60) 2008; AB 2702 (Ch. 288) 2008; and by AB 1475 (Ch. 537) 2009.]

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund, or, if no moneys were deposited into the fund, the reason or reasons for the lack of deposits. The total amounts of penalty assessments shall be listed on the basis of each statute that provides the authority for the penalty assessment, including Sections 76000, 76000.5, and 76104 of the Government Code, and Section 42007 of the Vehicle Code.

(2) The amount of penalty assessment funds collected under Section 76000.5 of the Government Code that are used for the purposes of subdivision (e) of Section 1797.98a.

(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.

(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contacted to review claims payment methodologies.

(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.

(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98c.

(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.

(B) The amount of moneys available to be disbursed to hospitals.

(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.

(11) The name and contact information of the entity responsible for each of the following:

(A) Collection of fines, forfeitures, and penalties.

(B) Distribution of penalty assessments into the Emergency Medical Services Fund.

(C) Distribution of moneys to physicians and surgeons.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis. [Amended by SB 623 (Ch. 679) 1999; SB 476 (Ch. 707) 2003; and AB 1059 (Ch. 403) 2011.]

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations. [Amended by SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; AB 1833 (Ch. 430) 2002; SB 476 (Ch. 707) 2003; and SB 941 (Ch. 671) 2005.]

1797.98d. [Repealed by AB 1257 (Ch. 237) 1989.]

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's

administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(5) A standby emergency room in existence on January 1, 2007, in a hospital located in Los Angeles County that meets all of the following requirements:

(A) The requirements of subdivision (m) of Section 70413 and Sections 70415 and 70417 of Title 22 of the California Code of Regulations.

(B) Reported at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in 2007 and continues to report at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in each year thereafter.

(C) A hospital with a standby emergency department meeting the requirements of this paragraph shall do both of the following:

(i) Annually provide the State Department of Public Health and the local emergency medical services agency with certification that it meets the requirements of subparagraph (A). The department shall confirm the hospital's compliance with subparagraph (A).

(ii) Annually provide to the State Department of Public Health and the local emergency medical services agency the emergency department patient encounters it reports to the Office of Statewide Health Planning and Development to establish that it meets the requirement of subparagraph (B).

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(l) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

SEC. 3. Section 16953 of the Welfare and Institutions Code is amended to read:

16953. (a) For purposes of this chapter "emergency services" means physician services in one of the following:

(1) A general acute care hospital which provides basic or comprehensive emergency services for emergency medical conditions.

(2) A site which was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients, for emergency medical conditions.

(3) Beginning in the 1991-92 fiscal year and each fiscal year thereafter, in a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services, for emergency medical conditions.

(4) A standby emergency room in a hospital specified in Section 124840 of the Health and Safety Code, for emergency medical conditions.

(5) A standby emergency room in a hospital in existence on January 1, 2007, located in Los Angeles County that meets all of the following requirements:

(A) The requirements of subdivision (m) of Section 70413 and Sections 70415 and 70417 of Title 22 of the California Code of Regulations.

(B) Reported at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in 2007 and continues to report at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in each year thereafter.

(C) A hospital with a standby emergency department meeting the requirements of this paragraph shall do both of the following:

(i) Annually provide the State Department of Public Health and the local emergency medical services agency with certification that it meets the requirements of subparagraph (A). The department shall confirm the hospital's compliance with subparagraph (A).

(ii) Annually provide to the State Department of Public Health and the local emergency medical services agency the emergency department patient encounters it reports to the Office of Statewide Health Planning and Development to establish that it meets the requirement of subparagraph (B).

(b) For purposes of this chapter, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part.

(c) It is the intent of this section to allow reimbursement for all inpatient and outpatient services which are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider. [Amended by SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; SB 1497 (Ch. 1023) 1996; AB 1833 (Ch. 430) 2002; SB 476 (Ch. 707) 2003; SB 635 (Ch. 524) 2004; SB 941 (Ch. 671) 2005; and AB 2702 (Ch. 288) 2008.] [Section 1797.98e of the Health and Safety Code, as added by Section 3 of Chapter 524 of the Statutes of 2004, was repealed by SB 941 (Ch. 671) of 2005.]

1797.98f. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings

arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients. [Added by SB 2098 (Ch. 1171) 1990. Amended by SB 277 (Ch. 1016) 1998.]

1797.98g. The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code. [Added by SB 946 (Ch. 1169) 1991.]

1797.98h. [Automatically repealed on January 1, 2000 as stated in SB 1683 (Ch. 1143) 1994.]

CHAPTER 3. STATE ADMINISTRATION

Article 1. The Emergency Medical Services Authority

1797.100. There is in the state government in the Health and Welfare Agency, the Emergency Medical Services Authority. [Name amended by SB 595 (Ch. 1246) 1983.]

1797.101. The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services. The director shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine. [Amended by SB 898 (Ch. 1074) 1981; AB 2917 (Ch. 274) 2008.]

1797.102. The authority, utilizing regional and local information, shall assess each EMS area or the system's service area for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services.

1797.103. The authority shall develop planning and implementation guidelines for emergency medical services systems which address the following components:

- (a) Manpower and training.
- (b) Communications.
- (c) Transportation.
- (d) Assessment of hospitals and critical care centers.
- (e) System organization and management.
- (f) Data collection and evaluation.
- (g) Public information and education.
- (h) Disaster response.

1797.104. The authority shall provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems.

1797.105. (a) The authority shall receive plans for the implementation of emergency medical services and trauma care systems from EMS agencies.

(b) After the applicable guidelines or regulations are established by the authority, a local EMS agency may implement a local plan developed pursuant to Section 1797.250, 1797.254, 1797.257, or 1797.258 unless the authority determines that the plan does not effectively meet the needs of the persons served and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority.

(c) A local EMS agency may appeal a determination of the authority pursuant to subdivision (b) to the commission.

(d) In an appeal pursuant to subdivision (c), the commission may sustain the determination of the authority or overrule and permit local implementation of a plan, and the decision of the commission is final. [Amended by AB 1235 (Ch. 1735) 1984.]

1797.106. (a) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall not prohibit hospitals which contract with group practice prepayment health care service plans from providing necessary medical services for the members of those plans.

(b) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall provide for the transport and transfer of a member of a group practice prepayment health care service plan to a hospital that contracts with the plan when the base hospital determines that the condition of the member permits the transport or when the condition of the member permits the transfer, except that when the dispatching agency determines that the transport by a transport unit would unreasonably remove the transport unit from the area, the member may be transported to the nearest hospital capable of treating the member. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.107. The authority shall adopt, amend, or repeal, after approval by the commission and in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division and to enable the authority to exercise the powers and perform the duties conferred upon it by this division not inconsistent with any of the provisions of any statute of this state.

1797.108. Subject to the availability of funds appropriated therefore, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

In addition, the authority may provide special funding to multi-county EMS agencies which serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

Each local or multi-county EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation. [Added by SB 1157 (Ch. 191) 1983.]

1797.109. (a) The director may develop, or prescribe standards for and approve, an emergency medical technician training and testing program for the Department of the California Highway Patrol, Department of Forestry and Fire Protection, California Fire Fighter Joint Apprenticeship Committee, and other public safety agency personnel, upon the request of, and as deemed appropriate by, the director for the particular agency.

(b) The director may, with the concurrence of the Department of the California Highway Patrol, designate the California Highway Patrol Academy as a site where the training and testing may be offered.

(c) The director may prescribe that each person, upon successful completion of the training course and upon passing a written and a practical examination, be certified as an emergency medical technician of an appropriate classification. A suitable identification card may be issued to each certified person to designate that person's emergency medical skill level.

(d) The director may prescribe standards for refresher training to be given to persons trained and certified under this section.

(e) The Department of the California Highway Patrol shall, subject to the availability of federal funds, provide for the initial training of its uniformed personnel in the rendering of emergency medical technician services to the public in specified areas of the state as designated by the Commissioner of the California Highway Patrol. [Added by SB 898 (Ch. 1074) 1981; amended by AB 3355 (Ch. 427) 1992; and amended by AB 2469 (Ch. 157) 2000.]

1797.110. The Legislature finds that programs funded through the authority are hindered by the length of time required for the state process to execute approved contracts and payment of vendor claims. These programs include, but are not limited to, general fund assistance to rural multi-county EMS agencies and dispersal of federal grant moneys for EMS systems development to local EMS agencies. This hardship is particularly felt by new or rural community based EMS agencies with modest reserves and cash flow problems. It is the intent of the Legislature that advance payment authority be established for the authority in order to alleviate such problems for those types of contractors to the extent possible.

Notwithstanding any other provision of law, the authority may, to the extent funds are available, provide for advanced payment under any financial assistance contract which the authority determines has been entered into with any small rural, or new EMS agency with modest reserves and potential cash flow problems, as determined by the authority. Such programs include, but are not limited to, local county or multi-county EMS agencies. No advance payment or aggregate of advance payments made pursuant to this section shall exceed 25 percent of the total annual contract amount. No advance payment should be made pursuant to this section if the applicable federal law prohibits advance payment. [Added by SB 1157 (Ch. 191) 1983.]

1797.111. With the approval of the Department of Finance, and for use in the furtherance of the work of the authority, the director may accept all of the following:

(a) Grants of interest in real property.

(b) Gifts of money from public agencies or from organizations or associations organized for scientific, educational, or charitable purpose. [Added by SB 595 (Ch. 1246) 1983.]

1797.112. (a) The Emergency Medical Services Personnel Fund is hereby created in the State Treasury, the funds in which are to be held in trust for the benefit of the authority's testing and personnel licensure program and for the purpose of making

reimbursements to entities for the performance of functions for which fees are collected pursuant to Section 1797.172, for expenditure upon appropriation by the Legislature.

(b) The authority may transfer unused portions of the Emergency Medical Services Personnel Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Emergency Medical Services Personnel Fund, together with interest earned, when requested by the authority.

(c) The authority shall maintain a reserve balance in the Emergency Medical Services Personnel Fund of five percent. Any increase in the fees deposited in the Emergency Medical Services Personnel Fund shall be effective upon a determination by the authority that additional moneys are required to fund expenditures of the personnel licensure program, including, but not limited to, reimbursements to entities set forth in subdivision (a).

[Added by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989; technically, as two identical sections with the same number. SB 2510 (Ch. 216) 1990, repealed the duplicate as part of a general code cleanup. Amended by SB 463 (Ch. 100) 1993 which provided authority from July 13, 1993 through December 31, 1993 for EMSA to temporarily certify EMT-Ps. AB 1980 (Ch. 997) 1993, extended the authority to certify EMT-Ps through December 31, 1993.

Note that AB 1980 (Ch. 997) 1993, also amends this section back to its pre July 1993 language effective January 1, 1995. Amended by AB 3123 (Ch. 709) 1994 to remove continuous appropriation, establish a trust and authority to maintain a reserve; amended by AB 2877 (Ch. 93) 2000 to reduce the reserve to five percent.]

1797.113. The Emergency Medical Services Training Program Approval Fund is hereby established in the State Treasury and, notwithstanding Section 13340 of the Government Code, is continuously appropriated to the authority for the authority's training program review and approval activities. The fees charged by the authority under Section 1797.191 shall be deposited in this fund. The authority may transfer unexpended and unencumbered moneys contained in the Emergency Medical Services Training Program Approval Fund to the Surplus Money Investment Fund for investment pursuant to Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest, dividends, and pecuniary gains from such investments or deposits shall accrue to the Emergency Medical Services Training Program Approval Fund. [Added by AB 243 (Ch. 246) 1994 to correspond with Health & Safety Code Section 1596.866. Amended by SB 1524 (Ch. 666) 1998.]

1797.114. The rules and regulations of the authority established pursuant to Section 1797.107 shall include a requirement that a local EMS agency local plan developed pursuant to this division shall require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. Emergency health care need shall be determined by the prehospital emergency medical care personnel under the direction of a base hospital physician and surgeon or in conformance with the regulations of the authority adopted pursuant to Section 1797.107. [Added by AB 984 (Ch. 979) 1998.]

1797.115. (a) To the extent permitted by federal law and upon appropriation in the annual Budget Act or another statute, the Director of Finance may transfer any moneys in the Federal Trust Fund established pursuant to Section 16360 of the Government Code to the Emergency Medical Services Authority if the money is made available by the United States for expenditure by the state for purposes consistent with the implementation of this section.

(b) Moneys appropriated pursuant to subdivision (a) shall be allocated by the authority to the California Fire Fighter Joint Apprenticeship Program to do all of the following:

(1) Offset the cost of paramedic training course development.

(2) Enter into reimbursement contracts with eligible state and local agencies that in turn may contract with educational institutions for the delivery of paramedic training conducted in compliance with the requirements of subdivision (a) of Section 1797.172.

(3) Allocate funds, in the form of grants, to eligible state and local agencies to defray the cost of providing paramedic training for fire services personnel, including, but not limited to, instructional supplies and trainee compensation expenses.

(c) To the extent permitted by federal law, the authority shall recover its costs for administration of this section from the funds transferred pursuant to subdivision (a).

(d) In order to be eligible for a grant under paragraph (3) of subdivision (b), a state or local agency shall demonstrate a need for additional paramedics.

(e) For purposes of this section, the following definitions apply:

(1) "Fire service personnel" includes, but is not limited to, a firefighter or prehospital emergency medical worker employed by a state or local agency.

(2) "Local agency" means any city, county, city and county, fire district, special district, joint powers agency, or any other political subdivision of the state that provides fire protection services.

(3) "State agency" means any state agency that provides residential or institutional fire protection, including, but not limited to, the Department of Forestry and Fire Protection.

[Added by SB 1629 (Ch. 1050) 2002; amended by SB 600 (Ch. 62) 2003.]

1797.116. (a) The authority shall establish additional training standards that include the criteria for the curriculum content recommended by the Emergency Response Training Advisory Committee established pursuant to Section 8588.10 of the Government Code, involving the responsibilities of first responders to terrorism incidents and to address the training needs of those identified as first responders.

(b) Every EMT I, EMT II, and EMT-P, as defined in Sections 1797.80, 1797.82, and 1797.84, may receive the appropriate training described in this section. Pertinent training previously completed by any jurisdiction's EMT I, EMT II, or EMT-P personnel and meeting the training requirements of this section may be submitted to the training program approving authority to assess its content and determine whether it meets the training standards prescribed by the authority. [Added by SB 1629 (Ch. 1050) 2002.]

1797.117. (a) The authority shall establish and maintain a centralized registry system for the monitoring and tracking of each EMT-I and EMT-II certificate status and each EMT-P license status. This centralized registry system shall be used by the certifying entities as part of the certification process for an EMT-I and EMT-II and by the authority

as part of the licensure process for an EMT-P license. The authority shall, by regulation, specify the data elements to be included in the centralized registry system, the requirements for certifying entities to report the data elements for inclusion in the registry, including reporting deadlines, the penalties for failure of a certifying entity to report certification status changes within these deadlines, and requirements for submission to the Department of Justice fingerprint images and related information required by the Department of Justice of, except as otherwise provided in this division, EMT-I and EMT-II certificate candidates or holders and EMT-P license candidates or holders for the purposes described in subdivision (c). The data elements to be included in the centralized registry system shall include, but are not limited to, data elements that are to be made publicly available pursuant to subdivision (b).

(b) The information made available to the public through the centralized registry system shall include all of the following data elements: the full name of every individual who has been issued an EMT-I or EMT-II certificate or EMT-P license, the name of the entity that issued the certificate or license, the certificate or license number, the date of issuance of the license or certificate, and the license or certificate status.

(c) (1) As part of the centralized registry system, the authority shall electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice of all EMT-I and EMT-II certificate candidates or holders, and of all EMT-P license applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this subdivision. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and electronically disseminate a primary response to the authority and electronically disseminate a dual response to one government agency certifying entity.

(3) The Department of Justice shall electronically provide the primary response to the authority and also electronically, the dual response to one certifying entity that is a government agency, pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(d) The authority shall request the Department of Justice to provide subsequent arrest notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in subdivision (c). All subsequent arrest notifications provided to the authority for persons described in subdivision (c) shall be electronically submitted to one government agency certifying entity, as a dual response by the Department of Justice.

(e) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section. [Added by AB 2917 (Ch. 274) 2008.]

1797.118. (a) On and after July 1, 2010, and except as provided in subdivision (b), every EMT-I and EMT-II certificate candidate or holder shall have their fingerprint images and related information submitted to the authority for submission to the Department of Justice pursuant to the regulations adopted pursuant to Section 1797.117

for a state and federal level criminal offender record information search, including subsequent arrest information.

(b) If a state level criminal offender record information search, including subsequent arrest information, has been conducted on a currently certified EMT-I or EMT-II, who was certified prior to July 1, 2010, for the purposes of employment or EMT-I or EMT-II certification, then the certifying entity or employer as identified in paragraph (2) of subdivision (a) of Section 1798.200 shall verify in writing to the authority pursuant to regulations adopted pursuant to Section 1797.117 that a state level criminal offender record information search, including subsequent arrest information, has been conducted and that nothing in the criminal offender record information search precluded the individual from obtaining EMT-I or EMT-II certification. [Added by AB 2917 (Ch. 274) 2008.]

Article 2. Recodifications

1797.120. [Repealed by AB 1123 (Ch. 1058); 1987.]

1797.121. The authority shall report to the Legislature on the effectiveness of the systems provided for in this division on or before January 1, 1984, and annually thereafter, including within this report, systems impact evaluations on death and disability.

Article 3. Coordination With Other State Agencies

1797.130. The director shall chair an Interdepartmental Committee on Emergency Medical Services established pursuant to Section 1797.132.

1797.131. [Repealed by AB 1153 (Ch. 477) 1987.]

1797.132. An Interdepartmental Committee on Emergency Medical Services is hereby established. This committee shall advise the authority on the coordination and integration of all state activities concerning emergency medical services. The committee shall include a representative from each of the following state agencies and departments: the Office of Emergency Services, the Department of the California Highway Patrol, the Department of Motor Vehicles, a representative of the administrator of the California Traffic Safety Program as provided by Chapter 5 (commencing with Section 2900) of Division 2 of the Vehicle Code, the Medical Board of California, the State Department of Health Services, the Board of Registered Nursing, the State Department of Education, the National Guard, the Office of Statewide Health Planning and Development, the State Fire Marshal, the California Conference of Local Health Officers, the Department of Forestry and Fire Protection, the Chancellor's Office of the California Community Colleges, and the Department of General Services. [Amended by SB 595 (Ch. 1246) 1983; AB 184 (Ch. 886) 1989; and SB 3355 (Ch. 427) 1992.]

1797.133. The director may appoint select resource committees of experts and may contract with special medical consultants for assistance in the implementation of this division.

Article 4. Medical Disasters

1797.150. In cooperation with the Office of Emergency Services, the authority shall respond to any medical disaster by mobilizing and coordinating emergency medical services mutual aid resources to mitigate health problems.

1797.151. The authority shall coordinate, through local EMS agencies, medical and hospital disaster preparedness with other local, state, and federal agencies and departments having a responsibility relating to disaster response, and shall assist the Office of Emergency Services in the preparation of the emergency medical services component of the State Emergency Plan as defined in Section 8560 of the Government Code.

1797.152. (a) The director, and the Director of Health Services may jointly appoint a regional disaster medical and health coordinator for each mutual aid region of the state. A regional disaster medical and health coordinator shall be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency. Appointees shall be chosen from among persons nominated by a majority vote of the local health officers in a mutual aid region.

(b) In the event of a major disaster which results in a proclamation of emergency by the Governor, and in the need to deliver medical or public and environmental health mutual aid to the area affected by the disaster, at the request of the authority, the State Department of Health Services, or the Office of Emergency Services, a regional disaster medical and health coordinator in a region unaffected by the disaster may coordinate the acquisition of requested mutual aid resources from the jurisdictions in the region.

(c) A regional disaster medical and health coordinator may develop plans for the provision of medical or public health mutual aid among the counties in the region.

(d) No person may be required to serve as a regional disaster medical and health coordinator.

No state compensation shall be paid for a regional disaster medical and health coordinator position, except as determined appropriate by the state, if funds become available. [Added by AB 1390 (Ch. 185) 1989.]

1797.153. (a) In each operational area the county health officer and the local EMS agency administrator may act jointly as the medical health operational area coordinator (MHOAC). If the county health officer and the local EMS agency administrator are unable to fulfill the duties of the MHOAC they may jointly appoint another individual to fulfill these responsibilities. If an operational area has a MHOAC, the MHOAC in cooperation with the county office of emergency services, local public health department, the local office of environmental health, the local department of mental health, the local EMS agency, the local fire department, the regional disaster and medical health coordinator (RDMHC), and the regional office of the Office of Emergency

Services (OES), shall be responsible for ensuring the development of a medical and health disaster plan for the operational area. The medical and disaster plans shall follow the Standard Emergency Management System and National Incident Management System. The MHOAC shall recommend to the operational area coordinator of the Office of Emergency Services a medical and health disaster plan for the provision of medical and health mutual aid within the operational area.

(b) For purposes of this section, "operational area" has the same meaning as that term is defined in subdivision (b) of Section 8559 of the Government Code.

(c) The medical and health disaster plan shall include preparedness, response, recovery, and mitigation functions consistent with the State Emergency Plan, as established under Sections 8559 and 8560 of the Government Code, and, at a minimum, the medical and health disaster plan, policy, and procedures shall include all of the following:

- (1) Assessment of immediate medical needs.
- (2) Coordination of disaster medical and health resources.
- (3) Coordination of patient distribution and medical evaluations.
- (4) Coordination with inpatient and emergency care providers.
- (5) Coordination of out-of-hospital medical care providers.
- (6) Coordination and integration with fire agencies personnel, resources, and emergency fire prehospital medical services.
- (7) Coordination of providers of nonfire based prehospital emergency medical services.
- (8) Coordination of the establishment of temporary field treatment sites.
- (9) Health surveillance and epidemiological analyses of community health status.
- (10) Assurance of food safety.
- (11) Management of exposure to hazardous agents.
- (12) Provision or coordination of mental health services.
- (13) Provision of medical and health public information protective action recommendations.
- (14) Provision or coordination of vector control services.
- (15) Assurance of drinking water safety.
- (16) Assurance of the safe management of liquid, solid, and hazardous wastes.
- (17) Investigation and control of communicable disease.

(d) In the event of a local, state, or federal declaration of emergency, the MHOAC shall assist the OES operational area coordinator in the coordination of medical and health disaster resources within the operational area, and be the point of contact in that operational area, for coordination with the RDMHC, the OES, the regional office of the OES, the State Department of Public Health, and the authority.

(e) Nothing in this section shall be construed to revoke or alter the current authority for disaster management provided under either of the following:

- (1) The State Emergency Plan established pursuant to Section 8560 of the Government Code.
- (2) The California standardized emergency management system established pursuant to Section 8607 of the Government Code. [Added by AB 586 (Ch. 703) 2006. Amended by SB 1039 (Ch. 483) 2007.]

Article 5. Personnel

1797.160. No owner of a publicly or privately owned ambulance shall permit the operation of the ambulance in emergency service unless the attendant on duty therein, or, if there is no attendant on duty therein, the operator, possesses evidence of that specialized training as is reasonably necessary to ensure that the attendant or operator is competent to care for sick or injured persons who may be transported by the ambulance, as set forth in the emergency medical training and educational standards for ambulance personnel established by the authority pursuant to this article. This section shall not be applicable in any state of emergency declared pursuant to the California Emergencies Services Act (Chapter 7 commencing with Section 8550) of Division 1 of Title 2 of the Government Code), when it is necessary to fully utilize all available ambulances in an area and it is not possible to have the ambulance operated or attended by persons with the qualifications required by this section. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H&S Code Section 1760.5.]

1797.170. (a) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt regulations for the training and scope of practice for EMT-I certification.

(b) Any individual certified as an EMT-I pursuant to this division shall be recognized as an EMT-I on a statewide basis, and recertification shall be based on statewide standards. Effective July 1, 1990, any individual certified as an EMT-I pursuant to this act shall complete a course of training on the nature of sudden infant death syndrome which is developed by the California SIDS program in the State Department of Public Health in consultation with experts in the field of sudden infant death syndrome. [Amended by SB 1124 (Ch. 1391) 1984; SB 1067 (Ch. 1111) 1989; and AB 2917 (Ch. 274) 2008.]

1797.171. (a) The authority shall develop, and after approval of the commission pursuant to Section 1799.50, shall adopt, minimum standards for the training and scope of practice for EMT-II.

(b) An EMT-II shall complete a course of training on the nature of sudden infant death syndrome in accordance with subdivision (b) of Section 1797.170.

(c) In rural or remote areas of the state where patient transport times are particularly long and where local resources are inadequate to support an EMT-P program for EMS responses, the director may approve additions to the scope of practice of EMT-IIs serving the local system, if requested by the medical director of the local EMS agency, and if the EMT-II has received training equivalent to that of an EMT-P. The approval of the director, in consultation with a committee of local EMS medical directors named by the Emergency Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-IIs proposed by the medical director of a local EMS agency. No drug or procedure that is not part of the basic EMT-P scope of practice, including, but not limited to, any approved local options, shall be added to any EMT-II scope of practice pursuant to this subdivision.

Approval of additions to the scope of practices pursuant to this subdivision may be given only for EMT-II programs in effect on January 1, 1994. [Amended by AB 1123 (Ch. 1058) 1987; SB 1067 (Ch. 1111) 1989; and AB 3123 (Ch. 709) 1994.]

1797.172. (a) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt minimum standards for the training and scope of practice for EMT-P.

(b) The approval of the director, in consultation with a committee of local EMS medical directors named by the EMS Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-Ps proposed by the medical director of a local EMS agency.

(c) Notwithstanding any other provision of law, the authority shall be the agency solely responsible for licensure and licensure renewal of EMT-Ps who meet the standards and are not precluded from licensure because of any of the reasons listed in subdivision (d) of Section 1798.200. Each application for licensure or licensure renewal shall require the applicant's social security number in order to establish the identity of the applicant. The information obtained as a result of a state and federal level criminal offender record information search shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure or licensure renewal pursuant to this division. Submission of fingerprint images to the Department of Justice may not be required for licensure renewal upon determination by the authority that fingerprint images have previously been submitted to the Department of Justice during initial licensure, or a previous licensure renewal, provided that the license has not lapsed and the applicant has resided continuously in the state since the initial licensure.

(d) The authority shall charge fees for the licensure and licensure renewal of EMT-Ps in an amount sufficient to support the authority's licensure program at a level that ensures the qualifications of the individuals licensed to provide quality care. The basic fee for licensure or licensure renewal of an EMT-P shall not exceed one hundred twenty-five dollars (\$125) until the adoption of regulations that specify a different amount that does not exceed the authority's EMT-P licensure, license renewal, and enforcement programs. The authority shall annually evaluate fees to determine if the fee is sufficient to fund the actual costs of the authority's licensure, licensure renewal, and enforcement programs. If the evaluation shows that the fees are excessive or are insufficient to fund the actual costs of the authority's EMT-P licensure, licensure renewal, and enforcement programs, then the fees shall be adjusted accordingly through the rulemaking process described in the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Separate additional fees may be charged, at the option of the authority, for services that are not shared by all applicants for licensure and licensure renewal, including, but not limited to, any of the following services:

- (1) Initial application for licensure as an EMT-P.
- (2) Competency testing, the fee for which shall not exceed thirty dollars (\$30), except that an additional fee may be charged for the cost of any services that provide enhanced availability of the exam for the convenience of the EMT-P, such as on-demand electronic testing.

(3) Fingerprint and criminal record check. The applicant shall, if applicable according to subdivision (c), submit fingerprint images and related information for criminal offender record information searches with the Department of Justice and the Federal Bureau of Investigation.

(4) Out-of-state training equivalency determination.

(5) Verification of continuing education for a lapse in licensure.

(6) Replacement of a lost licensure card. The fees charged for individual services shall be set so that the total fees charged to EMT-Ps shall not exceed the authority's actual total cost for the EMT-P licensure program.

(e) The authority may provide nonconfidential, nonpersonal information relating to EMS programs to interested persons upon request, and may establish and assess fees for the provision of this information. These fees shall not exceed the costs of providing the information.

(f) At the option of the authority, fees may be collected for the authority by an entity that contracts with the authority to provide any of the services associated with the EMT-P program. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Services Personnel Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the designated entity, unless the contract between the entity and the authority specifies a different timeframe. [Amended by SB 595 (Ch. 1246) 1983; AB 1123 (Ch. 1058) 1987; SB 1067 (Ch. 1111), AB 1558 (Ch. 1134), AB 2159 (Ch. 1362) 1989; SB 463 (Ch. 100) 1993; and AB 1980 (Ch. 997) 1993. Note that AB 1980 (Ch. 997) 1993, did not take effect until January 1, 1995. Provisions of SB 1067 not given effect because of later signing of AB 1558 and AB 2159. AB 1558 and AB 2159 amended this section in an identical manner. Amended by AB 3123 (Ch. 709) 1994 to establish EMT-P licensure program under EMS Authority, places a maximum limit on fees except for special services; Amended by AB 1215 (Ch. 549) 1999 and Amended by AB 2917 (Ch. 274) 2008.]

1797.173. The authority shall assure that all training programs for EMT-I, EMT-II, and EMT-P are located in an approved licensed hospital or an educational institution operated with written agreements with an acute care hospital, including a public safety agency that has been approved by the local emergency medical services agency to provide training. The authority shall also assure that each training program has a competency-based curriculum. EMT-I training and testing for fire service personnel may be offered at sites approved by the State Board of Fire Services and training for officers of the California Highway Patrol may be provided at the California Highway Patrol Academy. [Amended by SB 595 (Ch. 1246) 1983.]

1797.174. In consultation with the commission, the Emergency Medical Directors Association of California, and other affected constituencies, the authority shall develop statewide guidelines for continuing education courses and approval for continuing education courses for EMT-Ps and for quality improvement systems which monitor and promote improvement in the quality of care provided by EMT-Ps throughout the state. [Repealed by AB 1123 (Ch. 1058) 1987. Added by AB 1980 (Ch. 997) 1993.]

1797.175. The authority shall establish the standards for continuing education and shall designate the examinations for certification and recertification of all prehospital personnel. The authority shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS). [Amended by SB 1552 (Ch. 1213) 1988; and AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.176. The authority shall establish the minimum standards for the policies and procedures necessary for medical control of the EMS system. [Amended by AB 3269 (Ch. 1390) 1988.]

1797.177. No individual shall hold himself or herself out to be an EMT-I, EMT-II, EMT-P, or paramedic unless that individual is currently certified as such by the local EMS agency or other certifying authority.

1797.178. No person or organization shall provide advanced life support or limited advanced life support unless that person or organization is an authorized part of the emergency medical services system of the local EMS agency or of a pilot program operated pursuant to the Wedworth-Townsend Paramedic Act, Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2.

1797.179. Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county or special district providing paramedic services as set forth in Section 1797.172, shall reimburse the Health Care Deposit Fund for the state costs of paying such medical claims. Funds allocated to the county from the County Health Services Fund pursuant to Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code may be utilized by the county or city to make such reimbursement. [Added by SB 735 (Ch. 1322) 1980.]

1797.180. No agency, public or private, shall advertise or disseminate information to the public that the agency provides EMT-II or EMT-P rescue or ambulance services unless that agency does in fact provide this service on a continuous 24 hours-per-day basis. If advertising or information regarding that agency's EMT-II or EMT-P rescue or ambulance service appears on any vehicle it may only appear on those vehicles utilized solely to provide that service on a continuous 24 hours-per-day basis. [Relocated and amended by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1484.3.]

1797.181. The authority may, by regulation, prescribe standardized insignias or emblems for patches which may be affixed to the clothing of an EMT-I, EMT-II, or EMT-P. [Relocated and by SB 595 (Ch. 1246); 1983. Formerly H & S Code Section 1481.5.]

1797.182. All ocean, public beach, and public swimming pool lifeguards and all firefighters in this state, except those whose duties are primarily clerical or administrative, shall be trained to administer first aid and cardiopulmonary resuscitation. The training shall meet standards prescribed by the authority, and shall be satisfactorily completed by such persons as soon as practical, but in no event more than one year

after the date of employment. Satisfactory completion of a refresher course which meets the standards prescribed by the authority in cardiopulmonary resuscitation and other first aid shall be required at least every three years. The authority may designate a public agency or private nonprofit agency to provide for each county the training required by this section. The training shall be provided at no cost to the trainee.

As used in this section, "lifeguard" means any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state.

As used in this section, "firefighter" means any regularly employed and paid officer, employee, or member of a fire department or fire protection or firefighting agency of the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state or member of an emergency reserve unit of a volunteer fire department or fire protection district. [Relocated and updated by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 217.]

1797.183. All peace officers described in Section 13518 of the Penal Code, except those whose duties are primarily clerical or administrative, shall be trained to administer first aid and cardiopulmonary resuscitation (CPR). The training shall meet standards prescribed by the authority, in consultation with the Commission on Peace Officers Standards and Training, and shall be satisfactorily completed by those officers as soon as practical, but in no event more than one year after the date of employment. Satisfactory completion of either refresher training or appropriate testing, which meets the standards of the authority, in cardiopulmonary resuscitation and other first aid, shall be required at periodic intervals as determined by the authority. [Added by SB 595 (Ch. 1246) 1983.]

1797.184. The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt all of the following:

- (a) Guidelines for disciplinary orders, temporary suspensions, and conditions of probation for EMT-I and EMT-II certificate holders that protects the public health and safety.
 - (b) Regulations for the issuance of EMT-I and EMT-II certificates by a certifying entity that protects the public health and safety.
 - (c) Regulations for the recertification of EMT-I and EMT-II certificate holders that protect the public health and safety.
 - (d) Regulations for disciplinary processes for EMT-I and EMT-II applicants and certificate holders that protect the public health and safety. These disciplinary processes shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.
- [Added by AB 2917 (Ch. 274) 2008.]

1797.185. (a) The authority shall establish criteria for the statewide recognition of the certification of EMT-P personnel in the basic scope of practice of those personnel. The criteria shall include, but need not be limited to, the following:

(1) Standards for training, testing, certification, and revocation of certification, as required for statewide recognition of certification. The standards may include designation by the authority of the specific examinations required for certification, including, at the option of the authority, an examination provided by the authority. At the option of the authority, the standards may include a requirement for registration of prehospital emergency care personnel with the authority or other entity designated by the authority.

(2) Conditions for local accreditation of certified EMT-P personnel which are reasonable in order to maintain medical control and the integrity of the local EMS system, as determined by the authority and approved by the commission.

(3) Provisions for local accreditation in approved optional scope of practice, if any, as allowed by applicable state regulations and statutes.

(4) Provisions for the establishment and collection of fees by the appropriate agency, which may be the authority or an entity designated by the authority to collect fees for the authority, for testing, certification, accreditation, and registration with the appropriate state or local agency in the appropriate scope of practice. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Services Personnel Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the designated entity.

(b) After January 1, 1991, all regulations for EMT-P personnel adopted by the authority shall, where relevant, include provisions for statewide recognition of certification or authorization for the scope of practice of those personnel.

(c) On or before July 1, 1991, the authority shall amend all relevant regulations for EMT-P care personnel to include criteria developed pursuant to subdivision (c) of Section 1797.7 and subdivision (b) of Section 1797.172 to ensure statewide recognition of certification for the scope of practice of those personnel.

(d) All future regulations for EMT-P personnel adopted by the authority shall, where relevant, include provisions for statewide recognition of certification or authorization for the scope of practice of those personnel. [Added by AB 3057 (Ch. 312) 1986. Amended by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989. Provisions from AB 2159 given effect over those from AB 1558.]

1797.186. All persons described in Sections 1797.170, 1797.171, 1797.172, 1797.182, and 1797.183, whether volunteers, partly paid, or fully paid, shall be entitled to prophylactic medical treatment to prevent the onset of disease, provided that the person demonstrates that he or she was exposed, while in the service of the department or unit, to a contagious disease, as listed in Section 2500 of Title 17 of the California Administrative Code, while performing first aid or cardiopulmonary resuscitation services to any person.

Medical treatment under this section shall not affect the provisions of Division 4 (commencing with Section 3200) or Division 5 (commencing with Section 6300) of the Labor Code or the person's right to make a claim for work-related injuries, at the time the contagious disease manifests itself. [Added by AB 140 (Ch. 1543) 1985.]

1797.187. A peace officer as described in Section 830.1, subdivision (a) of Section 830.2, or subdivision (g) of Section 830.3 of the Penal Code, while in the service of the agency or local agency which employs him or her, shall be notified by the agency or local agency if the peace officer is exposed to a known carcinogen, as defined by the International Agency for Research on Cancer, or as defined by its director, during the investigation of any place where any controlled substance, as defined in Section 11007 is suspected of being manufactured, stored, transferred, or sold, or any toxic waste spills, accidents, leaks, explosions, or fires.

The Commission on Peace Officers Standards and Training basic training course, and other training courses as the commission determines appropriate, shall include, on or before January 1, 1990, instruction on, but not limited to, the identification and handling of possible carcinogenic materials and the potential health hazards associated with these materials, protective equipment, and clothing available to minimize contamination, handling, and disposing of materials and measures and procedures that can be adopted to minimize exposure to possible hazardous materials. [This section was added to Division 2.5 in error by AB 2376 (Ch. 947) 1988. Amended by SB 1880 (Ch. 606) 1998.]

1797.188. (a) As used in this section:

(1) "Prehospital emergency medical care person or personnel" means any of the following: an authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(2) "Reportable disease or condition" or "a disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Administrative Code, as may be amended from time to time.

(3) "Exposed" means at risk for contracting the disease, as defined by regulations of the state department.

(4) "Health facility" means a health facility, as defined in Section 1250, including a publicly operated facility.

(b) In addition to the communicable disease testing and notification procedures applicable under Chapter 3.5 (commencing with Section 120260) of Part 1 of Division 105, all prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid, who have provided emergency medical or rescue services and have been exposed to a person afflicted with a disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease and should contact the county health officer if all the following are satisfied:

(1) The prehospital emergency medical care person, who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable disease or condition, provides the health facility with his or her name and telephone number at the time the patient is transferred from that prehospital emergency medical care person to the admitting health facility; or the party transporting the person afflicted

with the reportable disease or condition provides that health facility with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services.

(2) The health facility reports the name and telephone number of the prehospital emergency medical care person to the county health officer upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable disease or condition.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the health facility or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

In the event of the demise of the person afflicted with the reportable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable disease prior to the release of the decedent from the health facility to the funeral director.

Notwithstanding Section 1798.206, violation of this section is not a misdemeanor. [Added by SB 1518 (Ch. 999) 1986. Amended by AB 1119 (Ch. 260) 1988; and AB 2056 (Ch. 102) 2006.]

1797.189. (a) As used in this section:

(1) "Chief medical examiner-coroner" means the chief medical examiner or the coroner as referred to in subdivision (m) of Section 24000, Section 24010, subdivisions (k), (m), and (n) of Section 24300, subdivisions (k), (m), and (n) of Section 24304, and Sections 27460 to 27530, inclusive, of the Government Code and Section 102850.

(2) "Prehospital emergency medical care person or personnel" means any of the following: authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(3) "Reportable disease or condition" or "a disease or condition listed as reportable" means those diseases specified in Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Administrative Code, as may be amended from time to time."

(4) "Exposed" means at risk for contracting a disease, as defined by regulations of the state department.

(5) "Health facility" means a health facility, as defined in Section 1250, including a publicly operated facility.

(b) Any prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid who have provided emergency medical or rescue services and have been exposed to a person afflicted with a disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease and should contact the county health officer if all of the following conditions are met:

(1) The prehospital emergency medical care person, who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable disease or condition, provides the chief medical examiner-coroner with his or her name and telephone number at the time the patient is transferred from that prehospital medical care person to the chief medical examiner-coroner; or the party transporting the person afflicted with the reportable disease or condition provides that chief medical examiner-coroner with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services.

(2) The chief medical examiner-coroner reports the name and telephone number of the prehospital emergency medical care person to the county health officer upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable disease or condition.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the chief medical examiner-coroner or any of the prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

The chief medical examiner-coroner, or the county health officer shall notify the funeral director, charged with removing or receiving the decedent afflicted with a reportable disease or condition from the chief medical examiner-coroner, of the reportable disease prior to the release of the decedent from the chief medical examiner-coroner to the funeral director.

Notwithstanding Section 1798.206, violation of this section is not a misdemeanor. [Added by AB 2356 (Ch. 992) 1987. Amended by AB 1119 (Ch. 260) 1988; and SB 1497 (Ch. 1023) 1996.]

1797.190. The authority may establish minimum standards for the training and use of automatic external defibrillators. [Added by AB 3037 (Ch. 217) 1988. Amended by AB 2041 (Ch. 718) 2002.]

1797.191. (a) The authority shall establish minimum standards for the training in pediatric first aid, pediatric cardiopulmonary resuscitation (CPR), and preventive health practices required by Section 1596.866.

(b)(1) The authority shall establish a process for the ongoing review and approval of training programs in pediatric first aid, pediatric CPR, and preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866 to ensure that those programs meet the minimum standards established pursuant to subdivision (a). The authority shall charge fees equal to its costs incurred for the pediatric first aid and pediatric CPR training standards program and for the ongoing review and approval of these programs.

(2) The authority shall establish, in consultation with experts in pediatric first aid, pediatric CPR, and preventive health practices, a process to ensure the quality of the training programs, including, but not limited to, a method for assessing the appropriateness of the courses and the qualifications of the instructors.

(c) (1) The authority may charge a fee equal to its costs incurred for the preventive health practices program and for the initial review and approval and renewal of approval of the program.

(2) If the authority chooses to establish a fee process based on the use of course completion cards for the preventive health practices program, the cost shall not exceed seven dollars (\$7) per card for each training participant until January 1, 2001, at which time the authority may evaluate its administrative costs. After evaluation of the costs, the authority may establish a new fee scale for the cards so that revenue does not exceed the costs of the ongoing review and approval of the preventive health practices training.

(d) For the purposes of this section, "training programs" means programs that apply for approval by the authority to provide the training in pediatric first aid, pediatric CPR, or preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866. Training programs include all affiliated programs that also provide any of the authority-approved training required by this division. "Affiliated programs" means programs that are overseen by persons or organizations that have an authority-approved training program in pediatric first aid, pediatric CPR, or preventive health practices. Affiliated programs also include programs that have purchased an authority-approved training program in pediatric first aid, pediatric CPR, or preventive health practices. Training programs and their affiliated programs shall comply with this division and with the regulations adopted by the authority pertaining to training programs in pediatric first aid, pediatric CPR, or preventive health practices.

(e) The director of the authority may, in accordance with regulations adopted by the authority, deny, suspend, or revoke any approval issued under this division or may place any approved program on probation, upon the finding by the director of the authority of an imminent threat to the public health and safety as evidenced by the occurrence of any of the actions listed in subdivision (f).

(f) Any of the following actions shall be considered evidence of a threat to the public health and safety, and may result in the denial, suspension, probation, or revocation of a program's approval or application for approval pursuant to this division.

(1) Fraud.

(2) Incompetence.

(3) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of training program directors and instructors.

(4) Conviction of any crime that is substantially related to the qualifications, functions, and duties of training program directors and instructors. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

(5) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate, this division or the regulations promulgated by the authority pertaining to the review and approval of training programs in pediatric first aid, pediatric CPR, and preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866.

(g) In order to ensure that adequate qualified training programs are available to provide training in the preventive health practices course to all persons who are required to have that training, the authority may, after approval of the Commission on Emergency Medical Services pursuant to Section 1799.50, establish temporary standards for training programs for use until permanent standards are adopted pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Persons who, prior to the date on which the amendments to this section enacted in 1998 become operative, have completed a course or courses in preventive health practices as specified in subparagraph (C) of paragraph (2) of subdivision (a) of Section 1596.866, and have a certificate of completion card for a course or courses in preventive health practices, or certified copies of transcripts that identify the number of hours and the specific course or courses taken for training in preventive health practices shall be deemed to have met the requirement for training in preventive health practices. [Added by AB 243 (Ch. 246) 1994 to establish standards for training required in Health and Safety Code 1596.866. Urgency clause, effective July 21, 1994. Amended by SB 1524 (Ch. 666) 1998. Urgency clause, effective September 20, 1998; Amended by SB 966 (Ch. 83).]

1797.192. On or before July 1, 1991, the authority shall adopt standards for a standard statewide scope of practice which shall be utilized for the training and certification testing of EMT-P personnel for certification as EMT-P's. Local EMS systems shall not be required to utilize the entire standard scope of practice. Testing of EMT-P personnel for local accreditation to practice shall only include local operational policies and procedures, and drug, device, or treatment procedures being utilized within that local EMS system pursuant to Sections 1797.172 and 1797.221.

[Added by AB 1558 (Ch. 1134), AB 2159 (Ch. 1362) 1989; technically, as two identical sections with the same number. SB 1510 (Ch. 216) 1990; repealed the duplicate as part of a general code cleanup.]

1797.193. (a) By July 1, 1992, existing firefighters in this state shall complete a course on the nature of sudden infant death syndrome taught by experts in the field of sudden infant death syndrome. All persons who become firefighters after January 1, 1990, shall complete a course on this topic as part of their basic training as firefighters. The course

shall include information on the community resources available to assist families who have lost children to sudden infant death syndrome.

(b) For purposes of this section, the term "firefighter" has the same meaning as that specified in Section 1797.182.

(c) When the instruction and training are provided by a local agency, a fee shall be charged sufficient to defray the entire cost of the instruction and training. [Added by SB 1067 (Ch. 1111) 1989 as Section 1797.192. Renumbered as 1797.193 by SB 2510 (Ch. 216) 1990.]

1797.194. The purpose of this section is to provide for the state licensure of EMT-P personnel. Notwithstanding any provision of law, including, but not limited to, Section 1797.208 and 1797.214, all of the following applies to EMT-P personnel:

(a) Any reference to EMT-P certification pursuant to this division shall be equivalent to EMT-P licensure pursuant to this division, including, but not limited to, any provision in this division relating to the assessment of fees.

(b) The statewide examination designated by the authority for licensure of EMT-P personnel and the licensure issued by the authority shall be the single sufficient examination and licensure required for practice as an EMT-P.

(c) EMT-P licenses shall be renewed every two years upon submission to the authority of proof of satisfactory completion of continuing education or other educational requirements established by regulations of the authority, upon approval by the commission. If the evaluation and recommendations of the authority required pursuant to Section 8 of Chapter 997 of the Statutes of 1993, so concludes, the renewal of EMT-P licenses shall, in addition to continuing education requirements, be contingent upon reexamination at 10-year intervals to ensure competency.

(d) Every EMT-P licensee may be disciplined by the authority for violations of this division. The proceedings under this subdivision shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the authority shall have all the powers granted therein for this purpose.

(e) Nothing in this section shall be construed to extend the scope of practice of an EMT-P beyond prehospital settings, as defined by regulations of the authority.

(f) Nothing in this section shall be construed to alter or interfere with the local EMS agency's ability to locally accredit licensed EMT-Ps.

(g) Nothing in this section shall be construed to hinder the ability of the medical director of the local EMS agency to maintain medical control within the local EMS system in accordance with this division, including, but not limited to, Chapter 5 (commencing with Section 1798.) [Added by AB 3123 (Ch. 709) 1994.]

1797.195. (a) Notwithstanding any other provision of law to the contrary, an EMT-I, EMT-II, or EMT-P may provide emergency medical care pursuant to this section in the emergency department of a hospital that meets the definition of small and rural hospital pursuant to Section 1188.855, except that in the case of a hospital meeting the definition contained in Section 1188.855 the population of the incorporated place or census designated place where the hospital is located shall not have increased to more than 20,000 since 1980, and all of the following conditions are met:

(1) The EMT-I, EMT-II, or EMT-P is on duty as a prehospital emergency medical care provider.

(2) The EMT-I, EMT-II, or EMT-P shall function under direct supervision as defined in hospital protocols that have been issued pursuant to paragraph (3), and only where the physician and surgeon or the registered nurse determines that the emergency department is faced with a patient crisis, and that the services of the EMT-I, EMT-II, or EMT-P are necessary to temporarily meet the health care needs of the patients in the emergency department.

(3) The utilization of an EMT-I, EMT-II, or EMT-P in the emergency department is done pursuant to hospital protocols that have been developed by the hospital's nursing staff, the physician and surgeon medical director of the emergency department, and the administration of the hospital, with the approval of the medical staff, and that shall include at least all of the following:

(A) A requirement that the EMT-I, EMT-II, or EMT-P successfully completes a hospital training program on the protocols and procedures of the hospital emergency department. The program shall include, but not be limited to, features of the protocols for which the EMT-I, EMT-II, or EMT-P has not previously received training and a post program evaluation.

(B) A requirement that the EMT-I, EMT-II, or EMT-P annually demonstrates and documents to the hospital competency in the emergency department procedures.

(C) The emergency medical care to be provided in the emergency department by the EMT-I, EMT-II, or EMT-P shall be set forth or referenced in the protocols and shall be limited to that which is otherwise authorized by their certification or licensure as defined in statute or regulation. The protocols shall not include patient assessment in this setting, except when the assessment is directly related to the specific task the EMT-I, EMT-II, or EMT-P is performing.

(D) A process for continuity of patient care when the EMT-I, EMT-II, or EMT-P is called to an off-site emergency situation.

(E) Procedures for the supervision of the EMT-I, EMT-II, or EMT-P.

(4) The protocols for utilization of an EMT-I, EMT-II, or EMT-P in the emergency department are developed in consultation with the medical director of the local EMS agency and the emergency medical care committee, if a committee has been formed.

(5) A written contract shall be in effect relative to the services provided pursuant to this section, between the ambulance company and the hospital, where the EMT-I, EMT-II, or EMT-P is employed by an ambulance company that is not owned by the hospital.

(b) When services of emergency personnel are called upon pursuant to this section, responsibility for the medical direction of the EMT-I, EMT-II, or EMT-P rests with the hospital, pursuant to the hospital protocols as set forth in paragraph (3) of subdivision (a).

(c) Although this section authorizes the provision of services in an emergency department of certain small and rural hospitals, nothing in this section is intended to expand or restrict the types of services or care to be provided by EMT-I, EMT-II, or EMT-P pursuant to this article.

* Due to the unique circumstances concerning the very limited resources of small and rural hospitals and the need for temporary personnel in emergency departments of those hospitals, it is necessary to permit the use of EMS personnel to meet this need, and the Legislature finds and declares that a general statute cannot be made applicable

within the meaning of Section 16 of Article IV of the California Constitution. [Added by SB 422 (Ch. 239) 1995. *Intent language to clarify need and limited uses for EMS personnel in small and rural hospitals was not included in code.]

1797.196. (a) For purposes of this section, “AED” or “defibrillator” means an automated or automatic external defibrillator.

(b) In order to ensure public safety, any person or entity that acquires an AED is not liable for any civil damages resulting from any acts or omissions in the rendering of the emergency care under subdivision (b) of Section 1714.21 of the Civil Code, if that person or entity does all of the following:

(1) Complies with all regulations governing the placement of an AED.

(2) Ensures all of the following:

(A) That the AED is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, the American Heart Association, and the American Red Cross, and according to any applicable rules and regulations set forth by the governmental authority under the federal Food and Drug Administration and any other applicable state and federal authority.

(B) That the AED is checked for readiness after each use and at least once every 30 days if the AED has not been used in the preceding 30 days. Records of these checks shall be maintained.

(C) That any person who renders emergency care or treatment on a person in cardiac arrest by using an AED activates the emergency medical services system as soon as possible, and reports any use of the AED to the licensed physician and to the local EMS agency.

(D) For every AED unit acquired up to five units, no less than one employee per AED unit shall complete a training course in cardiopulmonary resuscitation and AED use that complies with the regulations adopted by the Emergency Medical Service Authority and the standards of the American Heart Association or the American Red Cross. After the first five AED units are acquired, for each additional five AED units acquired, one employee shall be trained beginning with the first AED unit acquired. Acquirers of AED units shall have trained employees who should be available to respond to an emergency that may involve the use of an AED unit during normal operating hours.

(E) That there is a written plan that describes the procedures to be followed in the event of an emergency that may involve the use of an AED, to ensure compliance with the requirements of this section. The written plan shall include, but not be limited to, immediate notification of 911 and trained office personnel at the start of AED procedures.

(3) When an AED is placed in a building, building owners shall ensure that tenants annually receive a brochure, approved as to content and style by the American Heart Association or American Red Cross, which describes the proper use of an AED, and also ensure that similar information is posted next to any installed AED.

(4) When an AED is placed in a building, no less than once a year, building owners shall notify their tenants as to the location of AED units in the building.

(5) When an AED is placed in a public or private K–12 school, the principal shall ensure that the school administrators and staff annually receive a brochure, approved as to content and style by the American Heart Association or the American Red Cross,

that describes the proper use of an AED. The principal shall also ensure that similar information is posted next to every AED. The principal shall, at least annually, notify school employees as to the location of all AED units on the campus. The principal shall designate the trained employees who shall be available to respond to an emergency that may involve the use of an AED during normal operating hours. As used in this paragraph, "normal operating hours" means during the hours of classroom instruction and any school-sponsored activity occurring on school grounds.

(c) Any person or entity that supplies an AED shall do all of the following:

(1) Notify an agent of the local EMS agency of the existence, location, and type of AED acquired.

(2) Provide to the acquirer of the AED all information governing the use, installation, operation, training, and maintenance of the AED.

(d) A violation of this provision is not subject to penalties pursuant to Section 1798.206.

(e) The protections specified in this section do not apply in the case of personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of the person who renders emergency care or treatment by the use of an AED.

(f) Nothing in this section or Section 1714.21 of the Civil Code may be construed to require a building owner or a building manager to acquire and have installed an AED in any building.

SEC. 2. Section 1797.196 of the Health and Safety Code, as amended by Section 2 of Chapter 85 of the Statutes of 2006, is repealed. [Added by SB 911 (Ch. 163) 1999. Amended and repealed by AB 2041 (Ch. 718) 2002. Amended, by SB 600 (Ch. 62) 2003; AB 254 (Ch. 111) 2005, AB 2083 (Ch. 85) 2006; and SB 1436 (Ch. 71) 2012.]

1797.197. The authority shall establish training and standards for all prehospital emergency care personnel, as defined pursuant to paragraph (2) of subdivision (a) of Section 1797.189, regarding the characteristics and method of assessment and treatment of anaphylactic reactions and the use epinephrine. The authority shall promulgate regulations regarding these matters for use by all prehospital emergency care personnel. [Added by AB 559 (Ch. 458) 2001.]

1797.198. The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the “golden hour,” when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers. [Added by AB 430 (Ch. 171) 2001. Amended by AB 131 (Ch. 80) 2005.]

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section 100257 of Title 22 of the California Code of Regulations. However, the local EMS agency’s report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center’s emergency department without being admitted to the hospital unless the nonadmission is due to the patient’s death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency’s jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency’s area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(l) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars (\$280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process. [Added by AB 430 (Ch. 171) 2001. Amended by AB 131 (Ch. 80) 2005]

Uncodified Language from AB 430 (Ch. 171), 2001 added in Section 50.5

Local emergency medical services agencies that do not have existing trauma care system plans may submit proposals for funding their preparation of a trauma care system plan to the Emergency Medical Services Authority by January 15, 2002. Upon the receipt of all local EMS agency proposals, the authority shall establish an appropriate funding level for a one-time payment to fund preparation and implementation of their trauma care system plans, contingent upon funding for this purpose in the Budget Act or another statute.

The authority may retain from any state appropriation for the purpose of this section an amount sufficient to implement this section, up to one hundred seven thousand dollars (\$107,000) subject to approval in the budget process.

Uncodified Language Contained in AB 1988 (Ch. 333), 2002

SECTION 1.

(a) Access to trauma and emergency medical services has been greatly reduced in recent years due to emergency department closures and a great increase in uninsured patients without access to primary care. As a result, ambulance diversion and waiting time has dramatically increased.

(b) Eighty percent of licensed emergency departments reported monetary losses during the 1999-2000 fiscal year.

(c) Hospitals and physicians provided over four hundred fifty million dollars (\$450,000,000) in uncompensated emergency medical services last year.

(d) California lacks a statewide trauma and emergency medical services plan.

SECTION 2. (a) The Emergency Medical Services Authority (EMSA) shall convene a task force of interested parties to study the delivery and provision of emergency medical services in California.

(b) The task force shall do all of the following:

(1) (A) Develop a plan to ensure that all Californians are served by appropriate coverage areas for emergency and trauma services and that sufficient numbers of emergency departments and trauma centers exist to serve each area's population. If the task force determines that some areas lack coverage, it shall develop recommendations to extend coverage to those areas.

(B) The plan developed pursuant to subparagraph (A) shall include specific consideration of, and recommendations developed by the task force for, ensuring access to emergency and trauma services for uninsured patients.

(2) Review emergency department and trauma center standards to ensure appropriate levels of care that maximize state resources and ensure coverage for all Californians including, but not limited to, the State Department of Health Services emergency department regulations and EMSA trauma center regulations.

(3) Review the roles, responsibilities, and interactions of the EMSA and the State Department of Health Services related to emergency medical service oversight and administration.

(4) Submit a report that includes the plan described in paragraph (1) and the recommendations of the task force with regard to paragraphs (1), (2), and (3) to the Legislature within two years from the date that funding and positions have been provided for the project.

(c) The task force shall be comprised of all the following members:

(1) Three members appointed by the Senate Committee on Rules, at least one of whom is a member of the Senate, and at least one of whom is a public member.

(2) Three members appointed by the Speaker of the Assembly, at least one of whom is a member of the Assembly, and at least one of whom is a public member.

(3) One representative appointed by EMSA from a list provided by the California Medical Association.

(4) One representative appointed by EMSA from a list provided by the California Healthcare Association.

(5) One representative appointed by EMSA from a list provided by the California Chapter of the American College of Emergency Physicians.

(6) One representative appointed by EMSA from a list provided by the California Professional Firefighters.

(7) One representative appointed by EMSA from a list provided by the Emergency Medical Services Administrators Association of California.

(8) One representative appointed by EMSA from a list provided by the California Nurses Association.

(9) One representative appointed by EMSA from a list provided by the California Ambulance Association.

(10) One representative appointed by EMSA from a list provided by consumer organizations.

(11) One representative appointed by EMSA from a list provided by the Rural Healthcare Center.

(12) One representative appointed by EMSA from a list provided by the California Children's Hospital Association.

(13) One representative appointed by EMSA from a list provided by the Children's Specialty Care Coalition.

(14) One representative appointed by EMSA from a list provided by the California Association of Public Hospitals and Health Systems.

(15) One representative of organized labor, appointed by EMSA.

(16) One representative appointed by EMSA from a list provided by the California Emergency Nurses Association.

(17) One representative appointed by EMSA from a list provided by the California State Firefighters' Association.

(18) One representative from the State Department of Health Services appointed by the director of the department.

(19) One representative appointed by EMSA from a list provided by the California Fire Chiefs Association.

(20) One representative appointed by EMSA from a list provided by the California Dental Association.

(d) The task force shall terminate after issuing the report required by subdivision (b).

(e) This section shall be implemented only to the extent that the authority obtains private funding needed to support and monitor the work of the task force for the purposes of this section.

CHAPTER 4. LOCAL ADMINISTRATION

Article 1. Local EMS Agency

1797.200. Each county may develop an emergency medical services program. Each county developing such a program shall designate a local EMS agency which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties pursuant to the provisions of Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

1797.201. Upon the request of a city or fire district that contracted for or provided, as of June 1, 1980, prehospital emergency medical services, a county shall enter into a written agreement with the city or fire district regarding the provision of prehospital emergency medical services for that city or fire district. Until such time that an agreement is reached, prehospital emergency medical services shall be continued at not less than the existing level, and the administration of prehospital EMS by cities and fire districts presently providing such services shall be retained by those cities and fire districts, except the level of prehospital EMS may be reduced where the city council, or the governing body of a fire district, pursuant to a public hearing, determines that the reduction is necessary.

Notwithstanding any provision of this section the provisions of Chapter 5 (commencing with Section 1798) shall apply.

1797.202. (a) Every local EMS agency shall have a full- or part-time licensed physician and surgeon as medical director, who has substantial experience in the practice of emergency medicine, as designated by the county or by the joint powers agreement, to provide medical control and to assure medical accountability throughout the planning, implementation and evaluation of the EMS system. The authority director may waive the requirement that the medical director have substantial experience in the practice of emergency medicine if the requirement places an undue hardship on the county or counties.

(b) The medical director of the local EMS agency may appoint one or more physicians and surgeons as assistant medical directors to assist the medical director with the discharge of the duties of medical director or to assume those duties during any time that the medical director is unable to carry out those duties as the medical director deems necessary.

(c) The medical director may assign to administrative staff of the local EMS agency for completion under the supervision of the medical director, any administrative functions of his or her duties which do not require his or her professional judgment as medical director.

[Amended by AB 2329 (Ch. 567) 1987; and AB 2159 (Ch. 1362) 1989.]

1797.204. The local EMS agency shall plan, implement, and evaluate an emergency medical services system, in accordance with the provisions of this part, consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures.

1797.206. The local EMS agency shall be responsible for implementation of advanced life support systems and limited advanced life support systems and for the monitoring of training programs.

[Amended by SB 595 (Ch. 1246) 1983.]

1797.208. The local EMS agency shall be responsible for determining that the operation of training programs at the EMT-I, EMT-II, and EMT-P levels are in compliance with this division, and shall approve the training programs if they are found to be in compliance with this division. The training program at the California Highway Patrol Academy shall be exempt from the provisions of this section. [Amended by SB 595 (Ch. 1246) 1983.]

1797.210. (a) The medical director of the local EMS agency shall issue a certificate, except an EMT-P certificate, to an individual upon proof of satisfactory completion of an approved training program, passage of the certifying examination designated by the authority, completion of any other requirements for certification established by the authority, and a determination that the individual is not precluded from certification for any of the reasons listed in Section 1798.200. The certificate shall be proof of the individual's initial competence to perform at the designated level.

(b) The medical director of the local EMS agency shall, at the interval specified by the authority, recertify an EMT-I or EMT-II upon proof of the individual's satisfactory passage of the examination for recertification designated by the authority, completion of any continuing education or other requirements for recertification established by the authority, and a determination that the individual is not precluded from recertification because of any of the reasons listed in Section 1798.200. [Amended by SB 595 (Ch. 1246) 1983; by AB 3269 (Ch. 1390) 1988; by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989; and SB 627 (Ch. 64) 1993.]

1797.211. Each local EMS agency shall submit certificate status updates to the authority within three working days after a final determination is made regarding a certification disciplinary action taken by the medical director that results in a change to an EMT-I or EMT-II certificate status. [Added by AB 2917 (Ch. 274) 2008.]

1797.212. The local EMS agency may establish a schedule of fees for certification in an amount sufficient to cover the reasonable cost of administering the certification provisions of this division. However, a local EMS agency shall not collect fees for the certification or recertification of an EMT-P. [Amended by SB 595 (Ch. 1246) 1983; and SB 627 (Ch. 64) 1993.]

1797.213. (a) Any local EMS agency conducting a program pursuant to this article may provide courses of instruction and training leading to certification as an EMT-I, EMT-II,

EMT-P, or authorized registered nurse. When such instruction and training are provided, a fee may be charged sufficient to defray the cost of such instruction and training.

(b) Effective July 1, 1990, any courses of instruction and training leading to certification as an EMT-I, EMT-II, EMT-P, or authorized registered nurse shall include a course of training on the nature of sudden infant death syndrome which is developed by the California SIDS program in the State Department of Health Services in consultation with experts in the field of sudden infant death syndrome, and effective January 1, 1990, any individual certified as an EMT-I, EMT-II, EMT-P, or authorized registered nurse shall complete that course of training. The course shall include information on the community resources available to assist families who have lost a child to sudden infant death syndrome. An individual who was certified as an EMT-I, EMT-II, EMT-P, or authorized registered nurse prior to January 1, 1990, shall complete supplementary training on this topic on or before January 1, 1992. [Relocated and amended by SB 595 (Ch. 1246) 1983. Formerly H&S Code 1481.3. Amended by SB 1067 (Ch. 1111) 1989.]

1797.214. A local EMS agency may require additional training or qualifications, for the use of drugs, devices, or skills in either the standard scope of practice or a local EMS agency optional scope of practice, which are greater than those provided in this chapter as a condition precedent for practice within such EMS area in an advanced life support or limited advanced life support prehospital care system consistent with standards adopted pursuant to this division.[Amended by SB 595 (Ch. 1246) 1983; and AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.215. Notwithstanding any other provision of law, EMT-I's, EMT-II's, and EMT-P's shall be required to renew their cardiopulmonary resuscitation certificate no more than once every two years.
[Added by SB 916 (Ch. 774) 1983.]

1797.216. Public safety agencies that are certifying entities may certify and recertify public safety personnel as EMT-I. The state fire marshal, subject to policy guidance and advice from the State Board of Fire Services, may certify and recertify fire safety personnel as EMT-I. All persons certified shall have completed a program of training approved by the local EMS agency or the authority and have passed a competency-based examination. [Amended by SB 595 (Ch. 1246) 1983 and amended by AB 2917 (Ch. 274) 2008.]

1797.217. (a) Every certifying entity shall submit to the authority certification data required by Section 1797.117.

(b) The authority shall collect fees from each certifying entity for the certification and certification renewal of each EMT-I and EMT-II in an amount sufficient to support the authority's central registry program and the local EMS agency administrative law judge reimbursement program. Separate additional fees may be charged, at the option of the authority, for services that are not shared by all applicants.

(c) The authority's fees shall be established in regulations, and fees charged for individual services shall be set so that the total fees charged shall not exceed the

authority's actual total cost for the authority's central registry program, state and federal criminal offender record information search response program, and the local EMS agency administrative law judge reimbursement program.

(d) In addition to any fees collected by EMT-I or EMT-II certifying entities to support their certification, recertification, or enforcement programs, EMT-I or EMT-II certifying entities shall collect fees to support the authority's central registry program, and the local EMS agency administrative law judge reimbursement program. In lieu of collecting fees from an individual, pursuant to an employer choice, a collective bargaining agreement, or other employment contract, the certifying entity shall provide the appropriate fees to the authority pursuant to this subdivision.

(e) All fees collected for or provided to the authority in a calendar month by an EMT-I or EMT-II certifying entity pursuant to this section shall be transmitted to the authority for deposit into the Emergency Medical Technician Certification Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the certifying entity, unless a contract between the certifying entity and the authority specifies a different timeframe.

(f) At the option of the authority, fees may be collected for the authority by an entity that contracts with the authority to provide any of the services associated with the registry program, or the state and federal criminal offender record information search response program, or the local EMS agency administrative law judge reimbursement program. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Technician Certification Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the designated entity, unless the contract between the entity and the authority specifies a different timeframe.

(g) The authority shall annually evaluate fees to determine if the fee is sufficient to fund the actual costs of the authority's central registry program, state and federal criminal offender record information search response program, and local EMS agency administrative law judge reimbursement program. If the evaluation shows that the fees are excessive or are insufficient to fund the actual costs of these programs, then the fees will be adjusted accordingly through the rulemaking process as outlined in the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(h) The Emergency Medical Technician Certification Fund is hereby created in the State Treasury. All moneys deposited in the fund shall be made available, upon appropriation, to the authority for purposes of the central registry program, state and federal criminal offender record information search response program, and the local EMS agency administrative law judge reimbursement program. The local EMS agency administrative law judge reimbursement program is solely for the purpose of making reimbursements to local emergency medical service agencies for actual administrative law judge costs regarding EMT-I or EMT-II disciplinary action appeals. Reimbursement to the local emergency medical service agencies shall only be made if adequate funds are available from fees collected for the authority's local EMS agency administrative law judge reimbursement program.

(i) The authority may transfer unused portions of the Emergency Medical Technician Certification Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Emergency Medical Technician Certification Fund, together with interest earned, when requested by the authority.

(j) The authority shall maintain a reserve balance in the Emergency Medical Technician Certification Fund of 5 percent of annual revenues. Any increase in the fees deposited in the Emergency Medical Technician Certification Fund shall be effective upon a determination by the authority that additional moneys are required to fund expenditures of this section. [Added by AB 2917 (Ch. 274) 2008.]

1797.218. Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general acute care hospital until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital. [Amended by SB 595 (Ch. 1246) 1983.]

1797.219. All investigatory and disciplinary processes for EMT-I and EMT-II certificate holders shall be, subject to Chapter 9.6 (commencing with Section 3250) of Division 4 of Title 1 of the Government Code, with respect to certificate holders who are firefighters otherwise subject to these provisions, and Chapter 9.7 (commencing with Section 3300) of Division 4 of Title 1 of the Government Code, with respect to certificate holders who are peace officers otherwise subject to these provisions. [Added by AB 2917 (Ch. 274) 2008.]

1797.220. The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. [Amended by AB 3269 (Ch. 1390) 1988.]

1797.221. The medical director of the local EMS agency may approve or conduct any scientific or trial study of the efficacy of the prehospital emergency use of any drug, device, or treatment procedure within the local EMS system, utilizing any level of prehospital emergency medical care personnel. The study shall be consistent with any requirements established by the authority for scientific or trial studies conducted within the prehospital emergency medical care system, and, where applicable, with Article 5 (commencing with Section 111550) of Chapter 6 of Part 5 of Division 104. No drug, device, or treatment procedure which has been specifically excluded by the authority from usage in the EMS system shall be included in such a study. [Added by AB 3119

(Ch. 299) 1988. Provisions became effective July 8, 1988. Amended by SB 1497 (Ch. 1023) 1996.]

1797.222. A county, upon the recommendation of its local EMS agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local EMS agency.

The ordinances shall, to the extent possible, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources. These ordinances shall be consistent with Sections 1797.106, 1798.100, and 1798.102, and shall not conflict with any state regulations or any guidelines adopted by the Emergency Medical Service Authority.

This section shall not be construed as prohibiting the helicopter program of the Department of the California Highway Patrol from a role in providing emergency medical services when the best medically qualified person at the scene of an accident determines it is in the best interests of any injured party. [Added by SB 358 (Ch. 1237) 1983.]

1797.224. A local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more exclusive operating areas in the development of a local plan shall develop and submit for approval to the authority, as part of the local EMS plan, its competitive process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. Nothing in this section supersedes Section 1797.201.

[Added by AB 3153 (Ch. 1349) 1984.]

1797.226. Without altering or otherwise affecting the meaning of any portion of this division as to any other county, as to San Bernardino County only, it shall be competent for any local EMS agency which establishes exclusive operating areas pursuant to Section 1797.224 to determine the following:

(a) That a minor alteration in the level of life support personnel or equipment, which does not significantly reduce the level of care available, shall not constitute a change in the manner and scope of providing service.

(b) That a successor to a previously existing emergency services provider shall qualify as an existing provider if the successor has continued uninterrupted the emergency transportation previously supplied by the prior provider. [Added by AB 3434 (Ch. 965) 1986.]

Article 2. Local Emergency Medical Services Planning

1797.250. In each designated EMS area, the local EMS agency may develop and submit a plan to the authority for an emergency medical services system according to the guidelines prescribed pursuant to Section 1797.103.

1797.251. [Added by SB 534 (Ch. 1067) 1983. Repealed by AB 1235 (Ch. 1735) 1984.]

1797.252. The local EMS agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop the emergency medical services system.

1797.254. Local EMS agencies shall annually submit an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority. [Amended by AB 1119 (Ch. 260) and AB 3483 (Ch. 197) 1996.]

1797.256. A local EMS agency may review applications for grants and contracts for federal, state, or private funds concerning emergency medical services or related activities in its EMS area.

1797.257. A local EMS agency which elects to implement a trauma care system on or after the effective date of the regulations adopted pursuant to Section 1798.161 shall develop and submit a plan for that trauma care system to the authority according to the requirements of the regulations prior to the implementation of that system. [Added by AB 1235 (Ch. 1735) 1984.]

1797.258. After the submission of an initial trauma care system plan, a local EMS agency which has implemented a trauma care system shall annually submit to the authority an updated plan which identifies all changes, if any, to be made in the trauma care system. [Added by AB 1235 (Ch. 1735) 1984.]

Article 3. Emergency Medical Care Committee

[Article 3 was relocated and amended by SB 595 (Ch. 1246) 1983. Article 3 sections were formerly located in Article 1 of Chapter 9 of Division 2 of H & S Code.]

1797.270. An emergency medical care committee may be established in each county in this state. Nothing in this division should be construed to prevent two or more adjacent counties from establishing a single committee for review of emergency medical care in these counties. [Formerly H & S Code Section 1751. Amended by SB 627 (Ch. 64) 1993.]

1797.272. The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more

adjacent counties establish a committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee. [Formerly H & S Code Section 1752.]

1797.274. The emergency medical care committee shall, at least annually, review the operations of each of the following:

- (a) Ambulance services operating within the county.
- (b) Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.
- (c) First aid practices in the county. [Formerly H & S Code Section 1755.]

1797.276. Every emergency medical care committee shall, at least annually, report to the authority, and the local EMS agency its observations and recommendations relative to its review of the ambulance services, emergency medical care, and first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The emergency medical care committee shall submit its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board or boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors. [Formerly H & S Code Section 1756. Amended by AB 1119 (Ch. 260) 1988.]

CHAPTER 5. MEDICAL CONTROL

1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall promptly convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall remain in effect only until the authority adopts more comprehensive regulations that supersede this subdivision. [Amended by SB 1124 (Ch. 1391) 1984. Subsection (c) added by AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987. Paragraphs (1), (2), and (3) under subsection (a) deleted by AB 3269 (Ch. 1390) 1988.]

1798.2. The base hospital shall implement the policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency for medical direction of prehospital emergency medical care personnel. [Amended by SB 1124 (Ch. 1391) 1984; and AB 3269 (Ch. 1390) 1988.]

1798.3. Advanced life support and limited advanced life support personnel may receive medical direction from an alternative base station in lieu of a base hospital when the following conditions are met:

(a) The alternative base station has been designated by the local EMS agency and approved by the medical director of the local EMS agency, pursuant to Section 1798.105, to provide medical direction to prehospital personnel because no base hospital is available to provide medical direction for the geographical area assigned.

(b) The medical direction is provided by either of the following:

(1) A physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel.

(2) A mobile intensive care nurse who has been authorized by the medical director of the local EMS agency, pursuant to Section 1797.56, as qualified to issue instructions to prehospital emergency medical care personnel. [Added by AB 3269 (Ch. 1390) 1988.]

1798.4. [Repealed by AB 3269 (Ch. 1390) 1988.]

1798.6. (a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency

who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

(b) If any county desires to establish a unified command structure for patient management at the scene of an emergency within that county, a committee may be established in that county comprised of representatives of the agency responsible for county emergency medical services, the county sheriff's department, the California Highway Patrol, public prehospital-care provider agencies serving the county, and public fire, police, and other affected emergency service agencies within the county. The membership and duties of the committee shall be established by an agreement for the joint exercise of powers under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(c) Notwithstanding subdivision (a), authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks. [Relocated by AB 334 (Ch. 206) 1983. Formerly H & S Code Section 1482.5.]

CHAPTER 6. FACILITIES

Article 1. Base Hospitals

[Heading amended by SB 1124 (Ch. 1391); 1984.]

1798.100. In administering the EMS system, the local EMS agency, with the approval of its medical director, may designate and contract with hospitals or other entities approved by the medical director of the local EMS agency pursuant to Section 1798.105 to provide medical direction of prehospital emergency medical care personnel, within its area of jurisdiction, as either base hospitals or alternative base stations, respectively. Hospitals or other entities so designated and contracted with as base hospitals or alternative base stations shall provide medical direction of prehospital emergency medical care provided for the area defined by the local EMS agency in accordance with policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency pursuant to Sections 1797.220 and 1798. [Amended by SB 1124 (Ch. 1391) 1984; and AB 3269 (Ch. 1390) 1988.]

1798.101. (a) In rural areas, as determined by the authority, where the use of a base hospital having a basic emergency medical services special permit pursuant to subdivision (c) of Section 1277 is precluded because of geographic or other extenuating circumstances, a local EMS agency, in order to assure medical direction to prehospital emergency medical care personnel, may utilize other hospitals which do not have a basic emergency medical service permit but which have been approved by the medical director of the local EMS agency for utilization as a base hospital, if both of the following apply:

(1) Medical control is maintained in accordance with policies and procedures established by the local EMS agency, with the approval of the medical director of the local EMS agency.

(2) Approval is secured from the authority.

(b)(1) In rural areas, as determined by the authority, when the use of a hospital having a basic emergency medical service special permit is precluded because of geographic or other extenuating circumstances, as determined by the authority, the medical director of the local EMS agency may authorize another facility which does not have this special permit to receive patients requiring emergency medical services if the facility has adequate staff and equipment to provide these services, as determined by the medical director of the local EMS agency.

(2) A local EMS agency which utilizes in its EMS system any facility which does not have a special permit to receive patients requiring emergency medical care pursuant to paragraph (1) shall submit to the authority, as part of the plan required by Section 1797.254, protocols approved by the medical director of the local EMS agency to ensure that the use of that facility is in the best interests of patient care. The protocols addressing patient safety and the use of the nonpermit facility shall take into account, but not be limited to, the following:

(A) The medical staff, and the availability of the staff at various times to care for patients requiring emergency medical services.

(B) The ability of staff to care for the degree and severity of patient injuries.

(C) The equipment and services available at the hospital necessary to care for patients requiring emergency medical services and the severity of their injuries.

(D) The availability of more comprehensive emergency medical services and the distance and travel time necessary to make the alternative emergency medical services available.

(E) The time of day and any limitations which may apply for a nonpermit facility to treat patients requiring emergency medical services.

(3) Any change in the status of a nonpermit facility, authorized pursuant to this subdivision to care for patients requiring emergency medical services, with respect to protocols and the facility's ability to care for the patients shall be reported by the facility to the local EMS agency. [Added by SB 1791 (Ch. 1162) 1986. Amended by AB 3269 (Ch. 1390) 1988.]

1798.102. The base hospital shall supervise prehospital treatment, triage, and transport, advanced life support or limited advanced life support, and monitor personnel program compliance by direct medical supervision. [Amended by SB 1124 (Ch. 1391) 1984.]

1798.104. The base hospital shall provide, or cause to be provided, EMS prehospital personnel training and continuing education in accordance with local EMS policies and procedures. [Amended by 1124 (Ch. 1391) 1984.]

1798.105. The medical director of the local EMS agency may approve an alternative base station, as defined in Section 1797.53, to provide medical direction to advanced life support or limited advanced life support personnel for an area of the local EMS system for which no qualified base hospital is available, to provide that medical direction, providing that both the following conditions are met:

(a) Medical control is maintained in accordance with policies and procedures established by the local EMS agency, with the approval of the medical director of the local EMS agency.

(b) Any responsibilities of a base station hospital, including review of run reports or provision of continuing education, which are not assigned to the alternative base station, are assigned to either the local EMS agency, a base hospital for another area of the local EMS system, or a receiving hospital which has been approved by the medical director to, and has agreed to, assume the responsibilities.

[Added by AB 3269 (Ch. 1390) 1988.]

Article 2. Critical Care

1798.150. The authority may establish, in cooperation with affected medical organizations, guidelines for hospital facilities according to critical care capabilities.

Article 2.5 Regional Trauma Systems

[Article 2.5 was added by SB 534 (Ch. 1067) 1983.]

1798.160. Except where the context otherwise requires, the following definitions in this section govern construction of this article:

(a) "Trauma case" means any injured person who has been evaluated by prehospital personnel according to policies and procedures established by the local EMS agency pursuant to Section 1798.163 and has been found to require transportation to a trauma facility.

(b) "Trauma facility" means a health facility, as defined by regulation, which is capable of treating one or more types of potentially seriously injured persons and which has been designated as part of the regional trauma care system by the local EMS agency.

(c) "Trauma care system" means an arrangement under which trauma cases are transported to, and treated by, the appropriate trauma facility. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.161. (a) The authority shall submit draft regulations specifying minimum standards for the implementation of regional trauma systems to the commission on or before July 1, 1984, and shall adopt the regulations on or before July 1, 1985. These regulations shall provide specific requirements for the care of trauma cases and shall ensure that the trauma care system is fully coordinated with all elements of the existing emergency medical services system. The regulations shall be adopted as provided in Section 1799.50, and shall include, but not be limited to, all of the following:

(1) Prehospital care management guidelines for triage and transportation of trauma cases.

(2) Flow patterns of trauma cases and geographic boundaries regarding trauma and non-trauma cases.

(3) The number of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(4) The resources and equipment needed by trauma facilities to treat trauma cases.

(5) The availability and qualifications of the health care personnel, including physicians and surgeons, treating trauma cases with a trauma facility.

(6) Data collection regarding system operation and patient outcome.

(7) Periodic performance evaluation of the trauma system and its components.

(b) The authority may grant an exception to a portion of the regulations adopted pursuant to subdivision (a) upon substantiation of need by a local EMS agency that, as defined in the regulations, compliance with the requirement would not be in the best interests of the persons served within the affected local EMS area. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.162. (a) A local emergency medical services agency may implement a trauma care system only if the system meets the minimum standards set forth in the regulations for implementation established by the authority and the plan required by Section 1797.257 has been submitted to, and approved by, the authority. Prior to submitting the plan for the trauma care system to the authority, a local emergency medical services

agency shall hold a public hearing and shall give adequate notice of the public hearing to all hospitals and other interested parties in the area proposed to be included in the system. This subdivision does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations.

(b) Notwithstanding subdivision (a) or any other provision of this article, the Santa Clara County Emergency Medical Services Agency may implement a trauma care system prior to the adoption of regulations by the authority pursuant to Section 1798.161. If the Santa Clara County Emergency Medical Services Agency implements a trauma care system pursuant to this subdivision prior to the adoption of those regulations by the authority, the agency shall prepare and submit to the authority a trauma care system plan which conforms to any regulations subsequently adopted by the authority. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.163. A local emergency medical services agency implementing a trauma care system shall establish policies and procedures which are concordant and consistent with the minimum standards set forth in the regulations adopted by the authority. This section does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.164. (a) A local emergency medical services agency may charge a fee to an applicant seeking initial or continuing designation as a trauma facility in an amount sufficient to cover the costs directly related to the designation of trauma facilities pursuant to Section 1798.165 and to the development of the plans prepared pursuant to Sections 1797.257 and 1797.258, and subdivision (b) of Section 1798.162.

(b) Each local emergency medical services agency charging fees pursuant to subdivision (a) shall annually provide a report to the authority and to each trauma facility having paid a fee to the agency. The report shall contain sufficient detail to apprise facilities of the specific application of fees collected and to assure the authority that fees collected were expended in compliance with subdivision (a).

(c) The authority may establish a prescribed format for the report required in subdivision (b). [Amended by AB 1235 (Ch. 1735) 1984, and AB 2934 (Ch. 768) 1988.]

1798.165. (a) Local emergency medical services agencies may designate trauma facilities as part of their trauma care system pursuant to the regulations promulgated by the authority.

(b) The health facility shall only be designated to provide the level of trauma care and service for which it is qualified and which is included within the system implemented by the agency.

(c) No health care provider shall use the terms "trauma facility," "trauma hospital," "trauma center," "trauma care provider," "trauma vehicle," or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the local EMS agency. [Amended by AB 1235 (Ch. 1735) 1984; and SB 702 (Ch. 570) 1985.]

1798.166. A local emergency medical services agency which elects to implement a trauma care system on or after January 1, 1984, shall develop and submit a plan to the authority according to the regulations established prior to the implementation.

1798.167. Nothing in this article shall be construed to restrict the authority of a health care facility to provide a service for which it has received a license pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

1798.168. Nothing in this article shall be construed as changing the boundaries of any local emergency medical services agency in existence on January 1, 1984.

1798.169. Nothing in this article shall be construed as restricting the use of a helicopter of the Department of the California Highway Patrol from performing missions which the department determines are in the best interests of the people of the State of California.

Article 3. Transfer Agreements

1798.170. A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital's consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements. [Amended by AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987.]

1798.172. (a) The local EMS agency shall establish guidelines and standards for completion and operation of formal transfer agreements between hospitals with varying levels of care in the area of jurisdiction of the local EMS agency consistent with Sections 1317 to 1317.9a, inclusive, and Chapter 5 (commencing with Section 1798). Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, initial patient care treatments, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient.

(b) Notwithstanding subdivision (a), and in addition to Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the transfer. [Amended by AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987; and AB 3217 (Ch. 888) 1988.]

Article 3.5. Use of "Emergency"

1798.175. (a) No person or public agency shall advertise itself as, or hold itself out as, providing emergency medical services, by using in its name or advertising the word "emergency" or any derivation thereof, or any words which suggest that it is staffed and equipped to provide emergency medical services, unless the person or public agency satisfies one of the following requirements:

- (1) Is a general acute care hospital providing approved standby, basic, or comprehensive emergency medical services regulated by this chapter.
- (2) Meets all of the following minimum standards:
 - (A) Emergency services are available in the facility seven days a week, 24 hours a day.
 - (B) Has equipment, medication, and personnel experienced in the provision of services needed to treat life-, limb-, or function threatening conditions.
 - (C) Diagnostic radiology and clinical laboratory services are provided by persons on duty or on call and available when needed.
 - (D) At least one physician who is trained and experienced in the provision of emergency medical care who is on duty or on call so as to be immediately available to the facility.
 - (E) Medical records document the name of each patient who seeks care, as well as the disposition of each patient upon discharge.
 - (F) A roster of specialty physicians who are available for referral, consultation, and specialty services is maintained and available.
 - (G) Policies and procedures define the scope and conduct of treatment provided, including procedures for the management of specific types of emergencies.
 - (H) The quality and appropriateness of emergency services are evaluated at least annually as part of a quality assurance program.
 - (I) Provide information to the public that describes the capabilities of the facility, including the scope of services provided, the manner in which the facility complies with the requirements of this section pertaining to the availability and qualifications of personnel or services, and the manner in which the facility cooperates with the patient's primary care physician in follow-up care.
 - (J) Clearly identifies the responsible professional or professionals and the legal owner or owners of the facility in its promotion, advertising, and solicitations.
 - (K) Transfer agreements are in effect at all times with one or more general acute care hospitals which provide basic or comprehensive emergency medical services wherein patients requiring more definitive care will be expeditiously transferred and receive prompt hospital care. Reasonable care shall be exercised to determine whether an emergency requiring more definitive care exists and the person seeking emergency care shall be assisted in obtaining these services, including transportation services, in every way reasonable under the circumstances.
- (b) Nothing in this article shall be construed to require the licensing or certification of any person or public agency meeting the minimum standards of paragraph (2) of subdivision (a), nor to exempt from licensure those health facilities covered by paragraph (1) of sub-division (a).
- (c) Nothing in this article shall be construed to:

(1) Prohibit a physician in private practice, an outpatient department of a general acute care hospital whether located on or off the premises of the hospital, or other entity authorized to offer medical services from advertising itself as, or otherwise holding itself out as, providing urgent, immediate, or prompt medical services, or from using in its name or advertising the words "urgent", "prompt", "immediate", any derivative thereof, or other words which suggest that it is staffed and equipped to provide urgent, prompt, or immediate medical services.

(2) Prohibit prehospital emergency medical care personnel certified pursuant to, or any state or local agencies established pursuant to, this division, or any emergency vehicle operating within the emergency medical services system from using the word "emergency" in the title, classification, or designation of the personnel agency, or vehicle.

(d) Any person or public agency using the word "emergency" or any derivation thereof in its name or advertising on January 1, 1987, but which would be prohibited from using the word or derivation thereof by this article, shall have until January 1, 1988, to comply with this article. [Added by SB 2162 (Ch. 1377) 1986.]

Article 4. Poison Control Centers

[Article 4. was added by SB 1124 (Ch. 1391); 1984.]

1798.180. (a) The authority shall establish minimum standards for the operation of poison control centers.

(b) The authority shall establish geographical service areas and criteria for designation of regional poison control centers. The authority may designate poison control centers which have met the standards established pursuant to subdivision (a), in accordance with the criteria adopted pursuant to this subdivision.

(c) No person or persons, business, agency, organization, or other entity, whether public or private, shall hold itself out as providing a poison advice service or use the term poison control center, poison advice center, or any other term which implies that it is qualified to provide advice on the treatment or handling of poisons in its advertising, name, or in printed materials and information it furnishes to the general public unless that entity meets one of the following conditions:

(1) Has been designated as a poison control center by the authority.

(2) Is a company or organization which provides a poison information service for products or chemicals which it manufactures or distributes.

(d) Nothing in this section shall prohibit a qualified health care professional, within his or her level

of professional expertise, from providing advice regarding poisoning or poisons to his or her patient or patients upon request or whenever he or she deems it warranted in the exercise of his or her professional judgment, as otherwise permitted by law. [Amended by AB 580 (Ch. 972) 1987.]

1798.181. The authority shall consolidate the number of poison control centers if it is determined by the authority that the consolidation will result in cost savings. [Added by AB 861 (Ch. 1366) 1992.]

1798.182. The authority may authorize a poison control center, instead of providing poison control services directly, to contract with an entity in another state to provide poison control services during any part of the 24-hour period for which the center is required to provide poison control services, if both of the following conditions are met:

(a) The center is unable to provide poison control services 24 hours a day.

(b) The entity in the other state provides substantially the same poison control services as required under Section 1798.180, and regulations adopted pursuant thereto. An entity in another state shall not be deemed not to provide substantially the same poison control services solely because the staff of the entity is licensed in the other state, and not licensed in the State of California. [Added by SB 66 (Ch. 236) 1993.]

1798.183. The authority may authorize a poison control center to provide poison control services for fewer than 24 hours a day, as the authority deems necessary. [Added by SB 66 (Ch. 236) 1993.]

CHAPTER 7. PENALTIES

1798.200. (a) (1) (A) Except as provided in paragraph (2), an employer of an EMT-I or EMT-II may conduct investigations, as necessary, and take disciplinary action against an EMT-I or EMT-II who is employed by that employer for conduct in violation of subdivision (c). The employer shall notify the medical director of the local EMS agency that has jurisdiction in the county in which the alleged violation occurred within three days when an allegation has been validated as a potential violation of subdivision (c).

(B) Each employer of an EMT-I or EMT-II employee shall notify the medical director of the local EMS agency that has jurisdiction in the county in which a violation related to subdivision (c) occurred within three days after the EMT-I or EMT-II is terminated or suspended for a disciplinary cause, the EMT-I or EMT-II resigns following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or the EMT-I or EMT-II is removed from EMT-related duties for a disciplinary cause after the completion of the employer's investigation.

(C) At the conclusion of an investigation, the employer of an EMT-I or EMT-II may develop and implement, in accordance with the guidelines for disciplinary orders, temporary suspensions, and conditions of probation adopted pursuant to Section 1797.184, a disciplinary plan for the EMT-I or EMT-II. Upon adoption of the disciplinary plan, the employer shall submit that plan to the local EMS agency within three working days. The employer's disciplinary plan may include a recommendation that the medical director of the local EMS agency consider taking action against the holder's certificate pursuant to paragraph (3).

(2) If an EMT-I or EMT-II is not employed by an ambulance service licensed by the Department of the California Highway Patrol or a public safety agency or if that ambulance service or public safety agency chooses not to conduct an investigation pursuant to paragraph (1) for conduct in violation of subdivision (c), the medical director of a local EMS agency shall conduct the investigations, and, upon a determination of disciplinary cause, take disciplinary action as necessary against the EMT-I or EMT-II. [Amended by SB 1330 (Ch. 328) Statutes of 2010.] At the conclusion of these investigations, the medical director shall develop and implement, in accordance with the recommended guidelines for disciplinary orders, temporary orders, and conditions of probation adopted pursuant to Section 1797.184, a disciplinary plan for the EMT-I or EMT-II. The medical director's disciplinary plan may include action against the holder's certificate pursuant to paragraph (3).

(3) The medical director of the local EMS agency may, upon a determination of disciplinary cause and in accordance with regulations for disciplinary processes adopted pursuant to Section 1797.184, deny, suspend, or revoke any EMT-I or EMT-II certificate issued under this division, or may place any EMT-I or EMT-II certificate holder on probation, upon the finding by that medical director of the occurrence of any of the actions listed in subdivision (c) and the occurrence of one of the following:

(A) The EMT-I or EMT-II employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the medical director makes a determination that the discipline imposed was not according to the guidelines for disciplinary orders and conditions of probation and the conduct of the EMT-I or EMT-II certificate holder constitutes grounds for disciplinary action against the certificate.

(B) Either the employer of an EMT-I or EMT-II further determines, after an investigation conducted under paragraph (1), or the medical director determines after an investigation conducted under paragraph (2), that the conduct requires disciplinary action against the certificate.

(4) The medical director of the local EMS agency, after consultation with the employer of an EMT-I or EMT-II, may temporarily suspend, prior to a hearing, any EMT-I or EMT-II certificate or both EMT-I and EMT-II certificates upon a determination that both of the following conditions have been met:

(A) The certificate holder has engaged in acts or omissions that constitute grounds for revocation of the EMT-I or EMT-II certificate.

(B) Permitting the certificate holder to continue to engage in the certified activity without restriction would pose an imminent threat to the public health or safety.

(5) If the medical director of the local EMS agency temporarily suspends a certificate, the local EMS agency shall notify the certificate holder that his or her EMT-I or EMT-II certificate is suspended and shall identify the reasons therefor. Within three working days of the initiation of the suspension by the local EMS agency, the agency and employer shall jointly investigate the allegation in order for the agency to make a determination of the continuation of the temporary suspension. All investigatory information not otherwise protected by law held by the agency and employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend. The local EMS agency shall decide within 15 calendar days, whether to serve the certificate holder with an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. If the certificate holder files a notice of defense, the hearing shall be held within 30 days of the local EMS agency's receipt of the notice of defense. The temporary suspension order shall be deemed vacated if the local EMS agency fails to make a final determination on the merits within 15 days after the administrative law judge renders the proposed decision.

(6) The medical director of the local EMS agency shall refer, for investigation and discipline, any complaint received on an EMT-I or EMT-II to the relevant employer within three days of receipt of the complaint, pursuant to subparagraph (A) of paragraph (1) of subdivision (a).

(b) The authority may deny, suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P licenseholder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c). Proceedings against any EMT-P license or licenseholder shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial, suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate holder or licenseholder under this division:

- (1) Fraud in the procurement of any certificate or license under this division.
- (2) Gross negligence.
- (3) Repeated negligent acts.
- (4) Incompetence.

(5) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

(6) Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

(7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

(8) Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.

(9) Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

(10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.

(11) Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

(12) Unprofessional conduct exhibited by any of the following:

(A) The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT-I, EMT-II, or EMT-P from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT-I, EMT-II, or EMT-P, from using that force that is reasonably necessary to effect a lawful arrest or detention.

(B) The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Part 2.6 (commencing with Sections 56) of Division 1 of the Civil Code. [Amended by SB 1330 (Ch. 328) Statutes of 2010.]

(C) The commission of any sexually related offense specified under Section 290 of the Penal Code.

(d) The information shared among EMT-I, EMT-II, and EMT-P employers, medical directors of local EMS agencies, the authority, and EMT-I and EMT-II certifying entities shall be deemed to be an investigative communication that is exempt from public disclosure as a public record pursuant to subdivision (f) of Section 6254 of the Government Code. A formal disciplinary action against an EMT-I, EMT-II, or EMT-P shall be considered a public record available to the public, unless otherwise protected from disclosure pursuant to state or federal law.

(e) For purposes of this section "disciplinary cause" means an act that is substantially related to the qualifications, functions, and duties of an EMT-I, EMT-II, or EMT-P and is evidence of a threat to the public health and safety described in subdivision (c).

SEC. 16. This act shall become operative only if Senate Bill 997 of the 2007-08 Regular Session is enacted and becomes effective on or before January 1, 2009.

SEC. 17. This act shall not be construed to limit or otherwise impair the medical control of the medical director of a local EMS agency granted pursuant to Section 1798 of the Health and Safety Code.

SEC. 18. The Legislature finds and declares that Section 15 of this act, which amends Section 1798.200 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest: emergency medical technicians serve a critical role in the state's emergency response network. The public safety is best protected when appropriate and consistent disciplinary standards are applied. When accusations have been made against a certified EMT-I or EMT-II, the individual must be given the investigatory and due process protection that is offered to other licensed and certified professionals such as paramedics, physicians, nurses, and other health care providers. The public shall have certification, licensure, disciplinary and other information readily available with the implementation of the EMT-I, EMT-II, and EMT-P registry as created by Section 1797.117 of the Health and Safety Code.

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution. However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. [Amended by AB 1853 (Ch. 1156) 1983; AB 3269 (Ch. 1390) 1988; and SB 463 (Ch. 100) 1993. AB 1980 (Ch. 997) 1993; amended this section as well but would not take effect until January 1, 1995. Amended by AB 3123 (Ch. 709) 1994; AB 1215 (Ch. 549) 1999; AB 2917 (Ch. 274) 2008; and by AB 1164 (Ch. 140) 2009.]

1798.201. (a) When information comes to the attention of the medical director of the local EMS agency that an EMT-P licenseholder has committed any act or omission that appears to constitute grounds for disciplinary action under this division, the medical director of the local EMS agency may evaluate the information to determine if there is reason to believe that disciplinary action may be necessary.

(b) If the medical director sends a recommendation to the authority for further investigation or discipline of the licenseholder, the recommendation shall include all documentary evidence collected by the medical director in evaluating whether or not to make that recommendation. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by Section 6254 of the Government Code. In deciding what level of disciplinary action is appropriate in the case, the authority shall consult with the medical director of the local EMS agency. [Added by AB 3123 (Ch. 709) 1994.]

1798.202. (a) The director of the authority or the medical director of the local EMS agency, after consultation with the relevant employer, may temporarily suspend, prior to

hearing, any EMT-P license upon a determination that: (1) the licensee has engaged in acts or omissions that constitute grounds for revocation of the EMT-P license; and (2) permitting the licensee to continue to engage in the licensed activity, or permitting the licensee to continue in the licensed activity without restriction, would present an imminent threat to the public health or safety. When the suspension is initiated by the local EMS agency, subdivision (b) shall apply. When the suspension is initiated by the director of the authority, subdivision (c) shall apply.

(b) The local EMS agency shall notify the licensee that his or her EMT-P license is suspended and shall identify the reasons therefore. Within three working days of the initiation of the suspension by the local EMS agency, the agency shall transmit to the authority, via facsimile transmission or overnight mail, all documentary evidence collected by the local EMS agency relative to the decision to temporarily suspend. Within two working days of receipt of the local EMS agency's documentary evidence, the director of the authority shall determine the need for the licensure action. Part of that determination shall include an evaluation of the need for continuance of the suspension during the licensure action review process. If the director of the authority determines that the temporary suspension order should not continue, the authority shall immediately notify the licensee that the temporary suspension is lifted. If the director of the authority determines that the temporary suspension order should continue, the authority shall immediately notify the licensee of the decision to continue the temporary suspension and shall, within 15 calendar days of receipt of the EMS agency's documentary evidence, serve the licensee with a temporary suspension order and accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The director of the authority shall initiate a temporary suspension with the filing of a temporary suspension order and accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code and shall notify the director of the local EMS agency, and the relevant employer.

(d) If the licensee files a notice of defense, the hearing shall be held within 30 days of the authority's receipt of the notice of defense. The temporary suspension order shall be deemed vacated if the authority fails to make a final determination on the merits within 15 days after the administrative law judge renders the proposed decision.

[Amended by SB 595 (Ch. 1246) 1983. Repealed by AB 3123 (Ch. 709) 1994 and language moved to new Section 1798.209. Added new Section 1798.202 by AB 3123 (Ch. 709) 1994.]

1798.204. Proceedings for probation, suspension, revocation, or denial of a certificate, or a denial of a renewal of a certificate, under this division shall be conducted in accordance with guidelines established by the Emergency Medical Services Authority. [Amended by AB 1853 (Ch. 1156) 1983.]

1798.205. Any alleged violations of local EMS agency transfer protocols, guidelines, or agreements shall be evaluated by the local EMS agency. If the local EMS agency has concluded that a violation has occurred, it shall take whatever corrective action it deems appropriate within its jurisdiction, including referrals to the district attorney under Section 1798.206 and 1798.208 and shall notify the State Department of Health

Services if it concludes that any violation of Sections 1317 to 1317.9a, inclusive, has occurred. [Added by AB 214 (Ch. 1225). Substantially duplicate section was added by SB 12 (Ch. 1240) 1987 and was repealed by AB 1910 (Ch. 1360) 1990, as part of a general code cleanup.]

1798.206. Any person who violates this part, the rules and regulations adopted pursuant thereto, or county ordinances adopted pursuant to this part governing patient transfers is guilty of a misdemeanor. The attorney general or the district attorney may prosecute any of these misdemeanors which fall within his or her jurisdiction. [Amended by AB 214 (Ch. 1225) 1987.]

1798.207. (a) It is a misdemeanor for any person to knowingly and willfully engage in conduct that subverts or attempts to subvert any licensing or certification examination, or the administration of any licensing or certification examination, conducted pursuant to this division, including, but not limited to, any of the following:

- (1) Conduct that violates the security of the examination material.
 - (2) Removing from the examination room any examination materials without authorization.
 - (3) The unauthorized reproduction by any means of any portion of the actual licensing or certification examination.
 - (4) Aiding by any means the unauthorized reproduction of any portion of the actual licensing or certification examination.
 - (5) Paying or using professional or paid examination-takers, for the purpose of reconstructing any portion of the licensing or certification examination.
 - (6) Obtaining or attempting to obtain examination questions or other examination material from examinees or by any other method, except by specific authorization either before, during, or after an examination.
 - (7) Using or purporting to use any examination questions or materials that were improperly removed or taken from any examination for the purpose of instructing or preparing any applicant for examination.
 - (8) Selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered licensing or certification examination.
 - (9) Communicating with any other examinee during the administration of a licensing or certification examination.
 - (10) Copying answers from another examinee or permitting one's answers to be copied by another examinee.
 - (11) Having in one's possession during the administration of the licensing or certification examination any books, equipment, notes written or printed materials, or data of any kind, other than the examination materials distributed, or otherwise authorized to be in one's possession during the examination.
 - (12) Impersonating any examinee or having an impersonator take the licensing or certification examination on one's behalf.
- (b) The penalties provided in this section are not exclusive remedies and shall not preclude remedies provided pursuant to any other provision of law.

(c) In addition to any other penalties, a person found guilty of violating this section shall be liable for the actual damages sustained by the agency administering the examination not to exceed ten thousand dollars (\$10,000) and the costs of litigation. [Added by AB 3138 (Ch. 215) 1992.]

1798.208. Whenever any person who has engaged, or is about to engage, in any act or practice which constitutes, or will constitute, a violation of any provision of this division, the rules and regulations promulgated pursuant thereto, or local EMS agency mandated protocols, guidelines, or transfer agreements, the superior court in and for the county wherein the acts or practices take place or are about to take place may issue an injunction or other appropriate order restraining the conduct on application of the authority, the Attorney General, or the district attorney of the county. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required. [Amended by AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987.]

1798.209. The local EMS agency may place on probation, suspend, or revoke the approval under this division of any training program for failure to comply with this division or any rules or regulations adopted pursuant thereto. [Added by AB 3123 (Ch. 709) 1994; language was formerly in Section 1798.202.]

1798.210. (a) The authority may impose an administrative fine of up to two thousand five hundred dollars (\$2,500) per violation on any licensed paramedic found to have committed any of the actions described by subdivision (c) of Section 1798.200 that did not result in actual harm to a patient. Fines may not be imposed if a paramedic has previously been disciplined by the authority for any other act committed within the immediately preceding five-year period.

(b) The authority shall adopt regulations establishing an administrative fine structure, taking into account the nature and gravity of the violation. The administrative fine shall not be imposed in conjunction with a suspension for the same violation, but may be imposed in conjunction with probation for the same violation except when the conditions of the probation require a paramedic's personal time or expense for training, clinical observation, or related corrective instruction.

(c) In assessing the fine, the authority shall give due consideration to the appropriateness of the amount of the fine with respect to factors that include the gravity of the violation, the good faith of the paramedic, the history of previous violations, any discipline imposed by the paramedic's employer for the same occurrence of that conduct, as reported pursuant to Section 1799.112, and the totality of the discipline to be imposed. The imposition of the fine shall be subject to the administrative adjudication provisions set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) If a paramedic does not pay the administrative fine imposed by the authority and chooses not to renew his or her license, the authority may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the authority may have to require a paramedic to pay costs.

(e) In any action for collection of an administrative fine, proof of the authority's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(f) (1) Except as provided in paragraph (2), the authority shall not license or renew the license of any paramedic who has failed to pay an administrative fine ordered under this section.

(2) The authority may, in its discretion, conditionally license or renew for a maximum of one year the license of any paramedic who demonstrates financial hardship and who enters into a formal agreement with the authority to reimburse the authority within that one-year period for the unpaid fine.

(g) All funds recovered under this section shall be deposited into the state General Fund.

(h) Nothing in this section shall preclude the authority from imposing an administrative fine in any stipulated settlement.

(i) For purposes of this section, "licensed paramedic" includes a paramedic whose license has lapsed or has been surrendered. [Added by AB 1655 (Ch. 513) 2004.]

1798.211. When making a decision regarding a disciplinary action pursuant to Section 1798.200 or Section 1798.210, the authority, and when applicable the administrative law judge, shall give credit for discipline imposed by the employer and for any immediate suspension imposed by the local EMS agency for the same conduct. [Added by AB 1655 (Ch. 513) 2004.]

CHAPTER 8. COMMISSION ON EMERGENCY MEDICAL SERVICES

Article 1. The Commission

1799. The Commission on Emergency Medical Services is hereby created in the Health and Human Services Agency. [Amended by SB 997 (Ch. 275) 2008.]

1799.2. The commission shall consist of 18 members appointed as follows:

(a) One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Committee on Rules from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(b) One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.

(c) One physician and surgeon appointed by the Senate Committee on Rules from a list of three names submitted by the California Medical Association.

(d) One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers.

(e) One registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a list of three names submitted by the Emergency Nurses Association.

(f) One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Committee on Rules from a list of three names submitted by the California Rescue and Paramedic Association.

(g) One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.

(h) One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.

(i) One physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues appointed by the Speaker of the Assembly.

(j) One hospital administrator of a base hospital who is appointed by the Governor from a list of three names submitted by the California Association of Hospitals and Health Systems.

(k) One full-time peace officer, who is either an EMT-II or a paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.

(l) Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the authority, and who are appointed by the Governor.

(m) One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrator's Association of California.

(n) One medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California and who is appointed by the Governor.

(o) One person appointed by the Governor, who is an active member of the California State Firemen's Association.

(p) One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(q) One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

SEC. 5. This act shall become operative only if Assembly Bill 2917 of the 2007-08 Regular Session is enacted and becomes effective on or before January 1, 2009. [Amended by SB 1124 (Ch. 1391) 1984; AB 99 (Ch. 42) 1985; AB 1017 (Ch. 1102) 1987; SB 217 (Ch. 220) 1989; and by SB 997 (Ch. 275) 2008.]

1799.3. At the discretion of the appointing power or body, a member of the commission may be reappointed or may continue to serve if he or she no longer continues to function in the capacity which originally qualified him or her for appointment. However, where Section 1799.2 requires that an appropriate organization submit names to the appointing power or body, a person shall not be reappointed pursuant to this section unless his or her name is submitted by that appropriate organization. [Added by AB 99 (Ch. 42) 1985.]

1799.4. (a) Except as otherwise provided in this section, the terms of the members of the commission shall be three calendar years, commencing January 1 of the year of appointment. No member shall serve more than two consecutive full terms; provided, however, that a term or part of a term served pursuant to paragraph (1) or (2) of subdivision (b) shall not be included in this limitation.

(b) (1) The first members appointed on or after January 1, 1985, pursuant to subdivisions (a), (b), (c), and (d) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus one additional year.

(2) The first members appointed on or after January 1, 1985, pursuant to subdivisions (e), (f), (g), (h), and (i) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus two additional years.

(3) The first members appointed on or after January 1, 1985, pursuant to subdivisions (j), (k), and (m) of Section 1799.2 shall be from the date of appointment to the end of that calendar year, plus three additional years.

(4) The first member appointed on or after January 1, 1985, pursuant to subdivision (l) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus one additional year and the second member shall serve from the date of appointment to the end of that calendar year, plus two additional years.

(5) The first member appointed pursuant to subdivision (n) of Section 1799.2 shall serve from the date of appointment to the end of the 1991 calendar year.

(6) It is the purpose of this subdivision to provide for staggered terms for the members of the commission. [Amended by AB 2840 (Ch. 1726) 1984; AB 99 (Ch. 42) 1985; and AB 1017 (Ch. 1102) 1987.]

1799.6. The members of the commission shall receive no compensation for their services, but shall be reimbursed for their actual, necessary, traveling and other expenses incurred in the discharge of their duties.

1799.8. The commission shall select a chairperson from its members and shall meet at least quarterly on the call of the director, the chairperson, or three members of the commission.

Article 2. Duties of the Commission

1799.50. The commission shall review and approve regulations, standards, and guidelines to be developed by the authority for implementation of this division.

1799.51. The commission shall advise the authority on the development of an emergency medical data collection system.

1799.52. The commission shall advise the director concerning the assessment of emergency facilities and services.

1799.53. The commission shall advise the director with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system.

1799.54. The commission shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed pursuant to Section 127155. [Amended by SB 1497 (Ch. 1023) 1996.]

1799.55. Based upon evaluations of the EMS systems in the state and their coordination, the commission shall make recommendations for further development and future directions of the emergency medical services in the state.

1799.56. The commission may utilize technical advisory panels established pursuant to the provisions of Section 1797.133 as are needed to assist in developing standards for emergency medical services.

CHAPTER 9. LIABILITY LIMITATION

1799.100. In order to encourage local agencies and other organizations to train people in emergency medical services, no local agency, entity of state or local government, private business or nonprofit organization included on the statewide registry that voluntarily and without expectation and receipt of compensation donates services, goods, labor, equipment, resources, or dispensaries or other facilities, in compliance with Section 8588.2 of the Government Code, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of people, or certifies those people, excluding physicians and surgeons, registered nurses, and licensed vocational nurses, as defined, in emergency medical services, shall be liable for any civil damages alleged to result from those training programs.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution. [Amended by SB 595 (Ch. 1246) 1983; AB 2796 (Ch. 363) 2008.]

1799.102. (a) No person who in good faith, and not for compensation, renders emergency care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered. This subdivision applies only to the medical, law enforcement, and emergency personnel specified in this chapter.

(b) (1) It is the intent of the Legislature to encourage other individuals to volunteer, without compensation, to assist others in need during an emergency, while ensuring that those volunteers who provide care or assistance act responsibly.

(2) Except for those persons specified in subdivision (a), no person who in good faith, and not for compensation, renders emergency medical or nonmedical care or assistance at the scene of an emergency shall be liable for civil damages resulting from any act or omission other than an act or omission constituting gross negligence or willful or wanton misconduct. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered. This subdivision shall not be construed to alter existing protections from liability for licensed medical or other personnel specified in subdivision (a) or any other law.

(c) Nothing in this section shall be construed to change any existing legal duties or obligations, nor does anything in this section in any way affect the provisions in Section 1714.5 of the Civil Code, as proposed to be amended by Senate Bill 39 of the 2009-10 Regular Session of the Legislature.

(d) The amendments to this section made by the act adding subdivisions (b) and (c) shall apply exclusively to any legal action filed on or after the effective date of that act.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

Because the state has long encouraged Californians to assist others facing danger in an emergency, and the ability to do so without fear of potential suit has been thrown into question by the recent California Supreme Court decision of *Van Horn v. Watson*, (2008) 45 Cal.4th 322, decided on December 18, 2008, this legislation clarifying the intent of the Legislature needs to go into effect immediately so as to avoid any confusion in this important area of the law. [Amended by AB 83 (Ch. 77) 2009.]

1799.104. (a) No physician or nurse, who in good faith gives emergency instructions to an EMT-II or mobile intensive care paramedic at the scene of an emergency, shall be liable for any civil damages as a result of issuing the instructions.

(b) No EMT-II or mobile intensive care paramedic rendering care within the scope of his duties who, in good faith and in a nonnegligent manner, follows the instructions of a physician or nurse shall be liable for any civil damages as a result of following such instructions.

1799.105. (a) A poison control center which (1) meets the minimum standards for designation and operation established by the authority pursuant to Section 1798.180, (2) has been designated a regional poison control center by the authority, and (3) provides information and advice for no charge on the management of exposures to poisonous or toxic substances, shall be immune from liability in civil damages with respect to the emergency provision of that information or advice, for acts or omissions by its medical director, poison information specialist, or poison information provider as provided in subdivisions (b) and (c).

(b) Any poison information specialist or poison information provider who provides emergency information and advice on the management of exposures to poisonous or toxic substances, through, and in accordance with, protocols approved by the medical director of a poison control center specified in subdivision (a), shall only be liable in civil damages, with respect to the emergency provision of that information or advice, for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. This subdivision shall not be construed to immunize the negligent adoption of a protocol.

(c) The medical director of a poison control center specified in subdivision (a) who provides emergency information and advice on the management of exposures to poisonous or toxic substances, where the exposure is not covered by an approved protocol, shall be liable only in civil damages, with respect to the emergency provision of that information or advice, for acts or omission performed in a grossly negligent manner or acts or omissions not performed in good faith. This subdivision shall neither be construed to immunize the negligent failure to adopt adequate approved protocols nor to confer liability upon the medical director for failing to develop or approve a protocol when the development of a protocol for a specific situation is not practical or the situation could not have been reasonably foreseen. [Added by AB 4587 (Ch. 1192) 1988.]

1799.106. (a) In addition to the provisions of Section 1799.104 of this code, Section 2727.5 of the Business and Professions Code, and Section 1714.2 of the Civil Code, and in order to encourage the provision of emergency medical services by firefighters,

police officers or other law enforcement officers, EMT-I, EMT-II, EMT-P, or registered nurses, a firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse who renders emergency medical services at the scene of an emergency or during an emergency air or ground ambulance transport shall only be liable in civil damages for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. A public agency employing such a firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse shall not be liable for civil damages if the firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse is not liable.

(b) For purposes of this section, "registered nurse" means a registered nurse trained in emergency medical services and licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

[Amended by SB 595 (Ch. 1246) 1983 and SB 1365 (Ch. 69) 2012.]

1799.107. (a) The Legislature finds and declares that a threat to the public health and safety exists whenever there is a need for emergency services and that public entities and emergency rescue personnel should be encouraged to provide emergency services. To that end, a qualified immunity from liability shall be provided for public entities and emergency rescue personnel providing emergency services.

(b) Except as provided in Article 1 (commencing with Section 17000) of Chapter 1 of Division 9 of the Vehicle Code, neither a public entity nor emergency rescue personnel shall be liable for any injury caused by an action taken by the emergency rescue personnel acting within the scope of their employment to provide emergency services, unless the action taken was performed in bad faith or in a grossly negligent manner.

(c) For purposes of this section, it shall be presumed that the action taken when providing emergency services was performed in good faith and without gross negligence. This presumption shall be one affecting the burden of proof.

(d) For purposes of this section, "emergency rescue personnel" means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a private fire department, whether such person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services as defined by subdivision (e).

(e) For purposes of this section, "emergency services" includes, but is not limited to, first aid and medical services, rescue procedures and transportation, or other related activities necessary to insure the health or safety of a person in imminent peril. [Added by SB 1120 (Ch. 275) 1984. Amended by AB 2173 (Ch. 617) 1998.]

1799.108. Any person who has a certificate issued pursuant to this division from a certifying agency to provide prehospital emergency field care treatment at the scene of an emergency, as defined in Section 1799.102, shall be liable for civil damages only for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith.

1799.110. (a) In any action for damages involving a claim of negligence against a physician and surgeon arising out of emergency medical services provided in a general acute care hospital emergency department, the trier of fact shall consider, together with all other relevant matters, the circumstances constituting the emergency, as defined herein, and the degree of care and skill ordinarily exercised by reputable members of the physician and surgeon's profession in the same or similar locality, in like cases, and under similar emergency circumstances.

(b) For the purposes of this section, "emergency medical services" and "emergency medical care" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

(c) In any action for damages involving a claim of negligence against a physician and surgeon providing emergency medical coverage for a general acute care hospital emergency department, the court shall admit expert medical testimony only from physicians and surgeons who have had substantial professional experience within the last five years while assigned to provide emergency medical coverage in a general acute care hospital emergency department. For purposes of this section, "substantial professional experiences" shall be determined by the custom and practice of the manner in which emergency medical coverage is provided in general acute care hospital emergency departments in the same or similar localities where the alleged negligence occurred. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1768.]

1799.111. (a) A licensed general acute care hospital, as defined by subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for detaining a person who is subject to detention pursuant to Section 5150 of the Welfare and Institutions Code, if all of the following conditions exist during the detention:

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, "gravely disabled" means an inability to provide for his or her basic personal needs of food, clothing, or shelter.

(2) The hospital staff, treating physician and surgeon, or appropriate licensed medical health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(5) If the person is detained beyond eight hours, but less than 24 hours, all of the following additional conditions shall be met:

(A) A transfer for appropriate mental health treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(B) In the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a medical disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(b) In addition to the conditions set forth in subdivision (a), a licensed general acute care hospital, as defined by subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital as defined by subdivision (b) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to Section 5150 of the Welfare and Institutions Code after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:

(1) The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

(2) The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the person detained, that the person does not present a danger to himself or herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and the surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and the surgeon opposing the release. Both the physician and surgeon and the clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

(c) Nothing in this section shall affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(d) A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

(e) The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapists contained in Section 43.92 of the Civil Code.

(f) Nothing in this section is intended to expand the scope of licensure of clinical psychologists. [Added by SB 2003 (Ch. 716) 1996. Amended by SB 1111 (Ch. 547) 1997, and by SB 916 (Ch. 608) 2007.]

1799.112. (a) EMT-P employers shall report in writing to the local EMS agency medical director and the authority and provide all supporting documentation within 30 days of whenever any of the following actions are taken:

- (1) An EMT-P is terminated or suspended for disciplinary cause or reason.
- (2) An EMT-P resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.
- (3) An EMT-P is removed from paramedic duties for disciplinary cause or reason following the completion of an internal investigation.

(b) The reporting requirements of subdivision (a) do not require or authorize the release of information or records of an EMT-P who is also a peace officer protected by Section 832.7 of the Penal Code.

(c) For purposes of this section, "disciplinary cause or reason" means only an action that is substantially related to the qualifications, functions, and duties of a paramedic and is considered evidence of a threat to the public health and safety as identified in subdivision (c) of Section 1798.200.

(d) Pursuant to subdivision (i) of Section 1798.24 of the Civil Code, upon notification to the paramedic, the authority may share the results of its investigation into a paramedic's misconduct with the paramedic's employer, prospective employer when requested in writing as part of a preemployment background check, and the local EMS agency.

(e) The information reported or disclosed in this section shall be deemed in the nature of an investigative communication and is exempt from disclosure as a public record by subdivision (f) of Section 6254 of the Government Code.

(f) A paramedic applicant or licensee to whom the information pertains may view the contents, as set forth in subdivision (a) of Section 1798.24 of the Civil Code, of a closed investigation file upon request during the regular business hours of the authority. [Added by AB 1655 (Ch. 513) 2004.]

CHAPTER 11. EMERGENCY AND CRITICAL CARE SERVICES FOR CHILDREN

[Chapter 11 added by SB 1170 (Ch. 1206) 1989.]

1799.200. (a) The State Department of Health Services shall contract with an organization with expertise in program evaluation, pediatric emergency medical services and critical care for the purposes specified in subdivision (b).

(b) The contractor, in consultation with a professional pediatric association, a professional emergency physicians association, a professional emergency medical services medical directors association, the Emergency Medical Services Authority, and the State Department of Health Services, shall perform a study that will identify the outcome criteria which can be used to evaluate pediatric critical care systems. This study shall include, but not be limited to, all of the following:

(1) Development of criteria to identify how changes in pediatric critical care systems affect the treatment of critically ill and injured children.

(2) Development of criteria to compare the systems in place in various areas of the state.

(3) Determination of whether the necessary data is currently available.

(4) Estimate of the cost to providers, such as emergency medical services agencies and hospitals, of collecting this data.

(5) Recommendations concerning the most reliable and cost-effective monitoring plan for use by agencies and facilities at the state, regional, and local levels.

1799.201. The contractor shall submit the results of the study to the Legislature and the Governor not later than January 1, 1991.

[*These sections were numbered 1199.200 and 1199.201 in SB 1170, but were apparently intended to be numbered 1799.200 and 1799.201, respectively, as indicated by the placement of Chapter 11 in Division 2.5.]

CHAPTER 12. EMERGENCY MEDICAL SERVICES FOR CHILDREN

[Chapter 12 added by AB 3483 (Ch. 197) 1996.]

1799.202. This chapter shall be known and may be cited as the California Emergency Medical Services for Children Act of 1996. [Added by AB 3483 (Ch. 197) 1996.]

1799.204. (a) For purposes of this chapter, the following definitions apply:

(1) "EMSC Program" means the Emergency Medical Services For Children Program administered by the authority.

(2) "Technical advisory committee" means a multidisciplinary committee with pediatric emergency medical services, pediatric critical care, or other related expertise.

(3) "EMSC component" means the part of the local agency's EMS plan that outlines the training, transportation, basic and advanced life support care requirements, and emergency department and hospital pediatric capabilities within a local jurisdiction.

(b) Contingent upon available funding, an Emergency Medical Services For Children Program is hereby established within the authority.

(c) The authority shall do the following to implement the EMSC Program:

(1) Employ or contract with professional, technical, research, and clerical staff as necessary to implement this chapter.

(2) Provide advice and technical assistance to local EMS agencies on the integration of an EMSC Program into their EMS system.

(3) Oversee implementation of the EMSC Program by local EMS agencies.

(4) Establish an EMSC technical advisory committee.

(5) Facilitate cooperative interstate relationships to provide appropriate care for pediatric patients who must cross state borders to receive emergency and critical care services.

(6) Work cooperatively and in a coordinated manner with the State Department of Health Services and other public and private agencies in the development of standards and policies for the delivery of emergency and critical care services to children.

(7) On or before March 1, 2000, produce a report for the Legislature describing any progress on implementation of this chapter. The report shall contain, but not be limited to, a description of the status of emergency medical services for children at both the state and local levels, the recommendation for training, protocols, and special medical equipment for emergency services for children, an estimate of the costs and benefits of the services and programs authorized by this chapter, and a calculation of the number of children served by the EMSC system. [Added by AB 3483 (Ch. 197) 1996 and amended by AB 430 (Ch. 171) 2001.]

1799.205. A local EMS agency may develop an EMSC Program in its jurisdiction, contingent upon available funding. If a local EMS agency develops an EMSC Program in its jurisdiction, the local EMS agency shall develop and incorporate in its EMS plan an EMSC component that complies with EMS plan requirements. The EMSC component shall include, but need not be limited to, the following:

(a) EMSC system planning, implementation, and management.

(b) Injury and illness prevention planning, that includes, among other things, coordination, education, and data collection.

- (c) Care rendered to patients outside the hospital.
- (d) Emergency department care.
- (e) Interfacility consultation, transfer, and transport.
- (f) Pediatric critical care and pediatric trauma services.
- (g) General trauma centers with pediatric considerations.
- (h) Pediatric rehabilitation plans that include, among other things, data collection and evaluation, education on early detection of need for referral, and proper referral of pediatric patients.
- (i) Children with special EMS needs outside the hospital.
- (j) Information management and system evaluation. [Added by AB 3483 (Ch. 197) 1996.]

1799.207. The authority may solicit and accept grant funding from public and private sources to supplement state funds. [Added by AB 3483 (Ch. 197) 1996.]

Chapter	Bill Number/ Author	Year	Subject/Sections Affected
Ch. 1260	SB 125/ Garamendi	1980	Creation of Division 2.5/ EMS System: 1797 et seq (added)
Ch. 1322	SB 735/Greene	1980	City/County reimbursement of state for paramedic services paid for by federal government: 1797.179 (added)
Ch. 1074	SB 898/ Garamendi	1981	Appointment of director; EMT-I training by CHP and CDF: 1797.101 (amended) 1797.109 (added)
Ch. 191	SB 1157/ Nielsen	1983	Funding of local EMS agencies: 1797.108 (added) 1797.110 (added)
Ch. 206	AB 334/ Moorhead	1983	Medical control at the scene: 1798.6 (added)
Ch. 774	SB 916/Marks	1983	Limitation on CPR training requirements: 1797.215 (added)
Ch. 1067	SB 534/Maddy	1983	Regional Trauma Systems: 1797.251 (added) Article 2.5: 1797.260 through 1797.169 (added to Ch. 6) 1797.109 (added)
Ch. 1156	AB 1853/Filante	1983	Guidelines for negative certification proceedings: 1798.200 (amended) 1798.204 (amended)
Ch. 1237	SB 358/Carpenter	1983	County transportation ordinance: 1797.222 (added)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 1246	SB 595/Watson	1983	<p>EMS recodification:</p> <p>1797.1 (amended)</p> <p>1797.4 (repealed)</p> <p>1797.5 (added)</p> <p>1797.54 (amended)</p> <p>1797.56 (amended)</p> <p>1797.665 (added)</p> <p>1797.67 (added)</p> <p>1797.68 (amended)</p> <p>1797.76 (amended)</p> <p>1797.84 (amended)</p> <p>1797.100 (amended)</p> <p>1797.101 (amended)</p> <p>1797.111 (added)</p> <p>1797.132 (amended)</p> <p>1797.160 (added)</p> <p>1797.172 (amended)</p> <p>1797.173 (amended)</p> <p>1797.180 – 1797.83 (added)</p> <p>1797.206 (amended)</p> <p>1797.208 (amended)</p> <p>1797.210 (amended)</p> <p>1797.212 (amended)</p> <p>1797.213 (added)</p> <p>1797.214 (amended)</p> <p>1797.216 (amended)</p> <p>1797.218 (amended)</p> <p>Article 3: 1797.270 - 1797.276 (added)</p> <p>1798.200 (amended)</p> <p>1798.202 (amended)</p> <p>1798.204 (amended)</p> <p>1799.100 (amended)</p> <p>1799.106 (amended)</p> <p>1799.110 (added)</p>

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 275	SB1120/Keene	1984	Liability limit for rescue personnel 1799.107 (added)
Ch. 349	SB 3153/Bronzan	1984	Exclusive operating zones: 1797.6 (added) 1797.85 (added) 1797.224 (added)
Ch. 1391	SB 1124/Watson	1984	EMS recodifications-final sections: 1797.52 (amended) 1797.56 (amended) 1797.58 (amended) 1797.59 (added) 1797.74 (amended) 1797.97 (added) 1797.106 (amended) 1797.170 (amended) 1798. (amended) 1798.2 (amended) 1798.4 (amended) 1798.100 (amended) 1798.102 (amended) 1798.104 (amended) Article 4: 1798.180 (added to Ch. 6) 1799.2 (amended)
Ch. 1726	AB 2840/Felando	1984	Commission on EMS terms 1799.4 (amended)
Ch. 1735	AB 1235/Frazee	1984	Trauma systems - technical changes: 1797.105 (amended) 1797.251 (repealed) 1797.257 (added) 1797.258 (added) 1798.160 – 1798.165 (amended)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 42	AB 99/Johnston	1985	Membership of Commission on EMS: 1799.2 (amended) 1799.3 (added) 1799.4 (amended)
Ch. 570	SB 702/Watson	1985	Prohibition on use of term “trauma”: 1798.165 (amended)
Ch. 1543	AB 140/ Lancaster	1985	Prophylactic medical treatment: 1797.186 (added)
Ch. 312	AB 3057/Tucker	1986	Statewide recognition of certification/authorization: 1797.7 (added) 1797.185 (added)
Ch. 965	AB 3434/Eaves	1986	San Bernardino County definition of exclusive operating areas: 1797.226 (added)
Ch. 999	SB 1518/Royce	1986	Notification of exposure to reportable disease - Hospital: 1797.188 (added)
Ch. 1162	SB 1791/Carpenter	1986	Expansion of definition of “hospital”: 1797.88 (amended) 1798.101 (added)
Ch. 1377	SB 2162/Mello	1986	Prohibitions on use of word “emergency” in advertising of emergency services: Article 3.5: 1798.175 (added to Ch. 6)
Ch. 477	AB 1153/Wyman	1987	Repeal of reporting requirement: 1797.131 (repealed)
Ch. 567	AB 2329/Filante	1987	Medical director of local EMS agency: 1797.202 (amended)
Ch. 972	AB 580/Allen	1987	Regional poison control centers: 1797.97 (amended) 1798.180 (amended)
Ch. 992	AB 2356/ McClintock	1987	Notification of exposure to reportable disease - Coroner: 1797.189 (added)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 1058	AB 1123/Zeltner	1987	Elimination of obsolete provisions: 1797.120 (repealed) 1797.171 (amended) 1797.172 (amended) 1797.174 (repealed)
Ch. 1102	AB 1017/Bronzan	1987	Addition of medical director of a local EMS agency to Commission: 1799.2 (amended) 1799.4 (amended)
Ch. 1225	AB 214/Margolin	1987	Hospital emergency patient transfers/medical control: 1798. (amended) 1798.170 (amended) 1798.172 (amended) 1798.205 (added) 1798.208 (amended)
Ch. 1240	SB 12/Maddy	1987	Hospital emergency patient transfers/medical control/EMS Fund: 1797.98a through 1797.98e 1798. (amended) 1798.170 (amended) 1798.172 (amended) 1798.205 (added)
Ch. 217	AB 3037/Chandler	1988	AED training for use of automated external defibrillators: 1797.190 (added)
Ch. 260	AB 1119/Zeltner	1988	Wedforth-Townsend reference update; notification of exposure cleanup; deletion of health systems agency references: 1797.4 (added) 1797.188 (amended) 1797.189 (amended) 1797.254 (amended) 1797.276 (amended)
Ch. 299	AB 3119/Allen	1988	Utilization of prehospital emergency medical care personnel in trial studies: 1797.221

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 768	AB 2934/ Quackenbush	1988	Trauma center designation fee: report on application of fees: 1798.164 (amended)
Ch. 945	SB 612/Presley	1988	EMS fund: Increase in assessment; reallocation of proceeds: 1797.98(a)
Ch. 1192	AB 4587/Leslie	1988	Liability limitation poison control centers: 1799.105 (added)
Ch. 1213	SB 1552	1988	EMSA to consider including information on AIDS in continuing education requirements: 1797.175 (amended)
Ch. 1390	AB 3269/Filante	1988	Medical control update; alternative base stations; alternative receiving facilities: 1797.53 (added) 1797.665 (repealed) 1797.176 (amended) 1797.210 (amended) 1797.220 (amended) 1798. (amended) 1798.2 (amended) 1798.3 (added) 1798.4 (repealed) 1798.100 (amended) 1798.101 (amended) 1798.105 (added) 1798.200 (amended)
Ch. 185	AB 1390/Kelly	1989	Appointment of (RDMHC): 1797.152 (added)
Ch. 220	SB 217/Royce	1989	Addition of firefighter to the Commission on EMS: 1799.2 (amended)
Ch. 237	AB 1257/Filante	1989	Repeal of obsolete provision: 1797.98d (repealed)
Ch. 886	AB 184/Speier	1989	Changes the name of the Medical Board: 1797.132 (amended)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 1111	SB 1067/Boatwright	1989	SIDS training requirements: 1797.170 (amended) 1797.171 (amended) 1797.192 (added) 1797.213 (amended)
Ch. 1134	AB 1558/Allen	1989	EMS personnel fund and clarification for state testing of EMT-Ps: 1797.3 (amended) 1797.7 (amended) 1797.63 (added) 1797.112 (added) 1797.172 (amended) 1797.185* (amended) 1797.192 (added) 1797.210 (amended) 1797.214 (amended)
Ch. 1362	AB 2159/Bronzan	1989	EMT-P optional S.O.P.; medical director experience requirement: 1797.3 (amended) 1797.7 (amended) 1797.63 (added) 1797.112 (added) 1797.172 (amended) 1797.175 (amended) 1797.185* (amended) 1797.192 (added) 1797.202 (amended) 1797.210 (amended) 1797.214 (amended)
Ch. 1206	SB 1170/Morgan	1989	Pediatric critical care study: 1799 (1199).200** (added) 1799 (1199).201** (added)

*Slightly different amendments were made to Section 1797.185 by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362). Since AB 2159 was chaptered after AB 1558, the amendments made by AB 2159 are given effect.

** These sections were numbered 1199.200 and 1199.201 in SB 1170, but were apparently intended to be numbered 1799.200 and 1799.201, respectively, as indicated by the placement of Chapter 11 in Division 2.5.

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 216	SB 2510/Lockyer	1990	Maintenance of Codes: 1797.63 (duplicate repealed) 1797.112 (duplicate repealed) 1797.192 (duplicate repealed) 1797.193 (renumbered)
Ch. 1171	SB 2098/Maddy	1990	Changes to EMS Fund rules: 1797.98a (amended) 1797.98c (amended) 1797.98e (amended) 1797.98f (added)
Ch. 1360	AB 1910/Assembly Committee on Judiciary	1990	Maintenance of Codes: 1798.205 (duplicate repealed)
Ch. 1169	SB 946/Maddy	1991	Changes to EMS Fund rules: 1797.98a (amended) 1797.98c (amended) 1797.98e (amended) 1797.98g (added)
Ch. 215	AB 3138/Hunter	1992	Certification Examination security 1798.207 (added)
Ch. 427	AB 3355/Assembly Committee on Judiciary	1992	Maintenance of Codes: Change name of CDF to CDF&FP 1797.109 (amended) 1797.132 (amended)
Ch. 1366	SB 861/Connelly	1992	Consolidation of PCCs 1798.181 (added)
Ch. 997	AB 1980/Klehs	1993	State certification sunseting 1-1-95 1797.112 (amended) 1797.172 (amended) 1797.174 (amended) 1798.200 (amended)
Ch. 236	SB 66/Bergeson	1993	PCC standards 1798.182 (added) 1798.183 (added)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 100	SB 463/Bergeson	1993	Temporary State Certification from 7-13-93 through 12-31-93 1797.112 (amended) 1797.172 (amended) 1798.200 (amended)
Ch. 64	SB 627/Committee on Budget and Fiscal Review	1993	Removes EMT-P Certification from individual county control. 1797.210 1797.212 1797.270
Ch. 246	AB 243/Alpert	1994	Child daycare facilities; pediatric first aid and CPR training programs. 1797.113 (added) 1797.191 (added)
Ch. 709	AB 3123/Klehs	1994	State Licensure of EMT-P personnel: 1797.112 (amended) 1797.171 (amended) 1797.172 (amended) 1797.194 (added) 1797.200 (amended) 1798.201 (added) 1798.202 (repealed) 1798.202 (added) 1798.209 (added)
Ch. 1143	SB 1683/Thompson	1994	Poison control centers funding; Expending unencumbered funds: 1797.98a (amended) 1797.98h (added)
Ch. 239	SB 422/Thompson	1995	Use of EMS personnel in emergency departments: 1797.195 (added)
Ch. 197	AB 3483/Friedman	1996	EMS for Children Program: 1797.254 (amended) 1799.202 (adds Chapter 12) 1799.204 (added Chapter 12) 1799.205 (added) 1799.207 (added)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 716	SB 2003/Costa	1996	Liability immunity hospital EMS providers: 1799.111 (added)
Ch. 1023	SB 1497/Committee on HHS	1996	Recodifications and corrections to cross-reference: 1797.98e (amended) 1797.189 (amended) 1797.221 (amended) 1799.54 (amended)
Ch. 547	SB 111/Costa	1997	Liability immunity: clinical psychologist: 1799.111 (amended)
Ch. 58	AB 2021/Poohigian	1998	Maddy Fund change. Heading (amended) 1797.98a (amended)
Ch. 606	SB 1880/Committee on Public Safety	1998	Corrects obsolete cross-reference: 1797.187 (amended)
Ch. 617	AB 2173/Pacheco	1998	Firefighter worker's Compensation: 1799.107 (amended)
Ch. 666	SB 1524/Alpert	1998	Daycare Preventive Health Practices training program: 1797.113 (amended) 1797.191 (amended)
Ch. 979	AB 984/Davis	1998	Health care coverage for ambulance transport: 1797.114 (added)
Ch. 1016	SB 277/Maddy	1998	EMS Fund physician reimbursement: 1797.98f (amended)
Ch. 83	SB 966/ Committee on Judiciary	1999	Clean up language: 1797.191 (amended)
Ch. 163	SB 911/Figueroa	1999	Liability immunity for use of AED: 1797.196 (added)
Ch. 549	AB 1215/ Thompson	1999	EMT background checks: 1797.172 (amended) 1798.200 (amended)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 679	SB 623/Speier	1999	County EMS Fund accounting and reporting requirements: 1797.98b (amended)
Ch. 93	AB 2877/Thomson	2000	EMS Personnel Fund reserve : 1797.112 (amended)
Ch. 157	AB 2469/Reyes	2000	EMS training for California Fire Fighter Joint Apprenticeship Committee. 1797.109 (amended)
Ch. 171	AB 430/Cardenas	2001	Trauma Care Fund. 1797.198 and 1797.199 (added) 1799.204 (amended) Uncodified language related to 1797.199 (added)
Ch. 458	AB 559/Wiggins	2001	Use of epinephrine auto-injectors. 1797.197 (added)
Ch. 333	AB 1988/Diaz	2002	Trauma Task Force. (uncodified language inserted following Section 1797.199)
Ch. 430	AB 1833/Nakano	2002	Revisions to EMS Fund. 1797.98c (amended) 1797.98e (amended)
Ch. 612	SB 1350/McPherson	2002	Terrorism response training. 1797.116 (added)
Ch. 678	SB 1695/Escutia	2002	Administration of naloxone hydrochloride. 1797.8 (added)
Ch. 718	AB 2041/Vargas	2002	CPR training and AED immunity. 1797.190 (amended) 1797.196 (amended, repealed, added)
Ch. 1050	AB 1629/Soto	2002	Funding for California Fire Fighter Joint Apprenticeship Program paramedic training. 1797.115 (added)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 62	SB 600/Committee on Judiciary	2003	Technical non-substantive changes: 1797.115 (amended) 1797.196 (amended)
Ch. 707	SB 476/Florez	2003	EMS Fund reserve requirement and distribution formula: 1797.98 (a) (amended) 1797.98 (b) (amended) 1797.98 (c) (amended) 1797.98 (e) (amended)
Ch. 513	AB 1655/ Negrete-McLeod	2004	EMT-P fines and employer reporting: 1798.210 (added) 1798.211 (added) 1799.112 (added)
Ch. 524	SB 635/Dunn	2004	Modifies Maddy EMS Fund: 1797.98 (e) (amend/repeal) 1797.98 (e) (added)
Ch. 80	AB 131/Committee on Budget	2005	Trauma care funding Intent language and distribution process: 1797.198 (amended) 1797.199 (amended)
Ch. 111	AB 254/Nakanishi	2005	AED program for K-12 schools: 1797.196 (amended)
Ch. 671	SB 941/Alquist	2005	Changes to Maddy EMS Fund: 1797.98 (a) (amended) 1797.98 (c) (amended) 1797.98 (e) (amended)
Ch. 60	SB 1236/Padilla	2008	Penalty assessment for pediatric trauma centers: 1797.98a (amended)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 274	AB 2917/Torricono	2008	EMT certification and enforcement, establishes statewide EMT Registry: 1797.61 (added) 1797.62 (repealed and added) 1797.101 (amended) 1797.117 (added) 1797.118 (added) 1797.170 (amended) 1797.172 (amended) 1797.184 (added) 1797.211 (added) 1797.216 (amended) 1797.217 (added) 1797.219 (added) 1798.200 (amended)
Ch. 275	SB 997/ Ridley-Thomas	2008	Adds Advanced EMT & Commission seats: 1797.82 (amended) 1799 (amended) 1799.2 (amended)
Ch. 288	AB 2702/Nunez	2008	Maddy Funds provisions for Los Angeles County; Extends sunset date on EMS Funds for pediatric trauma: 1797.98a (amended) 1797.98e (amended)
Ch. 289	SB 1141/Margett	2008	Public aircraft used for EMS: 1797.9 (added)
Ch. 363	AB 2796/Nava	2008	OES Donation Registry: 1799.100 (amended)
Ch. 77	AB 83/Feuer	2009	Limits liability for nonmedical care provided at an emergency scene: 1799.102 (amended)
Ch. 140	AB 1164/Tran	2009	Maintenance of the codes: 1798.200 (amended)
Ch. 537	AB 1475/Solorio	2009	Limits use of EMS Fund: 1797.98a (amended)

Chapter	Bill Number/Author	Year	Subject/Sections Affected
Ch. 403	AB 1059/Huffman	2011	Expands reporting for EMS Fund: 1797.98(b)
Ch. 71	SB 1436/Lowenthal	2012	Eliminates sunset date for AED liability provisions 1797.196 (a)

California Code of Regulations, Title 22

Chapter 1: Conflict of Interest

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1. Emergency Medical Services Authority and
Commission on Emergency Medical Services--Conflict of Interest Code

NOTE: It having been found, pursuant to Government Code Section 11344, that the printing of the regulations constituting the Conflict of Interest Code is impractical and these regulations being of limited and particular application are not published in full in the California Code of Regulations. The regulations are available to the public for review or purchase at cost at the following locations:

EMERGENCY MEDICAL SERVICES AUTHORITY
1930 9TH STREET, SUITE 100
SACRAMENTO, CA 95814

FAIR POLITICAL PRACTICES COMMISSION
428 J STREET, SUITE 800
SACRAMENTO, CA 95814

ARCHIVES
SECRETARY OF STATE
1020 "O" STREET
SACRAMENTO, CA 95814

The Conflict of Interest Code is designated as Chapter 1, Division 9 of Title 22 of the California Code of Regulations, and consists of sections numbered and titled as follows:

Chapter 1. Emergency Medical Services Authority and Commission on Emergency Medical Services--Conflict of Interest Code

Section

100000. General Provisions

Appendix

Note: Authority cited: Section 87300, Government Code. Reference: Section 87300, Government Code.

CONFLICT OF INTEREST CODE FOR STATE EMERGENCY MEDICAL SERVICES AUTHORITY

The Political Reform Act, Government Code Sections 81000, et seq., requires state and local government agencies and commissions to adopt and promulgate Conflict of Interest Codes. The Fair Political Practices Commission has adopted a regulation, 2 Cal. Code of Regulations Section 18730, which contains the terms of a standard Conflict of Interest Code, which can be incorporated by reference, and which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings. Therefore, the terms of 2 Cal. Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission, along with the attached Appendix in which officials and employees are designated and disclosure categories are set forth, are hereby incorporated by reference and constitute the Conflict of Interest Code of the State Emergency Medical Services Authority and the Commission on Emergency Medical Services.

Designated employees and Commission members shall file statements of economic interests with the Authority. Upon receipt of the statements of the Director of Emergency Medical Services Authority and the Commission Members, the Authority shall make and retain a copy and forward the original of these statements to the Fair Political Practices Commission.

STATE EMS AUTHORITY AND EMS COMMISSION MEMBERS

Designated Positions	Disclosure Categories
Commission Members	1, 2, 3
Director, EMSA	1, 2, 3, 4
Chief Deputy Director	1, 2, 3, 4
Consultants	1, 2, 3, 4

1/ With respect to Consultants, the Director may determine in writing that a particular consultant is hired to perform a range of duties that are limited in scope and thus is not required to comply with the disclosure requirements described in these categories. Such description shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Director shall forward a copy of this determination to the Fair Political Practices Commission. Nothing herein excuses any such consultant from any other provision of this Conflict of Interest Code.

STATE EMERGENCY MEDICAL SERVICES AUTHORITY
AND
COMMISSION ON EMERGENCY MEDICAL SERVICES
DISCLOSURE CATEGORIES

Category 1

Designated employees in this category shall disclose investments in, income from, and business positions with any business entity or non-profit corporation which:

- (a) Provides emergency medical services including, but not limited to hospitals, medical clinics, laboratories, pharmacies and ambulance companies;
- (b) Manufactures, sells, or distributes medical equipment, supplies or services;
- (c) Provides training or training materials for persons engaged in emergency medical services programs; or,
- (d) Provides consulting services for the planning or provision of emergency medical services.

Category 2

Designated employees in this category shall disclose investments in, income from, and business positions with any business entity or non-profit corporation of the type which provides goods or services to the EMS Authority.

Category 3

Designated employees in this category shall disclose investments in and sources of income from business entities of the type providing training for persons engaged in Emergency Medical Services programs.

Category 4

Designated employees in this category shall disclose investments in and sources of income from business entities of the type which provide goods or services to the EMS Authority.

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California Code of Regulations, Title 22

Chapter 1.1: Training Standards for Child Care Providers

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.1. Training Standards for Child Care Providers

Article 1. Definitions

§ 100000.1. Child.

"Child" means a person who is under 18 years of age who is being provided care and supervision in a child care facility.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.750, 1596.866 and 1797.191, Health and Safety Code.

§ 100000.2. Child Care Facility.

"Child care facility" means a facility which provides non-medical care to children under 18 years of age in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. Child care facility includes child care centers and family child care homes.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.750, 1596.866 and 1797.191, Health and Safety Code.

§ 100000.3. Child Care Center.

"Child care center" means any child care facility other than a family child care home, and includes infant centers, preschools, and extended child care facilities.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.750, 1596.866 and 1797.191, Health and Safety Code.

§ 100000.4. Family Child Care Home.

"Family Child Care Home" means a home which regularly provides care, protection, and supervision of 14 or fewer children, in the provider's own home, for periods of less than 24 hours per day, while the parents or guardians are away, and includes the following:

(a) "Large family child care home" means a home that provides family child care for 7 to 14 children, inclusive, including children under the age of 10 years who reside at the home, as set forth in Section 1597.465 of the Health and Safety Code and as defined in Chapter 3 of Division 12 of Title 22 of the California Code of Regulations.

(b) "Small family child care home" means a home that provides family child care to eight or fewer children, including children under the age of 10 years who reside at the home, as set forth in Section 1597.44 of the Health and Safety Code and as defined in Chapter 3 of Division 12 of Title 22 of the California Code of Regulations.

NOTE: Authority cited: Sections 1797.107, and 1797.191. Reference: Sections 1597.44, 1597.465, 1596.78, 1596.866 and 1797.191, Health and Safety Code.

§ 100000.5. Child Care Provider.

“Child care provider” means a person who provides care to children in a child care facility that is licensed pursuant to Chapter 3.5 (commencing with Section 1596.90) or Chapter 3.6 (commencing with Section 1597.30) of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.6. Training Program.

“Training program” means a program that applies to the Emergency Medical Services Authority (EMS Authority) for review and approval of its child care pediatric first aid, CPR, and/or preventive health and safety training program.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.7. Approved Training Program.

“Approved training program, or approved program”, means a training program that is approved by the EMS Authority to provide pediatric first aid, CPR, and/or preventive health and safety training to child care providers.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.8. Affiliate Program.

“Affiliate program” means the training program that provides an approved child care pediatric first aid, CPR, or preventive health and safety training because of its association with a training program approved by the EMS Authority.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.9. Training Program Director.

“Training program director” means the person who is named in the EMS Authority review and approval application as being the director of a pediatric first aid, CPR and/or preventive health and safety training program. This person is responsible for the administration of the child care pediatric first aid, CPR or preventive health and safety training program that has been approved by the EMS Authority.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.10. Training Program Instructor.

“Training program instructor” means a person who teaches the approved child care pediatric first aid, CPR, or preventive health and safety training to child care providers, pursuant to the Health and Safety Code Section 1596.866.

NOTE: Authority cited: Sections 1797.107 and 1797.191. Reference Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.

§ 100000.11. Pediatric First Aid.

"Pediatric first aid" means the recognition of, and immediate care for injury or sudden illness, including medical emergencies, to an infant or child, prior to the availability of medical care by licensed or certified health care professionals.

NOTE: Authority cited: Sections 1797.107 and 1797.191. References Sections 1596.866 and 1797.191, Health and Safety Code.

§ 100000.12. Pediatric Cardiopulmonary Resuscitation.

"Pediatric cardiopulmonary resuscitation" or "pediatric CPR" means establishing and maintaining, on an infant or child, an open airway, ensuring adequate respiration either spontaneously or by use of rescue breathing, and ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression. Pediatric CPR includes adult CPR for purposes of children over eight years of age.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference Section 1596.866, Health and Safety Code.

§ 100000.13. Preventive Health and Safety.

"Preventive health and safety" means the course required for child care providers that encompasses study in recognition, management, and prevention of infectious diseases, including immunizations, and prevention of childhood injuries among children in child care facilities.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference Section 1596.866, Health and Safety Code.

§ 100000.14. Certificate of Approval.

"Certificate of approval" means the certificate that is issued by the EMS Authority to the approved training program. The certificate shall state that the program is approved to provide child care pediatric first aid, CPR, or preventive health and safety training.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference Section 1596.866, Health and Safety Code.

§ 100000.15. Course Completion Document.

"Course completion document" means the card, certificate, or other written document issued by an approved training program to a student who has completed the child care pediatric first aid, pediatric CPR, or the preventive health and safety training.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference Section 1596.866, Health and Safety Code.

§ 100000.16. Course Completion Sticker.

“Course completion sticker” means the EMS Authority sticker that is purchased by the approved training program and its affiliate for pediatric first aid, CPR, or the preventive health and safety training. An appropriate sticker shall be affixed to each course completion document issued by approved training programs and their affiliates for the pediatric first aid, CPR, or preventive health and safety training.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference Section 1596.866, Health and Safety Code.

Article 2. Training Requirements for Child Care Providers

§ 100000.17. Training Requirements for Child Care Providers.

(a) The training requirements for pediatric first aid and CPR for child care providers shall be satisfied by maintaining current certification in pediatric first aid and CPR. Current certification is demonstrated by possession of the following:

- (1) A current pediatric first aid course completion card issued either by the American Red Cross or by a training program that has been approved by the EMS Authority, and
- (2) A current pediatric CPR course completion card issued either by the American Red Cross or the American Heart Association, or by a training program that has been approved by the EMS Authority.

(b) Retraining in pediatric first aid and CPR shall occur at least every two years.

(c) The training requirements for preventive health and safety for child care providers may be satisfied by completion of a course and certification in preventive health and safety. Certification in preventive health and safety is demonstrated by a child preventive health and safety course completion document issued by an approved training program.

(d) The requirement for taking the preventive health and safety training is one time only.

NOTE: Authority cited: Sections 1596.866, 1797.107 and 1797.191, Health and Safety Code.

Reference: Sections 1595.866 and 1797.191, Health and Safety Code.

Article 3. Training Program Approval

§ 100000.18. Application Process for Program Review and Approval.

Training programs in pediatric first aid, pediatric CPR, and preventive health and safety shall submit to the EMS Authority the following information when applying for program review and approval:

- (a) Name of the program, name of the business (if it is different than the name of the program), business address, telephone number and program director of the training program, institution, organization, or agency;
- (b) A resume of the director's education and experience in methods, materials, and evaluation of instruction in the areas of child care training (pediatric first aid, CPR, and preventive health and safety);
- (c) Completed application (Form EMS-App 100-1/95 for the pediatric first aid and CPR program or Form EMS-App 102-1/99 for the child preventive health and safety program incorporated by reference) with the following attachments:
 - (1) A copy of the training course curriculum, including any workbooks, videos, textbooks, or handouts if used in the course;
 - (2) A detailed plan for evaluation of trainee competency;
 - (3) A detailed plan for evaluation of instructor competency;
 - (4) A detailed curriculum for instructor training in the pediatric first aid, and CPR, or the preventive health and safety training for child care providers;
 - (5) A list of all affiliated training programs;
 - (6) A copy of the business license (if licensed); and
 - (7) The required fees for program review and EMS Authority course completion stickers.
- (d) All program materials specified in this chapter shall be subject to periodic review, evaluation and monitoring by the EMS Authority.

NOTE: Authority cited: Sections 1596.866 and 1797.107, Health and Safety Code. Reference: Sections 1596.866, 1797.113 and 1797.191, Health and Safety Code.

§ 100000.19. Program Approval Documentation.

- (a) The EMS Authority shall notify the training program within twenty working days of receiving its request for training program approval, that the request was received and contains the information

requested in Section 100000.18 of this Chapter or shall specify what information is missing from the request.

(b) Program approval or disapproval shall be made in writing by the EMS Authority to the applying training program within sixty days of receiving all application information. The training program shall complete all modifications to an application or program required by the EMS Authority before approval can be given.

(c) The EMS Authority shall establish the effective date of training program approval in writing once the training program is reviewed and found in compliance with all program requirements. The EMS Authority shall issue a program approval certificate with the effective date and an expiration date.

(d) Program approval shall be for two years from the last day of the month in which the approval is given.

(e) Approved training programs shall notify the EMS Authority in writing, and within thirty days of any change in course content, hours of instruction, or program director. Advance notice shall be given whenever possible. All changes shall be reviewed and approved by the EMS Authority.

(f) Directors of training programs shall provide a copy of the EMS Authority certificate of training program approval to all of their affiliate programs.

(g) All training programs and their affiliate programs shall show a copy of their EMS Authority certificate of approval to students who are taking their child care provider first aid, CPR, or preventive health and safety training, and to the prospective child care training students who inquire about these training programs.

NOTE: Authority cited: Sections 1596.866 and 1797.107, Health and Safety Code. Reference: Sections 1596.750 1596.866 and 1797.191, Health and Safety Code.

§ 100000.20. Withdrawal of Program Approval.

Failure to comply with any requirement for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in probation, suspension, revocation, or denial of renewal of program approval by the EMS Authority following the provisions of the Administrative Procedures Act, Section 11500 et. Seq. of the Government Code. An approved

training program shall have no more than (30) days from date of written notice to comply with this chapter.

NOTE: Authority cited: Sections 1596.866, 1797.107 and 1797.191, Health and Safety Code.

Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

Article 4. Training Program Director and Instructor Requirements

§ 100000.21. Director Requirements.

Each training program shall have an approved program director who shall be qualified by education and experience in methods, materials, and evaluation of instruction. Duties of the program director shall include but not be limited to:

- (a) Administering the training program.
- (b) Approving course content.
- (c) Approving all written and skills examinations.
- (d) Coordinating all instructional activities related to the course.
- (e) Approving and monitoring instructor training.
- (f) Approving, monitoring, and evaluating all instructors and affiliate program directors.
- (g) Notifying in writing their affiliate programs of all policies, curriculum changes, and regulations that are issued by the EMS Authority.
- (h) Assuring that all aspects of the training program are in compliance with this Chapter and other related laws.

NOTE: Authority cited: Sections 1596.866 and 1797.107, Health and Safety Code. Reference: Sections 1596.866, 1596.750, and 1797.191, Health and Safety Code.

§ 100000.22. Requirements for Instructor Training for Pediatric First Aid and CPR.

- (a) Only instructors who possess a current pediatric first aid and CPR card shall teach EMSA-approved pediatric first aid and CPR training program courses.

(b) Approved training programs shall determine which of the following hours of training are required for instructors, based on competency in essential knowledge and skills and previous hours of training in relevant courses.

(1) Eight hours of training in the approved program curriculum are required for instructor certification/authorization after completion of first aid and CPR training and/or demonstrated competency in essential skills.

(2) Thirty-two hours of training are required for instructor certification/authorization if applicant has no prior training and/or demonstrated competency in essential skills.

(c) This training shall be provided by the approved training program that is hiring, franchising, or affiliating with an instructor. The training shall be given as a condition of hiring, franchising, or affiliating with an instructor, and shall include, but not be limited to, the course content specified in Section 100000.23 of this chapter.

(d) Each training organization shall maintain written verification of instructor qualifications for each certified instructor.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1597.866 and 1797.191, Health and Safety Code.

§ 100000.23. Required Course Content for Pediatric First Aid and CPR Instructor Training.

(a) The training program for instructors shall include, but not be limited to, the following topics:

(1) Teaching methods;

(2) Teaching presentation and student assessment;

(3) Child development impact and issues;

(4) Administrative and quality assurance;

(5) Participant health and safety, including care and use of manikins;

(6) Issues of cultural sensitivity;

(7) Assurance that child care context is part of all content areas; and

(8) Topics and skills specified in Sections 100000.30(a)

(b) The training program for instructors shall also assess and evaluate an instructor's ability to teach the following essential skills:

- (1) Primary assessment, including management of suspected head and neck injuries;
 - (2) Rescue breathing;
 - (3) Techniques for response to choking (conscious and unconscious children);
 - (4) Techniques for controlling bleeding;
 - (5) Pediatric CPR; and
 - (6) Splinting of fractures and sprains.
- (c) The training program shall assess and evaluate an instructor's teaching presentation and competency at assessing student skills.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.798, 1596.8661, 1597.866, and 1797.191, Health and Safety Code; Section 3765 Business and Professions Code.

§ 100000.24. Requirements for Instructor Training for Child Preventive Health and Safety.

- (a) Only instructors who possess a current pediatric first aid and CPR card shall teach approved child preventive health and safety training program courses. In addition, all child preventive health and safety instructors shall have completed a minimum of twenty-four hours of child preventive health and safety training that included, but is not limited to, the course content specified in Section 100000.30 (b) of this chapter, within twelve months prior to beginning to teach an approved program. Until January 1, 2001, the twenty-four hours of training may include preventive health and safety training given by the instructor.
- (b) Approved training programs shall determine which of the following hours of training are required for instructors, based on competency in essential knowledge and skills and previous hours of training in relevant courses.
- (1) Eight hours of training in the approved program curriculum are required for instructor certification/authorization if applicant has previous instructor training after completion of first aid, CPR, and preventive health and safety training and/or demonstrated competency in essential skills.
 - (2) Twenty-four hours of training are required for instructor certification/authorization if applicant has no prior instructor training and/or demonstrated competency in essential skills.

(c) The training required in subsection (b) of this section shall be provided by the approved training program that is hiring, franchising or affiliating with an instructor. The training shall be given as a condition of hiring, franchising or affiliating with an instructor, and shall include, but not be limited to, the course content specified in Section 100000.25 of this chapter.

(d) Each training organization shall maintain written verification of instructor qualifications for each certified instructor.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 1597.866 and 1797.191, Health and Safety Code.

§100000.25. Required Course Content for Child Preventive Health and Safety Instructor Training.

The training program for instructors shall include, but not be limited to the following topics:

- (a) Teaching methods for adult students;
- (b) Teaching presentation and student assessment;
- (c) Child development impact and issues;
- (d) Administrative and training quality assurance;
- (e) Topics and skills specified in Section 100000.30 (b);
- (f) Issues of cultural awareness and sensitivity;
- (g) Assurance that child care context is part of all content areas;
- (h) Knowledge of child care; and
- (i) Knowledge of child care statutes and regulations.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

§ 100000.26. Methodology for Evaluation of Instructor Competence.

Methods to evaluate instructor competence shall include, but not be limited to, the following:

- (a) Demonstration of mastery in all curriculum areas;
- (b) Essential knowledge and skills assessment; and
- (c) Use of problem solving scenarios as teaching tools.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

§100000.27. Instructor Certification/Authorization Requirements.

(a) Approved training programs shall issue certification cards that document certification of instructors. Certification cards shall contain an expiration date not to exceed two years from the date of instructor certification.

(b) Approved training programs shall evaluate their instructors, determine the number of retraining hours needed, and provide retraining to their instructors in any of the course content specified in Sections 100000.23 and 100000.25.

(c) Approved training programs shall issue recertification cards upon expiration of original certification, to document recertification of qualified instructors. These recertification cards shall contain an expiration date not to exceed two years from the date of instructor recertification.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

§ 100000.28. Monitoring of Instructors.

(a) Methods to monitor certified instructors by training organizations shall include, but not be limited to, review of student evaluations and periodic direct observation of provider training.

(b) Training organizations shall have an agreement of understanding with their program instructors specifying that the instructors shall teach according to the stated organization standards. These agreements shall be signed by the program instructor and program director.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

Article 5. Course Hours and Class Requirements

§ 100000.29. Course Hours and Class Size Requirements.

(a) The initial course of instruction shall consist of no less than eight hours in pediatric first aid and pediatric CPR. Training programs teaching pediatric first aid only are allowed with instruction in pediatric first aid to consist of no less than four hours in addition to a minimum of four hours of pediatric CPR. The eight hour course shall consist of no less than four hours of pediatric first aid and no less than four hours of pediatric CPR. Training programs may teach these four hour courses in pediatric first aid and pediatric CPR separately.

(b) Retraining in pediatric first aid and CPR shall consist of no less than four hours of pediatric first aid and no less than four hours of pediatric CPR. Retraining in pediatric first aid and CPR shall be completed at least every two years.

(c) The course of instruction in child preventive health and safety shall consist of no less than seven hours. The requirement for taking this course is one time only.

(d) The class size ratio for pediatric first aid and pediatric CPR shall not exceed one instructor to twelve students for the skills practice and evaluation components of the curriculum.

(e) The class size ratio for preventive health and safety training shall not exceed one instructor to thirty students.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

§ 100000.30. Required Course Content.

(a) The course content for pediatric first aid and CPR shall include instruction to result in competence in the following topics and skills, which shall prepare personnel within the child care setting to recognize and treat the ill or injured child, as follows:

- (1) Patient examination and injury assessment principles;
- (2) Orientation and access to the emergency medical services system;
- (3) Recognition and treatment of:
 - (A) Burns;

- (B) Environmental exposure;
 - (C) Bleeding;
 - (D) Bites and stings (including human, animal, snake, insect and marine life);
 - (E) Fainting and seizures;
 - (F) Dental emergencies;
 - (G) Diabetic emergencies;
 - (H) Eye injuries and irritants;
 - (I) Head and neck injuries;
 - (J) Respiratory distress (including use of inhaled medications and nebulizers for children with lung diseases);
 - (K) Fractures and sprains;
 - (L) Exposure and response to toxic substances;
 - (M) Shock management; and
 - (N) Wounds (including cuts, bruises, scrapes, punctures, slivers, penetrating injuries from foreign objects, amputations and avulsions).
- (4) Assembly and use of first aid kits and supplies;
 - (5) Understanding of standard precautions and personal safety in giving emergency care;
 - (6) First aid action plan within a group care setting (including classroom management while caring for an injured or ill child);
 - (7) Injury reporting;
 - (8) Reassuring parents and children in an emergency situation and;
 - (9) How to talk to young children about emergencies and instructing children in the emergency action plan.
- (b) The course content for preventive health and safety training shall include instruction to result in competence in the following topics and skills, which shall prepare personnel to recognize, manage, and prevent infectious diseases and childhood injuries as follows:
 - (1) Prevention of Infectious Disease.
 - (A) Standard precautions.
 - 1. Sanitation;

2. Hand washing; and

3. Use of gloves.

(B) Hygiene for children and care givers.

1. Hand washing; and

2. Diapering.

(C) Childhood immunizations; i.e., age and type requirements;

(D) Maintenance of health records and forms;

(E) Process for review of medical form information, including medication administration, allergies, immunizations, and health insurance; and

(F) Infectious disease policies.

1. Notices for exposure to disease;

2. Guidelines for the exclusion/inclusion of sick children;

3. Diseases that should be reported to local health agencies and to the child care facility children's parents;

4. Guidelines for managing mildly ill children; and

5. Guidelines for staff health regarding potential risk of infectious diseases, including but not limited to cytomegalovirus (CMV) and Hepatitis B.

(G) Community Resources, to include information on local resources for services that deal with children's health and the prevention of infectious disease shall be given to trainees by the training instructor.

(2) Child Injury Prevention

(A) Risk of injury related to developmental stages (i.e., falling, choking, head injuries);

(B) Establishing and adhering to safety policies in the child care setting;

(C) Procedures to reduce the risks of Sudden Infant Death Syndrome (SIDS) and Shaken Baby Syndrome;

(D) Managing children's risky behaviors that can lead to injury;

(E) Regular assessments for the safety of indoor and outdoor child care environments and play equipment; and

(F) Transportation of children during child care.

1. Motor vehicle safety;

2. Child passenger safety;
3. Field trip safety; and
4. School bus safety.

(G) Community resources, to include information on local resources for services that deal with children's health and the prevention of childhood injuries shall be given to trainees by the training instructor.

(H) Child abuse resources, i.e., where to go in your community for help and information regarding child abuse.

(c) The course content for preventive health training may include instruction in the following:

(1) Children's nutrition, i.e., age-appropriate meal planning to ensure nutritional requirements and the correct portions of food for monitoring children's food intake.

(A) The food pyramid and how to apply it to children;

(B) Appropriate eating behaviors for children (i.e., snacking); and

(C) Specialized diets, including diet restrictions based upon medical needs. These medical needs include but are not limited to food allergies and diabetes.

(D) Awareness of feeding/growth problems such as failure-to-thrive.

(E) The connection between diet and dental decay in children.

(2) Environmental sanitation.

(A) Vector prevention;

(B) Kitchen cleanliness and sanitation practices;

(C) Toilet and diapering area sanitation.

(3) Air quality.

(A) Hazards of smoking (including, second hand smoke);

(B) Importance of keeping air filters clean;

(C) Importance of fresh air;

(D) Hazards of use of fireplaces; and

(E) The connection between allergens and children's respiratory illnesses, and how to reduce airborne allergens.

(4) Food quality.

(A) Safe food practices;

- (B) Safe food handling;
 - (C) Cooking safety;
 - (D) Preparing foods safely (i.e., washing produce; keeping raw meats and utensils used on raw meats away from cooked foods or foods that will be eaten raw; the importance of keeping cold foods cold, and hot foods hot);
 - (E) Safe storage of food (including prevention of lead poisoning);
 - (F) Fully cooking meats and eggs;
 - (G) Use of only pasteurized fruit juices; and
 - (H) Dangers of e. coli and salmonella.
- (5) Water quality.
- (6) Children with special needs.
- (A) Knowledge of resources for services for children with special health care needs; and
 - (B) Knowledge of the Americans with Disabilities Act, and how it pertains to children with special needs in child care.
- (7) Community resources, knowledge of city, county and state resources, both non-profit and governmental, for services for children.
- (8) Child abuse identification and prevention.
- (A) Child abuse mandated reporting requirements;
 - (B) Signs of child abuse and neglect; and
 - (C) Care giver stress and the relation of this to abuse issues.
- (9) Procedures to reduce the risks of the following injuries, including but not limited to: burns, choking, falls, poisonings (lead, iron, acetaminophen, and other medications), oral injury, suffocation, drowning, injuries from weapons, and injuries from animals.
- (10) Earthquake and emergency preparedness.
- (A) Preparing the child care environment for major disasters; and
 - (B) Community resources for gaining information regarding preparing for disasters and/or assistance in case of a disaster.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.798, 1596.8661, 1597.866, and 1797.191, Health and Safety Code; Section 3765 Business and Professions Code.

§ 100000.31. Essential Skills Practice and Evaluation.

The pediatric first aid and CPR training program shall include practice and evaluation of the following skills:

- (a) Primary assessment, including management of suspected head and neck injuries.
- (b) Care for pediatric choking victims, both conscious and unconscious.
- (c) Control of bleeding.
- (d) Splinting and care for fractures, sprains, strains and dislocated joints.
- (e) Pediatric CPR.
- (f) Pediatric rescue breathing.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1597.866 and 1797.191, Health and Safety Code.

§ 100000.32. Methodology for Evaluation of Trainee Competency.

Each training program shall develop, and submit as part of the course, a plan for evaluating trainee competence in all content and skills areas. Following are methods which may be used to evaluate competency:

- (a) Self-evaluation in conjunction with other methods.
- (b) Demonstration of mastery other than written.
- (c) Written skills test with option for oral testing.
- (d) Use of problem-solving scenarios.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1597.866, and 1797.191, Health and Safety Code.

Article 6. Class Rosters, Course Completion Documents and Stickers

§ 100000.33. Class Rosters.

Each EMS Authority-approved pediatric first aid and CPR training program and child preventive health and safety training program shall submit class rosters to the EMS Authority for each of the pediatric first aid and CPR training sessions and for each of the child preventive health and safety training sessions, within 30 calendar days of course completion. These class rosters shall include the name, address, and phone number of each student of the training. The rosters shall also include the serial number listed on the course completion sticker that is issued to each student upon the completion of the training.

NOTE: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code.

§ 100000.34. Course Completion Documents and Stickers.

- (a) Approved programs in pediatric first aid, CPR and preventive health and safety practices training shall place pre-printed stickers from the EMS Authority on their course completion documents. The stickers verify that the training program is EMS Authority-approved, indicate which training the student completed, and assigns a tracking number to the course completion document.
- (b) Affiliate programs shall order their course completion stickers from the EMS Authority.
- (c) Approved programs that have affiliate programs are responsible for providing a complete list of their affiliate programs, including the instructor names, program names, business addresses and business telephone numbers to the EMS Authority.
- (d) Affiliate programs shall complete and submit to the EMS Authority the first page of the application (EMS-APP100-1/95, Rev. 3/99 and EMS-APP102-1/99, Rev. 10/99) and a course completion sticker order form (EMS-900, Rev. 8/99) and turn this into the EMS Authority prior to purchasing course completion stickers.
- (e) Course completion documents with the appropriate EMS Authority course completion stickers for the child care training in pediatric first aid, CPR and preventive health and safety training shall be issued by the training program to the student within 21 calendar days after the training is completed.

(f) The course completion documents for pediatric first, CPR, and preventive health and safety training shall have the name of the program training director, the name and signature of the course instructor, the course completion date and expiration date.

NOTE: Authority cited: Sections 1797.107, 1797.191 and 1797.113, Health and Safety Code.

Reference: Sections 1596.866, 1797.191 and 1797.113, Health and Safety Code.

Article 7. Fees

§ 100000.35. Fees.

Each training program submitting an application (Form EMS-App100-1/95, Rev. 3/99 and EMS-APP 102-1/99, Rev. 10/99) for program review, shall be assessed a fee of:

- (a) Two hundred and forty (\$240) dollars for the initial training program review for the pediatric first aid and CPR training course. Training programs that have been reviewed and approved by the EMS Authority will receive 40 course completion stickers, at no extra cost, for their \$240 review fee.
- (b) Two hundred and forty (\$240) dollars for the initial training and program review of the preventive health and safety training course. Training programs that have been reviewed and approved by the EMS Authority will receive 40 course completion stickers, at no extra cost, for their \$240 review fee.
- (c) Two hundred and forty (\$240) dollars for the biannual training review for the pediatric first aid and CPR training course. Training programs that have been reviewed and approved by the EMS Authority will receive 40 course completion stickers, at no extra cost, for their \$240 review fee.
- (d) Two hundred and forty (\$240) dollars for the biannual training review for the preventive health and safety training course. Training programs that have been reviewed and approved by the EMS Authority will receive 40 course completion stickers, at no extra cost, for their \$240 review fee. Three dollars for each (pediatric first aid, pediatric CPR, and/or preventive health and safety) preprinted course completion sticker, to be issued by the approved program to students upon course completion.

NOTE: Authority cited: Sections 1797.107, 1797.113 and 1797.191, Health and Safety Code.

Reference: Sections 1596.866, 1797.113 and 1797.191, Health and Safety Code.

California Code of Regulations, Title 22

Chapter 1.2: First Aid for School Bus Drivers

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.2. First Aid Testing for School-Bus Drivers

Article 1. Definitions

§ 100001. First Aid.

“First Aid” means the recognition of and immediate care for injury or sudden illness prior to the availability of emergency medical care by licensed or certified health care professionals.

NOTE: Authority cited: Section 12522, Vehicle Code. Reference: Section 12522, Vehicle Code.
(Section filed 8-29-86, operative 9-28-86; Register 86, No. 35)

§ 100002. Pre-Established Standard.

Pre-established standard means a determined passing score established by the testing agency prior to the commencement of the examination.

NOTE: Authority cited: Section 12522, Vehicle Code. Reference: Section 12522, Vehicle Code.
(Section filed 8-29-86, operative 9-28-86; Register 86, No. 35)

Article 2. General

§ 100003. Application of Chapter to School Bus Drivers.

All school bus drivers shall demonstrate proficiency in first aid practices by successfully completing in accordance with pre-established standards, a competency based written examination administered by the California Highway Patrol, in addition to any other requirement for a school bus driver's certificate.

NOTE: Authority cited: Section 12522, Vehicle Code. Reference: Section 12522, Vehicle Code.
(Section filed 8-29-86, operative 9-28-86; Register 86, No. 35)

Article 3. Examination Standards

§ 100004. First Aid Practices Proficiency.

The examination administered by the California Highway Patrol in first aid practices shall test an applicant's ability to recognize and render first aid in the following emergency medical situations:

- (a) Respiratory emergencies: obstructed airway and difficulty breathing;
- (b) Cardiac arrest: severe allergic reaction and shock;
- (c) Traumatic emergencies: open wounds, penetrating or blunt injuries of chest and abdomen, suspected fractures and dislocations; burns; suspected internal bleeding and suspected spinal injuries;
- (d) Poisonings: drug or alcohol overdose;
- (e) Altered consciousness: diabetic emergencies and convulsions;
- (f) Environmental emergencies: heat illness and hypothermia; and
- (g) Knowledge of EMS system access (utilization of emergency phone number: “9-1-1”).

NOTE: Authority cited: Section 12522, Vehicle Code. Reference: Section 12522, Vehicle Code.
(Section filed 8-29-86, operative 9-28-86; Register 86, No. 35)

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California Code of Regulations, Title 22

Chapter 1.5: Public Safety Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.5. First Aid Standards for Public Safety Personnel

Article 1. Definitions

§ 100005. Automated External Defibrillator or AED.

“Automated External Defibrillator or AED” means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by user interaction after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.52, 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100006. Public Safety AED Service Provider

“Public Safety AED Service Provider” means an agency, or organization which is responsible for, and is approved to operate, an AED.

NOTE: Authority cited: Section 1797.107, 1797.182 and 1797.183, Health and Safety Code.

Reference: Sections 1797.182 and 1797.183, Health and Safety Code and Section 13518, Penal Code.

§ 100007. Cardiopulmonary Resuscitation.

“Cardiopulmonary resuscitation” or “CPR” means establishing and maintaining an open airway, ensuring adequate respiration either spontaneously or by use of rescue breathing, and ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression, according to standards promulgated by the American Heart Association and/or the American Red Cross.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100008. Firefighter.

“Firefighter” means any regularly employed and paid officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.182, Health and Safety Code.

1 **§ 100009. First Aid.**

2 “First aid” means the recognition of and immediate care for injury or sudden illness, including
3 medical emergencies, prior to the availability of medical care by licensed or certified health care
4 professionals.

5 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182
6 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.
7

8 **§ 100010. Lifeguard.**

9 “Lifeguard” means any regularly employed and paid officer, employee, or member of a public
10 aquatic safety department or marine safety agency of the State of California, or any city, county,
11 city and county, district or other public or municipal corporation or political subdivision of
12 California.

13 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.182,
14 Health and Safety Code.
15

16 **§ 100011. Peace Officer.**

17 “Peace officer” means any city police officer, sheriff, deputy sheriff, peace officer member of
18 the California Highway Patrol, marshal or deputy marshal or police officer of a district
19 authorized by statute to maintain a police department or other peace officer required by law to
20 complete the training specified in this Chapter.

21 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.183,
22 Health and Safety Code; and Section 13518, Penal Code.
23

24 **§ 100012. Primarily Clerical or Administrative.**

25 “Primarily clerical or administrative” means the performance of clerical or administrative duties
26 for ninety percent (90%) or more of the time worked within each pay period.

27 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182
28 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.
29

30 **§ 100013. Qualified Instructor.**

31 “Qualified instructor” is a trained individual who shall be certified to teach first aid and/or CPR
32 by the approving authority specified in Section 100026 of this Chapter.

33 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182
34 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.
35

36 **§ 100014. Regularly Employed.**

37 “Regularly employed” means being given wages, salary, or other remuneration for the
38 performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

39 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182
40 and 1797.183, Health and Safety Code.
41

Article 2. General Training Provisions

§ 100015. Application and Scope.

Except those whose duties are primarily clerical or administrative, the following regularly employed public safety personnel shall be trained to administer first aid, and cardiopulmonary resuscitation, according to the standards set forth in this Chapter:

- (a) lifeguard;
- (b) firefighter;
- (c) peace officer.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100016. Training Programs In Operation.

Training programs in operation prior to the effective date of these regulations shall submit evidence of compliance with this Chapter to the appropriate approving Authority as specified in Section 100026 of this Chapter within six (6) months after the effective date of these regulations.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100017. Time Limitation for Initial Training.

The initial training requirements specified in this Chapter shall be satisfactorily completed within one (1) year from the effective date of the individual's initial employment and, whenever possible, prior to assumption of regular duty in one of the personnel categories set forth in Section 100016 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

Article 3. Training Standards

§ 100018. Scope of Course.

(a) The initial course of instruction shall at a minimum consist of not less than fifteen (15) hours in first aid and six (6) hours in cardiopulmonary resuscitation.

(b) The course of instruction shall include, but need not be limited to, the following scope of course which shall prepare personnel specified in Section 100016 of this Chapter to recognize the injury or illness of the individual and render assistance:

- (1) Emergency action principles which describe the basic problems of decision making in first aid;
- (2) First aid for medical emergencies, including sudden illnesses;
- (3) Cardiac and respiratory emergencies, including cardiac and/or respiratory failures in victims of all ages;
- (4) First aid for traumatic injuries including wounds, and life threatening bleeding;

- (5) First aid for specific injuries, including care for specific injuries to different parts of the body;
- (6) Bandaging, including materials and guidelines used in bandaging;
- (7) First aid for environmental emergencies including burns, heat and chemical burns, electrical emergencies and exposure to radiation, or climatic changes;
- (8) First aid for injuries to bones, muscles, and joints;
- (9) Emergency rescue and transfer;
- (10) First aid for obstetrical emergencies.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100019. Required Topics.

The content of the training course shall include at least the following topics and shall be skill-oriented:

- (a) Examination and assessment of the victim;
- (b) Orientation to the EMS system;
- (c) Suspected heart attack or stroke;
- (d) Fainting, convulsions, and/or suspected drug abuse;
- (e) Heat exhaustion, heat stroke, hypothermia and frost bite;
- (f) Mouth to mouth breathing and care for choking victims whether conscious or unconscious;
- (g) Types of wounds and control of bleeding;
- (h) Shock, and its causes, infection and closed wounds;
- (i) Eye, face, scalp, jaw and ear injuries;
- (j) Injuries of the head, neck, back, trunk, arms and legs;
- (k) Exposure to toxic substances;
- (l) Bites and stings by snakes, marine life and insects;
- (m) Bandaging techniques, first aid kits and supplies;
- (n) Determination of the severity of burns, including first, second, and third degree burns;
- (o) Fractures, both open and closed, splinting, and care for fractures, sprains, strains and dislocated joints;
- (p) Techniques of cardiopulmonary resuscitation; and
- (q) Obstetrical emergencies.

Note: Authority cited: Section: 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100020. Optional Skill.

(a) In addition to the activities authorized by Section 100019 of this Chapter, public safety personnel may perform AED when authorized by a public safety AED service provider.

(1) Training for the AED shall consist of not less than four (4) hours and shall include the following topics and skills:

1 (A) Proper use, maintenance and periodic inspection of the AED.

2 (B) The importance of cardiopulmonary resuscitation (CPR), defibrillation, advanced life
3 support (ALS), adequate airway care, and internal emergency response system, if applicable.

4 (C) Overview of the EMS system, the local EMS system's medical control policies,
5 9-1-1 access, and interaction with EMS personnel.

6 (D) Assessment of an unconscious patient, to include evaluation of airway, breathing, and
7 circulation to determine cardiac arrest.

8 (E) Information relating to AED safety precautions to enable the individual to administer a
9 shock without jeopardizing the safety of the patient or rescuers or other nearby persons.

10 (F) Recognition that an electrical shock has been delivered to the patient and that the
11 defibrillator is no longer charged.

12 (G) Rapid, accurate assessment of the patient's post-shock status.

13 (H) The appropriate continuation of care following a successful defibrillation.

14 (b) In order to be authorized to utilize the defibrillator, an individual shall pass a written and
15 skills examination with a pre-established standard, which tests the ability to assess and manage
16 the specified conditions listed in subsection (a) of this section.

17 (c) A local EMS agency that approves public safety AED service providers shall:

18 (1) Approve and monitor training programs including refresher training within its jurisdiction
19 to assure compliance with this Chapter.

20 (2) Approve the written and skills exam required for AED training course completion.

21 (3) Develop policies and procedures for approval of AED instructors by the local EMS agency
22 medical director. To be authorized to instruct public safety personnel in the use of an AED, an
23 AED instructor shall either:

24 (A) Complete an American Red Cross or American Heart Association recognized instructor
25 course (or equivalent) including instruction and training in the use of an AED, or

26 (B) Be approved by the local EMS agency director and meet the following requirements:

27 1. Be AED accredited or able to show competency in the proper utilization of an AED, and

28 2. Be able to demonstrate competency in adult teaching methodologies.

29 (4) Establish policies and procedures for medical control pursuant to Section 1798 of the
30 Health and Safety Code.

31 (5) Establish policies and procedures for the approval and designation of public safety AED
32 service provider(s) which will include requirements that public safety AED service providers
33 have policies and procedures, approved by the local EMS agency medical director, to

34 (A) provide orientation of AED accredited personnel to the AED,

35 (B) ensure continued competency of AED accredited personnel, and

36 (C) collect and report data to the local EMS agency, pursuant to Section 100021.

37 (6) Establish policies and procedures to collect, maintain and evaluate patient care records.

38 (7) Report annually to the EMS Authority on:

39 (A) The total number of patients, defibrillated; , who were discharged from the hospital alive,
40 and

(B) The data collected by public safety AED service providers pursuant to Section 100021 of this chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.52, 1797.58, 1797.74, 1797.90, 1797.175, 1797.176, 1797.182, 1797.183, 1798, 1798.2, 1798.4, 1798.100, 1798.102 and 1797.104, Health and Safety Code; and Section 13518, Penal Code.

§Section 100021. Public Safety AED Service Provider

A public safety AED service provider is an agency or organization that employs individuals as defined in Section 100015, and who obtain AEDs for the purpose of providing AED services to the general public.

(a) A public safety AED service provider shall be approved by the local EMS agency, or in the case of state or federal agencies, the EMS Authority, prior to beginning service. In order to receive and maintain AED service provider approval, a public safety AED service provider shall ensure compliance with the requirements of this Chapter.

(b) Public safety AED service provider approval may be revoked or suspended for failure to maintain the requirements of this section.

(c) A public safety AED service provider applicant shall be approved if they meet and provide the following:

- (1) Provide orientation of AED authorized personnel to the AED;
- (2) Ensure maintenance of AED equipment;
- (3) Ensure initial training and continued competency of AED authorized personnel;
- (4) Collect and report to the local EMS agency where the defibrillation occurred, as required by the local EMS agency but no less than annually, data that includes, but is not limited to:
 - (A) The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
 - (B) The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed; and
 - (C) The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation..
- (5) Authorize personnel and maintain a listing of all public safety AED service provider authorized personnel and provide upon request to the local EMS agency or the EMS Authority.

(c) An approved public safety AED service provider and their authorized personnel shall be recognized statewide.

NOTE: Authority cited: Section 1797.107, 1797.182 and 1797.183, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code and Section 13518, Penal Code.

§ 100022. Testing.

(a) The course of instruction shall include a written and skills examination which tests the ability to assess and manage all the conditions listed in Sections 100018 and 100019 of this Chapter.

(b) A passing standard shall be established by the training agency before administration of the examination.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100023. Training Instructor Requirements.

(a) Training in first aid and CPR for the personnel specified in Section 100016 of this Chapter shall be conducted by an instructor who is:

- (1) Proficient in the skills taught; and
- (2) qualified to teach by education and/or experience.

(b) Determination of the instructor's qualifications shall be the responsibility of the agency whose training program has been approved by the Authority pursuant to Section 100026 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100024. Validation of Course Completion.

(a) Each trainee who successfully completes an approved course of instruction and successfully passes a proficiency test shall be given written verification to that effect by the institution, organization or agency which provides the instruction.

(b) Employing agencies which provide approved courses of instruction to their employees need not provide individual written verification but shall maintain a record of the names of trainees and the date(s) on which training courses have been completed for at least three (3) years.

(c) Such training records shall be made available for inspection by the local EMS agency upon request.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100025. Retraining Requirements.

(a) The retraining requirements of this Chapter shall be satisfied by successful completion of either:

- (1) An approved retraining course which includes a review of the topics and demonstration of skills prescribed in this Chapter and which consists of no less than twelve (12) hours; or
- (2) A competency based written and skills pretest of the topics and skills prescribed in this Chapter with the following restrictions:

(A) That appropriate retraining be provided on those topics indicated necessary by the pretest, in addition to any new developments in first aid and CPR;

(B) A final test be provided covering those topics included in the retraining for those persons failing to pass the pretest; and

(C) The hours for the retraining may be reduced to those hours needed to cover the topics indicated necessary by the pretest.

(b) The entire retraining course or pretest may be offered yearly by the training agency, but in no event shall the retraining course or pretest be offered less than once every three (3) years.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

Article 4. Training Approval Options

§ 100026. Approved Courses.

The training requirements of this Chapter may be satisfied by successfully completing any one of the following course options as determined by the employing agency:

(a) A course in first aid, including CPR, developed and/or authorized by the Fire Service Training Program of the Office of the State Fire Marshal and approved by the EMS Authority; or

(b) A course in first aid, including CPR, authorized by the Commission on Peace Officer's Standards and Training (POST) and approved by the EMS Authority; or

(c) A course in first aid, including CPR, developed and authorized by the California Department of Parks and Recreation and approved by the EMS Authority; or

(d) A course in first aid, including CPR, developed and authorized by the California Department of Forestry and Fire Protection and approved by the EMS Authority; or

(e) A course in first aid, including CPR, developed and authorized by the Department of the California Highway Patrol and approved by the EMS Authority; or

(f) A course in first aid, including CPR, sponsored and/or approved by the American Red Cross; or

(g) A course in first aid sponsored and/or approved by the American Red Cross and a course in CPR sponsored and/or approved by the American Heart Association; or

(h) The U.S. Department of Transportation's first responder course which includes first aid practices and CPR approved by the local EMS agency; or

(i) A course in first aid and/or CPR equivalent to the standards of the American Red Cross and/or American Heart Association and approved by the local EMS agency; or

(j) An EMT-I course which has been approved pursuant to Chapter 2 of this division; or

(k) An EMT-II course which has been approved pursuant to Chapter 3 of this division; or

(l) An EMT-P course which has been approved pursuant to Chapter 4 of this division.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100027. Course Approval Process.

For those courses requiring approval, the following shall be submitted to the approving authority when requesting approval:

- (a) Name of the sponsoring institution, organization, or agency;
- (b) course outline;
- (c) final written examination with pre-established scoring standards; and
- (d) skill proficiency testing criteria, with pre-established scoring standards.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100028. Program Review.

All course outlines, written tests, and proficiency testing criteria used in an approved program shall be subject to periodic review as determined by the approving Authority.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

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California Code of Regulations, Title 22

Chapter 1.8: Layperson Defibrillation Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.8. Lay Rescuer Automated External Defibrillator Regulations

Article 1. Definitions

§ 100031. AED Service Provider.

“AED Service Provider” means any agency, business, organization or individual who purchases an AED for use in a medical emergency involving an unconscious, person who is not breathing. This definition does not apply to individuals who have been prescribed an AED by a physician for use on a specifically identified individual.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code. Section 1714.21, Civil Code.

§ 100032. Lay Rescuer

“Lay Rescuer” means any person, not otherwise licensed or certified to use the automated external defibrillator, who has met the training standards of this chapter.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code, Section 1714.21, Civil Code.

§ 100033. Automated External Defibrillator.

“Automated external defibrillator” or “AED” means an external defibrillator that after user activation is capable of cardiac rhythm analysis and will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code. Section 1714.21, Civil Code.

§ 100034. Cardiopulmonary Resuscitation.

“Cardiopulmonary resuscitation” or “CPR” means a basic emergency procedure for life support, consisting of artificial respiration, manual external cardiac massage, and maneuvers for relief of foreign body airway obstruction.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code. Section 1714.21, Civil Code.

§ 100035. Internal Emergency Response Plan.

“Internal Emergency Response Plan” means a written Internal Emergency Response Plan of action which utilizes responders within a facility to activate the

1 “9-1-1” emergency system, and which provides for the access, coordination, and
2 management of immediate medical care to seriously ill or injured individuals.

3 Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.

4 Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and
5 Safety Code. Section 1714.21, Civil Code.

6
7 **§ 100036. Medical Director.**

8 “Medical Director” means a physician and surgeon, currently licensed in
9 California, who provides medical oversight to the AED Service Provider as set
10 forth in Section 100040.

11 Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.

12 Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and
13 Safety Code. Section 1714.21, Civil Code.

14
15 **Article 2. General Training Provisions**

16
17 **§ 100037. Application and Scope.**

18 (a) Any training program, AED Service Provider or vendor may authorize a Lay
19 Rescuer to apply and operate an AED on an unconscious person who is not
20 breathing only if that Lay Rescuer has successfully completed a CPR and AED
21 course according to the standards prescribed by this chapter.

22 (b) The training standards prescribed by this chapter shall apply to employees of
23 the AED Service Provider and not to licensed, certified or other prehospital
24 emergency medical care personnel as defined by Section 1797.189 of the Health
25 and Safety Code.

26 Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.

27 Reference: Sections 1797.5, 1797.189, 1797.190, 1797.196, and 104113, Health
28 and Safety Code. Section 1714.21, Civil Code.

29
30 **Article 3. AED Training Program Requirements**

31
32 **§ 100038. Required Topics and Skills.**

33 (a) CPR and AED training shall comply with the American Heart Association or
34 American Red Cross CPR and AED guidelines. The training shall include the
35 following topics and skills:

36 (1) basic CPR skills;

37 (2) proper use, maintenance and periodic inspection of the AED;

38 (3) the importance of:

39 (A) early activation of an Internal Emergency Response Plan,

40 (B) early CPR,

41 (C) early defibrillation,

42 (D) early advanced life support, and

43 (E) internal emergency response plan, if applicable;

44 (4) overview of the local EMS system, including 9-1-1 access, and interaction
45 with EMS personnel;

- (5) assessment of an unconscious patient, to include evaluation of airway and breathing, to determine appropriateness of applying and activating an AED;
- (6) information relating to defibrillator safety precautions to enable the individual to administer shock without jeopardizing the safety of the patient or the Lay Rescuer or other nearby persons to include, but not be limited to;
- (A) age and weight restrictions for use of the AED,
- (B) presence of water or liquid on or around the victim,
- (C) presence of transdermal medications, and
- (D) implantable pacemakers or automatic implantable cardioverter-defibrillators;
- (7) recognition that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged;
- (8) rapid, accurate assessment of the patient's post-shock status to determine if further activation of the AED is necessary; and,
- (9) the responsibility for continuation of care, such as continued CPR and repeated shocks, as indicated, until the arrival of more medically qualified personnel.

(b) The Lay Rescuer shall maintain current CPR and AED training, as prescribed in this Chapter.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code. Section 1714.21, Civil Code.

§ 100039. Testing.

CPR and AED training for Lay Rescuers shall include a competency demonstration of skills on a manikin, directly observed by an instructor which tests the specified conditions prescribed in Section 100038.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and Safety Code. Section 1714.21, Civil Code.

Article 4. Operational AED Service Provider and Vendor Requirements

§ 100040. Medical Director Requirements

Any AED Service Provider shall have a physician Medical Director who:

- (a) Meets the qualifications of a Medical Director per Section 100036 of this Chapter.
- (b) Shall ensure that AED Service Provider's Lay Rescuer CPR and AED training meets the requirements of this Chapter.
- (c) Shall review each incident where emergency care or treatment on a person in cardiac arrest is rendered and to ensure that the Internal Emergency Response Plan, along with the CPR and AED standards that the Lay Rescuer was trained to, were followed.
- (d) Is involved in developing an Internal Emergency Response Plan and to ensure compliance for training, notification and maintenance as set forth in this Chapter.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and
Safety Code. Section 1714.21, Civil Code.

§100041. AED Service Provider Operational Requirements.

(a) An AED Service Provider shall ensure their internal AED programs include all
of the following:

(1) Development of a written Internal Emergency Response Plan which describes
the procedures to be followed in the event of an emergency that may involve the
use of an AED and complies with the regulations contained in this Chapter. The
written Internal Emergency Response Plan shall include, but not be limited to,
immediate notification of 9-1-1 and trained office personnel at the start of AED
procedures.

(2) Maintain AEDs in working order and maintain current protocols on the AEDs.

(3) That all applicable local EMS policies and procedures are followed.

(4) That Lay Rescuers complete a training course in CPR and AED use and
maintain current CPR and AED training that complies with requirements of this
Chapter at a minimum of every two years and are familiar with the Internal
Emergency Response Plan.

(5) For every AED unit acquired up to five units, no less than one Lay Rescuer
per AED unit shall complete a training course in CPR and AED use that complies
with the requirements of this chapter. After the first five AED units are acquired,
one Lay Rescuer shall be trained for each additional five AED units acquired.
AED Service Providers shall have Lay Rescuers who should be on site to
respond to an emergency that may involve the use of an AED unit during normal
operating hours.

(6) That the defibrillator is maintained and regularly tested according to the
operation and maintenance guidelines set forth by the manufacturer, and
according to any applicable rules and regulations set forth by the governmental
authority under the federal Food and Drug Administration and any other
applicable state and federal authority.

(7) That the defibrillator is checked for readiness after each use and at least once
every 30 days if the AED has not been used in the previous 30 days. Records of
these periodic checks shall be maintained.

(8) That a mechanism exists to ensure that any person, either a Lay Rescuer as
part of the AED Service Provider, or member of the general public who renders
emergency care or treatment on a person in cardiac arrest by using the service
provider's AED activates the emergency medical services system as soon as
possible, and reports any use of the AED to the Medical Director and the local
EMS agency.

(9) That there is involvement of a currently licensed California physician and
surgeon that meets the requirements of Section 100040 of this Chapter.

(10) That a mechanism exists that will assure the continued competency of the
CPR and AED trained individuals in the AED Service Provider's employ to
include periodic training and skills proficiency demonstrations.

Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.

1 Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and
2 Safety Code. Section 1714.21, Civil Code.

3
4 **§100042. AED Vendor Requirements**

5 Any AED vendor who sells an AED to an AED Service Provider shall notify the
6 AED Service Provider, at the time of purchase, both orally and in writing of the
7 AED Service Provider's responsibility to comply with the regulations contained in
8 this Chapter.

9 (a) Notify the local EMS agency of the existence, location, and type of AED at the
10 time it is acquired.

11 (b) Provide to the acquirer of the AED all information governing the use,
12 installation, operation, training, and maintenance of the AED.

13 Note: Authority cited: Sections 1797.107 and 1797.190, Health and Safety Code.
14 Reference: Sections 1797.5, 1797.190, 1797.196, and 104113, Health and
15 Safety Code. Section 1714.21, Civil Code.

16
17
18 THIS REGULATION WAS SUPPORTED BY THE PREVENTIVE HEALTH AND HEALTH
19 SERVICES BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE
20 AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF CDC.

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California Code of Regulations, Title 22

Chapter 2: EMT Regulations

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**California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 2. Emergency Medical Technician**

Article 1. Definitions

§ 100056. Automated External Defibrillator or AED.

“Automated external defibrillator” or AED” means an external defibrillator capable of cardiac rhythm analysis that will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.52, 1797.107 and 1797.170, Health and Safety Code.

§100056.1 EMT AED Service Provider.

An AED service provider means an agency or organization which is responsible for, and is approved to operate, an AED.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.52, 1797.107 and 1797.170, Health and Safety Code.

§100056.2 Manual Defibrillator.

“Manual Defibrillator” means a monitor/defibrillator that has no capability or limited capability for rhythm analysis and will charge and deliver a shock only at the command of the operator.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.52, 1797.107 and 1797.170, Health and Safety Code.

§ 100057. Emergency Medical Technician Approving Authority.

“Emergency Medical Technician (EMT) approving authority” means an agency or person authorized by this Chapter to approve an EMT training program, as follows:

(a) The EMT approving authority for an EMT training program conducted by a qualified statewide public safety agency shall be the director of the Emergency Medical Services Authority (Authority).

(b) The EMT approving authority for any other EMT training programs not included in subsection (a) shall be the local EMS agency (LEMSA) within that jurisdiction.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.94, 1797.109, 1797.170 and 1797.208, Health and Safety Code.

§100058. California EMT Certifying Entity.

“California EMT certifying entity”, or “EMT certifying entity”, or “certifying entity” means a public safety agency or the Office of the State Fire Marshal, if the agency has a training program for EMT personnel that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety Code, or the medical director of a LEMSAs.

NOTE: Authority cited: Sections 1797.62, 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.118, 1797.170, 1797.210 and 1797.216, Health and Safety Code.

§ 100059. EMT Certifying Written Examination.

“EMT Certifying Written Examination” means the National Registry of Emergency Medical Technicians EMT-Basic Written Examination to test an individual applying for certification as an EMT. Examination results will be valid for application purposes two (2) years from the date of examination.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.63, 1797.170, 1797.175, 1797.184, 1797.210 and 1797.216, Health and Safety Code.

§ 100059.1. EMT Certifying Skills Examination

“Certifying Skills Examination” means the National Registry of Emergency Medical Technicians EMT-Basic Skills Examination to test an individual applying for certification as an EMT. Examination results will be valid for one (1) year for the purpose of being eligible for the National Registry of Emergency Medical Technicians EMT-Basic Written Examination.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.63, 1797.170, 1797.175, 1797.184, 1797.210 and 1797.216, Health and Safety Code.

§ 100059.2. EMT Optional Skills Medical Director.

“EMT Optional skills medical director” means a Physician and Surgeon licensed in California who is certified by or prepared for certification by either the American Board of Emergency Medicine or the Advisory Board for Osteopathic Specialties and is appointed by the LEMSAs medical director to be responsible for any of the EMT Optional Skills that are listed in Section 100064 of this Chapter including medical control. Waiver of the board-certified requirement may be granted by the LEMSAs medical director if such physicians are not available for approval.

NOTE: Authority cited: Sections 1797.107, and 1797.170, Health and Safety Code. Reference: Sections 1797.52, 1797.90, 1797.107, 1797.170, 1797.176 and 1797.202 Health and Safety Code.

§100060. Emergency Medical Technician.

“Emergency Medical Technician,” “EMT-Basic,” or “EMT” means a person who has successfully completed an EMT course that meets the requirements of this Chapter, has passed all required tests, and has been certified by a California EMT certifying entity.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.61, 1797.80 and 1797.170, Health and Safety Code.

§ 100061. EMT Local Accreditation.

“Local accreditation” or “accreditation” or “accredited to practice” as used in this Chapter, means authorization by the LEMSAs to practice the optional skill(s) specified in Section 100064. Such authorization assures that the EMT has been oriented to the

LEMSA and trained in the optional skill(s) necessary to achieve the treatment standard of the jurisdiction.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.170, 1797.176, 1797.177, 1797.178, 1797.200, 1797.204, 1797.206, 1797.210 and 1797.214, Health and Safety Code.

100061.1. Emergency Medical Services Quality Improvement Program.

"Emergency Medical Services Quality Improvement Program" or "EMSQIP" means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process, and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMSQIP.

NOTE: Authority cited: Sections 1797.103, 1797.107 and 1797.170 Health and Safety Code. Reference: Sections 1797.204, and 1797.220 Health and Safety Code.

§ 100061.2. Authority

"Authority" means the Emergency Medical Services Authority.

NOTE: Authority cited: Sections 1797.107, and 1797.170, Health and Safety Code.

Reference: Sections 1797.54 Health and Safety Code.

Article 2. General Provisions

§ 100062. Application of Chapter to Operation of Ambulances.

(a) Except as provided herein, the attendant on an ambulance operated in emergency service, or the driver if there is no attendant, shall possess a valid and current California EMT certificate. This requirement shall not apply during officially declared states of emergency and under conditions specified in Health and Safety Code, Section 1797.160.

(b) The requirements for EMT certification of ambulance attendants shall not apply, unless the individual chooses to be certified, to the following:

- (1) Physicians currently licensed in California.
- (2) Registered nurses currently licensed in California.
- (3) Physicians' assistants currently licensed in California.
- (4) Paramedics currently licensed in California.
- (5) Advanced Emergency Medical Technicians (Advanced EMTs) currently certified in California.

(c) EMTs who are not currently certified in California may temporarily perform their scope of practice in California, when approved by the medical director of the LEMSAs, in order to provide emergency medical services in response to a request, if all the following conditions are met:

- (1) The EMTs are registered by the National Registry of Emergency Medical Technicians or licensed or certified in another state or under the jurisdiction of a branch of the Armed Forces including the Coast Guard of the United States, National Park

Service, United States Department of the Interior-Bureau of Land Management, or the United States Forest Service; and

(2) The EMTs restrict their scope of practice to that for which they are licensed or certified.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.160 and 1797.170, Health and Safety Code.

§100063. Scope of Practice of Emergency Medical Technician.

(a) During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:

- (1) Evaluate the ill and injured.
- (2) Render basic life support, rescue and emergency medical care to patients.
- (3) Obtain diagnostic signs to include, but not be limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.
- (4) Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
- (5) Administer oxygen.
- (6) Use the following adjunctive airway and breathing aids:
 - (A) Oropharyngeal airway;
 - (B) Nasopharyngeal airway;
 - (C) Suction devices;
 - (D) Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
 - (E) Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure.
- (7) Use various types of stretchers and spinal immobilization devices.
- (8) Provide initial prehospital emergency care of trauma, including, but not limited to:
 - (A) Bleeding control through the application of tourniquets;
 - (B) Use of hemostatic dressings from a list approved by the Authority;
 - (C) Spinal immobilization;
 - (D) Seated spinal immobilization;
 - (E) Extremity splinting; and
 - (F) Traction splinting.
- (9) Administer over the counter medications when approved by the medical director of the LEMSA, including, but not limited to:
 - (A) Oral glucose or sugar solutions; and
 - (B) Aspirin.
- (10) Extricate entrapped persons.
- (11) Perform field triage.
- (12) Transport patients.
- (13) Mechanical patient restraint.
- (14) Set up for ALS procedures, under the direction of an Advanced EMT or Paramedic.
- (15) Perform automated external defibrillation.

(16) Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

(b) In addition to the activities authorized by subdivision (a) of this Section, the medical director of the LEMSA may also establish policies and procedures to allow a certified EMT or a supervised EMT student in the prehospital setting and/or during interfacility transport to:

(1) Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement;

(2) Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;

(3) Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines; and

(4) Monitor preexisting vascular access devices and intravenous lines delivering fluids with additional medications pre-approved by the Director of the Authority. Approval of such medications shall be obtained pursuant to the following procedures:

(A) The medical director of the LEMSA shall submit a written request, Form #EMSA-0391, revised March 18, 2003, and obtain approval from the director of the Authority, who shall consult with a committee of LEMSA medical directors named by the Emergency Medical Services Medical Directors' Association of California, Inc. (EMDAC), for any additional medications that in his/her professional judgment should be approved for implementation of Section 100063(b).

(B) The Authority shall, within fourteen (14) working days of receiving the request, notify the medical director of the LEMSA submitting the request that the request has been received, and shall specify what information, if any, is missing.

(C) The director of the Authority shall render the decision to approve or disapprove the additional medications within ninety (90) calendar days of receipt of the completed request.

(c) The scope of practice of an EMT shall not exceed those activities authorized in this Section, Section 100064, and Section 100064.1.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.170 and 1797.221, Health and Safety Code.

§100063.1. EMT AED Service Provider

An EMT AED service provider is an agency or organization that employs individuals as defined in Section 100060, and who obtain AEDs for the purpose of providing AED services to the general public.

(a) An EMT AED service provider shall be approved by the LEMSA, or in the case of state or federal agencies, the Authority, prior to beginning service. The Authority shall notify LEMSAs of state or federal agencies approved as EMT AED service providers. In order to receive and maintain EMT AED service provider approval, an EMT AED service provider shall comply with the requirements of this section.

(b) An EMT AED service provider approval may be revoked or suspended for failure to maintain the requirements of this section.

(c) An EMT AED service provider applicant shall be approved if they meet and provide the following:

- (1) Provide orientation of AED authorized personnel to the AED;
 - (2) Ensure maintenance of AED equipment;
 - (3) Prior to January 1, 2002, ensure initial training and, thereafter, continued competency of AED authorized personnel;
 - (4) Collect and report to the LEMSA where the defibrillation occurred, as required by the LEMSA but no less than annually, data that includes, but is not limited to:
 - (A) The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
 - (B) The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed; and
 - (C) The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
 - (5) Authorize personnel and maintain a current listing of all EMT AED service providers authorized personnel and provide listing upon request to the LEMSA or the Authority.
- (d) An approved EMT AED service provider and their authorized personnel shall be recognized statewide.
- (e) Authorized personnel means EMT personnel trained to operate an AED and authorized by an approved EMT AED service provider.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.170, 1797.178, 1797.196, 1797.200, 1797.202, 1797.204, 1797.220, 1798 and 1798.2, Health and Safety Code.

§ 100064. EMT Optional Skills.

(a) In addition to the activities authorized by Section 100063 of this Chapter, LEMSA may establish policies and procedures for local accreditation of an EMT student or certified EMT to perform any or all of the following optional skills specified in this section.

- (1) Accreditation for EMTs to practice optional skills shall be limited to those whose certificate is active and are employed within the jurisdiction of the LEMSA by an employer who is part of the organized EMS system.
- (b) Use of perilaryngeal airway adjuncts.
- (1) Training in the use of perilaryngeal airway adjuncts shall consist of not less than five (5) hours to result in the EMT being competent in the use of the device and airway control. Included in the above training hours shall be the following topics and skills:
 - (A) Anatomy and physiology of the respiratory system.
 - (B) Assessment of the respiratory system.
 - (C) Review of basic airway management techniques, which includes manual and mechanical.
 - (D) The role of the perilaryngeal airway adjuncts in the sequence of airway control.
 - (E) Indications and contraindications of the perilaryngeal airway adjuncts.
 - (F) The role of pre-oxygenation in preparation for the perilaryngeal airway adjuncts.
 - (G) perilaryngeal airway adjuncts insertion and assessment of placement.
 - (H) Methods for prevention of basic skills deterioration.
 - (I) Alternatives to perilaryngeal airway adjuncts.

(2) At the completion of initial training, a student shall complete a competency-based written and skills examination for airway management which shall include the use of basic airway equipment and techniques and use of perilaryngeal airway adjuncts.

(3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.

(c) Administration of naloxone for suspected narcotic overdose.

(1) Training in the administration of naloxone shall consist of no less than two (2) hours to result in the EMT being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose. Included in the training hours listed above shall be the following topics and skills:

(A) Common causative agents

(B) Assessment findings

(C) Management to include but not be limited to:

(D) Need for appropriate personal protective equipment and scene safety awareness

(E) Profile of Naloxone to include, but not be limited to:

1. Indications

2. Contraindications

3. Side/ adverse effects

4. Routes of administration

5. Dosages

(F) Mechanisms of drug action

(G) Calculating drug dosages

(H) Medical asepsis

(I) Disposal of contaminated items and sharps

(2) At the completion of this training, the student shall complete a competency based written and skills examination for administration of naloxone which shall include:

(A) Assessment of when to administer naloxone,

(B) Managing a patient before and after administering naloxone,

(C) Using universal precautions and body substance isolation procedures during medication administration,

(D) Demonstrating aseptic technique during medication administration,

(E) Demonstrate preparation and administration of parenteral medications by a route other than intravenous.

(F) Proper disposal of contaminated items and sharps.

(3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.

(d) Administration of epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma.

(1) Training in the administration of epinephrine shall consist of no less than two (2) hours to result in the EMT being competent in the administration of epinephrine and managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms. Included in the training hours listed above shall be the following topics and skills:

(A) Common causative agents

(B) Assessment findings

- (C) Management to include but not be limited to:
- (D) Need for appropriate personal protective equipment and scene safety awareness
- (E) Profile of epinephrine to include, but not be limited to:
 - 1. Indications
 - 2. Contraindications
 - 3. Side/ adverse effects
 - 4. Administration by auto-injector
 - 5. Dosages
 - 6. Mechanisms of drug action
- (F) Medical asepsis
- (H) Disposal of contaminated items and sharps
- (2) At the completion of this training, the student shall complete a competency based written and skills examination for administration of epinephrine which shall include:
 - (A) Assessment of when to administer epinephrine,
 - (B) Managing a patient before and after administering epinephrine,
 - (C) Using universal precautions and body substance isolation procedures during medication administration,
 - (D) Demonstrating aseptic technique during medication administration,
 - (E) Demonstrate preparation and administration of epinephrine by auto-injector.
 - (F) Proper disposal of contaminated items and sharps.
- (3) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.
- (e) Administer the medications listed in this subsection.
 - (1) Using prepackaged products, the following medications may be administered:
 - (A) Atropine
 - (B) Pralidoxime Chloride
 - (2) This training shall consist of no less than two (2) hours of didactic and skills laboratory training. In addition basic weapons of mass destruction training is recommended.
 - (A) Indications
 - (B) Contraindications
 - (C) Side/ adverse effects
 - (D) Routes of administration
 - (E) Dosages
 - (F) Mechanisms of drug action
 - (G) Disposal of contaminated items and sharps
 - (H) Medication administration.
 - (3) At the completion of this training, the student shall complete a competency based written and skills examination for the administration of medications listed in this subsection which shall include:
 - (A) Assessment of when to administer these medications,
 - (B) Managing a patient before and after administering these medications,
 - (C) Using universal precautions and body substance isolation procedures during medication administration,
 - (D) Demonstrating aseptic technique during medication administration,
 - (E) Demonstrate the preparation and administration of medications by the intramuscular

route,

(F) Proper disposal of contaminated items and sharps.

(4) A LEMSA shall establish policies and procedures for skills competency demonstration that requires the accredited EMT to demonstrate skills competency at least every two (2) years, or more frequently as determined by EMSQIP.

(f) The medical director of the LEMSA shall develop a plan for each optional skill allowed. The plan shall, at a minimum, include the following:

(1) A description of the need for the use of the optional skill.

(2) A description of the geographic area within which the optional skill will be utilized, except as provided in Section 100064(l).

(3) A description of the data collection methodology which shall also include an evaluation of the effectiveness of the optional skill.

(4) The policies and procedures to be instituted by the LEMSA regarding medical control and use of the optional skill.

(5) The LEMSA shall develop policies for accreditation action, pursuant to Chapter 6 of this Division, for individuals who fail to demonstrate competency.

(g) A LEMSA medical director who accredits EMTs to perform any optional skill shall:

(1) Establish policies and procedures for the approval of service provider(s) utilizing approved optional skills.

(2) Approve and designate selected base hospital(s) as the LEMSA deems necessary to provide direction and supervision of accredited EMTs in accordance with policies and procedures established by the LEMSA.

(3) Establish policies and procedures to collect, maintain and evaluate patient care records.

(4) Establish an EMSQIP. EMSQIP means a method of evaluation of services provided, which includes defined standards, evaluation of methodology(ies) and utilization of evaluation results for continued system improvement. Such methods may include, but not be limited to, a written plan describing the program objectives, organization, scope and mechanisms for overseeing the effectiveness of the program.

(5) Establish policies and procedures for additional training necessary to maintain accreditation for each of the optional skills contained in this section, if applicable.

(h) The LEMSA medical director may approve an optional skill medical director to be responsible for accreditation and any or all of the following requirements.

(1) Approve and monitor training programs for optional skills including refresher training within the jurisdiction of the LEMSA.

(2) Establish policies and procedures for continued competency in the optional skill which will consist of organized field care audits, periodic training sessions and/or structured clinical experience.

(i) The optional skill medical director may delegate the specific field care audits, training, and demonstration of competency, if approved by the LEMSA medical director, to a Physician, Registered Nurse, Physician Assistant, Paramedic, or Advanced EMT, licensed or certified in California or a physician licensed in another state immediately adjacent to the LEMSA jurisdiction.

(j) An EMT accredited in an optional skill may assist in demonstration of competency and training of that skill.

(k) In order to be accredited to utilize an optional skill, an EMT shall demonstrate competency through passage, by pre-established standards, developed and/or

approved by the LEMSA, of a competency-based written and skills examination which tests the ability to assess and manage the specified condition.

(l) During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained, certified and accredited according to the policies and procedures established by his/her certifying or accrediting LEMSA.

NOTE: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.8, 1797.52, 1797.58, 1797.90, 1797.170, 1797.173, 1797.175, 1797.176, 1797.202, 1797.208, 1797.212, 1798, 1798.2, 1798.100, 1798.102 and 1798.104, Health and Safety Code.

§ 100064.1. EMT Trial Studies.

An EMT may perform any prehospital emergency medical care treatment procedure(s) or administer any medication(s) on a trial basis when approved by the medical director of the LEMSA and the director of the Authority. The medical director of the LEMSA shall review the medical literature on the procedure or medication and determine in his/her professional judgment whether a trial study is needed.

(a) The medical director of the LEMSA shall review a trial study plan which, at a minimum, shall include the following:

(1) A description of the procedure(s) or medication(s) proposed, the medical conditions for which they can be utilized, and the patient population that will benefit.

(2) A compendium of relevant studies and material from the medical literature.

(3) A description of the proposed study design, including the scope of study and method of evaluating the effectiveness of the procedure(s) or medication(s), and expected outcome.

(4) Recommended policies and procedures to be instituted by the LEMSA regarding the use and medical control of the procedure(s) or medication(s) used in the study.

(5) A description of the training and competency testing required to implement the study. Training on subject matter shall be consistent with the related topic(s) and skill(s) specified in Section 100159, Chapter 4 (Paramedic regulations), Division 9, Title 22, California Code of Regulations.

(b) The medical director of the LEMSA shall appoint a local medical advisory committee to assist with the evaluation and approval of trial studies. The membership of the committee shall be determined by the medical director of the LEMSA, but shall include individuals with knowledge and experience in research and the effect of the proposed study on the EMS system.

(c) The medical director of the LEMSA shall submit the proposed study and a copy of the proposed trial study plan at least forty-five (45) calendar days prior to the proposed initiation of the study to the director of the Authority for approval in accordance with the provisions of Section 1797.221 of the Health and Safety Code. The Authority shall inform the Commission on EMS of studies being initiated.

(d) The Authority shall notify the medical director of the LEMSA submitting its request for approval of a trial study within fourteen (14) working days of receiving the request that the request has been received.

(e) The Director of the Authority shall render the decision to approve or disapprove the trial study within forty-five (45) calendar days of receipt of all materials specified in subsections (a) and (b) of this section.

(f) Within eighteen (18) months of the initiation of the procedure(s) or medication(s), the medical director of the LEMSA shall submit to the Commission on EMS a written report which includes at a minimum the progress of the study, number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(g) The Commission on EMS shall review the above report within two (2) meetings and advise the Authority to do one of the following:

(1) Recommend termination of the study if there are adverse effects or if no benefit from the study is shown.

(2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential but inconclusive benefit is shown.

(3) Recommend the procedure or medication be added to the EMT scope of practice.

(h) If option (g)(2) is selected, the Commission on EMS may advise continuation of the study as structured or alteration of the study to increase the validity of the results.

(i) At the end of the additional eighteen (18) month period, a final report shall be submitted to the Commission on EMS with the same format as described in (f) above.

(j) The Commission on EMS shall review the final report and advise the Authority to do one of the following:

(1) Recommend termination or further extension of the study.

(2) Accept the study recommendations.

(3) Recommend the procedure or medication be added to the EMT scope of practice.

(k) The Authority may require a trial study(ies) to cease after thirty-six (36) months.

NOTE: Authority cited: Section 1797.107 and 1797.170, Health and Safety Code.

Reference: Sections 1797.170 and 1797.221, Health and Safety Code.

Article 3. Program Requirements for EMT Training Programs

§ 100065. Approved Training Programs

(a) The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

(b) EMT training may be offered only by approved training programs. Eligibility for program approval shall be limited to:

(1) Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.

(2) Medical training units of a branch of the Armed Forces including the Coast Guard of the United States.

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5; and

(B) Provide continuing education to other health care professionals.

(4) Agencies of government including public safety agencies.

(5) LEMSAs.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.173, Health and Safety Code. Reference: Sections 1797.170, 1797.173, 1797.208 and 1797.213 Health and Safety Code.

§100066. Procedure for EMT Training Program Approval.

- (a) Eligible training programs may submit a written request for EMT program approval to an EMT approving authority.
- (b) The EMT approving authority shall review and approve the following prior to approving an EMT training program:
 - (1) A statement verifying usage of the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009).
 - (2) A statement verifying CPR training equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course.
 - (3) Samples of written and skills examinations used for periodic testing.
 - (4) A final skills competency examination.
 - (5) A final written examination.
 - (6) The name and qualifications of the program director, program clinical coordinator, and principal instructor(s).
 - (7) Provisions for clinical experience, as defined in Section 100068 of this Chapter.
 - (8) Provisions for course completion by challenge, including a challenge examination (if different from final examination).
 - (9) Provisions for a twenty-four (24) hour refresher course including subdivisions (1)-(6) above, required for recertification.
 - (A) A statement verifying usage of the United States Department of Transportation's EMT-Basic Refresher National Standard Curriculum, DOT HS 808 624, September 1996. The U.S. Department of Transportation's EMT-Basic Refresher National Standard Curriculum can be accessed through the U.S. Department of Transportation's website, <http://www.nhtsa.gov/people/injury/ems/pub/basicref.pdf>.
 - (10) The location at which the courses are to be offered and their proposed dates.
 - (11) Table of contents listing the required information listed in this subdivision, with corresponding page numbers.
- (c) In addition to those items listed in subdivision (b) of this Section, the Authority shall assure that a statewide public safety agency meets the following criteria in order to approve that agency as qualified to conduct a statewide EMT training program:
 - (1) Has a statewide role and responsibility in matters affecting public safety.
 - (2) Has a centralized authority over its EMT training program instruction which can correct any elements of the program found to be in conflict with this Chapter.
 - (3) Has a management structure which monitors all of its EMT training programs.
 - (4) Has designated a liaison to the Authority who shall respond to problems or conflicts identified in the operation of its EMT training program.
 - (5) In addition, these agencies shall meet the following additional requirements:
 - (A) Designate the principal instructor as a liaison to the EMT approving authority for the county in which the training is conducted; and
 - (B) Consult with the EMT approving authority for the county in which the training is located in developing the EMS System Orientation portion of the EMT course.

(d) The EMT approving authority shall make available to the Authority, upon request, any or all materials submitted pursuant to this Section by an approved EMT training program in order to allow the Authority to make the determination required by Section 1797.173 of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.170, 1797.173, 1797.208 and 1797.213, Health and Safety Code.

§ 100067. Didactic and Skills Laboratory.

An approved EMT training program shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during skills practice/laboratory sessions.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.173, Health and Safety Code. Reference: Sections 1797.170, 1797.173 and 1797.208, Health and Safety Code.

§ 100068. Clinical Experience for EMT.

Each approved EMT training program shall have written agreement(s) with one or more general acute care hospital(s) and/or operational ambulance provider(s) or rescue vehicle provider(s) for the clinical portion of the EMT training course. The written agreement(s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s). Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.173, Health and Safety Code. Reference: Sections 1797.170, 1797.173 and 1797.208, Health and Safety Code.

§ 100069. EMT Training Program Notification.

(a) In accordance with Section 100057 the EMT Approving Authority shall notify the training program submitting its request for training program approval within seven (7) working days of receiving the request that:

- (1) The request has been received,
- (2) The request contains or does not contain the information requested in Section 100066 of this Chapter and,
- (3) What information, if any, is missing from the request.

(b) Program approval or disapproval shall be made in writing by the EMT approving authority to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed three (3) months.

(c) The EMT approving authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

(d) Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program

approval specified in this section.

(e) Approved EMT training programs shall also receive approval as a continuing education CE provider effective the same date as the EMT training program approval. The CE program expiration date shall be the same expiration date as the EMT training program. The CE provider shall comply with all of the requirements contained in Chapter 11 of this Division.

(f) The LEMSA shall notify the Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, frequency and cost for both basic and refresher courses, student eligibility, and program approval/expiration date of program approval.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170, 1797.173 and 1797.208, Health and Safety Code.

§ 100070. Teaching Staff.

Each EMT training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this section precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions of this section:

(a) Each EMT training program shall have an approved program director who shall be qualified by education and experience in methods, materials, and evaluation of instruction which shall be documented by at least forty (40) hours in teaching methodology. The courses include but are not limited to the following examples:

- (1) State Fire Marshal Instructor 1A and 1B,
- (2) National Fire Academy's Instructional Methodology,
- (3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.

(b) Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to:

- (1) Administering the training program.
- (2) Approving course content.
- (3) Approving all written examinations and the final skills examination.
- (4) Coordinating all clinical and field activities related to the course.
- (5) Approving the principal instructor(s) and teaching assistants.
- (6) Signing all course completion records.
- (7) Assuring that all aspects of the EMT training program are in compliance with this Chapter and other related laws.

(c) Each training program shall have an approved program clinical coordinator who shall be either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:

- (1) Responsibility for the overall quality of medical content of the program;
- (2) Approval of the qualifications of the principal instructor(s) and teaching assistant(s).

(d) Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. The courses include but are not limited to the following examples:

- (1) State Fire Marshal Instructor 1A and 1B,
 - (2) National Fire Academy's Instructional Methodology,
 - (3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
- and who shall:

(A) Be a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California; or,

(B) Be an Advanced EMT or EMT who is currently certified in California.

(C) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.

(D) Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned. All principal instructors from approved EMT Training Programs shall meet the minimum qualifications as specified in subsection (d) of this Section.

(e) Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170 and 1797.208, Health and Safety Code.

§ 100071. EMT Training Program Review and Reporting.

(a) All program materials specified in this Chapter shall be subject to periodic review by the EMT approving authority.

(b) All programs shall be subject to periodic on-site evaluation by the EMT approving authority.

(c) Any person or agency conducting a training program shall notify the EMT approving authority in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in, program director, program clinical coordinator, principal instructor, change of address, phone number, and contact person.

(d) For the purposes of this Chapter, student records shall be kept for a period of not less than four (4) years.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170 and 1797.208, Health and Safety Code.

§ 100072. Withdrawal of EMT Training Program Approval.

(a) Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of

this Chapter may result in denial, probation, suspension or revocation of program approval by the EMT training program approving authority.

Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

(1) An EMT training program approving authority shall notify the approved EMT training program course director in writing, by registered mail, of the provisions of this Chapter with which the EMT training program is not in compliance.

(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved EMT training program shall submit in writing, by registered mail, to the EMT training program approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) working days of receipt of the response from the approved EMT training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMT training program, the EMT training program approving authority shall notify the Authority and the approved EMT training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the EMT training program approval.

(4) If the EMT training program approving authority decides to suspend, revoke, or place an EMT training program on probation the notification specified in subsection (a)(3) of this section shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) calendar days from the date of the EMT training program approving authority's letter of decision to the Authority and the EMT training program.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170, and 1797.208, Health and Safety Code; 11505, Government Code.

§ 100073. Components of an Approved Program.

(a) An approved EMT training program shall consist of all of the following:

(1) The EMT course, including clinical experience;

(2) Periodic and a final written and skill competency examinations;

(3) A challenge examination; and

(4) A refresher course required for recertification.

(b) The LEMSA may approve a training program that offers only refresher course(s).

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.109, 1797.170 and 1797.208, Health and Safety Code.

§100074. EMT Training Program Required Course Hours.

(a) The EMT course shall consist of not less than one-hundred sixty (160) hours.

These training hours shall be divided into:

(1) A minimum of one hundred thirty-six (136) hours of didactic instruction and skills laboratory; and

(2) A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated.

(3) Existing EMT training programs approved prior to the effective date of this chapter shall have a maximum of twelve (12) months from the date that this provision becomes effective to meet the minimum hourly requirements specified in this Section.

(b) The minimum hours shall not include the examinations for EMT certification.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Section 1797.170 and 1797.208 Health and Safety Code.

§100075. Required Course Content.

(a) The content of an EMT course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), incorporated herein by reference, to result in the EMT being competent in the EMT basic scope of practice specified in Section 100063 of this Chapter. The U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009) can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address:

<http://ems.gov/pdf/811077a.pdf>

(b) Training in the use of hemostatic dressings shall consist of not less than one (1) hour to result in the EMT being competent in the use of the dressing. Included in the training shall be the following topics and skills:

(1) Review of basic methods of bleeding control to include but not be limited to direct pressure, pressure bandages, tourniquets, and hemostatic dressings;

(2) Review treatment of open chest wall injuries;

(3) Types of hemostatic dressings; and

(4) Importance of maintaining normal body temperature.

(c) At the completion of initial training, a student shall complete a competency-based written and skills examination for controlling bleeding and the use of hemostatic dressings.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.170 and 1797.173, Health and Safety Code.

§ 100076. Required Testing.

Each component of an approved program shall include periodic and final competency-based examinations to test the knowledge and skills specified in this Chapter.

Satisfactory performance in these written and skills examinations shall be demonstrated for successful completion of the course. Satisfactory performance shall be determined by pre-established standards, developed and/or approved by the EMT approving authority pursuant to Section 100066 of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170, 1797.208 and 1797.210, Health and Safety Code.

§ 100077. EMT Training Program Course Completion Record.

- (a) An approved EMT training program provider shall issue a tamper resistant course completion record to each person who has successfully completed the EMT course, refresher course, or challenge examination.
- (b) The course completion record shall contain the following:
 - (1) The name of the individual.
 - (2) The date of course completion.
 - (3) Type of EMT course completed (i.e., EMT, refresher, or challenge), and the number of hours completed.
 - (4) The EMT approving authority.
 - (5) The signature of the program director.
 - (6) The name and location of the training program issuing the record.
 - (7) The following statement in bold print: **“This is not an EMT certificate”**.
- (c) This course completion record is valid to apply for certification for a maximum of two (2) years from the course completion date and shall be recognized statewide.
- (d) The name and address of each person receiving a course completion record and the date of course completion shall be reported in writing to the appropriate EMT certifying authority within fifteen (15) working days of course completion.
- (e) Approved EMT training programs which are also approved EMT Certifying Entities need not issue a Course Completion record to those students who will receive certification from the same agency.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170, and 1797.208 Health and Safety Code.

§100078. EMT Training Program Course Completion Challenge Process.

- (a) An individual may obtain an EMT course completion record from an approved EMT training program by successfully passing by pre-established standards, developed and/or approved by the EMT approving authority pursuant to Section 100066 of this Chapter, a course challenge examination if s/he meets one of the following eligibility requirements:
 - (1) The individual is currently licensed in the United States as a Physician, Registered Nurse, Physician Assistant, Vocational Nurse, or Licensed Practical Nurse.
 - (2) The individual provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces of the United States within the preceding two (2) years that meets the U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009). Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete CE courses as a condition of certification.
- (b) The course challenge examination shall consist of a competency-based written and skills examination to test knowledge of the topics and skills prescribed in this Chapter.
- (c) An approved EMT training program shall offer an EMT challenge examination no less than once each time the EMT course is given (unless otherwise specified by the program’s EMT approving authority).
- (d) An eligible individual shall be permitted to take the EMT course challenge examination only one (1) time.

(e) An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.109, 1797.170, 1797.208 and 1797.210, Health and Safety Code.

Article 4. EMT Certification

§100079. EMT Initial Certification Requirements.

(a) An individual who meets one of the following criteria shall be eligible for initial certification upon fulfilling the requirements of subdivision (b) of this Section:

(1) Pass the written examination and skills examination specified in Sections 100059 and 100059.1 of this Chapter and have either:

(A) A valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100066 of this Chapter dated within the last two (2) years,

(B) Documentation of successful completion of an approved out-of-state initial EMT training course, within the last two (2) years, that meets the requirements of this Chapter, or

(C) A current and valid out-of-state EMT certificate.

(2) Possess a current and valid National Registry EMT-Basic registration certificate.

(3) Possess a current and valid out-of-state or National Registry EMT-Intermediate or Paramedic certificate.

(4) Possess a current and valid California Advanced EMT or EMT-II certification or a current and valid California Paramedic license.

(b) In addition to meeting one of the criteria listed in subdivision (a), to be eligible for initial certification, an individual shall:

(1) Be eighteen (18) years of age or older;

(2) Complete the criminal history background check requirement as specified in Article 4, Chapter 10 of this Division;

(3) Complete an application form that contains this statement: "I hereby certify **under penalty of perjury** that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California.";

(4) Disclose any certification or licensure action:

(A) Against an EMT, Advanced EMT, or EMT-II certificate, or any denial of certification by a LEMSA, including any active investigations;

(B) Against a Paramedic license, or any denial of licensure by the Authority, including any active investigations;

(C) Against any EMS-related certification or license of another state or other issuing entity, including any active investigations; or

(D) Against any health-related license.

- (5) Pay the established fee.
- (c) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five (45) days to eligible individuals who apply for an EMT certificate and successfully complete the requirements of this Chapter.
- (d) The effective date of initial certification shall be the day the certificate is issued.
- (e) The expiration date for an initial EMT certificate shall be as follows:
 - (1) For an individual who meets the criteria listed in subdivisions (a)(1)(A) or (a)(1)(B) of this Section, the expiration date shall be the last day of the month two (2) years from the effective date of the initial certification.
 - (2) For an individual who meets the criteria listed in subdivisions (a)(1)(C), (a)(2), (a)(3) or (a)(4) of this Section, the expiration date shall be the lesser of the following:
 - (A) The last day of the month two (2) years from the effective date of the initial certification; or
 - (B) The expiration date of the certificate or license used to establish eligibility under subdivision (a) of this Section.
- (f) The EMT shall be responsible for notifying the certifying entity of her/his proper and current mailing address and shall notify the certifying entity in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and EMT registry number.
- (g) An EMT shall only be certified by one (1) certifying entity during a certification period.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.63, 1797.109, 1797.118, 1797.175, 1797.177, 1797.185, 1797.210 and 1797.216, Health and Safety Code.

Article 5. Maintaining EMT Certification and Recertification

§100080. EMT Recertification.

- (a) In order to recertify, an EMT shall:
 - (1) Possess a current EMT Certification issued in California.
 - (2) Obtain at least twenty-four (24) hours of continuing education hours (CEH) from an approved CE provider in accordance with the provisions contained in Chapter 11 of this Division, or successfully complete a twenty-four (24) hour refresher course from an approved EMT training program. An individual who is currently licensed in California as a Paramedic or certified as an Advanced EMT or EMT-II, or who has been certified within six (6) months of the date of application, may be given credit for CEH earned as a Paramedic, Advanced EMT or EMT-II to satisfy the CE requirement for EMT recertification as specified in this Chapter.
 - (3) Complete an application form and other processes as specified in Section 100079, subdivisions (b)(3)-(b)(5), of this Chapter.
 - (4) Complete the criminal history background check requirements as specified in Article 4, Chapter 10 of this Division.
 - (5) Submit a completed skills competency verification form, EMSA-SCV (08/10). Form EMSA-SCV (08/10) is herein incorporated by reference. Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an individual who is currently certified or licensed as an

EMT, AEMT, Paramedic, Registered Nurse, Physician's Assistant, or Physician and who shall be designated by an EMS approved training program (EMT training program, AEMT training program, Paramedic training program or CE provider) or an EMS service provider. EMS service providers include, but are not limited to, public safety agencies, private ambulance providers and other EMS providers. Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.

(b) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five (45) days to eligible individuals who apply for EMT recertification and successfully complete the requirements of this Chapter.

(c) If the EMT recertification requirements are met within six (6) months prior to the current certification expiration date, the EMT Certifying entity shall make the effective date of recertification the date immediately following the expiration date of the current certificate. The certification will expire two (2) years from the day prior to the effective date.

(d) If the EMT recertification requirements are met greater than six (6) months prior to the expiration date, the EMT Certifying entity shall make the effective date of recertification the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date will be the last day of the month two (2) years from the effective date.

(e) A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5). In order to qualify for this exception, the individual shall submit proof of their membership in the Armed Forces of the United States and documentation of their deployment starting and ending dates. Continuing education credit may be given for documented training that meets the requirements of Chapter 11 of this Division while the individual was deployed on active duty. The documentation shall include verification from the individual's Commanding Officer attesting to the training attended.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.109, 1797.118, 1797.170, 1797.184, 1797.210 and 1797.216, Health and Safety Code; and United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

§100081. Recertification of an Expired California EMT Certificate.

(a) The following requirements apply to individuals who wish to be eligible for recertification after their California EMT Certificates have expired:

(1) For a lapse of less than six (6) months, the individual shall complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5).

(2) For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall:

(A) Complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5), and

(B) Complete an additional twelve (12) hours of continuing education.

(3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall:

(A) Complete the requirements of Section 100080, subdivisions (a)(2)-(a)(5), and

(B) Complete an additional twenty-four (24) hours of continuing education, and

(C) Pass the written and skills certification exams as specified in Sections 100059 and 100059.1.

(4) For a lapse of greater than twenty-four (24) months the individual shall meet the requirements of Section 100079, subdivisions (a) and (b).

(b) For individuals who meet the requirements of Section 100081, subdivision (a)(1), (a)(2), or (a)(3), the EMT certifying entity shall make the effective date of recertification the day the certificate is issued. The certification expiration date will be the last day of the month two (2) years from the effective date. For individuals who meet the requirements of Section 100081, subdivision (a)(4), the EMT certifying entity shall make the certification effective and expiration dates consistent with Section 100079, subdivisions (d) and (e)..

(c) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100344, subdivisions (c) and (d), of Chapter 10 of this Division, within forty-five (45) days to eligible individuals who apply for EMT recertification and successfully complete the requirements of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.109, 1797.118, 1797.170, 1797.175, 1797.184, 1797.210 and 1797.216, Health and Safety Code; and United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

Article 6. Record Keeping and Fees

§ 100082. Record Keeping.

(a) Each EMT approving authority shall maintain a list of approved training programs within its jurisdiction and provide the Authority with a copy. The Authority shall be notified of any changes in the list of approved training programs as such occur.

(b) Each EMT approving authority shall maintain a list of current EMT program directors, clinical coordinators and principal instructors within its jurisdiction.

(c) The Authority shall maintain a record of approved EMT training programs.

(d) A LEMSA may develop policies and procedures which require basic life support services to make available the records of calls maintained in accordance with Section 1100.7, Title 13 of the California Code of Regulations.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.170 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.109, 1797.170, 1797.173, 1797.200, 1797.202, 1797.204, 1797.208, 1797.211 and 1797.220, Health and Safety Code.

§ 100083. Fees.

A LEMSA may establish a schedule of fees for EMT training program review, approval, EMT certification and EMT recertification in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.118, 1797.170, 1797.212, 1797.213, and 1797.217 Health and Safety Code.

THIS REGULATION WAS SUPPORTED BY THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF CDC.

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California Code of Regulations, Title 22

Chapter 3: Advanced EMT Regulations

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**California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 3. Advanced Emergency Medical Technician**

Article 1. Definitions

§ 100101. Advanced Emergency Medical Technician Approving Authority.

"Advanced Emergency Medical Technician (Advanced EMT) Approving Authority" means the local Emergency Medical Services Agency (LEMSA).

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.200, 1797.208, and 1797.218, Health and Safety Code.

§ 100102. Advanced EMT Certifying Entity.

"Advanced EMT Certifying Entity" means the medical director of the LEMSAs.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.62, 1797.82, 1797.118, 1797.171, 1797.210, and 1797.218, Health and Safety Code.

§ 100102.1. Emergency Medical Services Quality Improvement Program.

"Emergency Medical Services Quality Improvement Program" or "EMSQIP" means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process, and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMSQIP.

Note: Authority cited: Sections 1797.103, 1797.107, and 1797.171, Health and Safety Code. Reference: Sections 1797.204 and 1797.220, Health and Safety Code.

§ 100103. Advanced Emergency Medical Technician.

"Advanced Emergency Medical Technician" or "Advanced EMT" means:

(a) A California certified EMT with additional training in limited advanced life support (LALS) according to the standards prescribed by this Chapter, and who has a valid Advanced EMT wallet-sized certificate card issued pursuant to this Chapter, or

(b) An individual who was certified as an EMT-II prior to the effective date of this chapter, whose scope of practice includes the LEMSAs approved Advanced EMT Scope of Practice as well as the Local Optional Scope of Practice, and who was part of an EMT-II program in effect on January 1, 1994.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82 and 1797.171, Health and Safety Code.

§ 100103.1. Authority

“Authority” means the Emergency Medical Services Authority.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.54, 1797.82 and 1797.171, Health and Safety Code.

§ 100103.2. Limited Advanced Life Support Service Provider

A “limited advanced life support service” or “LALS service” means a service provider approved by a LEMSA or state statute that utilizes Advanced EMT and/or EMT-II personnel.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.92 and 1797.171, Health and Safety Code.

§ 100104. Advanced EMT Certifying Examination

“Advanced EMT Certifying Examination,” as used in this Chapter, means an examination, developed by the Advanced EMT Certifying Entity and selected by the Authority, given to an individual applying for certification as an Advanced EMT. The examination shall include both written and skills testing portions designed to determine an individual’s competence for certification as an Advanced EMT. Effective September 12, 2012, the National Registry of Emergency Medical Technicians Advanced EMT written and skills examination shall be the AEMT certifying examinations for AEMT certification.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.175, Health and Safety Code. Reference: Sections 1797.171, 1797.175 and 1797.210, Health and Safety Code.

Article 2. General Provisions

§ 100105. Application of Chapter; Displacement of Services.

(a) Any LEMSA may approve an advanced life support (ALS), meaning Paramedic or LALS, meaning Advanced EMT program which provides services utilizing Advanced EMTs, or Paramedics, or any combination thereof.

(b) Prior to considering and initiating a reduction of existing Paramedic services, or of existing services that utilize Advanced EMTs that are accredited in the local optional scope of practice, within the LEMSA’s jurisdiction, the LEMSA shall prepare an impact evaluation report. The impact evaluation report shall indicate why the continuation of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice, is not feasible or appropriate within that LEMSA’s jurisdiction. The impact evaluation report shall only be required when existing Paramedic services, or services utilizing Advanced EMTs accredited in the local optional scope of practice, are displaced by initiating new Advanced EMT services. The impact evaluation report shall include, but not be limited to:

(1) An evaluation describing why the geography, population density, and resources would not make the continuation of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice, more appropriate or feasible.

(2) The LEMSA shall hold a public hearing regarding the Paramedic services, or services utilizing Advanced EMTs accredited in the local optional scope of practice, that

may be displaced by the new Advanced EMT services. The public hearing shall be for the purpose of allowing the public an opportunity to provide the LEMSA with written and/or verbal input regarding the displacement of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice. The LEMSA may waive the public hearing if a public hearing was previously held that allowed the public an opportunity to provide written and/or verbal input regarding the displacement of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice.

(c) The governing body of a public safety agency that operates in the jurisdiction of a LEMSA and that may displace Paramedic services, or services utilizing Advanced EMTs accredited in the local optional scope of practice, by initiating new Advanced EMT services, shall meet the requirements of this subsection (c). The governing body of the public safety agency shall hold a public hearing prior to considering the displacement of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice, by initiating Advanced EMT services. The public safety agency shall:

(1) Provide the LEMSA in the jurisdiction in which it operates with written notice no less than six (6) months prior to the implementation date of the reduction of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice; and

(2) Provide the LEMSA in the jurisdiction in which it operates with an evaluation report no less than three (3) months prior to the implementation date of the reduction of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice. The public safety agency's evaluation report shall contain, at a minimum, an evaluation describing why the geography, population density, and resources would not make the continuation of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice, more appropriate or feasible.

Upon receipt of the evaluation report from the public safety agency, the LEMSA may, but is not required to, prepare a separate evaluation report with the contents specified in subsection (b)(1).

(d) If the LEMSA determines, pursuant to the impact evaluations from subsections (b) and/or (c) of this section, that the displacement of Paramedic services, or of services utilizing Advanced EMTs accredited in the local optional scope of practice, is not justified or feasible, the new Advanced EMT services shall not be approved. If the LEMSA determines, pursuant to the impact evaluations from subsections (b) and/or (c) of this section, that the displacement of Paramedic services, or of services utilizing Advanced EMT's accredited in the local optional scope of practice, is justified and feasible, then the new Advanced EMT services may be approved by the LEMSA. This approval by the LEMSA shall occur after the Advanced EMT service provider has met the requirements of Section 100126 of this Chapter.

(e) Any LEMSA which approves an Advanced EMT training program, or a LALS service which provides services utilizing Advanced EMT personnel, shall be responsible for approving Advanced EMT training programs, Advanced EMT service providers, Advanced EMT base hospitals, and for developing and enforcing standards, regulations, policies, and procedures in accordance with this Chapter so as to provide

for quality assurance, appropriate medical control and coordination of the Advanced EMT personnel and training program(s) within an EMS system.

(f) No person or organization shall offer an Advanced EMT training program or hold themselves out as offering an Advanced EMT training program, or provide LALS services, or hold themselves out as providing LALS services utilizing Advanced EMTs unless that person or organization is authorized by a LEMSA.

NOTE: Authority cited: Sections 1797.2, 1797.107, 1797.171, and 1797.218, Health and Safety Code. Reference: Sections 1797.2, 1797.82, 1797.171, 1797.178, 1797.200, 1797.201, 1797.204, 1797.206, 1797.208, 1797.218, 1797.220, 1798 and 1798.100, Health and Safety Code.

§ 100106. Advanced EMT Scope of Practice.

(a) An Advanced EMT may perform any activity identified in the scope of practice of an EMT in Chapter 2 of this Division.

(b) A certified Advanced EMT or an Advanced EMT trainee, as part of an organized EMS system, while caring for patients in a hospital as part of their training or continuing education, under the direct supervision of a Physician or Registered Nurse, or while at the scene of a medical emergency or during transport, or during interfacility transfer is authorized to do all of the following according to the policies and procedures approved by the LEMSA:

(1) Perform pulmonary ventilation by use of a perilaryngeal airway adjunct.

(2) Perform tracheo-bronchial suctioning of an intubated patient.

(3) Institute intravenous (IV) catheters, saline locks, needles or other cannulae (IV lines), in peripheral veins.

(4) Administer the following intravenously:

(A) Glucose solutions;

(B) Isotonic balanced salt solutions (including Ringer's lactate solution);

(C) Naloxone;

(D) Intravenous administration of 50% dextrose for adult patients, and 10% or 25% dextrose for pediatric patients.

(5) Establish and maintain intraosseous access in a pediatric patient.

(6) Obtain venous and/or capillary blood samples for laboratory analysis.

(7) Use blood glucose measuring device.

(8) Administer, the following drugs in a route other than intravenous:

(A) Sublingual nitroglycerine preparations;

(B) aspirin;

(C) glucagon;

(D) inhaled beta-2 agonists (bronchodilators);

(E) activated charcoal;

(F) naloxone;

(G) epinephrine.

(c) During a mutual aid response into another jurisdiction, an Advanced EMT may utilize the scope of practice for which s/he is trained and certified according to the policies and procedures established by his/her certifying LEMSA.

(d) The scope of practice of an Advanced EMT shall not exceed those activities authorized in this section except in those limited situations as approved in Section 100106.1.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.
Reference: Sections 8615, 8617, 8631, and 8632 Government Code; and Sections 1797.82, and 1797.171, Health and Safety Code.

§ 100106.1 Advanced EMT Local Optional Scope of Practice.

(a) Advanced EMTs who were not certified as EMT-ILs prior to the effective date of this Chapter are not eligible for accreditation in the scope of practice items listed in this Section.

(b) In addition to the activities authorized by Section 100106 of this Chapter, a LEMSA with an EMT-II program in effect on January 1, 1994, may establish policies and procedures for local accreditation of an individual previously certified, as an EMT-II, to perform any or all of the following optional skills specified in this section.

(1) Administer the Following Medications:

(A) Lidocaine hydrochloride

(B) Atropine sulfate

(C) Sodium bicarbonate

(D) Furosemide

(E) Epinephrine

(F) Morphine sulfate

(G) Benzodiazepines (midazolam)

(2) Perform synchronized cardioversion and defibrillation.

(3) Utilize electrocardiographic devices and monitor electrocardiograms.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.171 and 1797.214, Health and Safety Code.

§ 100106.2. Advanced EMT Trial Studies.

An Advanced EMT may perform any prehospital emergency medical care treatment procedure(s) or administer any medication(s) on a trial basis when approved by the medical director of the LEMSA and the Director of the Authority.

(a) The medical director of the LEMSA shall review a trial study plan, which at a minimum shall include the following:

(1) A description of the procedure(s) or medication(s) proposed, the medical conditions for which they can be utilized, and the patient population that will benefit.

(2) A compendium of relevant studies and material from the medical literature.

(3) A description of the proposed study design including the scope of the study and method of evaluating the effectiveness of the procedure(s) or medication(s), and expected outcome.

(4) Recommended policies and procedures to be instituted by the LEMSA regarding the use and medical control of the procedure(s) or medication(s) used in the study.

(5) A description of the training and competency testing required to implement the study.

(b) The medical director of the LEMSA shall appoint a local medical advisory committee to assist with the evaluation and approval of trial studies. The membership of the

committee shall be determined by the medical director of the LEMSA, but shall include individuals with knowledge and experience in research and the effect of the proposed study on the EMS system.

(c) The medical director of the LEMSA shall submit the proposed study and send a copy of the proposed trial study plan at least forty-five (45) calendar days prior to the proposed initiation of the study to the Director of the Authority for approval in accordance with the provisions of section 1797.221 of the Health and Safety Code. The Authority shall inform the Commission on EMS of studies being initiated.

(d) The Authority shall notify, within fourteen (14) working days of receiving the request, the medical director of the LEMSA submitting its request for approval of a trial study that the request has been received, and shall specify what information, if any, is missing.

(e) The Director of the Authority shall render the decision to approve or disapprove the trial study within forty-five (45) calendar days of receipt of all materials specified in subsections (a) and (b) of this section.

(f) The medical director of the LEMSA within eighteen (18) months of initiation of the procedure(s) or medication(s), shall submit a written report to the Commission on EMS which includes at a minimum the progress of the study, number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(g) The Commission on EMS shall review the above report within two meetings and advise the Authority to do one of the following:

(1) Recommend termination of the study if there are adverse effects or no benefit from the study is shown.

(2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential, but inconclusive benefit is shown.

(3) Recommend the procedure or medication be added to the Advanced EMT local optional scope of practice. Additions to the local optional scope of practice are only for those EMT-II programs that were in effect on January 1, 1994.

(h) If option (g)(2) is selected, the Commission on EMS may advise continuation of the study as structured or alteration of the study to increase the validity of the results.

(i) At the end of the additional eighteen (18) month period, a final report shall be submitted to the Commission on EMS with the same format as described in (f) above.

(j) The Commission on EMS shall review the final report and advise the Authority to do one of the following:

(1) Recommend termination or further extension of the study.

(2) Recommend the procedure or medication be added to the Advanced EMT local optional scope of practice. Additions to the local optional scope of practice are only for those EMT-II programs that were in effect on January 1, 1994.

(k) The Authority may require the trial study(ies) to cease after thirty-six (36) months.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.3, 1797.82, 1797.171 and 1797.221, Health and Safety Code.

§ 100107. Responsibility of the LEMSA.

The LEMSA, which approves a LALS service provider, shall develop and maintain policies and procedures that comply with guidelines established by the Authority for

training and maintenance of knowledge, skills and abilities contained in this Chapter which shall include, but not be limited to, the following:

- (a) Development or approval, monitoring, and enforcement of standards, policies, and procedures for the EMS system which relates to the Advanced EMT.
- (b) Approval, denial, revocation of approval, and suspension of training programs, Advanced EMT base and alternative base stations, and Advanced EMT service providers.
- (c) Assurance of compliance of the Advanced EMT training program and the EMS system with the provisions of this Chapter.
- (d) Submission annually to the Authority the names of approved Advanced EMT training programs.
- (e) Monitoring and evaluation of the EMS system as it applies to Advanced EMT personnel.
- (f) Development or approval, implementation and enforcement of policies for medical control and medical accountability for the Advanced EMT including:
 - (1) General treatment and triage protocols.
 - (2) Patient care record and reporting requirements.
 - (3) Field medical care protocols.
 - (4) Medical care audit system.
 - (5) Role and responsibility of the Advanced EMT base and alternative base stations and Advanced EMT service provider.
- (g) System data collection and evaluation.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.178, 1797.200, 1797.202, 1797.204, 1797.206, 1797.208, 1797.210, 1797.211, 1797.220, 1798 and 1798.100, Health and Safety Code.

§ 100107.1. Advanced EMT Quality Improvement Program.

- (a) The LEMSA shall establish a system-wide quality improvement program (EMSQIP) as defined in Section 100102.1 of this Chapter.
- (b) Each Advanced EMT service provider, as defined in Section 100126 and each Advanced EMT base hospital as defined in Section 100127, of this Chapter, shall have an EMSQIP approved by the LEMSA.
- (c) If, through the EMSQIP, the employer or medical director of the LEMSA determines that an Advanced EMT needs additional training, observation or testing, the employer and the medical director may create a specific and targeted program of remediation based upon the identified need of the Advanced EMT related to medical and patient care. If there is disagreement between the employer and the medical director, the decision of the medical director shall prevail.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.178, 1797.200, 1797.202, 1797.204, 1797.206, 1797.208, 1797.210, 1797.220, 1798 and 1798.100, Health and Safety Code.

Article 3. Program Requirements for Advanced EMT Training Programs

§ 100108. Advanced EMT Approved Training Programs.

(a) The purpose of an Advanced EMT training program shall be to prepare eligible EMTs to render prehospital LALS within an organized EMS system.

(b) Advanced EMT training shall be offered only by approved training programs.

Eligibility for training program approval shall be limited to the following institutions:

(1) Accredited universities and colleges, including junior and community colleges, and private postsecondary schools as approved by the State of California, Department of Consumer Affairs, Bureau for Private Postsecondary Education.

(2) Medical training units of a branch of the Armed Forces or Coast Guard of the United States.

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5; and

(B) Provide continuing education to other health care professionals.

(4) Agencies of government.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.173, Health and Safety Code. Reference: Sections 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100109. Advanced EMT Training Program Teaching Staff.

(a) Each program shall have an approved program medical director who shall be a physician currently licensed in the State of California, who has two (2) years academic or clinical experience in emergency medicine in the last five (5) years, and who is qualified by education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to:

(1) Approval of all course content.

(2) Approval of content of all written and skills examination.

(3) Approval of provision for hospital clinical and field internship experiences.

(4) Approval of principal instructor(s) qualifications.

(b) Each program shall have an approved course director who shall be a Physician, Registered Nurse, or Paramedic currently licensed in the State of California, or an individual who holds a baccalaureate degree or equivalent in a related health field or equivalent. The course director shall have a minimum of one (1) year experience in an administrative or management level position and have a minimum two (2) years academic or clinical experience in prehospital care education within the last five (5) years. The approved course director shall be qualified by education and experience in methods, materials, and evaluation of instruction which shall be documented by at least forty (40) hours in teaching methodology. The courses include, but are not limited to the following examples:

(1) State Fire Marshal Instructor 1A and 1B,

(2) National Fire Academy's Instructional Methodology,

(3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course. Duties of the course director shall include, but not be limited to:

(1) Administration of the training program.

- (2) In coordination with the program medical director, approve the principal instructor, teaching assistants, field preceptors, clinical and internship assignments, and coordinate the development of curriculum.
- (3) Ensure training program compliance with this Chapter and other related laws.
- (4) Sign all course completion records.
- (c) Each program shall have a principal instructor(s) who may also be the program medical director or course director, who shall:
 - (1) Be a Physician, Registered Nurse, or a Physician Assistant currently licensed in the State of California;
 - or
 - (2) Be a Paramedic or an Advanced EMT and/or EMT-II currently licensed or certified in California.
 - (3) Have two (2) years academic or clinical experience in emergency medicine within the last five (5) years.
 - (4) Be approved by the course director in coordination with the program medical director as qualified to teach those sections of the course to which s/he is assigned.
 - (5) Be responsible for areas including, but not limited to, curriculum development, course coordination, and instruction.
 - (6) Be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The courses include, but are not limited to the following examples:
 - (A) State Fire Marshal Instructor 1A and 1B,
 - (B) National Fire Academy's Instructional Methodology,
 - (C) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
- (d) Each program may have a teaching assistant'(s) who shall be an individual(s) qualified by training and experience to assist with the teaching of the course and shall be approved by the course director in coordination with the program medical director as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be directly supervised by a principal instructor, the course director, and/or the program medical director.
- (e) Each program shall have a field preceptor(s) who shall:
 - (1) Be a Physician, Registered Nurse, or Physician Assistant currently licensed in the State of California; or
 - (2) Be a Paramedic or an Advanced EMT currently licensed or certified in the State of California; and
 - (3) Have two (2) years academic or clinical experience in emergency medicine within the last five (5) years.
 - (4) Be approved by the course director in coordination with the program medical director to provide training and evaluation of an Advanced EMT trainee during field internship with an authorized service provider.
 - (5) Be under the supervision of a principal instructor, the course director and/or program medical director.
- (f) Each program shall have a hospital clinical preceptor(s) who shall:

- (1) Be a Physician, Registered Nurse, or Physician Assistant who is currently licensed in the State of California.
 - (2) Have two (2) years academic or clinical experience in emergency medicine within the last five (5) years.
 - (3) Be approved by the course director in coordination with the program medical director to provide evaluation of an Advanced EMT trainee during the clinical training.
- NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.
Reference: Sections 1797.82, 1797.171 and 1797.208, Health and Safety Code.

§ 100110. Advanced EMT Training Program Didactic and Skills Laboratory

An approved Advanced EMT training program shall insure that no more than six (6) trainees are assigned to one (1) instructor/teaching assistant during the skills practice/laboratory sessions.

NOTE: Authority cited: Section 1797.107, 1797.171 and 1797.173, Health and Safety Code. Reference: Sections: 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100111. Advanced EMT Training Program Hospital Clinical Training

(a) An approved Advanced EMT training program shall provide for and monitor a supervised clinical experience at a hospital(s) which is licensed as a general acute care hospital. The clinical setting may be expanded to include areas commensurate with the skills experience needed. Such settings may include surgicenters, clinics, jails or any other areas deemed appropriate by the LEMSA.

(b) Training programs in nonhospital institutions shall enter into a written agreement(s) with a licensed general acute care hospital(s) which holds a permit to operate a Basic or Comprehensive Emergency Medical Service for the purpose of providing this supervised clinical experience as well as a clinical preceptor(s) to instruct and evaluate the student.

(c) Advanced EMT clinical training hospital(s) shall provide clinical experience, supervised by a clinical preceptor(s) approved by the training program medical director. Hospitals providing clinical training and experience shall be approved by the program medical director, and shall provide for continuous assessment of student performance. No more than two (2) trainees will be assigned to one (1) preceptor during the supervised hospital clinical experience at any one time. The clinical preceptor may assign the trainee to another health professional for selected clinical experience. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities including the administration of additional drugs which are designed to result in the competencies specified in this Chapter. Clinical assignments shall include, but not be limited to: emergency, surgical, cardiac, obstetric, and pediatric patients.

(d) The Advanced EMT training program shall establish criteria to be used by clinical preceptors to evaluate trainees. Verification of successful performance in the prehospital setting shall be required prior to course completion or certification.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.173, Health and Safety Code. Reference: Sections 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100112. Advanced EMT Training Program Field Internship.

(a) An approved Advanced EMT training program shall provide for and monitor a field internship with a designated Advanced EMT or Paramedic service provider(s) approved by the training program medical director.

(b) After obtaining the approval of the LEMSA, the Advanced EMT training program shall enter into a written agreement with an Advanced EMT or Paramedic service provider(s) to provide for this field internship, as well as for a field preceptor(s) to directly supervise, instruct and evaluate students. The field internship shall include direct patient care responsibilities which, when combined with the other parts of the training program, shall result in the Advanced EMT competencies specified in this Chapter.

(c) The field internship shall be medically supervised and monitored in accordance with the policies of the LEMSA.

(d) No more than one (1) Advanced EMT trainee shall be assigned to an Advanced EMT or Paramedic response vehicle during the field internship.

(e) The Advanced EMT training program shall establish evaluation criteria to be used by field preceptors to evaluate trainees.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.173, Health and Safety Code. Reference: Sections 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100113. Advanced EMT Training Program Approval.

(a) Eligible training programs as defined in Section 100108 of this Chapter, shall submit a written request for Advanced EMT program approval to the Advanced EMT Approving Authority.

(b) The Advanced EMT Approving Authority shall receive and review the following prior to program approval:

(1) A statement verifying that the course content is equivalent to the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009).

(2) A course outline.

(3) Performance objectives for each skill.

(4) The name and qualifications of the training program course director, program medical director, and principal instructors.

(5) Provisions for supervised hospital clinical training, including standardized forms for evaluating Advanced EMT trainees.

(6) Provisions for supervised field internship, including standardized forms for evaluating Advanced EMT trainees.

(7) The location at which the course(s) are to be offered and their proposed dates.

(8) Provisions for course completion by challenge, including a challenge examination (if different from the final examination).

(c) The Advanced EMT Approving Authority shall review the following prior to program approval:

- (1) Samples of written and skills examinations used for periodic testing.
- (2) A final skills competency examination.
- (3) A final written examination.
- (4) Evidence that the program provides adequate facilities, equipment, examination security, student record keeping, clinical training and field internship training.

(d) The Advanced EMT Approving Authority shall make available to the Authority, upon request, any or all materials submitted pursuant to this Section by an approved Advanced EMT training program in order to allow the Authority to make the determinations required by Section 1797.173 of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100114. Advanced EMT Training Program Approval Notification.

(a) Program approval or disapproval shall be made in writing by the Advanced EMT Approving Authority to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed three (3) months.

(b) The Advanced EMT Approving Authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

(c) Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program approval specified in this Chapter.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.173 and 1797.208, Health and Safety Code.

§ 100115. Application of Regulations to Existing AEMT Training Programs.

All AEMT training programs in operation prior to the effective date of these regulations shall submit evidence of compliance with this Chapter to the Advanced EMT Approving Authority for the county in which they are located within six (6) months after the effective date of these regulations. AEMT training programs that do not submit the information, as required by this section, shall not be approved as an Advanced EMT Training Program.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82 and 1797.171, Health and Safety Code.

§ 100116. Advanced EMT Training Program Review and Reporting.

(a) All program materials specified in this Chapter shall be subject to periodic review by the Advanced EMT Approving Authority.

(b) All programs shall be subject to periodic on-site evaluation by the Advanced EMT Approving Authority.

(c) Any person or agency conducting a training program shall notify the Advanced EMT Approving Authority in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in course content, hours of instruction, course director, program medical director, principal instructor(s), course locations and proposed dates, provisions for hospital clinical experience, or field internship.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171 and 1797.208, Health and Safety Code.

§ 100117. Advanced EMT Denial or Withdrawal of Training Program Approval.

(a) Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in denial, probation, suspension or revocation of program approval by the Advanced EMT Approving Authority. Notification of noncompliance and action to place on probation, suspend or revoke shall be done as follows:

(1) An Advanced EMT Approving Authority shall notify the approved Advanced EMT training program course director in writing, by registered mail, of the provisions of this Chapter with which the Advanced EMT training program is not in compliance.

(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved Advanced EMT training program shall submit in writing, by registered mail, to the Advanced EMT Approving Authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) working days of receipt of the response from the approved Advanced EMT training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved Advanced EMT training program, the Advanced EMT Approving Authority shall notify the Authority and the approved Advanced EMT training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the Advanced EMT training program approval.

(4) If the Advanced EMT Approving Authority decides to suspend or revoke the Advanced EMT training program approval or place the Advanced EMT training program on probation, the notification specified in subsection (a)(3) of this section shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) calendar days from the date of the Advanced EMT Approving Authority's letter of decision to the Authority and the Advanced EMT training program.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.208, and 1798.209, Health and Safety Code.

§ 100118. Advanced EMT Student Eligibility.

(a) To be eligible to enter an Advanced EMT training program, an individual shall meet the following requirements:

- (1) Possess a high school diploma or general education equivalent; and
- (2) Possess a current EMT certificate in the State of California; and
- (3) Possess a current Basic Life Support (CPR) card according to the American Heart Association 2005 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171 and 1797.208, Health and Safety Code.

§ 100119. Advanced EMT Training Program Required Course Hours.

(a) The Advanced EMT training program shall consist of not less than one-hundred and sixty (160) hours. These training hours shall be divided into:

- (1) A minimum of eighty (80) hours of didactic instruction and skills laboratory;
- (2) The hospital clinical training shall consist of no less than forty (40) hours and field internship shall consist of no less than forty (40) hours.

(b) The trainee shall have a minimum of fifteen (15) ALS patient contacts during the field internship. An ALS patient contact shall be defined as the student performance of one or more of the skills specified in Section 100106(b) of this Chapter. Each ALS patient contact by an Advanced EMT student shall be documented in writing on a standard form and shall be signed by the training program medical director as verification of the fact that the ALS contact met the criteria set forth in this section.

(c) The trainee shall demonstrate competency in all skills listed in Section 100106 (b) of this Chapter.

(d) During the field internship, the student shall demonstrate competency as the team leader while on-scene delivering patient care at least five (5) times.

(e) Competency and success in the skills listed in subsections (c) and (d) of this section shall be evaluated and documented by the field preceptor.

(f) The minimum hours shall not include the following:

- (1) Course material designed to teach or test exclusively EMT knowledge or skills including CPR.
- (2) Examination for student eligibility.
- (3) The teaching of any material not prescribed in Section 100120 of this Chapter.
- (4) Examination for Advanced EMT certification.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Section 1797.82 and 1797.171, Health and Safety Code.

§ 100120. Advanced EMT Training Program Required Course Content

The content of an Advanced EMT course shall meet the objectives contained in the U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009), incorporated herein by reference, to result in the Advanced EMT being competent in the Advanced EMT basic scope of practice specified in section 100106 of this Chapter. The U.S. Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009) can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address:

<http://ems.gov/pdf/811077a.pdf>

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Section 1797.82, 1797.171 and 1797.173, Health and Safety Code.

§ 100121. Advanced EMT Training Program Required Testing.

(a) An approved Advanced EMT training program shall include periodic examinations and final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.

(b) Successful performance in the clinical and field setting shall be required prior to course completion.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.63, 1797.82, 1797.171, 1797.208 and 1797.210, Health and Safety Code.

§ 100122. Advanced EMT Training Program Course Completion Record.

(a) An approved Advanced EMT training program shall issue a course completion record to each person who has successfully completed the Advanced EMT training program.

(b) The course completion record shall contain the following:

(1) The name of the individual.

(2) The date of course completion.

(3) The type of course completed (i.e., Advanced EMT) and the number of hours completed.

(4) The following statement from an approved Advanced EMT training program: "The individual named on this record has successfully completed an approved Advanced EMT course", to indicate the appropriate type of course completed.

(5) The name of the Advanced EMT Approving Authority.

(6) The signature of the course director.

(7) The name and location of the training program issuing the record.

(8) The following statement in bold print: **"This is not an Advanced EMT certificate."**

(9) The following statement: "This course completion record is valid to apply for certification for a maximum of two (2) years from the course completion date and shall be recognized statewide."

(c) The name and address of each person receiving a course completion record and the date on which the record was issued shall be reported in writing to the appropriate Advanced EMT Certifying Entity fifteen (15) working days of course completion.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.82, 1797.171, 1797.208 and 1797.210, Health and Safety Code.

Article 4. Certification

§ 100123. Advanced EMT Initial Certification Requirements.

(a) In order to be eligible for initial certification an individual shall:

(1) Possess a current EMT certificate issued in the State of California.

- (2) Have an Advanced EMT course completion record or other documented proof of successful completion of the topics contained in an approved Advanced EMT training program.
- (3) Pass, by pre-established standards a competency based written and skills Advanced EMT certifying examination pursuant to Section 100104 of this Chapter.
- (4) Beginning July 1, 2010, complete the criminal history background check requirements as specified in Article 4, Chapter 10 of this Division.
- (5) Comply with other reasonable requirements, as may be established by the local Advanced EMT Certifying Entity, such as:
 - (A) Pay the established fee.
 - (B) Furnish a photograph for identification purposes.
- (6) Complete an application that contains this statement, "I hereby certify **under penalty of perjury** that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to Advanced EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an Advanced EMT in California."
- (7) Disclose any certification or licensure action:
 - (A) Against any EMT-related certification or license in California, and/or entity per statutes and/or regulations of that state or other issuing entity, including active investigations, or
 - (B) Against an EMT certificate, Advanced EMT certificate or a Paramedic license, or health related license, or
 - (C) Any denial of certification by a LEMSA or in the case of paramedic licensure a denial by the Authority.
- (8) Complete a precertification field evaluation.
- (9) Complete the additional training specified in Section 100106.1 if applicable, of this Chapter.
- (b) An individual who possesses a current California Advanced EMT certificate in one or more counties in California, shall be eligible for certification upon fulfilling the requirements of subsections (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), (a)(7), and (a)(8) of this section and meets the following requirements.
 - (1) Provides satisfactory evidence that his/her training included the required course content as specified in Section 100120 of this Chapter.
 - (2) Successfully completes training and demonstrates competency in any additional prehospital emergency medical care treatment practice(s) required by the local Advanced EMT Certifying Entity pursuant to subsection 100106.1 of this Chapter.
 - (c) An individual currently licensed in California as a Paramedic is deemed to be certified as an Advanced EMT, except when the Paramedic license is under suspension, with no further testing required. In the case of a Paramedic license under suspension, the Paramedic shall apply to a LEMSA for Advanced EMT certification.
 - (d) In order for an individual, whose National Registry EMT-Intermediate or Paramedic or out-of-state EMT-Intermediate certification or Paramedic license/certification has

lapsed, to be eligible for certification in California as an Advanced EMT the individual shall:

- (1) For a lapse of less than six (6) months, the individual shall comply with the requirements contained in Section 100124 (b), (c), (d), (e) and (f) of this Chapter.
- (2) For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall comply with the requirements of Section 100125 (a) (2) of this Chapter.
- (3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall comply with the requirements of Section 100125 (a) (3) of this Chapter.
- (4) For a lapse of twenty-four (24) months or more, the individual shall complete an entire Advanced EMT course and comply with the requirements of subsection (a) of this Section.
- (e) An individual who possesses a current and valid out-of-state or National Registry EMT-Intermediate certification or Paramedic license/certification shall be eligible for certification upon fulfilling the requirements of subsections (a)(3), (a)(4), (a)(5), (a)(6), (a)(7), and (a)(8) of this section.
- (f) A Physician, Registered Nurse, or a Physician Assistant currently licensed by the State of California shall be eligible for Advanced EMT certification upon:
 - (1) providing documentation of instruction in topics and skills equivalent to those listed in Section 100120.
 - (2) Successfully complete five (5) documented ALS contacts in a prehospital field internship as specified in Section 100119 (b).
 - (3) Fulfilling the requirements of Subsections (a)(3), (a) (4), (a) (5), (a)(6), (a)(7), and (a)(8) of this Section.
- (g) Each Advanced EMT Certifying Entity shall provide for adequate certification tests to accommodate the eligible individuals requesting certification within their area of jurisdiction, but in no case less than once per year, unless otherwise specified by their Advanced EMT Approving Authority.
- (h) The Advanced EMT Certifying Entity may waive portions of, or all of, the certifying examination for individuals who are currently certified as an Advanced EMT in California. In such situations, the Advanced EMT Certifying Entity shall issue a certificate, which shall have as its expiration date, a date not to exceed the expiration date on the individual's current certificate.
- (i) An individual currently accredited by a California LEMSA in the EMT Optional Skills contained in Section 100064 of Chapter 2 of this Division may be given credit for training and experience for those topics and scope of practice items contained in Section 100106 of this Chapter. The LEMSA shall evaluate prior training and competence in the EMT Optional Skills and determine what, if any, supplemental training and certification testing is required for an individual to be certified as an Advanced EMT. This provision will sunset twelve (12) months after this Chapter becomes effective.
- (j) The Advanced EMT Certifying Entity shall issue a wallet-sized certificate card to eligible individuals, using the single Authority approved wallet-sized certificate card format. The wallet-sized certificate card shall contain the information contained in Section 100344(c) of Chapter 10 of this Division.

(k) All California issued EMT and Advanced EMT wallet-sized certificate cards shall be printed by the Advanced EMT Certifying Entity using the central registry criteria, pursuant to Chapter 10 of this Division. Upon the written request of an Advanced EMT Certifying Entity, the Authority shall print and issue an EMT or Advanced EMT wallet-sized certificate card for the Advanced EMT Certifying Entity.

(l) The effective date of certification, shall be the date the individual satisfactorily completes all certification requirements and has applied for certification. Certification as an Advanced EMT shall be valid for a maximum of two (2) years from the effective date of certification. The certification expiration date shall be the final day of the month of the two (2) year period.

(m) An individual currently certified as an Advanced EMT by the provisions of this section is deemed to be certified as an EMT with no further testing required.

(n) The Advanced EMT shall be responsible for notifying the Advanced EMT Certifying Entity of her/his proper and current mailing address and shall notify the Advanced EMT Certifying Entity in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and Advanced EMT registry number.

(o) The Advanced EMT Certifying Entity shall issue, within forty-five (45) calendar days of receipt of a complete application as specified in Section 100123(j), a wallet-sized Advanced EMT certificate card to eligible individuals who apply for an Advanced EMT certificate and successfully complete the Advanced EMT certification requirements.

(p) An Advanced EMT shall only be certified by one (1) Advanced EMT Certifying Entity during a certification period.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.82, 1797.118, 1797.171, 1797.175, 1797.177, 1797.184, 1797.210, and 1797.212, Health and Safety Code.

§ 100124. Advanced EMT Recertification.

In order to recertify, an Advanced EMT shall:

(a) Possess a current Advanced EMT Certification issued in California.

(b) Obtain at least thirty-six (36) hours of continuing education hours (CEH) from an approved continuing education (CE) provider in accordance with the provisions contained in the Prehospital Continuing Education Chapter, Chapter 11 of this Division.

(c) Complete an application form that contains this statement, "I hereby certify **under penalty of perjury** that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to Advanced EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an Advanced EMT in California."

(d) Disclose any certification or licensure action against an EMT, Advanced EMT, EMT-II certificate or a Paramedic license or any denial of certification by a LEMSA or in the case of Paramedic licensure, a denial by the Authority.

(e) Starting July 1, 2010, complete the criminal history background check requirements as specified in Article 4, Chapter 10 of this Division.

(f) Submit a completed Advanced EMT Skills Competency Verification Form, EMSA-AEMT SCVF (01/07) incorporated herein by reference. Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an individual who is currently certified or licensed as an Advanced EMT, Paramedic, Registered Nurse, Physician Assistant, or Physician and who shall be designated as part of a skills competency verification process approved by the LEMSA. The skills requiring verification of competency are:

- (1) Injection (IM or SQ)
- (2) Peripheral IV
- (3) IV Push Medication
- (4) Inhaled medications
- (5) Blood Glucose Determination
- (6) Perilaryngeal Airway Adjunct

(g) If the Advanced EMT recertification requirements are met within six (6) months prior to the expiration date, the Advanced EMT Certifying Entity shall make the effective date of certification the date immediately following the expiration date of the current certificate. The certification expiration date will be the final day of the final month of the two (2) year period.

(h) If the Advanced EMT recertification requirements are met greater than six (6) months prior to the expiration date, the Advanced EMT Certifying Entity shall make the effective date of certification the date the individual satisfactorily completes all certification requirements and has applied for certification. The certification expiration date shall not exceed two (2) years and shall be the final day of the final month of the two (2) year period.

(i) An individual who is deployed for active duty with a branch of the Armed Forces of the United States, whose Advanced EMT or EMT-II certificate expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, may be given an extension of the expiration date of his/her Advanced EMT certificate for up to six (6) months from the date of the individual's deactivation/release from active duty in order to meet the renewal requirements for his/her Advanced EMT certificate upon compliance with the following provisions:

(1) Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from active duty.

(2) If there is no lapse in certification, meet the requirements of subsection (a) through (f) of this Section. If there is a lapse in certification, meet the requirements of Section 100125 of this Chapter.

(3) Provide documentation showing that the CE activities submitted for the certification renewal period were taken not earlier than thirty (30) days prior to the effective date of the individual's Advanced EMT or EMT-II certificate that was valid when he/she was activated for duty and not later than six (6) months from the date of deactivation/release from active duty.

(A) For an individual whose active duty required him/her to use his/her Advanced EMT or EMT-II skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS CE Regulations (Division 9, Title 22, California Code

of Regulations) while the individual was on active duty. The documentation shall include verification from the individual's Commanding Officer attesting to the classes attended.

(j) The Advanced EMT Certifying Entity shall issue a wallet-sized certificate card to eligible individuals who apply for Advanced EMT recertification. The wallet-sized certificate card shall contain the information specified in Section 100123 (j).

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.82, 1797.118, 1797.171, 1797.175, 1797.184, 1797.210, 1797.212, and 1797.214, Health and Safety Code; and United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

§ 100125. Advanced EMT Recertification After Lapse in Certification.

(a) In order to be eligible for recertification, for an individual whose Advanced EMT Certification has lapsed, the following requirements shall apply:

(1) For a lapse of less than six (6) months, the individual shall comply with the requirements contained in Section 100124 (b), (c), (d), (e) and (f) of this Chapter.

(2) For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall comply with the requirements of Section 100124 (b), (c), (d), (e) and (f) of this Chapter, and complete an additional twelve (12) hours of continuing education for a total of forty-eight (48) hours of training.

(3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall comply with the requirements of Section 100124 (b), (c), (d), (e) and (f) of this Chapter and complete an additional twenty-four (24) hours of continuing education for a total of sixty (60) hours of training and the individual shall pass the written and skills certification exam as specified in Section 100123 (a) (3).

(4) For a lapse of greater than twenty-four (24) months, the individual shall complete an entire Advanced EMT course and comply with the requirements of Section 100123 (a).

(5) Individuals who are a member of the reserves and are deployed for active duty with a branch of the Armed Forces of the United States, whose Advanced EMT or EMT-II certificate expires during the time they are on active duty may be given an extension of the expiration date of their Advanced EMT or EMT-II certificate for up to six (6) months from the date of their deactivation/release from active duty in order to meet the renewal requirements for their Advanced EMT certificate upon compliance with the provisions of Section 100124 (i) of this Chapter and the requirements of subsection (a) of this section.

(b) The effective date of recertification shall be the date the individual satisfactorily completes all certification requirements and has applied for recertification. The certification expiration date shall be the final day of the final month of the two (2) year period.

(c) The Advanced EMT Certifying Entity shall issue a wallet-sized certificate card to eligible individuals who apply for recertification and successfully complete the recertification requirements. The certificate shall contain the information specified in Section 100344(c) of Chapter 10 of this Division.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.175, Health and Safety Code. Reference: Sections 1797.61, 1797.82, 1797.62, 1797.118, 1797.171, 1797.175, 1797.184, 1797.210, and 1797.212, Health and Safety Code; and United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

Article 5. Operational Requirements.

§ 100126. Advanced EMT Service Provider.

(a) A LEMSA with a LALS system, shall establish policies and procedures for the approval, designation and evaluation through its EMSQIP of Advanced EMT service provider(s). These policies and procedures shall include provisions requiring an Advanced EMT to be affiliated with an approved Advanced EMT service provider in order to perform the scope of practice specified in this Chapter.

(b) An approved Advanced EMT service provider shall:

(1) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis unless otherwise specified by the LEMSA, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol, personnel, etc.).

(2) Have and agree to utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain a drug and solution inventory, basic and LALS medical equipment and supplies as specified by the LEMSA.

(4) Have a written agreement with the LEMSA to participate in the LALS program and to comply with all applicable State regulations, and local policies and procedures, including participation in the LEMSA's EMSQIP as specified in Section 100107.1.

(5) Be responsible for assessing the current knowledge of their Advanced EMTs in local policies, procedures, and protocols and for assessing their Advanced EMTs skills competency.

(c) No Advanced EMT service provider shall advertise itself as providing ALS or Paramedic services unless it does, in fact, routinely provide ALS or Paramedic services on a continuous twenty-four (24) hours per day basis and meets the requirements of subsection (b) of this section.

(d) For Advanced EMT service providers, no responding unit shall advertise itself as providing ALS services unless it does, in fact, provide ALS services and meets the requirements of subsection (b) of this section.

(e) The LEMSA may deny, suspend, or revoke the approval of an Advanced EMT service provider for failure to comply with applicable policies, procedures, and regulations.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.

Reference: Sections 1797.2, 1797.82, 1797.171, 1797.178, 1797.180, 1797.204 and 1797.218, Health and Safety Code.

§ 100127. Advanced EMT and/or EMT-II Base Hospital.

(a) A LEMSA with a LALS system shall designate an Advanced EMT and/or EMT-II base hospital(s) or alternative base stations to provide medical direction and supervision of Advanced EMT personnel. A Paramedic base hospital may serve as an Advanced EMT and/or EMT-II base hospital.

(b) A designated Advanced EMT and/or EMT-II base hospital shall:

(1) Be licensed by the California Department of Public Health as a general acute care hospital.

- (2) Have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5, or have been granted approval by the Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code.
- (3) Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.
- (4) Have and agree to utilize and maintain two-way telecommunications as specified by the LEMSA, capable of direct two-way voice communication with the Advanced EMT field units assigned to the hospital.
- (5) Have a written agreement with the LEMSA indicating the concurrence of hospital administration, medical staff and emergency department staff to meet the requirements for program participation as specified in this Chapter and by the LEMSA's policies and procedures.
- (6) Assure that a Physician, licensed in the State of California, experienced in emergency medical care, is assigned to the emergency department, and is available at all times to provide immediate medical direction to the Mobile Intensive Care Nurse, or Advanced EMT personnel. This Physician shall have experience in and knowledge of base hospital radio operations and LEMSA policies, procedures and protocols.
- (7) Assure that the nurses giving radio direction to Advanced EMT personnel are trained and certified as Mobile Intensive Care Nurses by the medical director of the LEMSA.
- (8) Designate an Advanced EMT base hospital medical director who shall be a Physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the medical director of the LEMSA. This Physician shall be regularly assigned to the emergency department, have experience in and knowledge of base hospital telecommunications and LEMSA policies and procedures and shall be responsible for functions of the base hospital including quality improvement as designated by the medical director of the LEMSA.
- (9) Identify a base hospital coordinator who is a California licensed Registered Nurse with experience in and knowledge of base hospital operations and LEMSA policies and procedures and is a prehospita liaison to the LEMSA.
- (10) Ensure that a mechanism exists for replacing medical supplies and equipment used by LALS personnel during treatment of patients according to policies and procedures established by the LEMSA.
- (11) Ensure a mechanism exists for initial supply and replacement of controlled substances administered by LALS personnel during treatment of patients according to policies and procedures established by the LEMSA.
- (12) Provide for CE in accordance with the policies and procedures of the LEMSA.
- (13) Agree to participate in the LEMSA's EMSQIP, which may include making available all relevant records for program monitoring and evaluation.
- (c) If no qualified base hospital is available to provide medical direction, the medical director of the LEMSA may approve an alternative base station pursuant to Health and Safety Code Section 1798.105.
- (d) The LEMSA may deny, suspend, or revoke the approval of a base hospital for failure to comply with any applicable policies, procedures, and regulations.

NOTE: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code.
Reference: Sections 1797.53, 1797.58, 1797.82, 1797.101, 1797.171, 1797.178, 1798, 1798.2, 1798.3, 1798.100, 1798.102, 1798.104, and 1798.105, Health and Safety Code.

§ 100128. Medical Control.

The medical director of a LEMSA shall establish and maintain medical control in the following manner:

- (a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:
 - (1) Treatment protocols that encompass the Advanced EMT scope of practice.
 - (2) Local medical control policies and procedures as they pertain to the Advanced EMT base hospitals, alternative base stations, patient destination, and the LEMSA.
 - (3) Criteria for initiating specified emergency treatments on standing orders, which are consistent with this Chapter.
 - (4) Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance or when the patient refuses transport.
 - (5) Requirements for initiating, completing, reviewing and retaining patient care records as specified in this Chapter. These requirements shall address, but not be limited to:
 - (A) Initiation of a record for every patient contact.
 - (B) Responsibilities for record completion.
 - (C) Responsibilities for record review and evaluation.
 - (D) Responsibilities for record retention.
 - (E) Record distribution to include the LEMSA, receiving hospital, Advanced EMT and/or EMT-II base hospital, alternative base station, and Advanced EMT and/or EMT-II service provider.
- (b) Establish policies which provide for direct voice communication between an Advanced EMT and/or EMT-II and base hospital Physician or Mobile Intensive Care Nurse, as needed.
- (c) Retrospectively, by providing for organized evaluation and CE for Advanced EMT and/or EMT-II personnel. This shall include, but need not be limited to:
 - (1) Review by a base hospital Physician or Mobile Intensive Care Nurse of the appropriateness and adequacy of ALS procedures initiated and decisions regarding transport.
 - (2) Maintenance of records of communications between the service provider(s) and the base hospital through audio recordings and through emergency department communication logs sufficient to allow for medical control and continuing education of the Advanced EMT and/or EMT-II.
 - (3) Organized field care audit(s).
 - (4) Organized opportunities for CE including maintenance and proficiency of skills specified in this Chapter.
- (d) In circumstances where use of a base hospital as defined in Section 100127 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the Authority.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.176, Health and Safety Code. Reference: Sections 1797.82, 1797.90, 1797.171, 1797.202, 1797.220, 1798, 1798.2, 1798.3, 1798.101 and 1798.105, Health and Safety Code.

Article 6. Record Keeping and Fees

§ 100129. Record Keeping.

(a) Each Advanced EMT Approving Authority shall maintain a list of approved training programs within its jurisdiction and provide the Authority annually with the names, addresses, phone number, course director, frequency of classes, student eligibility requirements and cost of each class and date of expiration for each approved program. The Authority shall be notified of any changes in the list of approved training programs as such occurs.

(b) Each Advanced EMT Approving Authority shall maintain a list of current Advanced EMT program medical directors, course directors and principal instructors within its jurisdiction.

(c) The Authority shall maintain a record of approved Advanced EMT training programs.

(d) The Advanced EMT is responsible for accurately completing the patient care record referenced in 100128(a)(5) which shall contain, but not be limited to, the following information when such information is available to the Advanced EMT:

- (1) The date and estimated time of incident.
- (2) The time of receipt of the call (available through dispatch records).
- (3) The time of dispatch to the scene.
- (4) Time of unit enroute.
- (5) Time of arrival at the scene.
- (6) The location of the incident.
- (7) The patient's:
 - (A) Name;
 - (B) age;
 - (C) gender;
 - (D) weight, if necessary for treatment;
 - (E) address;
 - (F) chief complaint; and
 - (G) vital signs.
- (8) Appropriate physical assessment.
- (9) The emergency care rendered and the patient's response to such treatment.
- (10) Name of designated Physician and/or authorized Registered Nurse issuing orders.
- (11) Patient disposition.
- (12) The time of departure from scene.
- (13) The time of arrival at receiving hospital (if transported).
- (14) The name of receiving facility (if transported).
- (15) The name(s) and unique identifier number(s) of the Advanced EMT(s).
- (16) Signature(s) of Advanced EMT(s).

(e) A LEMSAs utilizing computer or other electronic means of collecting and storing the information specified in subsection (d) of this section shall, in consultation with EMS providers, establish policies for the collection, utilization and storage of such data.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.175, Health and Safety Code. Reference: Sections 1797.82, 1797.171 and 1797.173, 1797.200, 1797.202, 1797.204 and 1797.208, Health and Safety Code.

§ 100130. Fees.

A LEMSA may establish a schedule of fees for Advanced EMT training program review and approval, Advanced EMT certification, and the Advanced EMT recertification in any amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.171 and 1797.212., Health and Safety Code. Reference: Sections 1797.61, 1797.82, 1797.171, 1797.184, and 1797.212, Health and Safety Code.

THIS REGULATION WAS SUPPORTED BY THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT. ITS CONTENTS ARE SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF CDC.

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California Code of Regulations, Title 22

Chapter 4: Paramedic Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Pre-Hospital Emergency Medical Services
Chapter 4. Paramedic

Article 1. Definitions

§ 100135. Approved Testing Agency.

"Approved Testing Agency" means an agency approved by the Emergency Medical Services Authority (Authority) to administer the licensure examination.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172 and 1797.185, Health and Safety Code.

§ 100136. Emergency Medical Services System Quality Improvement Program.

"Emergency Medical Services System Quality Improvement Program" or "EMSQIP" means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMSQIP.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.185, Health and Safety Code. Reference: Sections 1797.172 and 1797.204 Health and Safety Code.

§ 100137. Paramedic Training Program Approving Authority.

"Paramedic training program approving authority" means an agency or person authorized by this Chapter to approve a Paramedic training program and/or a Critical Care Paramedic (CCP) training program, as follows:

- (a) The approving authority for a Paramedic training program and/or a Critical Care Paramedic (CCP) training program conducted by a qualified statewide public safety agency shall be the director of the Authority.
- (b) The approving authority for any other Paramedic training program and/or a Critical Care Paramedic (CCP) training program not included in subsection (a) shall be the local EMS agency (LEMSA) which has jurisdiction in the area in which the training program is headquartered.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172, 1797.200 and 1797.208, Health and Safety Code.

§ 100138. Paramedic Licensing Authority.

"Paramedic Licensing Authority" means the director of the Authority.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.172, 1797.194 and 1797.210, Health and Safety Code.

§ 100139. Paramedic.

"Paramedic" or "EMT-P" or "mobile intensive care paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support (ALS); whose scope of practice to provide ALS is in accordance with the standards prescribed by this Chapter, and who has a valid license issued pursuant to this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172 and 1797.194, Health and Safety Code.

§ 100140. Licensure Skills Examination.

"Skills or practical examination" means the National Registry of Emergency Medical Technicians (NREMT) EMT-Paramedic Practical Examination to test the skills of an individual applying for licensure as a paramedic. Examination results shall be valid for application purposes for two (2) years from the date of examination.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code.

§ 100141. Licensure Written Examination.

"Licensure Written Examination" means the NREMT EMT-Paramedic Written Examination to test an individual applying for licensure as a paramedic. Examination results shall be valid for application purposes for two (2) years from date of examination.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100142. Local Accreditation.

"Local Accreditation" or "accreditation" or "accreditation to practice" means authorization by the LEMSA to practice as a paramedic within that jurisdiction. Such authorization indicates that the paramedic has completed the requirements of Section 100165 of this Chapter.

NOTE: Authority cited: Sections 1797.7, 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100143. State Paramedic Application.

"State Paramedic Application" or "state application" means an application form provided by the Authority to be completed by an individual applying for a license or renewal of license, as identified in Section 100163.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.185 and 1797.194, Health and Safety Code.

§ 100144. Critical Care Paramedic.

A “Critical Care Paramedic” (CCP) is an individual who is educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed by this Chapter, holds a current certification as a CCP by the Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA.

NOTE: Authority cited: 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172 and 1797.194, Health and Safety Code.

Article 2. General Provisions

§ 100145. Application of Chapter.

(a) Any LEMSA that authorizes a paramedic training program or an ALS service that provides services utilizing paramedic personnel as part of an organized EMS system, shall be responsible for approving paramedic training programs, paramedic service providers, paramedic base hospitals, and for developing and enforcing standards, regulations, policies and procedures in accordance with this chapter to provide an EMS system quality improvement program, appropriate medical control, and coordination of paramedic personnel and training program(s) within an EMS system.

(b) No person or organization shall offer a paramedic training program, or hold themselves out as offering a paramedic training program, or hold themselves out as providing ALS services utilizing paramedics for the delivery of emergency medical care unless that person or organization is authorized by the LEMSA.

(c) A paramedic who is not licensed in California may temporarily perform his/her scope of practice in California on a mutual aid response, on routine patient transports from out of state into California, or during a special event, when approved by the medical director of the LEMSA, if the following conditions are met:

(1) The paramedic is licensed or certified in another state/country or under the jurisdiction of the federal government.

(2) The paramedic restricts his/her scope of practice to that for which s/he is licensed or certified.

(3) Medical control as specified in Section 1798 of the Health and Safety Code is maintained in accordance with policies and procedures established by the medical director of the LEMSA.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.195, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.185, 1797.195, 1797.200, 1797.204, 1797.206, 1797.208, 1797.218, 1797.220, 1798 and 1798.100, Health and Safety Code.

§ 100146. Scope of Practice of Paramedic.

(a) A paramedic may perform any activity identified in the scope of practice of an EMT in Chapter 2 of this Division, or any activity identified in the scope of practice of an Advanced EMT (AEMT) in Chapter 3 of this Division.

(b) A paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this Chapter.

(c) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to Section 1797.195 of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.

(1) Basic Scope of Practice:

(A) Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).

(B) Perform defibrillation, synchronized cardioversion, and external cardiac pacing.

(C) Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with Magill forceps.

(D) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.

(E) Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/ bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.

(F) Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.

(G) Institute intraosseous (IO) needles or catheters.

(H) Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.

(I) Obtain venous blood samples.

(J) Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).

(K) Utilize Valsalva maneuver.

(L) Perform percutaneous needle cricothyroidotomy.

(M) Perform needle thoracostomy.

(N) Perform nasogastric and orogastric tube insertion and suction.

(O) Monitor thoracostomy tubes.

(P) Monitor and adjust IV solutions containing potassium, equal to or less than 40 mEq/L.

(Q) Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.

(R) Administer, using prepackaged products when available, the following medications:

1. 10%, 25% and 50% dextrose;
2. activated charcoal;
3. adenosine;
4. aerosolized or nebulized beta-2 specific bronchodilators;
5. amiodarone;
6. aspirin;
7. atropine sulfate;
8. pralidoxime chloride;
9. calcium chloride;
10. diazepam;
11. diphenhydramine hydrochloride;
12. dopamine hydrochloride;
13. epinephrine;
14. fentanyl;
15. glucagon;
16. ipratropium bromide;
17. lorazepam;
18. midazolam;
19. lidocaine hydrochloride;
20. magnesium sulfate;
21. morphine sulfate;
22. naloxone hydrochloride;
23. nitroglycerin preparations, except IV, unless permitted under (c)(2)(A) of this section;
24. ondansetron;
25. sodium bicarbonate.

(S) In addition to the approved paramedic scope of practice, the CCP may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports, when a licensed and accredited paramedic has completed a Critical Care Paramedic (CCP) training program as specified in Section 100160(b) and successfully completed competency testing, holds a current certification as a CCP from the BCCTPC, and other requirements as determined by the medical director of the LEMSA.

1. set up and maintain thoracic drainage systems;
2. set up and maintain mechanical ventilators;
3. set up and maintain IV fluid delivery pumps and devices;

4. blood and blood products;
5. glycoprotein IIB/IIIA inhibitors;
6. heparin IV;
7. nitroglycerin IV;
8. norepinephrine;
9. thrombolytic agents;
10. maintain total parenteral nutrition;

(2) Local Optional Scope of Practice:

(A) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgment of the medical director of the LEMSA, that have been approved by the Director of the Authority when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.

(B) The medical director of the LEMSA shall submit Form #EMSA-0391, Revised 03/18/03 to, and obtain approval from, the Director of the Authority in accordance with Section 1797.172 (b) of the Health and Safety Code for any procedures or medications proposed for use pursuant to this subsection prior to implementation of these medication(s) and or procedure(s).

(C) The Authority shall, within fourteen (14) days of receiving the request, notify the medical director of the LEMSA submitting request Form #EMSA-0391 that the request form has been received, and shall specify what information, if any, is missing.

(D) The Director of the Authority, in consultation with the Emergency Medical Directors Association of California's Scope of Practice Committee, shall approve or disapprove the request for additional procedures and/or medications and notify the LEMSA medical director of the decision within ninety (90) days of receipt of the completed request.

Approval is for a three (3) year period and may be renewed for another three (3) year period, based on evidence from a written request that includes at a minimum the utilization of the procedure(s) or medication(s), beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(E) The Director of the Authority, in consultation with a committee of the LEMSA medical directors named by the Emergency Medical Directors Association of California, may suspend or revoke approval of any previously approved additional procedure(s) or medication(s) for cause.

(d) The medical director of the LEMSA may develop policies and procedures or establish standing orders allowing the paramedic to initiate any paramedic activity in the approved scope of practice without voice contact for medical direction from a physician or mobile intensive care nurse (MICN), provided that an EMSQIP, as specified in Chapter 12 of this Division, is in place.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.185, 1797.192, 1797.195 and 1797.214, Health and Safety Code. Reference: Sections 1797.172 and 1797.185, Health and Safety Code.

§ 100147. Paramedic Trial Studies.

A paramedic may perform any prehospital emergency medical care treatment procedure(s) or administer any medication(s) on a trial basis when approved by the medical director of the LEMSA and the Director of the Authority.

(a) The medical director of the LEMSA shall review a trial study plan, which at a minimum shall include the following:

(1) A description of the procedure(s) or medication(s) proposed, the medical conditions for which they can be utilized, and the patient population that will benefit.

(2) A compendium of relevant studies and material from the medical literature.

(3) A description of the proposed study design including the scope of the study and method of evaluating the effectiveness of the procedure(s) or medication(s), and expected outcome.

(4) Recommended policies and procedures to be instituted by the LEMSA regarding the use and medical control of the procedure(s) or medication(s) used in the study.

(5) A description of the training and competency testing required to implement the study.

(b) The medical director of the LEMSA shall appoint a local medical advisory committee to assist with the evaluation and approval of trial studies. The membership of the committee shall be determined by the medical director of the LEMSA, but shall include individuals with knowledge and experience in research and the effect of the proposed study on the EMS system.

(c) The medical director of the LEMSA shall submit the proposed study and send a copy of the proposed trial study plan at least forty-five (45) days prior to the proposed initiation of the study to the Director of the Authority for approval in accordance with the provisions of section 1797.172 of the Health & Safety Code. The Authority shall inform the Commission on EMS (Commission) of studies being initiated.

(d) The Authority shall notify, within fourteen (14) days of receiving the request, the medical director of the LEMSA submitting its request for approval of a trial study that the request has been received, and shall specify what information, if any, is missing.

(e) The Director of the Authority shall render the decision to approve or disapprove the trial study within forty-five (45) days of receipt of all materials specified in subsections (a) and (b) of this section.

(f) The medical director of the LEMSA within eighteen (18) months of initiation of the procedure(s) or medication(s), shall submit a written report to the Commission which includes at a minimum the progress of the study, number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(g) The Commission shall review the above report within two (2) meetings and advise the Authority to do one of the following:

(1) Recommend termination of the study if there are adverse effects or no benefit from the study is shown.

(2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential but inconclusive benefit is shown.

(3) Recommend the procedure, or medication, be added to the paramedic basic or local optional scope of practice.

(h) If option (g)(2) is selected, the Commission may advise continuation of the study as structured or alteration of the study to increase the validity of the results.

(i) At the end of the additional eighteen (18) month period, a final report shall be submitted to the Commission with the same format as described in (f) above.

(j) The Commission shall review the final report and advise the Authority to do one of the following:

(1) Recommend termination or further extension of the study.

(2) Recommend the procedure or medication be added to the paramedic basic or local optional scope of practice.

(k) The Authority may require the trial study(ies) to cease after thirty-six (36) months.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.3, 1797.172 and 1797.221, Health and Safety Code.

§ 100148. Responsibility of the LEMSA.

The LEMSA that authorizes an ALS program shall establish policies and procedures approved by the medical director of the LEMSA that shall include:

(a) Approval, denial, revocation of approval, suspension, and monitoring of training programs, base hospitals or alternative base stations, and paramedic service providers.

(b) Assurance of compliance with provisions of this Chapter by the paramedic program and the EMS system.

(c) Submission to the Authority, as changes occur, of the following information on the approved paramedic training programs:

(1) Name of program director and/or program contact;

(2) Address, phone number, and facsimile number;

(3) Date of approval, date classes will initially begin, and date of expiration.

(d) Development or approval, implementation and enforcement of policies for medical control, medical accountability, and an EMSQIP of the paramedic services, including:

(1) Treatment and triage protocols.

(2) Patient care record and reporting requirements.

(3) Medical care audit system.

(4) Role and responsibility of the base hospital and paramedic service provider.

(e) System data collection and evaluation.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172, 1797.178, 1797.200, 1797.202, 1797.204, 1797.208, 1797.220, 1798 and 1798.100, Health and Safety Code.

Article 3. Program Requirements for Paramedic Training Programs

§ 100149. Approved Training Programs.

(a) An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in Section 100149(i) of this Chapter, may provide

CCP training upon approval by the paramedic training program approving authority.

The purpose of a paramedic training program shall be:

(1) to prepare individuals to render prehospital ALS within an organized EMS system;
and

(2) to prepare individuals to render critical care transport within an organized EMS system

(b) By January 1, 2004, all paramedic training programs approved by a paramedic training program approving authority prior to January 1, 2000, shall be accredited and maintain current accreditation by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in order to continue to operate as an approved paramedic training program.

(c) All paramedic training programs approved by a paramedic training program approving authority January 1, 2000, or thereafter shall submit their application, fee, and self study to CoAEMSP for accreditation within twelve (12) months of the start up of classes and receive and maintain CAAHEP accreditation no later than two (2) years from the date of application to CoAEMSP for accreditation in order to continue to operate as an approved paramedic training program.

(d) Paramedic training programs approved according to the provisions of this Chapter shall provide the following information to all their paramedic training program applicants prior to the applicants' enrollment in the paramedic training program:

(1) The date by which the paramedic training program must submit their application and self study for initial accreditation or their application for accreditation renewal to CoAEMSP.

(2) The date by which the paramedic training program must be initially accredited or have their accreditation renewed by CAAHEP.

(3) Failure of the paramedic training program to submit their application and self study or their accreditation renewal to CoAEMSP by the date specified will result in closure of the paramedic training program by their respective paramedic training program approving authority, unless the paramedic training program approving authority has approved a plan for meeting compliance as provided in Section 100157 of this Chapter. When a paramedic training program approval is revoked under this provision, the paramedic training program course director must demonstrate to the satisfaction of their respective paramedic training program approving authority that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.

(4) Failure of the paramedic training program to obtain or maintain CAAHEP accreditation by the required date will result in closure of the paramedic training program by their respective paramedic training program approving authority, unless the paramedic training program approving authority has approved a plan for meeting compliance as provided in Section 100157 of this Chapter. When a paramedic training program approval has been revoked under this provision, the paramedic training

program course director must demonstrate to the satisfaction of their respective paramedic training program approving authority that the deficiency for which the paramedic training program approval was revoked has been rectified before submitting a new application for paramedic training program approval.

(5) Students graduating from a paramedic training program that fails to apply for accreditation with, receive accreditation from, or maintain accreditation with, CAAHEP by the dates required will not be eligible for state licensure as a paramedic.

(e) Paramedic training programs shall submit to their respective paramedic training program approving authority all documents submitted to, and received from, CoAEMSP and CAAHEP for accreditation, including but not limited to, the initial application and self study for accreditation and the documents required for maintaining accreditation.

(f) Paramedic training programs shall submit to the Authority the date their initial application was submitted to CoAEMSP and copies of documentation from CoAEMSP and/or CAAHEP verifying accreditation.

(g) Paramedic training program approving authorities shall revoke approval, in accordance with Section 100157 of this Chapter, of any paramedic training program which fails to comply with subsections (b) through (e) of this Section.

(h) Approved paramedic training programs shall participate in the EMSQIP of their respective paramedic training program approving authority. In addition, an approved paramedic training program, which is conducting a paramedic training program outside the jurisdiction of their approving authority, shall also agree to participate in the EMSQIP of the LEMSA which has jurisdiction where the paramedic training program is being conducted.

(i) Eligibility for program approval shall be limited to the following institutions:

(1) Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary Education.

(2) Medical training units of a branch of the Armed Forces or Coast Guard of the United States.

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5;

(B) Provide continuing education (CE) to other health care professionals; and

(C) are accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

(4) Agencies of government.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.208 and 1797.213, Health and Safety Code.

§ 100150. Teaching Staff.

(a) Each training program shall have an approved program medical director who shall be a physician currently licensed in the State of California, who has two (2) years

experience in prehospital care in the last five (5) years, and who is qualified by education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to:

(1) Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

(2) Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

(3) Approval of provision for hospital clinical and field internship experiences.

(4) Approval of principal instructor(s).

(b) Each training program shall have an approved course director who shall be licensed in California as a physician, a registered nurse who has a baccalaureate degree or a paramedic who has a baccalaureate degree, or shall be an individual who holds a baccalaureate degree in a related health field or in education. The course director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one (1) year experience in an administrative or management level position and have a minimum of three (3) years academic or clinical experience in prehospital care education within the last five (5) years. Duties of the course director shall include, but not be limited to:

(1) Administration, organization and supervision of the educational program.

(2) In coordination with the program medical director, approve the principal instructor, teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.

(3) Ensure training program compliance with this chapter and other related laws.

(4) Sign all course completion records.

(5) Ensure that the preceptor(s) are trained according to the curriculum in subsection (e)(4).

(c) Each training program shall have a principal instructor(s), who may also be the program medical director or course director if the qualifications in subsections (a) and (b) are met, who shall:

(1) Be a physician, registered nurse, physician assistant, or paramedic, currently certified or licensed in the State of California.

(2) Be knowledgeable in the course content of the United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077A, January 2009, herein incorporated by reference; and

(3) Have six years (6) experience in an allied health field and an associate degree or two (2) years experience in an allied health field and a baccalaureate degree.

(4) Be responsible for areas including, but not limited to, curriculum development, course coordination, and instruction.

(5) Be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty (40) hours of instruction in

teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:

- (A) California State Fire Marshal (CSFM) "Training Instructor 1A, 1B, and 1C",
- (B) National Fire Academy (NFA) "Fire Service Instructional Methodology" course, and
- (C) A course that meets the U. S. Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the National Association of EMS Educators' EMS Educator Course.
- (d) Each CCP training program shall have a principal instructor(s) who shall be licensed in California as a physician and knowledgeable in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or FP certification from the BCCTPC.
- (e) Each training program may have a teaching assistant(s) who shall be an individual(s) qualified by training and experience to assist with teaching of the course. A teaching assistant shall be supervised by a principal instructor, the course director and/or the program medical director.
- (f) Each paramedic training program shall have a field preceptor(s) who shall:
 - (1) Be a certified or licensed paramedic; and
 - (2) Be working in the field as a certified or licensed paramedic for the last two (2) years; and
 - (3) Be under the supervision of a principal instructor, the course director and/or the program medical director.
 - (4) Have completed field preceptor training approved by the LEMSA and/or comply with the field preceptor guidelines approved by the LEMSA. Training shall include a curriculum that will result in the preceptor being competent to evaluate the paramedic student during the internship phase of the training program, and how to do the following in cooperation with the paramedic training program:
 - (A) Conduct a daily field evaluation of students.
 - (B) Conduct cumulative and final field evaluations of all students.
 - (C) Rate students for evaluation using written field criteria.
 - (D) Identify ALS contacts and requirements for graduation.
 - (E) Identify the importance of documenting student performance.
 - (F) Review field preceptor requirements contained in this Chapter.
 - (G) Assess student behaviors using cognitive, psychomotor, and affective domains.
 - (H) Create a positive and supportive learning environment.
 - (I) Measure students against the standard of entry level paramedics.
 - (J) Identify appropriate student progress.
 - (K) Counsel the student who is not progressing.
 - (L) Identify training program support services available to the student and the preceptor.
 - (M) Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material.
- (g) Each training program shall have a hospital clinical preceptor(s) who shall:

- (1) Be a physician, registered nurse or physician assistant currently licensed in the State of California.
- (2) Have worked in emergency medical care for the last two (2) years.
- (3) Be under the supervision of a principal instructor, the course director, and/or the program medical director.
- (4) Receive instruction in evaluating paramedic students in the clinical setting. Means of instruction may include, but need not be limited to, educational brochures, orientation, training programs, or training videos, and shall include how to do the following in cooperation with the paramedic training program:
 - (A) Evaluate a student's ability to safely administer medications and perform assessments.
 - (B) Document a student's performance.
 - (C) Review clinical preceptor requirements contained in this Chapter.
 - (D) Assess student behaviors using cognitive, psychomotor, and affective domains.
 - (E) Create a positive and supportive learning environment.
 - (F) Identify appropriate student progress.
 - (G) Counsel the student who is not progressing.
 - (H) Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100151. Didactic and Skills Laboratory.

An approved paramedic training program and/or CCP training program shall assure that no more than six (6) students are assigned to one instructor/teaching assistant during skills practice/laboratory.

NOTE: Authority cited: 1797.107, 1797.172 and 1797.173, Health and Safety Code.
Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

§ 100152. Hospital Clinical Education and Training for Paramedic.

(a) An approved paramedic training program shall provide for and monitor a supervised clinical experience at a hospital(s) that is licensed as a general acute care hospital and holds a permit to operate a basic or comprehensive emergency medical service. The clinical setting may be expanded to include areas commensurate with the skills experience needed. Such settings may include surgicenters, clinics, jails or any other areas deemed appropriate by the LEMSA. The maximum number of hours in the expanded clinical setting shall not exceed forty (40) hours of the total clinical hours specified in Section 100159(a)(2).

(b) Hospital clinical training, for an approved CCP training program, should consist of no less than ninety-four hours (94) in the following areas:

- (1) Labor & Delivery (8 hours),
- (2) Neonatal Intensive Care (16 hours),

- (3) Pediatric Intensive Care (16 hours),
- (4) Adult Cardiac Care (16 hours),
- (5) Adult Intensive Care (24 hours),
- (6) Adult Respiratory Care (6 hours), and
- (7) Emergency/ Trauma Care (8 hours).

(c) An approved paramedic training program and/or CCP training program shall not enroll any more students than the training program can commit to providing a clinical internship to begin no later than thirty (30) days after a student's completion of the didactic and skills instruction portion of the training program. The paramedic training program course director and/or CCP training program course director and a student may mutually agree to a later date for the clinical internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.).

(d) Training programs, both paramedic and CCP, in nonhospital institutions shall enter into a written agreement(s) with a licensed general acute care hospital(s) that holds a permit to operate a basic or comprehensive emergency medical service for the purpose of providing this supervised clinical experience.

(e) Paramedic clinical training hospital(s) and other expanded settings shall provide clinical experience, supervised by a clinical preceptor(s). The clinical preceptor may assign the student to another health professional for selected clinical experience. No more than two (2) students shall be assigned to one preceptor or health professional during the supervised clinical experience at any one time. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities, which may include the administration of any additional medications, approved by the LEMSAs medical director and the director of the Authority, to result in competency. Clinical assignments shall include, but are not to be limited to, emergency, cardiac, surgical, obstetric, and pediatric patients.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

§ 100153. Field Internship.

(a) A field internship shall provide emergency medical care experience supervised at all times by an authorized field preceptor to result in the paramedic student being competent to provide the medical procedures, techniques, and medications specified in Section 100146, in the prehospital emergency setting within an organized EMS system.

(b) An approved paramedic training program shall enter into a written agreement with a paramedic service provider(s) to provide for field internship, as well as for a field preceptor(s) to directly supervise, instruct, and evaluate the students. The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency. If the paramedic service provider is located outside the jurisdiction of the paramedic training program approving authority, then the training program shall do the following:

(1) in collaboration with the LEMSA in which the field internship will occur, ensure that the student has been oriented to that LEMSA, including local policies and procedures and treatment protocols,

(2) contact the LEMSA where the paramedic service provider is located and report to that LEMSA the name of the paramedic intern in their jurisdiction, the name of the EMS provider, and the name of the preceptor. The paramedic intern shall be under the medical control of the medical director of the LEMSA in which the internship occurs.

(c) The training program shall be responsible for ensuring that the field preceptor has the experience and training as required in Section 100150(g)(1)-(4).

(d) The paramedic training program shall not enroll any more students than the training program can commit to providing a field internship to begin no later than ninety (90) days after a student's completion of the hospital clinical education and training portion of the training program. The training program director and a student may mutually agree to a later date for the field internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.).

(e) For at least half of the ALS patient contacts specified in Section 100159(b), the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through release of the patient to a receiving hospital or medical care facility.

(f) All interns shall be continuously monitored by the training program, in collaboration with the assigned field preceptor, regardless of the location of the internship, as described in written agreements between the training program and the internship provider. The training program shall document a student's progress, based on the assigned field preceptor's input, and identify specific weaknesses of the student, if any, and/or problems encountered by, or with, the student. Documentation of the student's progress, including any identified weaknesses or problems, shall be provided to the student at least twice during the student's field internship.

(g) No more than one (1) EMT trainee, of any level, shall be assigned to a response vehicle at any one time during the paramedic student's field internship.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

§ 100154. Procedure for Training Program Approval.

(a) Eligible training institutions shall submit a written request for training program approval to the paramedic training program approving authority. A paramedic training program approving authority may deem a training program approved that has been accredited by the CAAHEP upon submission of proof of such accreditation, without requiring the paramedic training program to submit for review the information required in subsections (b) and (c) of this section.

(b) The paramedic training program approving authority shall receive and review the following prior to program approval:

- (1) A statement verifying that the course content meets the requirements contained in the U. S. DOT National Education Standards DOT HS 811 077A January 2009.
 - (2) A statement verifying that the CCP training program course content meets the requirements contained in Section 100160(b) of this Chapter. The CCP training program must also verify compliance with Subsections (b)(3)-(b)(6) and (b)(8)-(b)(9) of this Section.
 - (3) An outline of course objectives.
 - (4) Performance objectives for each skill.
 - (5) The name and qualifications of the training program course director, program medical director, and principal instructors.
 - (6) Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
 - (7) Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
 - (8) The location at which the courses are to be offered and their proposed dates.
 - (9) Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.
 - (10) Written contracts or agreements between the paramedic training program and a provider agency(ies) for student placement for field internship training.
 - (c) The paramedic training program approving authority shall review the following prior to program approval:
 - (1) Samples of written and skills examinations administered by the training program for periodic testing.
 - (2) A final written examination administered by the training program.
 - (3) Evidence that the training program provides adequate facilities, equipment, examination security, and student record keeping.
 - (d) The paramedic training program approving authority shall submit to the Authority an outline of program objectives and eligibility on each training program being proposed for approval in order to allow the Authority to make the determination required by section 1797.173 of the Health and Safety Code. Upon request by the Authority, any or all materials submitted by the training program shall be submitted to the Authority.
- NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

§ 100155. Paramedic Training Program Approval.

- (a) The paramedic training program approving authority shall, within thirty (30) working days of receiving a request for training program approval, notify the requesting training program that the request has been received, and shall specify what information, if any, is missing.
- (b) Paramedic training program approval or disapproval shall be made in writing by the

paramedic training program approving authority to the requesting training program after receipt of all required documentation. This time period shall not exceed three (3) months.

(c) The paramedic training program approving authority shall establish the effective date of program approval in writing upon satisfactory documentation of compliance with all program requirements.

(d) Paramedic training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years subject to the procedure for program approval specified in this chapter.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code; and section 15376, Government Code.

§ 100156. Program Review and Reporting.

(a) All program materials specified in this Chapter shall be subject to periodic review by the paramedic training program approving authority and may also be reviewed upon request by the Authority.

(b) All programs shall be subject to periodic on-site evaluation by the paramedic approving authority and may also be evaluated by the Authority.

(c) Any person or agency conducting a training program shall notify the paramedic training program approving authority in writing, in advance when possible, and in all cases within thirty (30) days of any change in course objectives, hours of instruction, course director, program medical director, principal instructor, provisions for hospital clinical experience, or field internship.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100157. Withdrawal of Program Approval.

(a) Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in denial, probation, suspension or revocation of program approval by the paramedic training program approving authority. Notification of noncompliance and action to place on probation, suspend or revoke shall be done as follows:

(1) A paramedic training program approving authority shall notify the approved training program course director in writing, by certified mail, of the provisions of this Chapter with which the paramedic training program is not in compliance.

(2) Within fifteen (15) days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by certified mail, to the paramedic training program approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) days of receipt of the response from the approved training program, or within thirty (30) days from the mailing date of the noncompliance notification if no response is received from the approved training program, the paramedic training program approving authority shall notify the Authority and the approved training program in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.

(4) If the paramedic training program approving authority decides to suspend or revoke the training program approval, the notification specified in subsection (a)(3) of this section shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) days from the date of the paramedic training program approving authority's letter of decision to the Authority and the training program.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172, 1797.208 and 1798.202, Health and Safety Code.

§ 100158. Student Eligibility.

(a) To be eligible to enter a paramedic training program an individual shall meet the following requirements:

- (1) Possess a high school diploma or general education equivalent; and
- (2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and
- (3) possess a current EMT certificate or NREMT-Basic registration; or
- (4) possess a current AEMT certificate in the State of California; or
- (5) be currently registered as an EMT-Intermediate with the NREMT.

(b) To be eligible to enter a CCP training program an individual shall be currently licensed, and accredited, in California as a paramedic with three (3) years of basic paramedic practice.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100159. Required Course Hours.

(a) The total paramedic training program shall consist of not less than one thousand and ninety (1090) hours. These training hours shall be divided into:

- (1) A minimum of four-hundred and fifty (450) hours of didactic instruction and skills laboratories;
- (2) The hospital clinical training shall consist of no less than one-hundred and sixty (160) hours and the field internship shall consist of no less than four-hundred and eighty (480) hours.

(b) The student shall have a minimum of forty (40) ALS patient contacts during the field internship as specified in Section 100153. An ALS patient contact shall be defined as

the student performance of one or more ALS skills, except cardiac monitoring and CPR, on a patient.

(c) The minimum hours shall not include the following:

(1) Course material designed to teach or test exclusively EMT knowledge or skills including CPR.

(2) Examination for student eligibility.

(3) The teaching of any material not prescribed in section 100160 of this Chapter.

(4) Examination for paramedic licensure.

(d) The total CCP training program shall consist of not less than two-hundred and two (202) hours. These training hours shall be divided into:

(1) A minimum of one-hundred and eight (108) hours of didactic and skills laboratories; and

(2) No less than ninety-four (94) hours of hospital clinical training as prescribed in Section 100152(b) of this Chapter.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Section 1797.172, Health and Safety Code.

§ 100160. Required Course Content.

(a) The content of a paramedic course shall meet the objectives contained in the U. S. Department of Transportation (DOT) National Emergency Medical Services Education Standards, DOT HS 811 077A, January 2009, to result in the paramedic being competent in the paramedic basic scope of practice specified in Section 100146(a) of this Chapter. The DOT HS 811 077A, can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following website address:

<http://www.ems.gov/education/nationalstandardandnecs.html>

(b) The content of the CCP course shall include:

1. Role of interfacility transport paramedic:

(A) Healthcare system

(B) Critical care vs. 9-1-1 system

(C) Integration and cooperation with other health professionals

(D) Hospital documentation and charts

(E) Physician orders vs. ALS protocols

2. Medical – legal issues:

(A) Emergency Medical Treatment and Active Labor Act (EMTALA)

(B) Health Insurance Portability and Accountability Act (HIPAA)

(C) Review of California paramedic scope of practice

(D) Consent issues

(E) Do Not Resuscitate (DNR) and Physicians Orders for Life-Sustaining Treatment (POLST)

3. Transport Fundamentals, Safety and Survival

(A) Safety of the work environment

(B) Transport vehicle integrity checks

(C) Equipment functionality checks

- (D) Transport mode evaluation, indications for critical care transport and policies
- (E) Aircraft Fundamentals and Safety
- (F) Flight Physiology
- (G) Mission safety decisions
- (H) Scene Safety and Post-accident duties at a crash site
- (I) Patient Packaging for transport
- (J) Crew Resource Management (CRM) & Air Medical Resource Management (AMRM)
- (K) Use of safety equipment while in transport
- (L) Passenger safety procedures (e.g., specialty teams, family, law enforcement, observer)
- (M) Hazard observation and correction during transport vehicle operation
- (N) Stressors related to transport (e.g., thermal, humidity, noise, vibration, or fatigue related conditions)
- (O) Corrective actions for patient stressors related to transport
- (P) Operational procedures:
 - (1) Dispatching and deployment
 - (2) Recognition of patients who require a higher level of care
 - a. What to do if you are not comfortable with a transport/ patient.
 - b. When a patient's needs exceed the staffing available on the unit.
 - (3) Review of specific county policies
 - (4) Obtaining and receiving reports from sending/ receiving facilities
 - (5) Re-calculating hanging dose prior to accepting patient
 - (6) Notification to receiving hospital while en route (cell phone)
 - a. Patient status
 - b. Estimated time of arrival (ETA)
 - (7) What to do if the patient deteriorates
 - (8) Diversion issues
 - (9) Wait and return calls – continuity of care issues
 - (10) Documentation
 - a. Patient consent forms
 - b. Physician order sheets
 - c. Critical care flow sheets

4 Shock and multi-system organ failure

- (A) Pathophysiology of shock
- (B) Types of shock
- (C) Shock management
- (D) Multi-system organ failure
 - 1. Recognition and management of sepsis
 - 2. Recognition and management of disseminated intravascular coagulation (DIC)

5. Basic Physiology for Critical Care Transport and Laboratory and Diagnostic Analysis

Laboratory values:

- (A) Arterial blood gases
 - 1. The potential hydrogen (pH) scale
 - 2. Bodily regulation of acid-base balance
 - 3. Practical evaluation of arterial blood gas results
- (B) Review of the following to include normal and abnormal values and implications
 - 1. Urinalysis
 - a. Normal output
 - b. Specific gravity
 - c. pH range
 - 2. Complete blood count (CBC)
 - a. Hematocrit and Hemoglobin (H&H)
 - b. Red blood cell (RBC)
 - c. White blood cell (WBC) with differential
 - d. Platelets
 - 3. Other
 - a. Albumin
 - b. Alkaline phosphate
 - c. Alanine transaminase (ALT)
 - d. Aspartate transaminase (AST)
 - e. Bilirubin
 - f. Calcium
 - g. Chloride
 - h. Creatine Kinase (CK) (total and fractions)
 - i. Creatinine
 - j. Glucose
 - k. Lactate
 - l. Lactic dehydrogenase (LDH)
 - m. Lipase
 - 4. Magnesium
 - 5. Phosphate
 - 6. Potassium
 - 7. Procalcitonin
 - 8. Protein, total
 - 9. Prothrombin Time (PT) and Activated Partial Thromboplastin Time (PTT)
 - 10. Sodium
 - 11. Troponin
 - 12. Urea nitrogen
- (C) Practical application of laboratory values to patient presentations
- (D) Use of laboratory devices for point of care testing (eg: ISTAT)
- (E) Radiographic Interpretation
- (F) Wherever appropriate, the above education should include information regarding radiographic findings, pertinent laboratory and bedside testing, and pharmacological interventions

6. Critical Care Pharmacology and Infusion Therapy

Pharmacology and infusion therapies:

(A) Review of common medications encountered in the critical care environment to include those in the following categories:

1. Analgesics
2. Antianginals
3. Antiarrhythmics
4. Antibiotics
5. Anticoagulants
6. Antiemetics
7. Anti-inflammatory agents
8. Antihypertensives
9. Antiplatelets
10. Antitoxins
11. Benzodiazepines
12. Bronchodilators
13. Glucocorticoids
14. Glycoprotein IIb/IIIa inhibitors
15. Histamine Blockers (1 and 2)
16. Induction agents
17. Neuroleptics
18. Osmotic diuretics
19. Paralytics
20. Proton Pump Inhibitors
21. Sedatives
22. Thrombolytics
23. Total Parenteral Nutrition
24. Vasopressors
25. Volume expanders

(B) Review of drug calculation mathematics

1. IV bolus medication
2. IV infusion rates
 - a. By volume
 - b. By rate

(C) Detailed instruction (drug action and indications, dosages, IV calculation, adverse reactions, contraindications and precautions) on following medications:

1. IV nitroglycerin (NTG)
2. Heparin
3. Potassium chloride (KCl) infusion
4. Lidocaine

(D) Blood and blood products

1. Blood components and their uses in therapy
2. Administrative procedures

3. Administration of blood products
4. Transfusion reactions – recognition, management
- (E) Infusion pumps:
 1. Set up and maintain IV fluid and medication delivery pumps and devices
 2. Discussion of various pumps that may be encountered
 3. Discussion of prevention of “run-away” IV lines while transitioning
 4. Practical application of transfer of IV infusions, setting drip rates and troubleshooting
- (F) Procedures to be used when re-establishing IV lines
 1. Hemodynamic monitoring and invasive lines:
 - a. Non-invasive monitoring
 - 1) Non-invasive blood pressure (NIBP)
 - 2) Pulse oximetry
 - 3) Capnography
 - 4) Heart and bowel sound auscultation
 - b. Intraosseous (IO) access and infusion - the student must demonstrate competency in the skill of IO infusion
 - c. Central Venous Access
 - 1) Subclavian - the student must demonstrate competency in the skill of subclavian access.
 - 2). Internal jugular - the student must demonstrate competency in the skill of internal jugular access.
 - 3) Femoral approach - the student must demonstrate competency in the skill of femoral access.
6. Respiratory Patient Management
 - (A) Pulmonary anatomy and physiology
 1. Upper and lower airway anatomy
 2. Mechanics of ventilation and oxygenation
 3. Gas Exchange
 4. Oxyhemoglobin dissociation
 - (B) Detailed assessment of the respiratory patient
 1. Obtaining a relevant history
 2. Physical exam
 3. Breath sounds
 4. Percussion
 - (C) Causes, pathophysiology, and stages of respiratory failure
 - (D) Assessment and management of patients with respiratory compromise
 1. Respiratory failure
 2. Atelectasis
 3. Pneumonia
 4. Pulmonary embolism
 5. Pneumothorax
 6. Spontaneous pneumothorax

- 7. Hemothorax
- 6. Pleural effusion
- 7. Pulmonary edema
- 8. Chronic obstructive pulmonary disease
- 9. Adult respiratory distress syndrome (ARDS)
- (E) Differential diagnosis of acute and chronic conditions
- (F) Management of patient status using
 - 1. Laboratory values, to include but not limited to,
 - a. Blood gas values,
 - b. Use of ISTAT
 - 2. Diagnostic equipment
 - a. Pulse oximetry,
 - b. Capnography
 - c. Chest radiography
 - d. CO-Oximetry (carbon monoxide measurement)
- (G) Application of pharmacologic agents for the respiratory patient
- (H) Management of complications during transport of the respiratory patient
- 7. Advanced Airway and Breathing Management Techniques
 - (A) Indications for basic and advanced airway management
 - 1. Crash airway assessment and management
 - 2. Deteriorating airway assessment and management
 - (B) Indications, contraindications, complications, and management for specific airway and breathing interventions
 - 1. Needle Cricothyroidotomy
 - 2. Surgical Cricothyroidotomy - the student must demonstrate competency in the skill of surgical cricothyroidotomy.
 - 3. Tracheostomies
 - a. Types of tracheostomies
 - b. Tracheostomy care
 - 4. Endotracheal intubation – adult, pediatric, and neonatal
 - a. Nasotracheal intubation
 - b. Rapid Sequence Intubation (RSI) – the student must demonstrate competency in the skill of RSI.
 - c. Perilaryngeal airway devices
 - 1) Combitube
 - 2) King Airway
 - 3) Supraglottic airway devices
 - 4) Laryngeal mask airway devices
 - 5. Pleural decompression
 - 6. Chest tubes
 - a. Set up and maintain thoracic drainage systems
 - b. Operation of and troubleshooting
 - c. Indications for and positioning of dependent tubing

- d. Varieties available
 - e. Gravity drainage
 - f. Suction drainage
 - g. On-going assessments of drainage amount and color
- 7. Portable ventilators
 - a. Principles of ventilator operation
 - b. Set-up and maintain mechanical ventilation devices
 - c. Procedures for transferring ventilator patients
 - d. Complications of ventilator management
 - e. Troubleshooting and practical application
- C. Perform advanced airway and breathing management techniques
 - 1. Endotracheal intubation – adult, pediatric, and neonatal
 - 2. Nasotracheal intubation
 - 3. Rapid Sequence Intubation (RSI)
 - 4. Pleural decompression
- D. Failed airway management and algorithms
- E. Perform alternative airway management techniques
 - 1. Needle Cricothyroidotomy
 - 2. Surgical Cricothyroidotomy
 - 3. Retrograde intubation
 - 4. Perilaryngeal airway devices
 - 5. Supraglottic airway devices
 - 6. Laryngeal mask airway devices
- F. Airway management and ventilation monitoring techniques during transport
- G. Use of mechanical ventilation
- H. Administer pharmacology agent for continued airway management
- 8. Cardiac Patient Management
 - (A) Cardiac Anatomy and Physiology and Pathophysiology
 - (B) Detailed Assessment of the Cardiac Patient
 - (C) Assessment and Management of patients with cardiac events
 - 1. Acute coronary syndromes,
 - 2. Heart failure,
 - 3. Cardiogenic shock,
 - 4. Primary arrhythmias,
 - 5. Hemodynamic instability
 - 6. Vascular Emergencies
 - (D) Invasive monitoring (use, care, and complication management)
 - 1. Arterial
 - 2. Central venous pressure (CVP)
 - (E) Vascular access devices usage and maintenance
 - (F) Dressing and site care
 - (G) Management of complications
 - (H) Manage patient's status using

1. laboratory values (e.g., blood gas values, ISTAT)
2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
3. 12-lead EKG interpretation:
 - a. Essential 12-lead interpretation
 - b. Acquisition and transmission
 - c. Acute coronary syndromes
 - d. The high acuity patient
 - e. Bundle branch block and the imitators of acute coronary syndrome (ACS)
 - f. Theory and Use of cardiopulmonary support devices as part of patient management
 - 1) Ventricular assist devices,
 - 2) Transvenous pacer,
 - 3) Intra-aortic balloon pump
 - g. Application of Pharmacologic agents in Cardiac Emergencies
 - h. Management of complications of cardiac patients
 - i. Implanted cardioverter defibrillators:
 - 1) Eligible populations
 - 2) Mechanism
 - 3) Complications and patient management
 - j. Cardiac pacemakers
 - 1) Normal operations, troubleshooting and loss of capture
 - a). Implanted devices
 - b). Unipolar and bipolar
 - (2) Temporary pacemakers
 - (3) Transcutaneous pacing
9. Trauma Patient Management
 - (A) Differentiate injury patterns associated with specific mechanisms of injury
 - (B) Rate a trauma victim using the Trauma Score, to include but not be limited to glasgow coma score, injury severity score, and revised trauma score
 - (C) Identify patients who meet trauma center criteria
 - (D) Perform a comprehensive assessment of the trauma patient
 - (E) Initiate the critical interventions for the management of the trauma patient
 1. Manage the patient with life-threatening thoracic injuries
 - a. Tension pneumothorax,
 - b. Pneumothorax,
 - c. Hemothorax,
 - d. Flail chest,
 - e. Cardiac tamponade,
 - f. Myocardial rupture
 2. Manage the patient with abdominal injuries
 - a. diaphragm,
 - b. liver,
 - c. spleen

3. Manage the patient with orthopedic injuries (e.g. pelvic, femur, spinal)
4. Manage the patient with neurologic injuries
 - a. Subdural,
 - b. Epidural,
 - c. Increased ICP
- (F) Manage patient's status using
 1. laboratory values (e.g., blood gas values, ISTAT)
 2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
- (G) Application of pharmacologic agents for trauma management
- (H) Manage trauma patient emergencies and complications
 1. the student must demonstrate competency in the skill of chest tube thoracostomy.
 2. The student must demonstrate competency in the skill of pericardiocentesis,
- (I) Administer blood and blood products
- (J) Trauma considerations:
 1. Trauma assessment,
 2. Adult thoracic & abdominal trauma,
 3. Vascular trauma,
 4. Musculoskeletal trauma,
 5. Burns,
 6. Ocular trauma,
 7. Maxillofacial trauma,
 8. Penetrating & blunt trauma,
 9. Distributive & hypovolemic shock states,
 - 10 Trauma Systems & Trauma Scoring, and
 11. Kinematics of trauma & injury patterns.
10. Neurologic Patient Management
 - (A) Perform an assessment of the patient
 - (B) Conduct differential diagnosis of patients with coma
 - (C) Manage patients with seizures
 - (D) Manage patients with cerebral ischemia
 - (E) Initiate the critical interventions for the management of a patient with a neurologic emergency
 - (F) Provide care for a patient with a neurologic emergency
 1. Trauma neurological emergencies
 2. Medical neurological emergencies
 3. Cerebrovascular Accidents,
 4. Neurological shock states
 - (G) Assess a patient using the Glasgow coma scale
 - (H) Manage patients with head injuries
 - (I) Manage patients with spinal cord injuries
 - (J). Manage patient's status using
 1. laboratory values (e.g., blood gas values, ISTAT)

- 2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
- (K) Intracranial Pressure monitoring.
- (L) Application of pharmacologic agents for neurologic patients
- (M). Manage neurologic patient complications
- 11. Toxic Exposure and Environmental Patient Management
 - (A) Toxic Exposure Patient
 - 1. Perform a detailed assessment of the patient
 - 2. Decontaminate toxicological patients (e.g., chemical/biological/radiological exposure)
 - 3. Administer poison antidotes
 - 4. Provide care for victims of envenomation
 - a. Snake bite,
 - b. Scorpion sting,
 - c. Spider bite
 - 5. Manage patient's status using
 - a. Laboratory values (e.g., blood gas values, ISTAT)
 - b. Diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
 - 6. Administer pharmacologic agents
 - 7. Manage toxicological patients
 - a. Medication overdose,
 - b. Chemical/biological/radiological exposure
 - 8. Manage toxicological patient complications
 - (B) Environmental Patient
 - 1. Perform an assessment of the patient
 - 2. Manage the patient experiencing a cold-related illness
 - a. Frostbite,
 - b. Hypothermia,
 - c. Cold water submersion
 - 3. Manage the patient experiencing a heat-related illness
 - a. Heat stroke,
 - b. Heat exhaustion,
 - c. Heat cramps
 - 4. Manage the patient experiencing a diving-related illness
 - a. Decompression sickness,
 - b. Arterial gas emboli,
 - c. Near drowning
 - 5. Manage the patient experiencing altitude-related illness
 - 6. Manage patient's status using
 - a. laboratory values (e.g., blood gas values, ISTAT)
 - b. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
 - 7. Application for pharmacologic agents for toxic exposure and environmental

- patients
- 8. Treat patient with environmental complications
- (C) Toxicology:
 - 1. Toxic exposures,
 - 2. Poisonings,
 - 3. Overdoses,
 - 4. Envenomations,
 - 5. Anaphylactic shock, and
 - 6. Infectious diseases.
- 12. Obstetrical Patient Management
 - (A) Perform a detailed assessment of the patient
 - (B) Assess and Manage fetal distress
 - (C) Manage obstetrical patients
 - (D) Assess uterine contraction pattern
 - (E) Conduct interventions for obstetrical emergencies and complications
 - 1. Pregnancy induced hypertension,
 - 2. Hypertonic or titanic contractions,
 - 3. Cord prolapse,
 - 4. Placental abruption
 - 5. Severe preeclampsia involving hemolysis, elevated liver function, and low platelets (HELLP) syndrome.
 - (F) Determine if transport can safely be attempted or if delivery should be accomplished at the referring facility
 - (G) Manage patient's status using
 - 1. laboratory values (e.g., blood gas values, ISTAT)
 - 2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
 - (H) Application of pharmacologic agents for obstetrical patient management
 - (I) Manage emergent delivery and post-partum complications
 - (J) Special Considerations in Obstetrics (OB)/ Gynecology (GYN) Patients
 - 1. Trauma in pregnancy,
 - 2. Renal disorders,
 - 3. Reproductive system disorders
- 13. Neonatal and Pediatric Patient Management
 - (A) Neonatal Patient
 - 1. Perform a detailed assessment of the neonatal patient
 - a. Management & delivery of the full-term or pre-term newborn,
 - b. Management of the complications of delivery
 - 2. Manage the resuscitation of the neonate, including
 - a. Umbilical artery catheterization – the student must demonstrate the skill of umbilical catheterization.
 - b. Neonatal Resuscitation Program & Pediatric Advanced Life Support.
 - 3. Manage patient's status using diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)

4. Application of pharmacologic agents for neonatal patient management
5. Manage neonatal patient complications
- (B) Pediatric Patient
 1. Perform a detailed assessment of the pediatric patient
 2. Manage the pediatric patient experiencing a medical event
 - a. Respiratory
 - b. Toxicity
 - c. Cardiac
 - d. Environmental
 - e. Gastrointestinal (GI)
 - f. Endocrine/Metabolic
 - f. Neurological
 - g. Infectious processes
 3. Manage the pediatric patient experiencing a traumatic event
 - a. Single vs. multiple system
 - b. Burns
 - c. Non-accidental trauma
 4. Manage patient's status using
 - a. laboratory values (e.g., blood gas values, ISTAT)
 - b. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
 - c. Application of pharmacologic agents for pediatric patient management
 - d. Treat patient with pediatric complications
 5. Considerations for Special needs children.
14. Burn Patient Management
 - (A) Perform a detailed assessment of the patient
 - (B) Calculate the percentage of total body surface area burned
 - (C) Manage fluid replacement therapy
 - (D) Manage inhalation injuries in burn injury patients
 - (E) Manage patient's status using
 1. laboratory values (e.g., blood gas values, ISTAT)
 2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
 - (F) Application of pharmacologic agents for burn patient management
 - (G) Provide treatment of burn complications - the student must demonstrate competency in the skill of escharotomy.
15. General Medical Patient Management
 - (A) Perform an assessment of the patient
 - (B). Manage patients experiencing a medical condition
 1. Abdominal aortic aneurysm (AAA),
 2. GI bleed,
 3. Bowel obstruction,
 4. Hyperosmolar Hyperglycemic Non-Ketotic Coma (HHNC)
 5. Septic shock,

- 6. Neurologic emergencies
- 7. Hypertensive emergencies,
- 8. Environmental emergencies,
- 9. Coagulopathies,
- 10. Endocrine emergencies,
- (C) Use of invasive monitoring for the purpose of clinical management
- (D) Manage patient's status using
 - 1. laboratory values (e.g., blood gas values, ISTAT)
 - 2. diagnostic equipment (e.g., pulse oximetry, chest radiography, capnography)
- (E) Application of pharmacologic agents for general medical patient management
- (F) Treat patient with general medical complications
- (G). Transport considerations of patients with renal or peritoneal dialysis
- (H) Transport of Patients with Infection Diseases:
 - 1 Pathogens
 - a. Human immunodeficiency virus (HIV)
 - b. Hepatitis
 - c. Vancomycin resistant enterococcus (VRE)
 - d. Multiple-antibiotic resistant bacteria (MRSA)
 - e. Tuberculosis (TB)
 - f. Immunocompromised
 - g. Others as appropriate
- (I) Transport and Management of Patients with Indwelling tubes
 - 1. Urinary
 - a. Foleys
 - b. Suprapubic
 - 2. Nasogastric (NG)
 - 3. Percutaneous endoscopic gastric (PEG)
 - 4. Dobhoff tube

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
 Reference: Sections 1797.172, 1797.173, 1797.185 and 1797.213, Health and Safety Code.

§ 100161. Required Testing.

- (a) Approved paramedic and CCP training programs shall include periodic examinations and final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.
- (b) Successful performance in the clinical and field setting shall be required prior to course completion.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.185, 1797.208, 1797.210 and 1797.213, Health and Safety Code.

§ 100162. Course Completion Record.

- (a) Approved paramedic training program and/or CCP training program shall issue a tamper resistant course completion record to each person who has successfully completed the paramedic training program and/or CCP training program. The course completion record shall be issued no later than ten (10) working days from the date of the student's successful completion of the paramedic training program and/or CCP training program.
 - (b) The course completion record shall contain the following:
 - (1) The name of the individual.
 - (2) The date of completion.
 - (3) The following statement:
 - (A) "The individual named on this record has successfully completed an approved paramedic training program", or
 - (B) "The individual named on this record has successfully completed an approved Critical Care Paramedic training program"
 - (4) The name of the paramedic training program or CCP training program approving authority, depending on the training program being taught.
 - (5) The signature of the course director.
 - (6) The name and location of the training program issuing the record.
 - (7) The following statement in bold print: **"This is not a paramedic license."**
 - (8) For paramedic training, a list of optional scope of practice procedures and/or medications approved pursuant to subsection (c) (2)(A)-(D) of Section 100146 taught in the course.
 - (9) For CCP training, a list of procedures and medications approved pursuant to subsection (c)(1)(S)(1-10) of Section 100146 taught in the course.
- NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Section 1797.172, Health and Safety Code.

Article 4. Applications and Examinations

§ 100163. Date and Filing of Applications.

- (a) The Authority shall notify the applicant within thirty (30) days of receipt of the state application that the application was received and shall specify what information, if any, is missing. The types of applications which may be required to be submitted by the applicant are as follows:
 - (1) Application for Initial License (California Graduate), Form #L-01, Revised 7/2011, herein incorporated by reference.
 - (2) Application for Initial License of Out-of-State Candidates who are registered with the National Registry of Emergency Medical Technicians, Form #L-01A, Revised 7/2011, herein incorporated by reference.
 - (3) Application for License Renewal, Form #RL-01, Revised 6/2011, herein incorporated by reference.
 - (4) Application for Lapsed License Reinstatement:

(A) Lapsed Less than One Year, Form #RLL-01A, Revised 06/2012, herein incorporated by reference.

(B) Lapse of One Year or More, Form #RLL-01B, Revised 06/2012, herein incorporated by reference.

(5) Application for Challenge, Form #C L-01A, Revised 06/2012, herein incorporated by reference.

(6) Applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Applicant Submission Form, BCII 8016 (Rev 06/09), submitted to the California Department of Justice (DOJ), for a state and federal criminal history summary provided by the Department of Justice in accordance with the provisions of section 11105 et seq. of the Penal Code.

(7) Statement of Citizenship, Alienage, and Immigration Status For State Paramedic License Application /Renewal Form IS-01 (8/11), herein incorporated by reference.

(b) Applications for renewal of license shall be postmarked, hand delivered, or otherwise received by the Authority at least thirty (30) calendar days prior to expiration of current license. Applications postmarked, hand delivered or otherwise received by the Authority less than thirty (30) days prior to the expiration date of the current license will not cause the license to lapse but will require the applicant to pay a \$50 late fee, as specified in Section 100172(b)(4) of this Chapter.

(c) Eligible out-of-state applicants defined in section 100165(b) and eligible applicants defined in section 100165(c) of this Chapter who have applied to challenge the paramedic licensure process shall be notified by the Authority within forty-five (45) working days of receiving the application. Notification shall advise the applicant that the application has been received, and shall specify what information, if any, is missing.

(d) An application shall be denied without prejudice when an applicant does not complete the application, furnish additional information or documents requested by the Authority or fails to pay any required fees. An applicant shall be deemed to have abandoned an application if the applicant does not complete the requirements for licensure within one (1) year from the date on which the application was filed. An application submitted subsequent to an abandoned application shall be treated as a new application.

(e) A complete state application is a signed application submitted to the Authority that provides the requested information and is accompanied by the appropriate application fee(s). All statements submitted by or on behalf of an applicant shall be made under penalty of perjury.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Section 1797.172, Health and Safety Code.

§ 100164. Written and Skills Examination.

(a) Applicants shall comply with the procedures for examination established by the Authority and the NREMT and shall not violate or breach the security of the examination. Applicants found to have violated the security of the examination or

examination process as specified in section 1798.207 of the Health and Safety Code shall be subject to the penalties specified therein.

(b) Students enrolled in an accredited paramedic training program, or a paramedic training program with a current Letter of Review on file with the NREMT, shall be eligible to take the practical examination specified in Sections 100140 of this chapter upon successful completion of didactic and skills laboratory, and shall be eligible to take the written examination specified in Section 100141 when they have successfully completed the didactic, clinical, and field training and have met all the provisions of the approved paramedic training program.

NOTE: Authority cited: Sections 1797.7, 1797.107, 1797.172, 1797.174 and 1797.185, Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, 1797.214 and 1798.207, Health and Safety Code.

Article 5. Licensure

§ 100165. Licensure.

(a) In order to be eligible for initial paramedic licensure an individual shall meet the following requirements.

(1) Have a paramedic training program course completion record as specified in Section 100162 of this Chapter or other documented proof of successful completion of an approved paramedic training program within the last two years from the date of application to the Authority for paramedic licensure.

(2) Complete and submit the appropriate state application forms as specified in Section 100163.

(3) Provide documentation of successful completion of the paramedic licensure written and practical examinations specified in sections 100140, 100141, and 100164.

(4) Pay the established fees pursuant to Section 100172.

(b) An individual who possesses a current paramedic registration issued by the NREMT, shall be eligible for licensure when that individual fulfills the requirements of subsection (a)(2) and (4) of this section and successfully completes a field internship as defined in Sections 100153 and 100159(b).

(c) A physician, registered nurse or physician assistant currently licensed shall be eligible for paramedic licensure upon:

(1) providing documentation that their training is equivalent to the DOT HS 811 077A specified in Section 100160;

(2) successfully completing a field internship as defined in Sections 100153(a) and 100159(b); and,

(3) fulfilling the requirements of subsection (a)(2) through (a)(4) of this section.

(d) All documentation submitted in a language other than English shall be accompanied by a translation into English certified by a translator who is in the business of providing certified translations and who shall attest to the accuracy of such translation under penalty of perjury.

(e) The Authority shall issue within forty-five (45) calendar days of receipt of a complete application as specified in Section 100163(e) a wallet-sized license to eligible individuals who apply for a license and successfully complete the licensure requirements.

(f) The effective date of the initial license shall be the day the license is issued. The license shall be valid for two (2) years from the last day of the month in which it was issued.

(g) The paramedic shall be responsible for notifying the ~~EMS~~ Authority of her/his proper and current mailing address and shall notify the Authority in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and paramedic license number.

(h) A paramedic may request a duplicate license if the individual submits a request in writing certifying to the loss or destruction of the original license, or the individual has changed his/her name. If the request for a duplicate card is due to a name change, the request shall also include documentation of the name change. The duplicate license shall bear the same number and date of expiration as the replaced license.

(i) An individual currently licensed as a paramedic by the provision of this section is deemed to be certified as an EMT and an AEMT, except when the paramedic license is under suspension, with no further testing required. If certificates are issued, the expiration date of the EMT or AEMT certification shall be the same expiration date as the paramedic license, unless the individual follows the EMT, or AEMT certification/recertification process as specified in Chapters 2 and 3 of this Division.

(j) An individual currently licensed as a paramedic by the provisions of this section may voluntarily deactivate his/her paramedic license if the individual is not under investigation or disciplinary action by the Authority for violations of Health and Safety Code Section 1798.200. If a paramedic license is voluntarily deactivated, the individual shall not engage in any practice for which a paramedic license is required, shall return his/her paramedic license to the Authority, and shall notify any LEMSA with which he/she is accredited as a paramedic or with which he/she is certified as an EMT-I or AEMT that the paramedic license is no longer valid. Reactivation of the paramedic license shall be done in accordance with the provisions of Section 100167(b) of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185, 1797.194, 1798.200 and 1798.202, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.177, 1797.185, 1797.194 and 1798.200, Health and Safety Code and section 15376, Government Code.

§ 100166. Accreditation to Practice.

(a) In order to be accredited an individual shall:

(1) Possess a current California paramedic license.

(2) Apply to the LEMSA for accreditation.

(3) Successfully complete an orientation of the local EMS system as prescribed by the LEMSA which shall include policies and procedures, treatment protocols, radio

communications, hospital/facility destination policies, and other unique system features. The orientation shall not exceed eight (8) classroom hours, except when additional hours are needed to accomplish subsection (a)(4) of this section, and shall not include any further testing of the paramedic basic scope of practice. Testing shall be limited to local policies and treatment protocols provided in the orientation.

(4) Successfully complete training in any basic and/or local optional scope of practice for which the paramedic has not been trained and tested.

(5) Pay the established local fee pursuant to Section 100172.

(6) In order for an individual to be eligible for accreditation, in the LEMSA's CCP scope of practice, the individual must obtain and maintain CCP certification from the BCCTPC by July 1, 2015.

(b) If the LEMSA requires a supervised field evaluation as part of the local accreditation process, the field evaluation shall consist of no more than ten (10) ALS patient contacts. The field evaluation shall only be used to determine if the paramedic is knowledgeable to begin functioning under the local policies and procedures.

(1) The paramedic accreditation applicant may practice in the basic scope of practice as a second paramedic until s/he is accredited.

(2) The paramedic accreditation applicant may only perform the local optional scope of practice while in the presence of the field evaluator who is ultimately responsible for patient care.

(c) The LEMSA medical director shall evaluate any candidate who fails to successfully complete the field evaluation and may recommend further evaluation or training as required to ensure the paramedic is competent. If, after several failed remediation attempts, the medical director has reason to believe that the paramedic's competency to practice is questionable, then the medical director shall notify the Authority.

(d) If the paramedic accreditation applicant does not complete accreditation requirements within thirty (30) calendar days, then the applicant may be required to complete a new application and pay a new fee to begin another thirty (30) day period.

(e) A LEMSA may limit the number of times that a paramedic applies for initial accreditation to no more than three (3) times per year.

(f) The LEMSA shall notify the individual applying for accreditation of the decision whether or not to grant accreditation within thirty (30) calendar days of submission of a complete application.

(g) Accreditation to practice shall be continuous as long as licensure is maintained and the paramedic continues to meet local requirements for updates in local policy, procedure, protocol and local optional scope of practice, and continues to meet requirements of the system-wide EMSQIP pursuant to Section 100168.

(h) An application and fee may only be required once for ongoing accreditation. An application and fee can only be required to renew accreditation when an accreditation has lapsed.

(i) The medical director of the LEMSA may suspend or revoke accreditation if the paramedic does not maintain current licensure or meet local accreditation requirements and the following requirements are met:

(1) The paramedic has been granted due process in accordance with local policies and procedures.

(2) The local policies and procedures provide a process for appeal or reconsideration.

(j) The LEMSA shall submit to the Authority the names and dates of accreditation for those individuals it accredits within twenty (20) working days of accreditation.

(k) During an interfacility transfer, a paramedic may utilize the scope of practice for which s/he is trained and accredited.

(l) During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting LEMSA.

NOTE: Authority cited: Sections 1797.7, 1797.107, 1797.172, 1797.185 and 1797.192, Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185 and 1797.214, Health and Safety Code.

Article 6. License Renewal

§ 100167. License Renewal

(a) In order to be eligible for renewal of a non-lapsed paramedic license, an individual shall comply with the following requirements:

(1) Possess a current paramedic license issued in California.

(2) Complete forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division.

(3) Complete and submit the state Paramedic Application for License Renewal, Form #RL-01, Revised 07/2011 including the Statement of Continuing Education located on the back of the license renewal application. EMSA will notify the paramedic, by mail, approximately six (6) months prior to their paramedic license expiration date on how to renew their license.

(4) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(b) In order for an individual whose license has lapsed to be eligible for license renewal, the following requirements shall apply:

(1) For a lapse of less than six (6) months, the individual shall comply with (a) (2), and (a)(4) of this section and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.

(2) For a lapse of six months (6) or more, but less than twelve (12) months, the individual shall comply with (a)(2), and (a)(4) of this section, complete an additional twelve (12) hours of CE, for a total of sixty (60) hours of CE, and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.

(3) For a lapse of twelve (12) months or more, but less than twenty-four (24) months, the individual shall pass the licensure examination specified in Sections 100140,

100141, and 100164 or possess a current paramedic registration issued by the NREMT, comply with (a) (2) and (a)(4) of this section, submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Rev 03/07), for a state summary criminal history provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code, complete an additional twenty-four (24) hours of CE, for a total of seventy-two (72) hours of CE and complete and submit a state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.

(4) For a lapse of twenty-four (24) months or more, the individual shall comply with (a)(2) and (a)(4) and (b)(3) of this section. Documentation of the seventy-two (72) hours of CE shall include completion of the following courses, or their equivalent:

- (A) Advanced Cardiac Life Support,
- (B) Pediatric Advanced Life Support,
- (C) Prehospital Trauma Life Support or International Trauma Life Support,
- (D) CPR.

(c) Renewal of a license shall be for two (2) years. If the renewal requirements are met within six months (6) prior to the expiration date of the current license, the effective date of licensure shall be the first day after the expiration of the current license. This applies only to individuals who have not had a lapse in licensure.

(d) For individuals whose license has lapsed, the licensure cycle shall be for two (2) years from the last day of the month in which all licensure requirements are completed and the license was issued.

(e) The Authority shall notify the applicant for license renewal within thirty (30) working days of receiving the application that the application has been received and shall specify what information, if any, is missing.

(f) An individual, who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose paramedic license expires during the time the individual is on active duty or less than six (6) months from the date the individual is deactivated/released from active duty, has an additional six (6) months to comply with the CE requirements and the late renewal fee is waived upon compliance with the following provisions:

(1) Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from active duty.

(2) Meet the requirements of Section 100167(a)(2) through (a)(4) of this Chapter, except the individual will not be subject to the \$50 late renewal application fee specified in Section 100172(b)(4).

(3) Provide documentation showing that the CE activities submitted for the license renewal period were taken not earlier than 30 days prior to the effective date of the individual's paramedic license that was valid when the individual was activated for active duty and not later than six (6) months from the date of deactivation/release from active duty.

(A) For an individual whose active duty required him/her to use his/her paramedic skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS Continuing Education Regulations (California Code of Regulations, Title 22, Division 9). The documentation shall include verification from the individual's Commanding Officer attesting to the classes attended.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code, and Section 101, Chapter 1, Part 1, Subtitle A, Title 10, United States Code.

Article 7. System Requirements

§ 100168. Paramedic Service Provider.

(a) A LEMSA with an ALS system shall establish policies and procedures for the approval, designation, and evaluation through its EMSQIP, of all paramedic service provider(s).

(b) An approved paramedic service provider shall:

(1) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol personnel, etc.).

(2) Utilize and maintain telecommunications as specified by the LEMSA.

(3) Maintain a drug and solution inventory as specified by the LEMSA of equipment and supplies commensurate with the basic and local optional scope of practice of the paramedic.

(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:

1. controlled substance ordering and order tracking;
2. controlled substance receipt and accountability;
3. controlled substance master supply storage, security and documentation;
4. controlled substance labeling and tracking;
5. vehicle storage and security;
6. usage procedures and documentation;
7. reverse distribution;
8. disposal;
9. re-stocking procedures.

(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to:

10. controlled substance testing;
11. discrepancy reporting;
12. tampering, theft and diversion prevention and detection;
13. usage audits.

(4) Have a written agreement with the LEMSA to participate in the EMS system and to

comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA's EMSQIP as specified in Chapter 12 of this Division.

(5) Be responsible for assessing the current knowledge of their paramedics in local policies, procedures and protocols and for assessing their paramedics' skills competency.

(6) If, through the EMSQIP the employer or medical director of the LEMSA determines that a paramedic needs additional training, observation or testing, the employer and the medical director may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the employer and the medical director, the decision of the medical director shall prevail.

(c) No paramedic service provider shall advertise itself as providing paramedic services unless it does, in fact, routinely provide these services on a continuous twenty-four (24) hours per day basis and meets the requirements of subsection (b) of this section.

(d) No responding unit shall advertise itself as providing paramedic services unless it does, in fact, provide these services and meets the requirements of subsection (a) of this section.

(e) The LEMSA may deny, suspend, or revoke the approval of a paramedic service provider for failure to comply with applicable policies, procedures, and regulations.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1798, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.180, 1797.204 and 1797.218, Health and Safety Code.

§ 100169. Paramedic Base Hospital.

(a) A LEMSA with an ALS system shall designate a paramedic base hospital(s) or alternative base station, pursuant to Health and Safety Code Section 1798.105 if no qualified base hospital is available to provide medical direction, to provide medical direction and supervision of paramedic personnel.

(b) A designated paramedic base hospital shall be responsible for the provisions of subsections (b)(1) through (b)(13) of this section, and alternate base stations shall be responsible for the provisions of subsections (b)(4) through (b)(13) of this section.

(1) Be licensed by the California Department of Public Health as a general acute care hospital, or, for an out of state general acute care hospital, meet the relevant requirements for that license and the requirements of this section where applicable, as determined by the LEMSA which is utilizing the hospital in the local EMS system.

(2) Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

(3) Have a special permit for basic or comprehensive emergency medical service pursuant to the provisions of Division 5, or have been granted approval by the Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the Health and Safety Code. Hospitals meeting requirements in this section shall be referenced in the EMS Plan of the approving LEMSA.

- (4) Have and agree to utilize and maintain two-way telecommunications equipment, as specified by the LEMSA, capable of direct two-way voice communication with the paramedic field units assigned to the hospital.
 - (5) Both parties shall maintain a record of all online medical direction between the service provider and base hospital or alternative base station as specified by LEMSA policy.
 - (6) Have a written agreement, which is reviewed every three (3) years, with the LEMSA indicating the concurrence of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation as specified in this Chapter and by the LEMSA's policies and procedures.
 - (7) Have a physician licensed in the State of California, experienced in emergency medical care, assigned to the emergency department, available at all times to provide immediate medical direction to the MICN or paramedic personnel. This physician shall have experience in and knowledge of base hospital radio operations and LEMSA policies, procedures, and protocols.
 - (8) Assure that nurses giving medical direction to paramedic personnel are trained and authorized as MICNs by the medical director of the LEMSA.
 - (9) Designate a paramedic base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the medical director of the LEMSA when the medical director determines that an individual with these qualifications is not available. The base hospital medical director shall be regularly assigned to the emergency department, have experience in and knowledge of base hospital radio operations and LEMSA policies and procedures, and shall be responsible for functions of the base hospital including the EMSQIP.
 - (10) Identify a base hospital coordinator who is a currently licensed in California registered nurse with experience in and knowledge of base hospital operations and LEMSA policies and procedures. The base hospital coordinator shall serve as a liaison to the local EMS system.
 - (11) Ensure that a mechanism exists for prehospital providers to contract for the provision of medications, medical supplies and equipment used by paramedics according to policies and procedures established by the LEMSA.
 - (12) Provide for CE in accordance with the policies and procedures of the LEMSA.
 - (13) Agree to participate in the LEMSA's EMSQIP which may include making available all relevant records for program monitoring and evaluation.
- (c) The LEMSA may deny, suspend, or revoke the approval of a base hospital or alternative base station for failure to comply with any applicable policies, procedures, and regulations.

NOTE: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.56, 1797.58, 1797.59, 1797.172, 1797.178, 1798, 1798.2, 1798.100, 1798.101, 1798.102 and 1798.104, Health and Safety Code.

§ 100170. Medical Control.

The medical director of the LEMSA shall establish and maintain medical control in the following manner:

- (a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:
 - (1) Treatment protocols that encompass the paramedic scope of practice.
 - (2) Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA.
 - (3) Criteria for initiating specified emergency treatments on standing orders or for use in the event of communication failure that is consistent with this Chapter.
 - (4) Criteria for initiating specified emergency treatments, prior to voice contact, that are consistent with this Chapter.
 - (5) Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance or when the patient refuses transport.
 - (6) Requirements for the initiation, completion, review, evaluation, and retention of a patient care record as specified in this Chapter. These requirements shall address but not be limited to:
 - (A) Initiation of a record for every patient response.
 - (B) Responsibilities for record completion.
 - (C) Record distribution to include LEMSA, receiving hospital, paramedic base hospital, alternative base station, and paramedic service provider.
 - (D) Responsibilities for record review and evaluation.
 - (E) Responsibilities for record retention.
- (b) Establish policies which provide for direct voice communication between a paramedic and a base hospital physician or MICN, as needed.
- (c) Retrospectively, by providing for organized evaluation and CE for paramedic personnel. This shall include, but not be limited to:
 - (1) Review by a base hospital physician or MICN of the appropriateness and adequacy of paramedic procedures initiated and decisions regarding transport.
 - (2) Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.
 - (3) Organized field care audit(s).
 - (4) Organized opportunities for CE including maintenance and proficiency of skills as specified in this Chapter.
- (d) In circumstances where use of a base hospital as defined in Section 100169 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the ~~EMS~~ Authority.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.176, Health and Safety Code. Reference: Sections 1797.90, 1797.172, 1797.202, 1797.220, 1798, 1798.2, 1798.3 and 1798.105, Health and Safety Code.

Article 8. Record Keeping and Fees.

§ 100171. Record Keeping.

- (a) Each paramedic approving authority shall maintain a record of approved training programs within its jurisdiction and annually provide the Authority with the name, address, and course director of each approved program. The Authority shall be notified of any changes in the list of approved training programs.
- (b) Each paramedic approving authority shall maintain a list of current paramedic program medical directors, course directors, and principal instructors within its jurisdiction.
- (c) The Authority shall maintain a record of approved training programs.
- (d) Each LEMSA shall, at a minimum, maintain a list of all paramedics accredited by them in the preceding five (5) years.
- (e) The paramedic is responsible for accurately completing the patient care record referenced in Section 100170(a)(6) which shall contain, but not be limited to, the following information when such information is available to the paramedic:
 - (1) The date and estimated time of incident.
 - (2) The time of receipt of the call (available through dispatch records).
 - (3) The time of dispatch to the scene.
 - (4) The time of arrival at the scene.
 - (5) The location of the incident.
 - (6) The patient's:
 - (A) Name;
 - (B) Age;
 - (C) Gender;
 - (D) Weight, if necessary for treatment;
 - (E) Address;
 - (F) Chief complaint; and
 - (G) Vital signs.
 - (7) Appropriate physical assessment.
 - (8) The emergency care rendered and the patient's response to such treatment.
 - (9) Patient disposition.
 - (10) The time of departure from scene.
 - (11) The time of arrival at receiving facility (if transported).
 - (12) The name of receiving facility (if transported).
 - (13) The name(s) and unique identifier number(s) of the paramedics.
 - (14) Signature(s) of the paramedic(s).
- (f) A LEMSA utilizing computer or other electronic means of collecting and storing the information specified in subsection (e) of this section shall in consultation with EMS providers establish policies for the collection, utilization and storage of such data.

NOTE: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.185, 1797.200, 1797.204 and 1797.208, Health and Safety Code.

§ 100172. Fees.

(a) A LEMSA may establish a schedule of fees for paramedic training program review and approval, CE provider approval, and paramedic accreditation in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.

(b) The following are the licensing fees established by the Authority:

(1) The fee for initial application for paramedic licensure for individuals who have completed training in California through an approved paramedic training program shall be \$50.00.

(2) The fee for initial application for paramedic licensure for individuals who have completed out-of-state paramedic training, as specified in Section 100165(b), or for individuals specified in Section 100165(c), shall be \$100.00.

(3) The fee for licensure or licensure renewal as a paramedic shall be \$195.00.

(4) The fee for failing to submit an application for renewal within the timeframe specified in Section 100163(b), or for an individual whose license has lapsed, as specified in Section 100167(b)(1), (2), (3) and (4) shall be \$50.00.

(5) The fee for state summary criminal history shall be in accordance with the schedule of fees established by the California DOJ.

(6) The fee for replacement of a license shall be \$10.00.

(7) The fee for approval and re-approval of an out-of-state CE provider shall be \$200.00.

(8) The fee for administration of the provisions of Section 17520 of the Family Code shall be \$5.00.

NOTE: Authority cited: Sections 1797.107, 1797.112, 1797.172, 1797.185 and 1797.212, Health and Safety Code. Reference: Sections 1797.172, 1797.185 and 1797.212, Health and Safety Code; and Section 11105, Penal Code.

Article 9. Discipline and Reinstatement of License

§ 100173. Proceedings.

(a) Any proceedings by the Authority to deny, suspend or revoke the license of a paramedic or place any paramedic license holder on probation pursuant to Section 1798.200 of the Health and Safety Code, or impose an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, shall be conducted in accordance with this article and pursuant to the provisions of the Administrative Procedure Act, Government Code, Section 11500 et seq.

(b) Before any disciplinary proceedings are undertaken, the Authority shall evaluate all information submitted to or discovered by the Authority including, but not limited to, a recommendation for suspension or revocation from a medical director of a LEMSA, for evidence of a threat to public health and safety pursuant to Section 1798.200 of the Health and Safety Code.

(c) The Authority shall use the “EMS Authority Recommended Guidelines for Disciplinary Orders and Conditions of Probation”, dated July 26, 2008 and incorporated by reference herein, as the standard in settling disciplinary matters when a paramedic applicant or license holder is found to be in violation of Section 1798.200 of Division 2.5 of the Health and Safety Code.

(d) The administrative law judge shall use the “EMS Authority Recommended Guidelines for Disciplinary Orders and Conditions of Probation”, dated July 26, 2008, as a guide in making any recommendations to the Authority for discipline of a paramedic applicant or license holder found in violation of Section 1798.200 of Division 2.5 of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1798.200, 1798.204 and 1798.210, Health and Safety Code. Reference: Sections 1797.172, 1797.174, 1797.176, 1797.185, 1798.200, 1798.204 and 1798.210, Health and Safety Code and Section 11500 et seq., Government Code.

§ 100174. Denial/Revocation Standards.

(a) The Authority shall deny/revoke a paramedic license if any of the following apply to the applicant:

(1) Has committed any sexually related offense specified under Section 290 of the Penal Code.

(2) Has been convicted of murder, attempted murder, or murder for hire.

(3) Has been convicted of two (2) or more felonies.

(4) Is on parole or probation for any felony.

(b) The Authority shall deny/revoke a paramedic license, if any of the following apply to the applicant:

(1) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

(2) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.

(3) Has been convicted of two (2) misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.

(4) Has been convicted of two (2) misdemeanors within the preceding five (5) years for any offense relating to force, violence, threat, or intimidation.

(5) Has been convicted within the preceding five (5) years of any theft related misdemeanor.

(c) The Authority may deny/revoke a paramedic license if any of the following apply to the applicant:

(1) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.

(2) Is required to register pursuant to Section 11590 of the Health & Safety Code.

(d) Subsections (a) and (b) shall not apply to convictions that have been pardoned by the governor, and shall only apply to convictions where the applicant/licensee was

prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (a) and (b). As used in this section, "felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

(e) This section shall not apply to those paramedics who obtained their California Paramedic License prior to the effective date of this Section; unless:

(1) The licensee is convicted of any misdemeanor or felony subsequent to the effective date of this Section.

(2) The licensee committed any sexually related offense specified under Section 290 of the Penal Code.

(3) The licensee failed to disclose to the Authority any prior convictions when completing his/her application for initial paramedic license or license renewal.

(f) Nothing in this section shall prevent the Authority from taking licensure action pursuant to Health & Safety Code Section 1798.200.

(g) The Director of the Authority may grant a license to anyone otherwise precluded under subsections (a) and (b) of this section if the Director of the Authority believes that extraordinary circumstances exist to warrant such an exemption.

(h) Nothing in this section shall negate an individual's right to appeal the denial of a license or petition for reinstatement of a license pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1798.200 and 1798.204, Health and Safety Code. Reference: Sections 1797.172, 1797.174, 1797.176, 1797.185, 1798.200 and 1798.204, Health and Safety Code.

§ 100175. Substantial Relationship Criteria for the Denial, Placement on Probation, Suspension, Fine, or Revocation of a License.

(a) For the purposes of denial, placement on probation, suspension, or revocation, of a license, pursuant to Section 1798.200 of the Health and Safety Code, or imposing an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, a crime or act shall be substantially related to the qualifications, functions and/or duties of a person holding a paramedic license under Division 2.5 of the Health and Safety Code. A crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a paramedic if to a substantial degree it evidences present or potential unfitness of a paramedic to perform the functions authorized by her/his license in a manner consistent with the public health and safety.

(b) For the purposes of a crime, the record of conviction or a certified copy of the record shall be conclusive evidence of such conviction. "Conviction" means the final judgment on a verdict or finding of guilty, a plea of guilty, or a plea of nolo contendere.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1798.200, 1798.210 and 1798.204, Health and Safety Code. Reference: Sections 1797.172, 1797.174, 1797.176, 1797.185, 1798.200, 1798.204 and 1798.210, Health and Safety Code.

§ 100176. Rehabilitation Criteria for Denial, Placement on Probation, Suspension, Revocations, and Reinstatement of License.

(a) At the discretion of the Authority, the Authority may issue a license subject to specific provisional terms, conditions, and review. When considering the denial, placement on probation, suspension, or revocation of a license pursuant to Section 1798.200 of the Health and Safety Code, or a petition for reinstatement or reduction of penalty under Section 11522 of the Government Code, the Authority in evaluating the rehabilitation of the applicant and present eligibility for a license, shall consider the following criteria:

- (1) The nature and severity of the act(s) or crime(s).
- (2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial, placement on probation, suspension, or revocation which also could be considered grounds for denial, placement on probation, suspension, or revocation under Section 1798.200 of the Health and Safety Code.
- (3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subsection (1) or (2) of this section.
- (4) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the person.
- (5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.
- (6) Evidence, if any, of rehabilitation submitted by the person.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1798.200 and 1798.204, Health and Safety Code. Reference: Sections 1797.172, 1797.174, 1797.176, 1797.185, 1798.200 and 1798.204, Health and Safety Code.

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California Code of Regulations, Title 22

Chapter 5: Process for Applicant Verification

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California Code of Regulations
TITLE 22. SOCIAL SECURITY
DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 5. PROCESS FOR APPLICANT VERIFICATION

§ 100190 Limitations on Paramedic Licenses for Aliens.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, or national origin of the individual applying for the public benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, (Pub. L. No. 104-193 (PRWORA)), (8 U.S.C. § 1621), and notwithstanding any other provision of this division, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. Section 1101 et seq.), or aliens paroled into the United States under Section 212(d) (5) of the INA (8 U.S.C. § 1182(d) (5)), for less than one year, are not eligible to receive a California paramedic license as set forth in Section 1797.172 of Division 2.5 of the Health and Safety Code, except as provided in 8 U.S.C. 1621 (c)(2).

(c) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive a public benefit, is, under Section 431(b) and (c) of the PWRORA (8 U.S.C. § 1641(b) and (c)), any of the following:

(1) An alien who is lawfully admitted for permanent residence under the INA (8 U.S.C. § 1101 et seq.).

(2) An alien who is granted asylum under Section 208 in the INA (8 U.S.C. § 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. § 1157).

(4) An alien who is paroled into the United States under Section 212(d) (5) of the INA (8 U.S.C. § 1182 (d) (5)) for a period of at least one year.

(5) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. § 1253 (h)) (as in effect immediately before the effective date of Section 307 of Division C of Public Law 104-208) or Section 241 (b) (3) of such Act (8 U.S.C. Section 1251 (b) (3)) (as amended by Section 305 (a) of Division C of Public Law 104-208).

(6) An alien who is granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to April 1, 1980. (8 U.S.C. Section 1153 (a) (7)) (See editorial note under 8 U.S.C. Section 1101, "Effective Date of 1980 Amendment.")

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501 (e) of the Refugee Education Assistance Act of 1980 (8 U.S.C. Section 1522 note)).

(8) An alien who meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape,

molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Emergency Medical Services Authority. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien to become self-sufficient following separation from the abuser.
2. The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.
3. The benefits are needed due to a loss of financial support resulting from the alien's separation from the abuser.
4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.
5. The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.
6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).
7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.
8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.
9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has a petition that has been approved or has a petition pending which sets forth a prima facie case for:

1. Status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a) (1) (A) of the INA (8 U.S.C. § 1154 (a) (1) (A) (ii), (iii) or (iv)),
2. Classification pursuant to clause (ii) or (iii) of Section 204(a) (1) (B) of the INA (8 U.S.C. § 1154(a) (1) (B) (ii) or (iii)),
3. Suspension of deportation and adjustment of status pursuant to section 214 (a) (3) of the INA (8 U.S.C. sec. 1254) as in effect prior to April 1, 1997 [Pub.L. 104-208, sec. 501 (effective September 30, 1996, pursuant to sec. 591); Pub.L. 104-208, sec. 304 (effective April 1, 1997, pursuant to sec. 309); Pub.L. 105-33, sec. 5581 (effective pursuant to sec. 5582)] (incorrectly codified as "cancellation of removal under section 240A of such Act [8 U.S.C. § 1229b (as in effect prior to April 1, 1997)),
4. Status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a) (1) (A) of the INA (8 U.S.C. § 1154(a) (1) (A) (i)) or classification pursuant to clause (i) of Section 204(a) (1) (B) of the INA (8 U.S.C. § 1154(a) (1) (B) (i)), or

5. Cancellation of removal pursuant to Section 240A (b) (2) of the INA (8 U.S.C. Section 1229b (b) (2)).

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Emergency Medical Services Authority. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien's child to become self-sufficient following separation from the abuser.
2. The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.
3. The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.
4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.
5. The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.
6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).
7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.
8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.
9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien child meets the requirements of subsection (c) (8) (C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(10) An alien child who meets all of the conditions of subparagraphs (A), (B), and (C) below:

(A) The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Emergency Medical Services Authority. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien child's parent to become self-sufficient following separation from the abuser.

2. The benefits are needed to enable the alien child's parent to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien child's parent from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien child's parent's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien child's parent to lose his or her job or to earn less or to require the alien child's parent to leave his or her job for safety reasons.

5. The benefits are needed because the alien child's parent requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien child's parent's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien child's parent and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien child's parent had when living with the abuser.

(C) The alien child meets the requirements of subsection (c) (8) (C) above.

(d) For purposes of this section, "nonimmigrant" is defined the same as in Section 101 (a) (15) of the INA (8 U.S.C. Section 1101 (a) (15)).

(e) For purposes of establishing eligibility for paramedic licensure as described in Section 1797.172 of Division 2.5 of the Health and Safety Code, the following requirements must be met:

(1) The applicant must declare himself or herself to be a citizen of the United States or a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212(d) (5) of the INA (8 U.S.C. § 1182(d) (5)). The applicant shall declare that status through use of the “Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits,” Form IS-01 (4/98, incorporated by reference).

(2) The applicant must present documents of a type acceptable to the Immigration and Naturalization Service (INS) which serve as a reasonable evidence of the applicant’s declared status. A fee receipt from the INS for replacement of a lost, stolen, or unreadable INS document is reasonable evidence of the alien’s declared status.

(3) The applicant must complete and sign Form IS-01.

(4) Where the documents presented do not on their face appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Emergency Medical Services Authority shall request verification from the INS by filing INS Form G-845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(5) The type of documentation referred to the INS for verification pursuant to INS Form G-845 shall include the following:

(A) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(B) The document is suspected to be counterfeit or to have been altered.

(C) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(D) The document is one of the following: an INS Form I-181b notification letter issued in connection with an INS Form I-181 Memorandum of Creation of Record of Permanent Residence, an Arrival-Departure Record (INS Form I-94) or a foreign passport stamped “PROCESSED FOR I-551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE” that INS issued more than one year before the date of application for paramedic licensure.

(6) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien, a nonimmigrant or alien paroled for less than one year under section 212 (d) (5) of the INA, the INS verification shall be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, a nonimmigrant or an alien paroled for less than one year under section 212 (d) (5) of the INA, benefits shall be denied and the applicant notified pursuant to the paramedic licensure program’s regular procedures of his or her rights to appeal the denial of benefits.

(f) Pursuant to Section 434 of the PRWORA (8 U.S.C. § 1644), where the Emergency Medical Services Authority reasonably believes that an alien is unlawfully in the state based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the Immigration and Naturalization Service.

(g) Provided that the applicant has completed and signed all licensure applications pursuant to Section (e)(1) under penalty of perjury, and has met all state eligibility requirements, eligibility for paramedic licensure shall not be delayed, denied, reduced or terminated while the status of the applicant is verified.

(h) Any applicant who is eligible for paramedic licensure, and whose license is denied or revoked pursuant to subsections (b) and (e), is entitled to a hearing, pursuant to CCR Title 22, Division 9, Chapter 4, Section 100175, and Division 2.5 of the Health and Safety Code, Chapter 7, Sections 1798.204 and 1798.207.

NOTE: Authority Cited: Health and Safety Code, Division 2.5, Sections 1797.107, 1797.172, 1798.204, and 1798.207.

Reference: Health and Safety Code, Division 2.5, Sections 1798.204 and 1798.207; U.S.C. §§ 1621, 1641, and 1642.

California Code of Regulations, Title 22

Chapter 6: Process for EMT and Advanced EMT Disciplinary Action

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 6. Process for EMT and Advanced EMT Disciplinary Action

Article 1. Definitions

§ 100201. Certificate.

"Certificate" means a valid Emergency Medical Technician (EMT) or Advanced EMT certificate issued pursuant to Division 2.5.

NOTE: Authority cited: Sections 1797.62, 1797.107, 1797.176, and 1798.204, Health and Safety Code. Reference: Sections: 1797.61, 1797.62, 1797.80, 1797.82, 1797.184, 1797.210, 1797.211, 1797.216, and 1798.200, Health and Safety Code.

§ 100202. Certifying Entity.

"Certifying entity," as used in this Chapter, means a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT personnel that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety Code, or the medical director of the local EMS agency (LEMSA).

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.210, 1797.216 and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.184, 1797.211, and 1798.204, Health and Safety Code.

§ 100202.1. Disciplinary Cause.

For the purposes of this Chapter, "Disciplinary Cause" means an act that is substantially related to the qualifications, functions, and duties of an EMT and/or Advanced EMT and is evidence of a threat to the public health and safety, per Health and Safety Code Section 1798.200.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, 1797.210, 1797.216 and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62 and 1798.204, Health and Safety Code.

§ 100203. Division 2.5.

"Division 2.5" means Division 2.5 of the Health and Safety Code, the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1798.204, Health and Safety Code.

§ 100204. Medical Director.

For the purposes of this Chapter, "medical director" means the medical director of the LEMSAs, pursuant to Section 1797.202(a) of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.62, 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1797.202, Health and Safety Code.

§ 100205. Multiple Certificate Holder.

"Multiple Certificate Holder" means a person who holds an EMT and Advanced EMT or EMT-II certificate issued pursuant to Division 2.5.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.80, 1797.82, 1797.210, 1797.216 and 1798.204, Health and Safety Code.

§ 100206. Relevant Employer(s).

"Relevant employer(s)" means those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency, that the certificate holder works for or was working for at the time of the incident under review, as an EMT or Advanced EMT either as a paid employee or a volunteer.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1797.61, 1798.200, 1798.204, Health and Safety Code.

§100206.1. Discipline

"Discipline" means either a disciplinary plan taken by a relevant employer pursuant to Section 100206.2 of this Chapter or certification action taken by a medical director pursuant to Section 100204 of this Chapter, or both a disciplinary plan and certification action.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1797.61, 1798.200, 1798.204, Health and Safety Code.

§ 100206.2. Disciplinary Plan.

"Disciplinary Plan" means a written plan of action that can be taken by a relevant employer as a consequence of any action listed in Section 1798.200 (c).

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1798.200, 1798.204, Health and Safety Code.

§ 100206.3. Certification Action.

"Certification Action" means those actions that may be taken by a medical director that include denial, suspension, revocation of a certificate, or placing a certificate holder on probation.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1797.204, 1798.200, Health and Safety Code.

§ 100206.4. Model Disciplinary Orders

“Model Disciplinary Orders” (MDOs) means the “RECOMMENDED GUIDELINES FOR DISCIPLINARY ORDERS AND CONDITIONS OF PROBATION FOR EMT (BASIC) AND ADVANCED EMT” (EMSA document #134, 4/1/2010) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Section 1797.61, 1798.200, 1798.204, Health and Safety Code.

Article 2. General Provisions

§ 100207. Application of Chapter.

(a) The certifying entity, relevant employer, or LEMSA shall adhere to the provisions of this Chapter, in applicable situations, when investigating or implementing any actions for disciplinary cause.

(b) In order to take disciplinary or certification action on an EMT, Advanced EMT, or EMT-II, it must first be determined that a disciplinary cause has occurred by the applicant or certificate holder and there exists a threat to the public health and safety, as evidenced by the occurrence of any of the actions listed in Section 1798.200(c) of the Health and Safety Code by the applicant or certificate holder.

(c) An application for certification or recertification shall be denied without prejudice and does not require an administrative hearing, when an applicant does not meet the requirements for certification or recertification, including but not limited to, failure to pass a certification or recertification examination, lack of sufficient continuing education or documentation of a completed refresher course, failure to furnish additional information or documents requested by the certifying entity, or failure to pay any required fees. The denial shall be in effect until all requirements for certification or recertification are met. If a certificate expires before recertification requirements are met, the certificate shall be deemed a lapsed certificate and subject to the provisions pertaining to lapsed certificates.

(d) Nothing in this Chapter shall be construed to limit the authority of a base hospital medical director to provide supervision and medical control for prehospital emergency medical care personnel, as specified in local medical control policies and procedures, developed pursuant to requirements of Division 2.5 and of Chapters 3 and 4 of this division for medical control and supervision.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798. 204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.176, 1797.202, 1797.210, 1797.216, 1797.220, 1798, 1798.100, 1798.102, 1798.200 and 1798.204, Health and Safety Code.

§ 100208. Substantial Relationship Criteria for the Denial, Placement on Probation, Suspension, or Revocation of a Certificate.

(a) For the purposes of denial, placement on probation, suspension, or revocation of a certificate, pursuant to Section 1798.200(c) of the Health and Safety Code, a crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a certificate holder if to a substantial degree it evidences unfitness of a certificate holder to perform the functions authorized by the certificate in that it poses a threat to the public health and safety.

(b) For the purposes of a crime, the record of conviction or a certified copy of the record shall be conclusive evidence of such conviction.

(1) "Crime" means any act in violation of the penal laws of this state, any other state, or federal laws. This also means violation(s) of any statute which impose criminal penalties for such violations.

(2) "Conviction" means the final judgment on a verdict of finding of guilty, a plea of guilty, or a plea of nolo contendere.

(c) The LEMSA, when determining the certification action to be imposed or reviewing a petition for reinstatement or reduction of penalty under Section 11522 of the Government Code, shall evaluate the rehabilitation of the applicant and present eligibility for certification of the respondent. When the certification action warranted is probation, denial, suspension, or revocation the following factors may be considered:

(1) Nature and severity of the act(s), offense(s), or crime(s) under consideration;

(2) Actual or potential harm to the public;

(3) Actual or potential harm to any patient;

(4) Prior disciplinary record;

(5) Prior warnings on record or prior remediation;

(6) Number and/or variety of current violations;

(7) Aggravating evidence;

(8) Mitigating evidence;

(9) Rehabilitation evidence;

(10) In the case of a criminal conviction, compliance with terms of the sentence and/or court-ordered probation;

(11) Overall criminal record;

(12) Time that has elapsed since the act(s) or offense(s) occurred;

(13) If applicable, evidence of expungement proceedings pursuant to Penal Code 1203.4.

(14) In determining appropriate certification disciplinary action, the LEMSA medical director may give credit for prior disciplinary action imposed by the respondent's employer.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, 1798.200, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.176, 1797.210, 1797.216, 1797.220, and 1798.200, Health and Safety Code.

§ 100208.1. Responsibilities of Relevant Employer.

Under the provisions of this Chapter, relevant employers:

- (a) May conduct investigations, according to the requirements of this Chapter, to determine disciplinary cause.
- (b) Upon determination of disciplinary cause, the relevant employer may develop and implement, a disciplinary plan, in accordance with the MDOs.
 - (1) The relevant employer shall submit that disciplinary plan, along with the relevant findings of the investigation related to disciplinary cause to the LEMSA that issued the certificate, within three (3) working days of adoption of the disciplinary plan. In the case where the certificate was issued by a non-LEMSA certifying entity, the disciplinary plan shall be submitted to the LEMSA that has jurisdiction in the county in which the headquarters of the certifying entity is located.
 - (2) The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
- (c) Shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days after an allegation has been validated as potential for disciplinary cause.
- (d) Shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days of the occurrence of any of following:
 - (1) The EMT or Advanced EMT is terminated or suspended for a disciplinary cause,
 - (2) The EMT or Advanced EMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
 - (3) The EMT or Advanced EMT is removed from EMT or Advanced EMT -related duties for a disciplinary cause after the completion of the employer's investigation.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, 1798.200, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.176, 1797.200, 1797.210, 1797.211, 1797.220, and 1798.200, Health and Safety Code.

§ 100209. Jurisdiction of the Medical Director.

- (a) The medical director who issued the certificate, or in the case where the certificate was issued by a non-LEMSA certifying entity, the LEMSA medical director that has jurisdiction in the county in which the headquarters of the certifying entity is located, shall conduct investigations to validate allegations for disciplinary cause when the certificate holder is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the medical director may take certification action as necessary against an EMT or Advanced EMT certificate.
- (b) The medical director may, upon determination of disciplinary cause and according to the provisions of this Chapter, take certification action against an EMT or Advanced

EMT to deny, suspend, or revoke, or place a certificate holder on probation, upon the findings by the medical director of the occurrence of any of the actions listed in Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:

(1) The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the medical director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.

(2) The medical director determines, following an investigation conducted in accordance with this Chapter, that the conduct requires certification action.

(c) The medical director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, an EMT or Advanced EMT certificate upon a determination of the following:

(1) The certificate holder has engaged in acts or omissions that constitute grounds for revocation of the EMT or Advanced EMT certificate; and

(2) Permitting the certificate holder to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.

(d) If the medical director takes any certification action the medical director shall notify the Authority of the findings of the investigation and the certification action taken by using Form EMSA-CRI (10/01) through June 30, 2010. Commencing July 1, 2010 and thereafter, this information shall be entered directly into the Central Registry by the LEMSA taking certification action.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.90, 1797.117, 1797.118, 1797.202, 1797.216, 1797.217, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

Article 3. Evaluation and Investigation.

§ 100210. Evaluation of Information.

(a) A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against an EMT or Advanced EMT and once the allegation is validated, shall notify the medical director of the LEMSA that has jurisdiction in the county in which the alleged violation occurred within three (3) working days, of the EMT's or Advanced EMT's name, certification number, and the allegation(s).

(b) A LEMSA that receives any complaint against an EMT or Advanced EMT shall forward the original complaint and any supporting documentation to the relevant employer for investigation pursuant to subsection (a) of this section, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the medical director shall evaluate the information received from a credible source, including but not limited to, information obtained from an application, medical audit, or

public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued pursuant to Division 2.5.

(c) The relevant employer or medical director shall conduct an investigation of the allegations in accordance with the provisions of this Chapter, if warranted.

(d) Statewide public safety agencies shall provide the Authority with current relevant employer contact information for their individual agencies.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.90, 1797.176, 1797.202, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

§ 100211. Investigations Involving Firefighters

(a) The rights and protections described in Chapter 9.6, Division 4 of Title 1 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.

(b) All investigations involving EMT s, Advanced EMT's, and EMT-IIs who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6, Division 4 of Title 1 of the Government Code, Section 3250 et. seq.

NOTE: Authority cited: Sections 1797.107, 1797.176 and 1798.204, Health and Safety Code. Sections 3250, 27727, Government Code. Reference: Sections 1797.90, 1797.176, 1797.202, 1797.220, and 1798.204, Health and Safety Code.

§ 100211.1. Due Process.

The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

NOTE: Authority cited: Sections: 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections: 1798.200 and 1798.204, Health and Safety Code.

Article 4. Determination and Notification of Action

§ 100212. Determination of Certification Action.

(a) certification action relative to the individual's certificate(s) shall be taken as a result of the findings of the investigation.

(b) Upon determining the disciplinary or certification action to be taken as authorized by this Chapter, the relevant employer or medical director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or LEMSA, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.

(c) In the case of a temporary suspension order pursuant to Section 100209 (c) of this Chapter, it shall take effect upon the date the notice required by Section 100213 of this Chapter is mailed to the certificate holder.

(d) For all other certification actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.176, 1797.202, 1797.211, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

§ 100213. Temporary Suspension Order.

(a) A medical director may temporarily suspend a certificate prior to hearing if, the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100214.3 (c) and (d) of this Chapter and if in the opinion of the medical director permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.

(b) Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the medical director shall consult with the relevant employer of the certificate holder.

(c) The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.

(d) Within three (3) working days of the initiation of the temporary suspension by the LEMSA, the LEMSA and relevant employer shall jointly investigate the allegation in order for the LEMSA to make a determination of the continuation of the temporary suspension.

(1) All investigatory information, not otherwise protected by the law, held by the LEMSA and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.

(2) The LEMSA shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).

(3) If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of the LEMSA's receipt of the Notice of Defense.

(4) The temporary suspension order shall be deemed vacated if the LEMSA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.90, 1797.160, 1797.176,

1797.200, 1797.202, 1797.211, 1797.220, 1798, 1798.2, 1798.100, 1798.200, and 1798.204, Health and Safety Code.

§ 100214. Final Determination of Certification Action by the Medical Director

Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of this Chapter, if the respondent so chooses, the medical director may take the following final actions on an EMT or Advanced EMT certificate:

- (a) Place the certificate holder on probation
- (b) Suspension
- (c) Denial
- (d) Revocation

Note: Reference: Section 1798.200, Health and Safety Code.

§ 100214.1. Placement of a Certificate Holder on Probation.

Pursuant to Section 100207, the medical director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with MDOs established by the Authority.. The medical director that placed the certificate holder on probation may revoke the EMT or Advanced EMT certificate if the certificate holder fails to successfully complete the terms of probation.

NOTE: Authority cited: Sections 1797.107, 1797.176 and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.176, 1797.202, 1797.184, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

§ 100214.2. Suspension of a Certificate.

(a) The medical director may suspend an individual's EMT or Advanced EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.

(b) The term of the suspension and any conditions for reinstatement, shall be in accordance with MDOs established by the Authority.

(c) Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The medical director shall continue the suspension until all conditions for reinstatement have been met.

(d) If the suspension period will run past the expiration date of the certificate, the EMT or Advanced EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

NOTE: Authority cited: Sections 1797.107, 1797.175, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.176, 1797.202, 1797.220, 1798, 1798.200, and 1798.204, Health and Safety Code.

§ 100214.3. Denial or Revocation of a Certificate.

(a) A certifying entity, that is not a LEMSA, shall advise a certification or recertification applicant whose conduct indicates a potential for disciplinary cause, based on an investigation by the certifying entity prompted by a DOJ and/or FBI CORI, pursuant to Section 100210(a) of this Chapter, to apply to a LEMSA for certification or recertification.

(b) The medical director may deny or revoke any EMT or Advanced EMT certificate for disciplinary cause that have been investigated and verified by application of this Chapter.

(c) The medical director shall deny or revoke an EMT or Advanced EMT certificate if any of the following apply to the applicant:

(1) Has committed any sexually related offense specified under Section 290 of the Penal Code.

(2) Has been convicted of murder, attempted murder, or murder for hire.

(3) Has been convicted of two (2) or more felonies.

(4) Is on parole or probation for any felony.

(5) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

(6) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.

(7) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.

(8) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.

(9) Has been convicted within the preceding five (5) years of any theft related misdemeanor.

(d) The medical director may deny or revoke an EMT or Advanced EMT certificate if any of the following apply to the applicant:

(1) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.

(2) Is required to register pursuant to Section 11590 of the Health and Safety Code.

(e) Subsection (a) and (b) shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (c) and (d). As used in this Section, "felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

(f) This Section shall not apply to those EMT's, or EMT-IIs who obtain their California certificate prior to the effective date of this Section; unless:

- (1) The certificate holder is convicted of any misdemeanor or felony after the effective date of this Section.
 - (2) The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.
 - (3) The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT or Advanced EMT certification or certification renewal.
- (g) Nothing in this Section shall negate an individual's right to appeal a denial of an EMT or Advanced EMT certificate pursuant to this Chapter.
- (h) Certification action by a medical director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT or Advanced EMT whose application was denied or an EMT or Advanced EMT whose certification was revoked by a medical director shall not be eligible for EMT or Advanced EMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT's or Advanced EMT's whose certification is placed on probation must complete their probationary requirements with the LEMSA that imposed the probation.
- Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code, Section 11522, Government Code. Reference: Sections 1797.61, 1797.62, 1797.118, 1797.176, 1797.202, 1797.220, 1798, 1798.200, 1798.204, and 1797.216, Health and Safety Code.

§ 100215. Notification of Final Decision of Certification Action.

- (a) For the final decision of certification action, the medical director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.
- (b) The notification of final decision shall be served by registered mail or personal service and shall include the following information:
- (1) The specific allegations or evidence which resulted in the certification action;
 - (2) The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
 - (3) Which certificate(s) the certification action applies to in cases of holders of multiple certificates;
 - (4) A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate;

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1797.160, 1797.176, 1797.202, 1797.217, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

Article 5. Local Responsibilities.

§ 100216. Development of Local Policies and Procedures.

Each Relevant Employer, Certifying Entity and LEMSA shall develop and adopt policies and procedures for local implementation of the provisions of this Chapter. All local policies and procedures so adopted must be in accordance with these provisions and must address all of the requirements of this Chapter, as applicable.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.204, Health and Safety Code. Reference: Sections 1797.176, 1797.202, 1797.220, 1798. 1798.200 and 1798.204, Health and Safety Code.

§ 100217. Reimbursement for Administrative Law Judge Costs.

(a) Actual fees paid by a LEMSA for the services of an ALJ, who is on the staff of the Office of Administrative Hearings, for disciplinary action appeals as required by this Chapter and in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code are eligible for reimbursement from the Emergency Medical Technician Certification Fund.

(1) Each LEMSA that has paid for the services of an ALJ under this section during the preceding fiscal year shall submit, to the Authority, copies of invoices for fees charged and proof of the actual amount paid according to the provisions of (a) (2) (A) of this section.

(2) The Authority shall reimburse the LEMSAs no more than the actual payment made for the ALJ in accordance with the following:

(A) Invoices for fees incurred between July 1 and June 30 shall be due at the Authority no later than August 31.

(B) The LEMSA has provided evidence of the costs to include an invoice, payment, the name and any other required identifying information for the emergency medical technician(s) whose disciplinary hearing was included in the costs.

(C) If there are insufficient monies available to reimburse each LEMSA the entire actual amount expended for ALJ services, then reimbursements will be allocated proportionately among all the LEMSAs for actual expenditures for ALJ services within that fiscal year.

NOTE: Authority cited: Sections 1797.107, 1797.176, 1797.184, and 1798.204, Health and Safety Code. Reference: Sections 1797.62, 1797.176, 1797.202, 1797.216, 1797.217, 1797.220, 1798, 1798.200, and 1798.204, Health and Safety Code.

California Code of Regulations, Title 22

Chapter 7: Trauma Systems Regulations

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Effective: August 12, 1999

California Code of Regulations
TITLE 22. SOCIAL SECURITY
DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 7. TRAUMA CARE SYSTEMS

Article 1. Definitions

§ 100236. Abbreviated Injury Scale

“Abbreviated Injury Scale” or “AIS” is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purpose of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100237. Immediately Available

"Immediately" or "immediately available" means:

- (a) unencumbered by conflicting duties or responsibilities;
- (b) responding without delay when notified; and
- (c) being physically available to the specified area of the trauma center when the patient is delivered in accordance with local EMS agency policies and procedures.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100238. Implementation

"Implementation" or "implemented" or "has implemented" means the development and activation of a trauma care system plan by a local EMS agency, including the actual triage, transport and treatment of trauma patients in accordance with the plan.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100239. Injury Severity Score

“Injury Severity Score” or “ISS” means the sum of the squares of the Abbreviated Injury Scale score of the three most severely injured body regions.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100240. On-Call

"On-call" means agreeing to be available to respond to the trauma center in order to provide a defined service.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100241. Promptly Available

"Promptly" or "promptly available" means:

- (a) responding without delay when notified and requested to respond to the hospital; and
- (b) being physically available to the specified area of the trauma center within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161 Health and Safety Code.

§ 100242. Qualified Specialist

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

- (a) A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:
 - (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada;
 - (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
 - (3) the physician has successfully completed a residency program.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100243. Receiving Hospital

"Receiving hospital" means a licensed general acute care hospital with a special permit for basic or comprehensive emergency service, which has not been designated as a trauma center according to this Chapter, but which has been formally assigned a role in the trauma care system by the local EMS agency. In rural areas, the local EMS agency may approve standby emergency service if basic or comprehensive services are not available.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100244. Residency Program

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100245. Senior Resident

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of the residency program as defined in Section 100244 of this Chapter, at the designated trauma center.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100246. Service Area

"Service area" means that geographic area defined by the local EMS agency in its trauma care system plan as the area served by a designated trauma center.

NOTE: Authority cited: Section 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100247. Trauma Care System

"Trauma care system" or "trauma system" or "inclusive trauma care system" means a system that is designed to meet the needs of all injured patients. The system shall be defined by the local EMS agency in its trauma care system plan as described in Section 100256 of this Chapter.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Sections 1798.160 and 1798.161, Health and Safety Code.

§ 100248. Trauma Center

"Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with Articles 2 through 5 of this Chapter.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.160 and 1798.161, Health and Safety Code.

§ 100249. Trauma Resuscitation Area

"Trauma Resuscitation Area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 178.161, Health and Safety Code.

§ 100250. Trauma Service

A “trauma service” is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured persons.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 178.161, Health and Safety Code.

§ 100251. Trauma Team

"Trauma team" means the multidisciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated trauma center. The trauma team consists of physicians, nurses and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and severity of injury which leads to trauma team activation.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100252. Triage Criteria

"Triage criteria" means a measure or method of assessing the severity of a person's injuries that is used for patient evaluation and that utilizes anatomic or physiologic considerations or mechanism of injury.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

Article 2. Local EMS Agency Trauma System Requirements

§ 100253. Application of Chapter

- (a) A local EMS agency which has implemented or plans to implement a trauma care system shall develop a written trauma care system plan that includes policies and/or procedures to assure compliance of the trauma system with the provisions of this Chapter.
- (b) A local EMS agency may specify additional requirements in addition to those specified in this Chapter.
- (c) A local EMS agency that implements a trauma care system on or after the effective date of this Chapter shall submit its trauma system plan to the EMS Authority and have it approved prior to implementation.
- (d) A local EMS agency that has implemented a trauma system prior to the effective date of the revisions to this Chapter shall submit its updated trauma system plan to the EMS Authority within two (2) years of the effective date of the revisions to this Chapter which is August 12, 1999.

- (e) The EMS Authority shall notify the local EMS agency submitting its trauma care system plan within fifteen (15) days of receiving the plan that:
 - (1) its plan has been received, and
 - (2) it contains or does not contain the information requested in Section 100255 of this Chapter.
- (f) The EMS Authority shall:
 - (1) notify the local EMS agency either of approval or disapproval of its trauma system plan within sixty (60) days of receipt of the plan; and
 - (2) provide written notification of approval or the reasons for disapproval of a trauma system plan.
- (g) If the EMS Authority disapproves a trauma system plan, the local EMS agency shall have six (6) months from the date of notification of the disapproval to submit a revised trauma system plan which conforms to this Chapter or to appeal the decision to the Commission on Emergency Medical Services (EMS) which shall make a determination within four (4) months of receipt of the appeal. If a revised trauma system plan is approved by the EMS Authority the local EMS agency shall begin implementation of the plan within six (6) months of its approval.
- (h) If the EMS Authority determines that a local EMS agency has failed to implement the trauma system in accordance with the approved plan, the approval of the plan may be withdrawn. The local EMS agency may appeal the decision to the Commission on EMS, which shall make a determination within six (6) months of the appeal.
- (i) After approval of a trauma system plan, the local EMS agency shall submit to the EMS Authority for approval any significant changes to that trauma system plan prior to the implementation of the changes. In those instances where a delay in approval would adversely impact the current level of trauma care, the local EMS agency may institute the changes and then submit the changes to the EMS Authority for approval within thirty (30) days of their implementation.
- (j) The local EMS agency shall submit a trauma system status report as part of its annual EMS Plan update. The report shall address, at a minimum, the status of trauma plan goals and objectives.
- (k) No health care facility shall advertise in any manner or otherwise hold themselves out to be a trauma center unless they have been so designated by the local EMS agency, in accordance with this Chapter.
- (l) No provider of prehospital care shall advertise in any manner or otherwise hold itself out to be affiliated with the trauma system or a trauma center unless they have been so designated by the local EMS agency, in accordance with this Chapter.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1797.257, 1798.161, 1798.163, and 1798.166, Health and Safety Code.

§ 100254. Trauma System Criteria

- (a) A local EMS agency that plans to implement or modify a trauma system shall include with the trauma plan, a description of the rationale used for trauma system design planning for number and location of trauma centers including:
 - (1) projected trauma patient volume and projected number and level of trauma centers necessary to provide access to trauma care;
 - (A) No more than one (1) Level I or II trauma center shall be designated for each 350,000 population within the service area.
 - (B) Where geography and population density preclude compliance with subsection (a)(1)(A), exemptions may be granted by the EMS Authority with the concurrence of the Commission on EMS on the basis of documented local needs.
 - (2) resource availability to meet staffing requirements for trauma centers;
 - (3) transport times;
 - (4) distinct service areas; and
 - (5) coordination with neighboring trauma systems.
- (b) The local EMS agency may authorize the utilization of air transport within its jurisdiction to geographically expand the primary service area(s) provided that the expanded service area does not encroach upon another trauma system, or that of another trauma center, unless written agreements have been executed between the involved local EMS agencies and/or trauma centers.
- (c) A local EMS agency may require trauma centers to have helicopter landing sites. If helicopter landing sites are required, then they shall be approved by the Division of Aeronautics, Department of Transportation pursuant to Division 2.5, Title 21 of the California Code of Regulations.
- (d) All prehospital emergency medical care personnel rendering trauma patient care within an organized trauma system shall be trained in the local trauma triage and patient care methodology.
- (e) All trauma patient transport vehicles shall be equipped with two-way telecommunications equipment capable of accessing hospitals, in accordance with local EMS agency policies regarding communication.
- (f) All prehospital providers shall have a policy approved by the local EMS agency for the early notification of trauma centers of the impending arrival of a trauma patient.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161, 1798.162, 1798.163, 1798.165, and 1798.166 of the Health and Safety Code.

§ 100255. Policy Development

A local EMS agency planning to implement a trauma system shall develop policies which provide a clear understanding of the structure of the trauma system and the manner in which it utilizes the resources available to it. The trauma system policies shall address at least the following:

- (a) system organization and management;
- (b) trauma care coordination within the trauma system;

- (c) trauma care coordination with neighboring jurisdictions, including EMS agency/system agreements;
- (d) data collection and management;
- (e) fees, including those for application, designation and redesignation, monitoring and evaluation;
- (f) establishment of service areas for trauma centers;
- (g) trauma center designation/redesignation process to include a written agreement between the local EMS agency and the trauma center;
- (h) coordination with all health care organizations within the trauma system to facilitate the transfer of an organization member in accordance with the criteria set forth in Article 5 of this Chapter;
- (i) coordination of EMS and trauma system for transportation including intertrauma center transfer and transfers from a receiving hospital to a trauma center;
- (j) the integration of pediatric hospitals, if applicable;
- (k) trauma center equipment;
- (l) ensuring the availability of trauma team personnel;
- (m) criteria for activation of trauma team;
- (n) mechanism for prompt availability of specialists;
- (o) quality improvement and system evaluation to include responsibilities of the multidisciplinary trauma peer review committee;
- (p) criteria for pediatric and adult trauma triage, including destination;
- (q) training of prehospital EMS personnel to include trauma triage;
- (r) public information and education about the trauma system;
- (s) marketing and advertising by trauma centers and prehospital providers as it relates to the trauma care system; and
- (t) coordination with public and private agencies and trauma centers in injury prevention programs.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.163, Health and Safety Code.

§ 100256. Trauma Plan Development

- (a) The initial plan for a trauma care system that is submitted to the EMS Authority shall be comprehensive with objectives that shall be clearly stated. The initial trauma care system plan shall contain at least the following:
 - (1) summary of the plan;
 - (2) organizational structure;
 - (3) needs assessment;
 - (4) inclusive trauma system design, which includes those facilities involved in the care of acutely injured patients, including coordination with neighboring agencies;
 - (5) documentation that any intercounty trauma center agreements have been approved by the EMS agencies of both counties;
 - (6) objectives;

- (7) implementation schedule;
 - (8) fiscal impact of the system;
 - (9) policy and plan development process;
 - (10) written documentation of local approval; and
 - (11) table of contents identifying where the information in this Section and Sections 100254, 100255 and 100257 of this Chapter can be found in the plan.
- (b) The system design shall address the operational implementation of the policies developed pursuant to Section 100255 and the following aspects of hospital service delivery:
- (1) Critical care capability including but not limited to burns, spinal cord injury, rehabilitation and pediatrics;
 - (2) medical organization and management; and
 - (3) quality improvement.
- (c) A local EMS agency shall advise the EMS Authority when there are any changes or revisions in policy or plan development pursuant to the sections of this Article.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1797.258, 1798.161, and 1798.166 Health and Safety Code.

§ 100257. Data Collection

- (a) The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care.
- (1) The system shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency;
 - (2) trauma data shall be integrated into the local EMS agency and State EMS Authority data management system; and
 - (3) all hospitals that receive trauma patients shall participate in the local EMS agency data collection effort in accordance with local EMS agencies policies and procedures.
- (b) The prehospital data shall include at least those data elements required on the EMT-II or EMT-P patient care record, as specified in Section 100129 of the EMT-II regulations and Section 100176 of the EMT-P regulations.
- (c) The hospital data shall include at least the following, when applicable:
- (1) Time of arrival and patient treatment in:
 - (A) Emergency department or trauma receiving area; and
 - (B) operating room.
 - (2) Dates for:
 - (A) Initial admission;
 - (B) intensive care; and
 - (C) discharge.
 - (3) Discharge data, including:

- (A) Total hospital charges (aggregate dollars only);
- (B) patient destination; and
- (C) discharge diagnosis.
- (4) The local EMS agency shall provide periodic reports to all hospitals participating in the trauma system.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100258. Trauma System Evaluation

- (a) The local EMS agency shall be responsible for the development and ongoing evaluation of the trauma system.
- (b) The local EMS agency shall be responsible for the development of a process to receive information from EMS providers, participating hospitals and the local medical community on the evaluation of the trauma system, including but not limited to:
 - (1) trauma plan;
 - (2) triage criteria;
 - (3) activation of trauma team; and
 - (4) notification of specialists.
- (c) The local EMS agency shall be responsible for periodic performance evaluation of the trauma system, which shall be conducted at least every two (2) years. Results of the trauma system evaluation shall be made available to system participants.
- (d) The local EMS agency shall be responsible for ensuring that trauma centers and other hospitals that treat trauma patients participate in the quality improvement process contained in Section 100265.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

Article 3. Trauma Center Requirements

§ 100259. Level I and Level II Trauma Centers

- (a) A Level I or II trauma center is a licensed hospital which has been designated as a Level I or II trauma center by the local EMS agency. While both Level I and II trauma centers are similar, a Level I trauma center is required to have staff and resources not required of a Level II trauma center. The additional Level I requirements are located in Section 100260. Level I and II trauma centers shall have appropriate pediatric equipment and supplies and be capable of initial evaluation and treatment of pediatric trauma patients. Trauma centers without a pediatric intensive care unit, as outlined in (e)(1) of this section, shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care. A Level I or Level II trauma center shall have at least the following:
 - (1) A trauma program medical director who is a board-certified surgeon, whose responsibilities

include, but are not limited to, factors that affect all aspects of trauma care such as:

- (A) recommending trauma team physician privileges;
 - (B) working with nursing and administration to support the needs of trauma patients;
 - (C) developing trauma treatment protocols;
 - (D) determining appropriate equipment and supplies for trauma care;
 - (E) ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
 - (F) having authority and accountability for the quality improvement peer review process;
 - (G) correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
 - (H) coordinating pediatric trauma care with other hospital and professional services;
 - (I) coordinating with local and State EMS agencies;
 - (J) assisting in the coordination of the budgetary process for the trauma program; and
 - (K) identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.
- (2) A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, administrative ability, and responsibilities that include but are not limited to:
- (A) organizing services and systems necessary for the multidisciplinary approach to the care of the injured patient;
 - (B) coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel; and
 - (C) collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program.
- (3) A trauma service which can provide for the implementation of the requirements specified in this Section and provide for coordination with the local EMS agency.
- (4) A trauma team, which is a multidisciplinary team responsible for the initial resuscitation and management of the trauma patient.
- (5) Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists:
- (A) general;
 - (B) neurologic;
 - (C) obstetric/gynecologic;
 - (D) ophthalmologic;
 - (E) oral or maxillofacial or head and neck;
 - (F) orthopaedic;
 - (G) plastic; and

- (H) urologic
- (6) Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
 - (A) anesthesiology;
 - (B) internal medicine;
 - (C) pathology;
 - (D) psychiatry; and
 - (E) radiology;
- (7) An emergency department, division, service or section staffed with qualified specialists in emergency medicine who are immediately available.
- (8) Qualified surgical specialist(s) or specialty availability, which shall be available as follows:
 - (A) general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation;
 - (B) On-call and promptly available:
 - 1. neurologic;
 - 2. obstetric/gynecologic;
 - 3. ophthalmologic;
 - 4. oral or maxillofacial or head and neck;
 - 5. orthopaedic;
 - 6. plastic;
 - 7. reimplantation/microsurgery capability. This surgical service may be provided through a written transfer agreement; and
 - 8. urologic.
 - (C) Requirements may be fulfilled by supervised senior residents as defined in Section 100245 of this Chapter who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:
 - 1. the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
 - 2. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available;
 - 3. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.

- (D) Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services;
 - 1. burns;
 - 2. cardiothoracic;
 - 3. pediatric;
 - 4. reimplantation/microsurgery; and
 - 5. spinal cord injury.
- (9) Qualified non-surgical specialist(s) or specialty availability, which shall be available as follows:
 - (A) Emergency medicine, in-house and immediately available at all times. This requirement may be fulfilled by supervised senior residents, as defined in Section 100245 of this Chapter, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialists in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an advanced trauma life support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.
 - (B) Anesthesiology. Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and be present for all operations.
 - (C) Radiology, promptly available; and
 - (D) Available for consultation:
 - 1. cardiology;
 - 2. gastroenterology;
 - 3. hematology;
 - 4. infectious diseases;
 - 5. internal medicine;
 - 6. nephrology;
 - 7. neurology;
 - 8. pathology; and
 - 9. pulmonary medicine.

- (b) In addition to licensure requirements, trauma centers shall have the following service capabilities:
 - (1) Radiological service. The radiological service shall have immediately available a radiological technician capable of performing plain film and computed tomography imaging. A radiological service shall have the following additional services promptly available:
 - (A) angiography; and
 - (B) ultrasound.
 - (2) Clinical laboratory service. A clinical laboratory service shall have:
 - (A) a comprehensive blood bank or access to a community central blood bank; and
 - (B) clinical laboratory services immediately available.
 - (3) Surgical service. A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
 - (A) Operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available; and
 - (B) appropriate surgical equipment and supplies as determined by the trauma program medical director.
- (c) A Level I and II trauma center shall have a basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
 - (1) designate an emergency physician to be a member of the trauma team;
 - (2) provide emergency medical services to adult and pediatric patients; and
 - (3) have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director.
- (d) In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
 - (1) Intensive Care Service:
 - (A) the ICU shall have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
 - (B) The ICU shall have a qualified specialist promptly available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making; and
 - (C) the qualified specialist in (B) above shall be a member of the trauma team.
 - (2) Burn Center. This service may be provided through a written transfer agreement with a Burn Center.
 - (3) Physical Therapy Service. Physical therapy services to include personnel trained in physical therapy and equipped for acute care of the critically injured patient.

- (4) Rehabilitation Center. Rehabilitation services to include personnel trained in rehabilitation care and equipped for acute care of the critically injured patient. These services may be provided through a written transfer agreement with a rehabilitation center.
 - (5) Respiratory Care Service. Respiratory care services to include personnel trained in respiratory therapy and equipped for acute care of the critically injured patient.
 - (6) Acute hemodialysis capability.
 - (7) Occupational therapy service. Occupational therapy services to include personnel trained in occupational therapy and equipped for acute care of the critically injured patient.
 - (8) Speech therapy service. Speech therapy services to include personnel trained in speech therapy and equipped for acute care of the critically injured patient.
 - (9) Social Service.
- (e) A trauma center shall have the following services or programs that do not require a license or special permit.
- (1) Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
 - (A) a pediatric intensive care unit approved by the California State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
 - (B) a multidisciplinary team to manage child abuse and neglect.
 - (2) Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a Rehabilitation Center;
 - (3) Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code;
 - (4) An outreach program, to include:
 - (A) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (B) trauma prevention for the general public;
 - (5) Written interfacility transfer agreements with referring and specialty hospitals;
 - (6) Continuing education. Continuing education in trauma care shall be provided for:
 - (A) staff physicians;
 - (B) staff nurses;
 - (C) staff allied health personnel;
 - (D) EMS personnel; and

- (E) other community physicians and health care personnel.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

§100260. Additional Level I Criteria

In addition to the above requirements, a Level I trauma center shall have:

- (a) One of the following patient volumes annually:
 - (1) a minimum of 1200 trauma program hospital admissions, or
 - (2) a minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is greater than 15, or
 - (3) an average of 35 trauma patients (with an ISS score greater than 15) per trauma program surgeon per year.
- (b) Additional qualified surgical specialists or specialty availability on-call and promptly available:
 - (1) cardiothoracic; and
 - (2) pediatrics;
- (c) A surgical service that has at least the following:
 - (1) operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.
 - (2) cardiopulmonary bypass equipment; and
 - (3) operating microscope.
- (d) Anesthesiology immediately available. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing treatment and are supervised by the staff anesthesiologist.
- (e) An intensive care unit with a qualified specialist in-house and immediately available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.
- (f) A Trauma research program; and
- (g) An ACGME approved surgical residency program.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

100261. Level I and Level II Pediatric Trauma Centers

- (a) A Level I or II pediatric trauma center is a licensed hospital which has been designated as a Level I or II pediatric trauma center by the local EMS agency. While both Level I and II pediatric trauma centers are similar, a Level I pediatric trauma center is required to have staff and resources not required of a Level II pediatric trauma center. The additional Level I requirements for pediatric trauma centers are located in Section 100262. A Level I or Level II pediatric trauma center shall have at least the following:
- (1) A pediatric trauma program medical director who is a board-certified surgeon with experience in pediatric trauma care (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
 - (A) recommending pediatric trauma team physician privileges;
 - (B) working with nursing and administration to support the needs of pediatric trauma patients;
 - (C) developing pediatric trauma treatment protocols;
 - (D) determining appropriate equipment and supplies for pediatric trauma care;
 - (E) ensuring the development of policies and procedures to manage domestic violence and child abuse and neglect;
 - (F) having authority and accountability for the pediatric trauma quality improvement peer review process;
 - (G) correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
 - (H) coordinating pediatric trauma care with other hospital and professional services;
 - (I) coordinating with local and State EMS agencies;
 - (J) assisting in the coordination of the budgetary process for the trauma program; and
 - (K) identifying representatives from neurosurgery, orthopedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.
 - (2) A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, administrative ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
 - (A) organizing services and systems necessary for the multidisciplinary approach to the care of the injured child;
 - (B) coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel; and

- (C) collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program.
- (3) A pediatric trauma service which can provide for the implementation of the requirements specified in this section and provide for coordination with the local EMS agency.
- (4) A pediatric trauma team, which is a multidisciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
 - (A) the pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director;
 - (B) the remainder of the team shall include physician, nursing and support personnel in sufficient numbers to evaluate, resuscitate, treat and stabilize pediatric trauma patients.
- (5) Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties and which are staffed by qualified specialists with pediatric experience:
 - (A) neurologic;
 - (B) obstetric/gynecologic (may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service);
 - (C) ophthalmologic;
 - (D) oral or maxillofacial or head and neck;
 - (E) orthopaedic;
 - (F) pediatric;
 - (G) plastic;
 - (H) urologic; and
 - (I) microsurgery/reimplantation (may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service).
- (6) Department(s), division(s), service(s), or section(s) that include at least the following non-surgical specialties which are staffed by qualified specialists with pediatric experience:
 - (A) anesthesiology;
 - (B) cardiology;
 - (C) critical care;
 - (D) emergency medicine;
 - (E) gastroenterology;
 - (F) general pediatrics;
 - (G) hematology/oncology;
 - (H) infectious disease;
 - (I) neonatology;
 - (J) nephrology;
 - (K) neurology;
 - (L) pathology;

- (M) psychiatry;
 - (N) pulmonology;
 - (O) radiology; and
 - (P) rehabilitation/physical medicine. This requirement may be provided through a written agreement with a pediatric rehabilitation center.
- (7) An emergency department, division, service or section staffed with qualified specialists in emergency medicine with pediatric trauma experience, who are immediately available.
- (8) Qualified surgical specialist(s) or specialty availability, which shall be available as follows:
- (A) Pediatric surgeon, capable of evaluating and treating pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation. This requirement may be fulfilled by:
 - 1. a staff pediatric surgeon with experience in pediatric trauma care; or
 - 2. a staff trauma surgeon with experience in pediatric trauma care; or
 - 3. a senior general surgical resident who has completed at least three clinical years of surgical residency training. When a senior resident is the responsible surgeon:
 - a. the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care; and
 - b. a staff pediatric surgeon with experience in pediatric trauma care or a staff trauma surgeon with experience in pediatric trauma care shall be on-call and promptly available; and
 - c. a staff pediatric surgeon or a staff surgeon with experience in pediatric trauma care shall participate in major therapeutic decisions, be advised of all pediatric trauma patient admissions and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.
 - (B) On-call and promptly available with pediatric experience;
 - 1. neurologic;
 - 2. obstetric/gynecologic. This surgical service may be provided through a written transfer agreement;
 - 3. ophthalmologic;
 - 4. oral or maxillofacial or head and neck;
 - 5. orthopaedic;
 - 6. plastic;
 - 7. reimplantation/microsurgery capability. This surgical service may be provided through a written transfer agreement;
 - 8. urologic;

- (C) Requirements may be fulfilled by supervised senior residents as defined in Section 100245 of this Chapter who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:
 - 1. The senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
 - 2. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available;
 - 3. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.
- (D) Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services;
 - 1. burns;
 - 2. cardiothoracic; and
 - 3. spinal cord injury.
- (9) Qualified nonsurgical specialist(s) or specialty availability, which shall be available as follows:
 - (A) Emergency medicine, in-house and immediately available at all times. This requirement may be fulfilled by a qualified specialist in pediatric emergency medicine; or a qualified specialist in emergency medicine with pediatric experience; or a subspecialty resident in pediatric emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialists in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an advanced trauma life support course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in-house:
 - 1. a qualified specialist in pediatric emergency medicine, or emergency medicine with pediatric experience shall be promptly available; and
 - 2. the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.
 - (B) Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by a senior resident or certified registered nurse anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff

anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and be present for all operations.

- (C) Radiology, promptly available; and
- (D) Available for consultation or provided through transfer agreement, qualified specialists with pediatric experience:
 - a. adolescent medicine;
 - b. child development;
 - c. genetics/dysmorphology;
 - d. neuroradiology;
 - e. obstetrics;
 - f. pediatric allergy and immunology;
 - g. pediatric dentistry;
 - h. pediatric endocrinology;
 - i. pediatric pulmonology; and
 - j. rehabilitation/physical medicine.
- (E) Pediatric critical care, in-house and immediately available. The in-house requirement may be fulfilled by:
 - 1. a qualified specialist in pediatric critical care medicine; or
 - 2. a qualified specialist in anesthesiology with experience in pediatric critical care;
 - 3. a qualified surgeon with expertise in pediatric critical care; or
 - 4. a physician who has completed at least two years of residency in pediatrics.When a senior resident is the responsible pediatric critical care physician then:
 - a. a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and;
 - b. the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions;
- (F) Qualified specialists with pediatric experience shall be on the hospital staff and available for consultation:
 - 1. general pediatrics;
 - 2. mental health;
 - 3. neonatology;
 - 4. nephrology;
 - 5. pathology;
 - 6. pediatric cardiology;
 - 7. pediatric gastroenterology;
 - 8. pediatric hematology/oncology;

9. pediatric infectious disease;
 10. pediatric neurology; and
 11. pediatric radiology.
- (b) In addition to licensure requirements, pediatric trauma centers shall have the following service capabilities:
- (1) Radiological service. The radiological service shall have in-house and immediately available a radiological technician capable of performing plain film and computed tomography imaging. A radiological service shall have the following additional services promptly available for children:
 - (A) angiography; and
 - (B) ultrasound.
 - (2) Clinical laboratory service. A clinical laboratory service shall have:
 - (A) a comprehensive blood bank or access to a community central blood bank; and
 - (B) clinical laboratory services immediately available with micro sampling capability.
 - (3) Surgical service. A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
 - (A) Operating staff who are promptly available unless operating on a trauma patient and back up personnel who are promptly available; and
 - (B) appropriate surgical equipment and supplies as determined by the pediatric trauma program medical director.
 - (4) Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.
- (c) A Level I and II pediatric trauma center shall have a basic or comprehensive emergency service which have special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
- (1) designate an emergency physician to be a member of the pediatric trauma team;
 - (2) provide emergency medical services to pediatric patients; and
 - (3) have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director.
- (d) In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
- (1) Burn Center. This service may be provided through a written transfer agreement with a Burn Center;
 - (2) Physical Therapy Service. Physical therapy services to include personnel trained in pediatric physical therapy and equipped for acute care of the critically injured child;
 - (3) Rehabilitation Center. Rehabilitation services to include personnel trained in rehabilitation care and equipped for acute care of the critically injured patient. These services may be provided through a written transfer agreement with a rehabilitation center;
 - (4) Respiratory Care Service. Respiratory care services to include personnel trained in respiratory

- therapy and equipped for acute care of the critically injured patient;
 - (5) Acute hemodialysis capability;
 - (6) Occupational therapy service. Occupational therapy services to include personnel trained in pediatric occupational therapy and equipped for acute care of the critically injured child;
 - (7) Speech therapy service. Speech therapy services to include personnel trained in pediatric speech therapy and equipped for acute care of the critically injured child; and
 - (8) Social Service.
- (e) A trauma center shall have the following services or programs that do not require a license or special permit.
- (1) A Pediatric Intensive Care Unit (PICU) approved by the California State Department of Health Services California Children Services (CCS).
 - (A) The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
 - (B) the pediatric intensive care specialist shall be promptly available to care for trauma patients in the intensive care unit; and
 - (C) the qualified specialist in (B) above shall be a member of the trauma team.
 - (2) Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a Rehabilitation Center;
 - (3) Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code;
 - (4) An outreach program, to include:
 - (A) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas;
 - (B) trauma prevention for the general public;
 - (C) public education and illness/injury prevention education.
 - (5) written interfacility transfer agreements with referring and specialty hospitals; and
 - (6) continuing education. Continuing education in pediatric trauma care shall be provided for:
 - (A) staff physicians;
 - (B) staff nurses;
 - (C) staff allied health personnel;
 - (D) EMS personnel; and
 - (E) other community physicians and health care personnel.

- (7) In addition to special permit licensing services, a pediatric trauma center shall have:
 - (A) outreach and injury prevention programs specifically related to pediatric trauma and injury prevention;
 - (B) a suspected child abuse and neglect team (SCAN);
 - (C) an aeromedical transport plan with designated landing site; and
 - (D) Child Life program.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

100262. Additional Level I Pediatric Trauma Criteria

In addition to the above requirements, a Level I pediatric trauma center shall have:

- (a) A pediatric trauma program medical director who is a board-certified pediatric surgeon, whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care.
- (b) Additional qualified pediatric surgical specialists or specialty availability on-call and promptly available:
 - (1) cardiothoracic;
 - (2) pediatric neurologic;
 - (3) pediatric ophthalmologic;
 - (4) pediatric oral or maxillofacial or head and neck; and
 - (5) pediatric orthopaedic,
- (c) A surgical service that has at least the following:
 - (1) operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.
 - (2) cardiopulmonary bypass equipment; and
 - (3) operating microscope.
- (d) Additional qualified pediatric non-surgical specialists or specialty availability on-call and promptly available:
 - (1) pediatric anesthesiology;
 - (2) pediatric emergency medicine;
 - (3) pediatric gastroenterology;
 - (4) pediatric infectious disease;
 - (5) pediatric nephrology;
 - (6) pediatric neurology;
 - (7) pediatric pulmonology; and
 - (8) pediatric radiology.
- (e) the qualified pediatric PICU specialist shall be immediately available, advised about all patients who may require admission to the PICU, and shall participate in all major therapeutic decisions and interventions;

- (f) Anesthesiology shall be immediately available. This requirement may be fulfilled by a senior resident or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and providing treatment and are supervised by the staff anesthesiologist.
- (g) Pediatric trauma research program.
- (h) Maintain an education rotation with an ACGME approved and affiliated surgical residency program.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

§ 100263. Level III Trauma Centers

A Level III trauma center is a licensed hospital which has been designated as a Level III trauma center by the local EMS agency. A Level III trauma center shall include equipment and resources necessary for initial stabilization and personnel knowledgeable in the treatment of adult and pediatric trauma. A Level III trauma center shall have at least the following:

- (a) A trauma program medical director who is a qualified surgical specialist, whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
 - (1) recommending trauma team physician privileges;
 - (2) working with nursing administration to support the nursing needs of trauma patients;
 - (3) developing trauma treatment protocols;
 - (4) having authority and accountability for the quality improvement peer review process;
 - (5) correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet the standards of the quality improvement program; and
 - (6) assisting in the coordination of budgetary process for the trauma program.
- (b) A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of adult and/or pediatric trauma patients, administrative ability, and responsibilities that include, but are not limited to:
 - (1) organizing services and systems necessary for the multidisciplinary approach to the care of the injured patient;
 - (2) coordinating day-to-day clinical process and performance improvement as pertains to nursing and ancillary personnel, and
 - (3) collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program.
- (c) A trauma service which can provide for the implementation of the requirements specified in this Section and provide for coordination with the local EMS agency.
- (d) The capability of providing prompt assessment, resuscitation and stabilization to trauma patients.
- (e) The ability to provide treatment or arrange for transportation to a higher level trauma center as appropriate.
- (f) An emergency department, division, service, or section staffed so that trauma patients are assured of immediate and appropriate initial care.

- (g) Intensive Care Service:
 - (1) the ICU shall have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
 - (2) the ICU shall have a qualified specialist promptly available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making; and
 - (3) the qualified specialist in (2) above shall be a member of the trauma team;
- (h) A trauma team, which will be a multidisciplinary team responsible for the initial resuscitation and management of the trauma patient.
- (i) Qualified surgical specialist(s) who shall be promptly available:
 - (1) general;
 - (2) orthopedic; and
 - (3) neurosurgery (can be provided through a transfer agreement)
- (j) Qualified non-surgical specialist(s) or specialty availability, which shall be available as follows:
 - (1) Emergency medicine, in-house and immediately available; and
 - (2) Anesthesiology, on-call and promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated emergent anesthesia treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and be present for all operations.
 - (3) The following services shall be in-house or may be provided through a written transfer agreement:
 - (A) Burn care.
 - (B) Pediatric care.
 - (C) Rehabilitation services.
- (k) The following service capabilities:
 - (1) Radiological service. The radiological service shall have a radiological technician promptly available.
 - (2) Clinical laboratory service. A clinical laboratory service shall have:
 - (A) a comprehensive blood bank or access to a community central blood bank; and
 - (B) clinical laboratory services promptly available.
 - (3) Surgical service. A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
 - (A) Operating staff who are promptly available; and
 - (B) appropriate surgical equipment and supplies requirements which have been approved by the local EMS agency.

- (l) Written transfer agreements with Level I or II trauma centers, Level I or II pediatric trauma centers, or other specialty care centers, for the immediate transfer of those patients for whom the most appropriate medical care requires additional resources.
- (m) An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (2) trauma prevention for the general public.
- (n) Continuing education. Continuing education in trauma care, shall be provided for:
 - (1) staff physicians;
 - (2) staff nurses;
 - (3) staff allied health personnel;
 - (4) EMS personnel; and
 - (5) other community physicians and health care personnel.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

§ 100264. Level IV Trauma Center

A Level IV trauma center is a licensed hospital which has been designated as a Level IV trauma center by the local EMS agency. A Level IV trauma center shall include equipment and resources necessary for initial stabilization and personnel knowledgeable in the treatment of adult and pediatric trauma. A Level IV trauma center shall have at least the following:

- (a) A trauma program medical director who is a qualified specialist whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care, including pediatric trauma care, such as:
 - (1) recommending trauma team physician privileges;
 - (2) working with nursing administration to support the nursing needs of trauma patients;
 - (3) developing treatment protocols;
 - (4) having authority and accountability for the quality improvement peer review process;
 - (5) correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet the standards of the quality improvement program; and
 - (6) assisting in the coordination of the budgetary process for the trauma program.
- (b) A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of adult and/or pediatric trauma patients, administrative ability, and responsibilities that include, but are not limited to:
 - (1) organizing services and systems necessary for the multidisciplinary approach to the care of the injured patient;
 - (2) coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel; and
 - (3) collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program.

- (c) A trauma service which can provide for the implementation of the requirements specified in this Section and provide for coordination with the local EMS agency.
- (d) The capability of providing prompt assessment, resuscitation and stabilization to trauma patients.
- (e) The ability to provide treatment or arrange transportation to higher level trauma center as appropriate.
- (f) An emergency department, division, service, or section staffed so that trauma patients are assured of immediate and appropriate initial care.
- (g) A trauma team, which will be a multidisciplinary team responsible for the initial resuscitation and management of the trauma patient.
- (h) The following service capabilities:
 - (1) Radiological service. The radiological service shall have a radiological technician promptly available.
 - (2) Clinical laboratory service. A clinical laboratory service shall have:
 - (A) a comprehensive blood bank or access to a community central blood bank; and
 - (B) clinical laboratory services promptly available.
- (i) Written transfer agreements with Level I, II or III trauma centers, Level I or II pediatric trauma centers, or other specialty care centers, for the immediate transfer of those patients for whom the most appropriate medical care requires additional resources.
- (j) An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (2) trauma prevention for the general public.
- (k) Continuing education. Continuing education in trauma care, shall be provided for:
 - (1) staff physicians;
 - (2) staff nurses;
 - (3) staff allied health personnel;
 - (4) EMS personnel; and
 - (5) other community physicians and health care personnel.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 and 1798.165, Health and Safety Code.

Article 4. Quality Improvement

100265. Quality Improvement

Trauma centers of all levels shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

A detailed audit of all trauma-related deaths, major complications and transfers (including interfacility transfer);

- (a) A multidisciplinary trauma peer review committee that includes all members of the trauma team;
- (b) Participation in the trauma system data management system;
- (c) Participation in the local EMS agency trauma evaluation committee; and
- (d) Each trauma center shall have a written system in place for patients, parents of minor children who are patients, legal guardian(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child.
- (e) Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.161 Health and Safety Code.

Article 5. Transfer of Trauma Patients

100266. Interfacility Transfer of Trauma Patients

- (a) Patients may be transferred between and from trauma centers providing that:
 - (1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and
 - (2) in accordance with local EMS agency interfacility transfer policies.
- (b) Hospitals shall have written transfer agreements with trauma centers. Hospitals shall develop written criteria for consultation and transfer of patients needing a higher level of care.
- (c) Hospitals which have repatriated trauma patients from a designated trauma center shall provide the information required by the system trauma registry, as specified by local EMS agency policies, to the transferring trauma center for inclusion in the system trauma registry.
- (d) Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients who have been transferred.

NOTE: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Sections 1798.160 and 1798.161, Health and Safety Code.

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Chapter 8: Prehospital EMS Air Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 8. Prehospital EMS Air Regulations

Article 1. Definitions

§§ 100276. Advanced Life Support.

"Advanced life support" or "ALS" as used in this Chapter means any definitive prehospital emergency medical care role approved by the local EMS agency, in accordance with state regulations, which includes all of the specialized care services listed in Section 1797.52 of the Health and Safety Code.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.206, 1797.218, 1797.220, 1797.252, 1798.2 and 1798.102, Health and Safety Code.

§§ 100277. Basic Life Support.

"Basic life support" or "BLS" as used in this Chapter means those procedures and skills contained in the EMT-I scope of practice as listed in Section 100063, Title 22, California Code of Regulations.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.80, 1797.103, 1797.170 and 1797.252, Health and Safety Code.

§§ 100278. Medical Flight Crew.

"Medical flight crew" as used in this Chapter means the individuals(s), excluding the pilot, specifically assigned to care for the patient during aircraft transport.

Note: Authority cited: Sections 1797.1, 1797.107, 1797.160, 1797.171 and 1797.172, Health and Safety Code. Reference: Sections 1797.80, 1797.82, 1797.84, 1797.103, 1797.160, 1797.170, 1797.171, 1797.172 and 1797.222, Health and Safety Code.

§§ 100279. Emergency Medical Services Aircraft.

"Emergency medical services aircraft" or "EMS aircraft" as used in this Chapter means any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.178, 1797.204, 1797.206 and 1797.222, Health and Safety Code.

§§ 100280. Air Ambulance.

"Air ambulance" as used in this Chapter means any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.52, 1797.82, 1797.84, 1797.103, 1797.171, 1797.172, 1797.206, 1797.218 and 1797.222, Health and Safety Code.

§§ 100281. Rescue Aircraft.

"Rescue aircraft" as used in this Chapter means an aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.52, 1797.60, 1797.82, 1797.84, 1797.103, 1797.171, 1797.172, 1797.206 and 1797.218, Health and Safety Code.

§§ 100282. Advanced Life Support Rescue Aircraft.

"Advanced life support rescue aircraft" or "ALS rescue aircraft" as used in this Chapter means rescue aircraft whose medical flight crew has at a minimum one attendant certified or licensed in advanced life support.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.52, 1797.82, 1797.84, 1797.103, 1797.171, 1797.172, 1797.206, 1797.218 and 1797.222, Health and Safety Code.

§§ 100283. Basic Life Support Rescue Aircraft.

"Basic life support rescue aircraft" or "BLS rescue aircraft" as used in this Chapter means a rescue aircraft whose medical flight crew has at a minimum one attendant certified as an EMT-IA, or an EMT-I-NA with at least eight (8) hours of hospital clinical training and whose field/clinical experience specified in Section 100074 (c) of Title 22, California Code of Regulations, is in the aeromedical transport of patients.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.60, 1797.80, 1797.103 and 1797.170, Health and Safety Code.

§§ 100284. Auxiliary Rescue Aircraft.

"Auxiliary rescue aircraft" as used in this Chapter means a rescue aircraft which does not have a medical flight crew, or whose medical flight crew do not meet the minimum requirements established in Section 100283.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Section 1797.103, Health and Safety Code.

§§ 100285. Air Ambulance Service.

"Air ambulance service" as used in this Chapter means an air transportation service which utilizes air ambulances.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.206, 1797.218 and 1797.222, Health and Safety Code.

§§ 100286. Air Rescue Service.

"Air rescue service" as used in this Chapter means an air service used for emergencies, including search and rescue.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.206 and 1797.218, Health and Safety Code.

§§ 100287. Air Ambulance or Air Rescue Service Provider.

"Air ambulance or air rescue service provider" as used in this Chapter means the individual or group that owns and/or operates an air ambulance or air rescue service.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.206, 1797.218 and 1797.222, Health and Safety Code.

§§ 100288. Classifying EMS Agency.

"Classifying EMS agency" or "classifying agency" as used in this Chapter means the agency which categorizes the EMS aircraft into the groups identified in Section 100300(c)(3). This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol, the California Department of Forestry or the California National Guard which shall be classified by the EMS Authority.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections

1797.54, 1797.94, 1797.103, 1797.204 and 1797.206 Health and Safety Code.

§§ 100289. Authorizing EMS Agency

"Authorizing EMS agency" or "authorizing agency" as used in this Chapter means the local EMS agency which approves utilization of specific EMS aircraft within its jurisdiction.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.84, 1797.103, 1797.204, 1797.206 and 1797.218, Health and Safety Code.

§§ 100290. Jurisdiction of Origin.

"Jurisdiction of origin" as used in this Chapter means the local EMS jurisdiction within which the authorized air ambulance or rescue aircraft is operationally based.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.222 and 1797.250, Health and Safety Code.

§§ 100291. Designated Dispatch Center.

"Designated dispatch center" as used in this Chapter means an agency which has been designated by the local EMS agency for the purpose of coordinating air ambulance or rescue aircraft response to the scene of a medical emergency within the jurisdiction of the local EMS agency.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.206, 1797.218, 1797.222, 1797.252 and 1798.6, Health and Safety Code.

Article 2. General Provisions

§§ 100300. Application of Chapter.

(a) It is the scope of this Chapter to establish minimum standards for the integration of EMS Aircraft and personnel into the local EMS prehospital patient transport system as a specialized resource for the transport and care of emergency medical patients.

(b) A local EMS agency may integrate aircraft into its prehospital patient transport system. Each local EMS agency choosing to integrate such aircraft into its prehospital care system shall develop a program which at minimum:

(1) Classifies EMS aircraft in accordance with Section 100300(c)(3).

(2) Incorporates into their EMS plan the utilization of EMS aircraft including but not limited to an

inventory of:

- (A) The number and type of authorized EMS aircraft.
- (B) The patient capacity of authorized EMS aircraft.
- (C) The level of patient care provided by EMS aircraft personnel.
- (D) Receiving facilities with landing sites approved by the State Department of Transportation, Aeronautics Division.
- (3) Establishes policies and/or procedures to assure compliance with the provisions of this Chapter.
- (4) Develops written agreements with air ambulance or rescue aircraft providers specifying conditions to routinely serve their jurisdiction.
- (c) In those jurisdictions where a local EMS agency has chosen to integrate aircraft into its prehospital patient transport system:
 - (1) No person or organization shall provide or hold themselves out as providing prehospital Air Ambulance or Air Rescue services unless that person or organization has aircraft which have been classified by a local EMS agency or in the case of the California Highway Patrol, California Department of Forestry, and California National Guard, the EMS Authority.
 - (2) All EMS Aircraft shall be classified.
 - (3) EMS aircraft classification shall be limited to the following categories:
 - (A) Air Ambulance
 - (B) ALS Rescue Aircraft
 - (C) BLS Rescue Aircraft
 - (D) Auxiliary Rescue Aircraft
 - (4) EMS Aircraft classification shall be reviewed in accordance with policies of the classifying agency. Reclassification shall occur if there is a transfer of ownership or a change in the aircraft's category.
 - (5) EMS aircraft must be authorized by the local EMS agency in order to provide prehospital patient transport within the jurisdiction of the local EMS agency.

A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, Department of Forestry, National Guard or the Federal Government.

(6) Air Ambulance and Air Rescue service providers including any company, lessee, agency (excluding agencies of the federal government), provider, owner, operator who provides or makes available prehospital air transport or medical personnel either directly or indirectly or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily shall adhere to all federal, state and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.

(7) The local EMS agency may charge a fee to cover the costs directly associated with the classification and authorization of EMS aircraft.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.212, 1797.218, 1797.224 and 1797.252, Health and Safety Code.

Article 3. Personnel

§§ 100302. Medical Flight Crew.

(a) The medical flight crew of an EMS aircraft shall have training in aeromedical transportation as specified and approved by the authorizing EMS agency including but not limited to:

- (1) General patient care in-flight.
 - (2) Changes in barometric pressure, and pressure related maladies.
 - (3) Changes in partial pressure of oxygen.
 - (4) Other environmental factors affecting patient care.
 - (5) Aircraft operational systems.
 - (6) Aircraft emergencies and safety.
 - (7) Care of patients who require special consideration in the airborne environment.
 - (8) EMS system and communications procedures.
 - (9) The prehospital care system(s) within which they operate including local medical and procedural protocols.
 - (10) Use of onboard medical equipment.
- (b) All medical flight crews shall participate in such continuing education requirements as required by their licensure or certification. Continuing education in aeromedical transportation subjects may be required by the authorizing EMS agency.
- (c) (Reserved)

(d) (Reserved)

(e) In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients they may assume patient care responsibility only in accordance with policies and procedures of the requesting local EMS agency.

(f) EMS aircraft that do not have a medical flight crew shall not transport patients except in accordance with the policies and procedures of the requesting local EMS agency.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.17, 1797.171, 1797.172, 1797.175, 1797.176, 1797.178, 1797.214, 1797.218, 1798 and 1798.6, Health and Safety Code.

Article 4. System Operation

§§ 100304. System Policies and Procedures.

(a) Those local EMS agencies choosing to integrate aircraft into the prehospital patient transport system shall develop policies and procedures for:

(1) the authorization of EMS aircraft to be utilized in prehospital patient care.

(2) requesting EMS aircraft including but not limited to the types of personnel and/or organizations that may request or cancel EMS aircraft. EMS aircraft requests shall only be made through a dispatch center which has been designated by a local EMS agency.

(3) the dispatching of EMS aircraft. These policies and procedures shall include but not be limited to:

(A) Availability and appropriateness of transportation and medical personnel resources including:

1. Ground versus air transport as related to proximity and type of incident.

2. Medical capability of potential responders.

(B) Notification of and coordination with other responding agencies.

(C) Termination of EMS aircraft response.

(4) Determining EMS aircraft patient destination including consideration of an interim stop at a rural hospital and continuation of care until the responsibility is assumed by the emergency or other staff of a final destination hospital.

(5) Orientation of pilots and medical flight crews to the local EMS system.

(6) Addressing and resolving formal complaints regarding the integration of aircraft into the prehospital patient transport system.

(b) The local agency's policies and procedures for medical control shall apply to the medical flight crew. Such policies and procedures may be modified by the local EMS agency, if required by the uniqueness of EMS aircraft response.

(c) The authorizing EMS agency's policies and procedures for record keeping and quality assurance, shall apply to EMS aircraft operations. Current policies and procedures may be modified if required by the uniqueness of EMS aircraft response.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.105, 1797.204, 1797.206, 1797.218, 1797.222 and 1797.252, Health and Safety Code.

Article 5. Equipment and Supplies, Aircraft Specifications

§§ 100306. Space and Equipment.

(a) All EMS aircraft shall be configured so that:

(1) There is sufficient space in the patient compartment to accommodate one (1) patient on the stretcher and one (1) patient attendant. Air ambulances shall at a minimum have space to accommodate one (1) patient and two (2) patient attendants.

(2) There is sufficient space for medical personnel to have adequate access to the patient in order to carry out necessary procedures including CPR on the ground and in the air.

(3) There is sufficient space for medical equipment and supplies required by State regulations or authorizing EMS agency policy.

(4) Additional authorizing EMS agency requirements are met.

(b) Each EMS aircraft shall have adequate safety belts and tie-downs for all personnel, patient(s), stretcher(s) and equipment to prevent inadvertent movement.

(c) Each EMS aircraft shall have on-board equipment and supplies commensurate with the scope of practice of the medical flight crew as specified by the classifying EMS agency. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried on a given flight to meet the needs of a specific type of patient and/or additional medical personnel not usually staffing the aircraft.

(d) Communications

(1) In accordance with authorizing EMS agency policies, all EMS aircraft shall have the capability of communicating with:

(A) Designated dispatch center(s).

(B) EMS ground units at the scene of an emergency.

(C) Designated base hospitals.

(D) Receiving hospitals.

(E) Other appropriate facilities or agencies.

(2) All EMS aircraft shall utilize appropriate radio frequencies for dispatch, routing and coordination of flights. This excludes use of Med 1-8 and HEAR (155.340 MHz and 155.280 MHz) for these purposes.

(3) Radio equipment may be inspected to assure compliance with the requirements of the authorizing EMS agency.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.206, 1797.220, 1797.222 and 1798.2, Health and Safety Code.

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California Code of Regulations, Title 22

Chapter 9: Poison Control Center Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 9. Poison Control Center Regulations

Article 1. Definitions

100321. Immediately Available

"Immediately available" means unencumbered by conflicting duties or responsibilities and being within the specified area of the poison control center.

NOTE: Authority Cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Section 1798.180, Health and Safety Code.

100322. On-call

"On-call" means agreeing to be available by telephone or beeper to respond to the poison control center in order to provide a defined service.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Section 1798.180, Health and Safety Code.

100323. Poison Control Center

"Poison control center" or "PCC" or "regional poison control center" or "regional poison center" means a facility designated by the EMS Authority that provides information and advice to the public and health professionals regarding the management of individuals who have or may have ingested or otherwise been exposed to poisonous or possibly toxic substances. This information and advice shall be given by the medical director, program director, specialist in poison information, poison information provider, or a poison center specialty consultant as defined in Section 100330.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97, 1798.180 and 1799.105, Health and Safety Code.

100324. Poison Control Center Service Area

"Poison control center service area" means the geographical service area of a regional poison control center as approved by the EMS Authority through designation.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Section 1798.180, Health and Safety Code.

100325. Product Information Resources

"Product information resources" are resources that provide information regarding ingredients contained in commercial products.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Section 1798.180, Health and Safety Code.

100326. Provisional Certificate

A "provisional certificate" shall be for two (2) years and may be given to a facility that does not meet the provisions of Section 100328(c) but that is otherwise in compliance with the requirements in this chapter as determined by an examination of the facility's application and/or by the site review. A provisional certificate gives the facility all the rights and privileges of a designated poison control center with the exception of eligibility for the California Regional Poison Control Centers' Funding Augmentation.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100327. Temporary Designation

"Temporary designation" shall be for one (1) year and may be given to a facility that meets the provisions of Section 100328(c), but that is not in compliance with the other requirements in this chapter as determined by an examination of the facility's application and/or by the site review. Temporary designation gives the facility all the rights and privileges of a designated poison control center.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

Article 2. General Provisions

100328. Poison Control Center Criteria

The EMS Authority shall utilize the following criteria in designating facilities as poison control centers:

(a) No more than one (1) poison control center shall be designated for each two (2) million people.

(1) For those poison control center service areas with populations greater than two (2) million, additional facilities may be designated on the basis of a change in local need within that area as determined by the EMS Authority, including population, geographic distribution, and other factors affecting the efficiency and effectiveness of providing poison information services.

(b) The poison control center service area of a designated poison control center shall be distinct from that covered by any other designated poison control center.

(1) If an additional facility is designated pursuant to subsection (a)(1) of this Section, the poison control center service area may be redefined by the EMS Authority.

(c) The applicant has provided poison control information to the public and health professionals in its proposed service area for at least a two (2) year period.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100329. Poison Control Center Responsibilities

(a) In order to be designated as a regional poison control center a facility shall:

(1) be immediately available by a direct incoming telephone system to the public and health professionals within the poison control center service area;

(2) have staff as defined in Section 100330(c) immediately available twenty-four (24) hours a day to

answer poison exposure calls;

(3) have, within the poison control center area, poison information resources which include at least the following:

(A) One (1) or more current product information resources;

(B) current texts covering both general and specific aspects of acute and chronic poisoning management available at the central telephone answering site; and

(C) a list of poison center specialty consultants available on an on-call basis through a written agreement.

(4) have access to journal articles and published studies regarding medical toxicology either in the poison control center or through access to a medical library.

(5) have written treatment and triage protocols that are developed and updated by the poison control center program director and approved by the medical director. Each written protocol shall include the following elements:

(A) Description and types of exposures which may need no medical intervention;

(B) description and types of exposures which may be managed at home by simple therapeutic procedures in the professional opinion of the medical director, and a treatment and triage protocol for such management;

(C) description and types of exposures which may require referral for medical evaluation and/or treatment;

(D) a protocol for initial patient management;

(E) a protocol for determining the need for patient transport to a facility in accordance with the policies and procedures of the local EMS agency; and

(F) a description of how the poison control center correlates with local EMS policies and procedures, including 9-1-1.

(6) develop and maintain a poisoning data collection and reporting system as defined in Section 100332 and as required by Title 17, Sections 2500 through 2653.

(7) develop and provide a poison oriented health education program for the public and health professionals to include at least physicians, nurses, prehospital emergency medical services personnel; and

(8) develop and maintain a quality assurance program as defined in Section 100331.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100330. Poison Control Center Staffing

(a) Each poison control center shall have a medical director who shall be a physician and surgeon currently licensed in the State of California, who has a minimum of two (2) years' postgraduate training in clinical toxicology and/or a minimum of three (3) years' clinical experience in the last five (5) years in toxicology or poison information sciences, and who devotes a minimum of ten (10) percent of his or her practice to treating poisoned patients. The medical director shall be on-call to the staff of the poison control center and shall participate in professional medical education programs pursuant to subsection (b)(4) of this Section. Duties of the medical director shall include, but not be limited to:

(1) Assisting the specialists in poison information upon request or in accordance with treatment and triage protocols;

- (2) approving treatment and triage protocols as specified in Section 100329(a)(4) which are written and updated by the program director pursuant to subsection (b)(3) of this Section;
- (3) reviewing the quality assurance program as specified in Section 100331;
- (4) consulting with physicians on the treatment of poisoned patients as appropriate; and
- (5) reviewing the poison center specialty consultant(s)' qualifications and approving or disapproving the consultation services applicant(s).

(b) Each poison control center shall have a program director who shall be a pharmacist, physician or registered nurse, licensed in the State of California, who has a minimum of two (2) years' postgraduate training in clinical toxicology and/or a minimum of three (3) years' clinical experience in the last five (5) years in toxicology and/or poison information sciences. The program director must have two (2) years' experience in the administration of a health related program. Duties of the program director shall be coordinated with the medical director and shall include, but not be limited to:

- (1) Supervising the poison control center's organization, staff, funding and quality assurance;
- (2) determining and ensuring the availability of staff identified in subsections (a), (c), (d) and (e) of this Section;
- (3) developing and updating treatment and triage protocols as specified in Section 100329(a)(4) to be approved by the medical director pursuant to subsection (a)(2) of this Section;
- (4) developing and/or approving poison oriented health education programs for the public and health professionals pursuant to Section 100329(a)(6). These education programs shall be coordinated with the local EMS agency(s);
- (5) developing and maintaining a data collection system as specified in Section 100332; and
- (6) assisting the specialists in poison information upon request or in accordance with treatment and triage protocols.

(c) Each poison control center shall have a specialist(s) in poison information who shall be a pharmacist, physician, or registered nurse currently licensed in the State of California, who has training or experience in toxicology and poison information sciences as defined by the medical and program director of the poison control center. Duties of the specialist in poison information shall include, but not be limited to:

- (1) Answering incoming telephone calls, evaluating the poison exposure history, providing management information and determining the necessity for additional medical consultation;
- (2) updating poison information files; and
- (3) teaching poison oriented health education programs.

(d) Each poison control center may have a poison information provider(s) trained in reading, understanding and transmitting poison information. The poison information provider will be under the direct on-site supervision of a specialist in poison information.

(e) Each poison control center shall have a poison center specialty consultant(s) who is qualified by training and/or experience to provide specialized toxicology information related to the poisonings encountered in the area serviced by the poison control center. The poison center specialty consultant shall have a written agreement with the poison control center that is updated yearly to provide consultation services on an on-call basis.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100331. Quality Assurance Program

(a) A poison control center shall have a quality assurance program which shall include at a minimum:

- (1) Case review of all deaths in which poison control center consultation was provided;
- (2) case review and critique of a sample of cases;
- (3) screenings of poisoning and exposure cases by type of poison; and
- (4) either direct monitoring of a sample of calls or tape recordings of calls.

(b) The medical director shall conduct an audit and case review of poisoning cases at least quarterly.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100332. Data Collection

(a) A poison control center shall implement a data management system capable of collecting poison information data, which shall be available from poison control center case records.

(b) The data shall be submitted annually to the EMS Authority and shall include at least the number of incoming calls for each county in and outside of the poison control center service area from the public and health professionals.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Section 1798.180, Health and Safety Code.

Article 3. Designation Process**100333. Designation Process**

(a) A facility that wishes to be designated as a poison control center shall submit a written application to the EMS Authority along with supporting documentation that explains how it meets the provisions of these regulations.

(b) The application for approval shall include at least the following:

- (1) Organization chart;
- (2) names, qualifications, duty statements, and hours available of:
 - (A) Medical director;
 - (B) program director or coordinator;
 - (C) specialist(s) in poison information;
 - (D) poison information provider(s); and
 - (E) poison center specialty consultants.
- (3) written verification of contracts with poison center specialty consultants;
- (4) information explaining how the responsibilities of Section 100329(a)(1) through 100329(a)(7) are being met;
- (5) description of proposed service area and how it will be integrated with:
 - (A) the affected local EMS agencies' service area and system; and
 - (B) other poison control centers.
- (6) intent to execute a written agreement with the EMS Authority committing the applicant to meet the requirements of this chapter.

(c) The EMS Authority shall notify the local EMS Agencies in the proposed poison control center service area within (10) working days of receiving the application that the facility is applying for designation.

(d) The EMS Authority shall notify the facility submitting its application for poison control center designation within thirty (30) working days of receiving the application that:

- (1) The application has been received;
- (2) the application contains or does not contain the information required by this Section; and
- (3) what information is missing, if any.

(e) The EMS Authority shall conduct a site visit to determine that the facility's resources and capabilities described in its application are in compliance with these regulations.

(f) The EMS Authority shall:

- (1) Notify the facility submitting an application for regional poison control center designation, and the EMS agencies in the proposed poison control center service area, that the facility either has been "designated," received "temporary designation," or received a "provisional certificate," or has been "disapproved for designation" within 120 days of receipt of a complete application; and
- (2) provide the reasons for disapproval of an application if disapproved for designation.

(g) A facility holding a temporary designation or a provisional certificate, must achieve full designation status on or before the conclusion of the temporary designation or provisional certificate or cease operation. No further action of the EMS Authority is required.

(h) If the EMS Authority disapproves an application, the facility submitting the application shall have three (3) months from the date notification of the disapproval is received to submit a written appeal which states the reasons for objecting to the EMS Authority's decision.

(1) The EMS Authority will present the appeal package to the Commission on Emergency Medical Services. The appeal package shall include the following:

- (A) The EMS Authority's written disapproval;
- (B) The facility's written appeal;
- (C) The facility's application and any documents the EMS Authority used to make the decision for disapproval.

(2) The Commission on EMS shall consider the appeal at their next regularly scheduled Commission meeting, at which time the facility shall have the opportunity to address the Commission. The Commission on EMS shall make a determination within one (1) year of receipt of the appeal.

(i) Poison control center designation shall be for four (4) years at which time a new application for continued poison control center designation shall be submitted.

(j) If a poison control center does not wish to continue being designated, it shall terminate its designation by notifying the EMS Authority at least sixty (60) days before the date of termination stating the reasons for its termination. The EMS Authority shall inform the local EMS agency(s) in the poison control center service area.

(k) The EMS Authority may conduct periodic evaluations of approved poison control centers. This may include a yearly site visit.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

100334. Revocation of Designation

(a) If the EMS Authority determines that a designated poison control center has not implemented a program consistent with its designation requirements, its designation as a poison control center may be withdrawn.

(b) When the EMS Authority intends to withdraw a poison control center's designation, the Director shall:

(1) Notify the poison control center of the proposed action;

(2) concurrently serve the poison control center with a description of the deficiencies; and

(3) advise the poison control center of the right to a hearing.

(c) The EMS Authority may temporarily terminate designation prior to any hearing when in the opinion of the Director, the action is necessary to protect the public's health or safety. The Director shall:

(1) Notify the poison control center of the temporary suspension and the effective date thereof; and

(2) serve the poison control center with a description of the deficiencies.

(d) When a poison control center receives written notice or service of the EMS Authority's intent to withdraw the poison control center's designation, the poison control center shall have seven (7) working days from the date of receipt of the written notice or service to respond in writing to the EMS Authority's description of deficiencies. Upon receipt of a notice of defense to the allegation by the poison control center, the EMS Authority shall, within fifteen (15) days, set the matter for hearing. The hearing shall be held as soon as possible but not later than thirty (30) days after receipt of the notice.

(e) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination on the merits.

(f) The temporary suspension shall be deemed vacated if the Director fails to make a final determination on the merits within thirty (30) days after the original hearing has been completed.

NOTE: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code.

Reference: Sections 1797.97 and 1798.180, Health and Safety Code.

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California Code of Regulations, Title 22

Chapter 10: EMT Registry Regulations

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California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 10. California EMT Central Registry.

Article 1. Definitions.

§100340. Authority.

“Authority” means the Emergency Medical Services Authority.

NOTE: Authority cited: Sections 1797.107 and 1797.117 Health and Safety Code.
Reference: Sections 1797.54, 1797.109, and 1797.217, Health and Safety Code.

§ 100341. California Central Registry.

“California Central Registry” or “Registry” means the single registry of EMT (Basic) and Advanced EMT certification information and EMT-P (Paramedic) licensure information. The Registry shall be used by certifying entities as part of the certification process and by the Authority as part of the licensure process for EMT-Ps.

NOTE: Authority cited: Sections 1797.107, 1797.117, and 1797.170, Health and Safety Code. Reference: Sections 1797.117, 1797.172, 1797.184, 1797.210 and 1797.216, Health and Safety Code.

§ 100342. EMT Certifying Entity.

“EMT certifying entity” means a public safety agency or the Office of the State Fire Marshal if the agency has a training program for EMT personnel that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety Code, or the medical director of a local EMS agency (LEMSA).

NOTE: Authority cited: Sections 1797.107 and 1797.210 Health and Safety Code.
Reference: Sections 1797.62, Health and Safety Code.

§ 100343. Advanced EMT Certifying Entity.

“Advanced EMT certifying entity” means the medical director of the LEMSAs authorized to certify and recertify applicants for Advanced EMT.

NOTE: Authority cited: Sections 1797.107, 1797.109, 1797.117, and 1797.184 (b) and (c) Health and Safety Code. Reference: Sections 1797.82, 1797.109, 1797.117, 1797.171, 1797.184, 1797.210, and 1797.217, Health and Safety Code.

§ 100343.1. Criminal Offender Record Information (CORI).

“Criminal Offender Record Information” or “CORI” means records and data compiled by criminal justice agencies for purposes of identifying criminal offenders and of maintaining as to each such offender a summary of arrests, pretrial proceedings, the

nature and disposition of criminal charges, sentencing, incarceration, rehabilitation, and release.

NOTE: Authority Cited: Sections 1797.107, and 1797.118, Health and Safety Code.
Reference: Sections 1797.117, 1797.118, and 1797.172, Health and Safety Code, Section 11075, Penal Code.

§ 100343.2. Subsequent Arrest Notification Report.

“Subsequent Arrest Notification Report” means reports issued by the Department of Justice (DOJ) to any agency authorized by Section 11105 of the Penal Code to receive state summary criminal history information to assist in fulfilling employment, licensing, or certification duties, upon the arrest of any person whose fingerprints are maintained on file at the DOJ as the result of an application for licensing, employment, or certification, or approval. The subsequent arrest notification shall consist only of any offense an individual is arrested for after the individual’s original fingerprint date for an authorized applicant agency.

NOTE: Authority Cited: Sections 1797.107, and 1797.118, Health and Safety Code.
Reference: Section 1797.117, Health and Safety Code. Section 11105.2 (a), Penal Code.

§ 100343.3. Live Scan Applicant Submission Form.

“Live Scan Applicant Submission Form” means the California DOJ “Request for Live Scan Service” application, form “BCII 8016 (06/09).” This form is used to request a state and federal criminal history report upon an individual as authorized by statute.

NOTE: Authority Cited: Sections 1797.107, 1797.117, 1797.118, Health and Safety Code. Reference: Section 1797.117, Health and Safety Code. Sections 11075, 11105, and 11105.2, Penal Code.

Article 2. General Provisions.

§100344. Registry Requirements.

(a) All EMT and Advanced EMT certifying entities shall enter certification and recertification information, as specified in Section 100346, into the Registry for each certification applicant no later than 14 calendar days from the date the applicant successfully meets the certification or recertification requirements.

(b) All EMT and Advanced EMT certifying entities shall provide the Authority with current contact information for their certification program that includes the following:

- (1) The certifying entity’s name.
- (2) The certifying entity’s address (business address, city, state, zip code).
- (3) The certifying entity’s telephone number.
- (4) The certifying entity’s fax number.

(c) All California issued EMT and Advanced EMT wallet-sized certification cards shall be printed by the certifying entity or the Authority using the Registry. The wallet-sized certification card shall contain the following:

- (1) Name of the individual certified.
- (2) Date the certificate was issued.
- (3) Date of expiration.
- (4) Certification status.
- (5) Registry number, generated by the registry.

(d) All EMT and Advanced EMT wallet-sized certification cards shall be printed using the single Authority approved format on cards provided by the Authority.

- (1) Upon request of a certifying entity, the Authority shall print and issue the certificate.
- (2) A certifying entity that exercises the option in subsection (d) (1) of this section, shall issue a temporary certificate that shall be valid for 45-calendar days and shall contain the following:

- (A) Name of the individual certified.
- (B) Date the temporary certificate was issued.
- (C) Date temporary certificate expires.
- (D) Certification status.
- (E) Registry number.

(e) LEMSAs shall update the Registry on certification actions taken on any EMT or Advanced EMT certificate within three (3) working days of either mailing the notification or notifying the individual in person of the certification action imposed.

(1) Certification action information, contained in the Registry, shall consist of the following for each applicant or certificate holder:

- (A) Registry number, generated by the Registry.
- (B) Last name.
- (C) First name.
- (D) Social security number.
- (E) Certificate number, if applicable.
- (F) Certifying entity that issued the certificate.
- (G) LEMSAs taking certification action.
- (H) Name of the medical director taking certification action.
- (I) The type of certification action (denial, revocation, suspension, probation)
- (J) The effective date of certification action and if applicable, in the case of suspension or probation, the expiration date of the certification action.
- (K) Occurrence of any of the actions listed in Section 1798.200(c) of the Health and Safety Code.

NOTE: Authority cited: Sections 1797.107, 1797.117, 1797.211, and 1797.217, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.117, 1797.211, 1797.217, and 1798.200 Health and Safety Code.

§100345. Fees.

(a) All monies owed by the certifying entities shall be received by the Authority within thirty (30) days of the last day of the calendar month in which a certificate was issued, unless an agreement for some other payment plan has been made between the certifying entity and the Authority. The following fees shall apply:

(1) \$75 per initial EMT or Advanced EMT certificate or per an applicant whose criminal background check from the DOJ is no longer active.

(2) \$37 per EMT or Advanced EMT certification renewal.

(b) A certifying entity shall pay a penalty of fifteen percent (15%) of the fees owed as specified in Subsection (a) of this Section to the Authority if the fees are not transmitted to the Authority within ninety (90) days of the last day of the calendar month in which a certificate was issued, unless the certifying entity enters into an agreement with the Authority which specifies different terms.

(c) The Authority may assess a penalty of \$500 for failure to update the Registry, within three (3) working days of taking certification action on an EMT or Advanced EMT certificate.

(d) Failure to comply with any provisions of this Chapter shall result in the suspension of the certifying entity's access to the Registry until such a time that the certifying entity comes into compliance including the receipt of any delinquent fees and/or penalties at the Authority. The process for suspending a certifying entity's access to the Registry will be as follows:

(1) The Authority will notify the certifying entity and their governing board in writing, by registered mail, of the provisions of this Chapter with which the certifying entity is not in compliance.

(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the certifying entity shall submit in writing, by registered mail, to the Authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within thirty (30) calendar days from the day of receipt of the notification of noncompliance.

(3) After thirty (30) calendar days from the mailing date of the noncompliance notification if no response pursuant to subsection (2) above is received from the certifying entity, the Authority shall suspend the certifying entity's access to the Registry and shall notify in writing, by registered mail, the certifying entity and their governing board of the suspension and the necessary steps that must be completed by the certifying entity in order to restore access to the Registry.

NOTE: Authority cited: Sections 1797.107, 1797.117, 1797.211, and 1797.217, Health and Safety Code. Reference: Sections 1797.62, 1797.211 and 1797.217, Health and Safety Code.

Article 3. Central Registry Data Requirements.

§100346. Certifying Entity Requirements.

(a) Each EMT or Advanced EMT certifying entity shall directly enter the following certification information on each EMT or Advanced EMT applicant into the Registry:

- (1) First name,
- (2) Last name,
- (3) Middle name, if available,
- (4) Date of Birth,
- (5) Phone number,
- (6) Mailing address,
- (7) Residential Address, if different from mailing address,
- (8) City of residence,
- (9) State of residence,
- (10) Zip code of residence,
- (11) Social security number,
- (12) Relevant employer as defined in Chapter 6 of this division, if applicable,
- (13) Prior certifying entity, if applicable,
- (14) Prior certification number, if applicable,
- (15) Beginning on or after July 1, 2010, date that a live scan was completed for the DOJ CORI, or, if finger print images were previously submitted, a letter from either the employer or the certifying entity verifying CORI with subsequent arrest notification report was completed and that the individual is not precluded from EMT or Advanced EMT certification,
- (16) Date EMT or Advanced EMT certification was issued,
- (17) Expiration date of EMT or Advanced EMT certification,
- (18) Current certification status:
 - (A) Active
 - (B) Expired
 - (C) Denied
 - (D) Revoked
 - (E) Suspended
 1. Suspension effective date
 2. Suspension expiration date
 - (F) Placed on probation
 1. Probation effective date
 2. Probation expiration date
 - (G) LEMSA that took certification action.

(b) EMT or Advanced EMT certification information available to EMT or Advanced EMT certifying entities:

- (1) First name,
- (2) Last name,
- (3) Middle name, if available,
- (4) Date of Birth,
- (5) Phone number,
- (6) Mailing address,
- (7) Residential Address, if different from mailing address,
- (8) City of residence,
- (9) State of residence,
- (10) Zip code of residence,
- (11) Social security number,
- (12) Relevant employer as defined in Chapter 6 of this division, if applicable,
- (13) Registry number,
- (14) Prior certifying entity,
- (15) Prior certification number,
- (16) Beginning on or after July 1, 2010, date that a live scan was completed for the DOJ CORI, or if finger print images were previously submitted, a letter from either employer or certifying entity verifying CORI with subsequent arrest notification report was completed and that the individual is not precluded from EMT or Advanced EMT certification,
- (17) Date EMT or Advanced EMT certification was issued,
- (18) Expiration date of EMT or Advanced EMT certification,
- (19) Current certification status:
 - (A) Active
 - (B) Expired
 - (C) Denied
 - (D) Revoked
 - (E) Suspended
 1. Suspension effective date
 2. Suspension expiration date
 - (F) Placed on probation
 1. Probation effective date
 2. Probation expiration date
 - (G) LEMSA that took certification action.

NOTE: Authority cited: Sections 1797.107, 1797.117, 1797.211, and 1797.217, Health and Safety Code. Reference: Sections 1797.61, 1797.62, 1797.117, 1797.211, 1797.217, and 1798.200 Health and Safety Code.

§100346.1. Public Access to Central Registry Data.

The following EMT or Advanced EMT certification information will be available to the public:

- (a) First name,
- (b) Last name,
- (c) Middle name, if available,
- (d) EMT or Advanced EMT certifying entity,
- (e) Registry number,
- (f) Current certification status:
 - (1) Active
 - (2) Expired
 - (3) Denied
 - (4) Revoked
 - (5) Suspended
 - (A) Suspension effective date
 - (B) Suspension expiration date
 - (6) Placed on probation
 - (A) Probation effective date
 - (B) Probation expiration date
 - (7) LEMSA that took certification action.

NOTE: Authority cited: Sections 1797.107 and 1797.117, Health and Safety Code.
Reference: Section 1797.117, Health and Safety Code.

Article 4. Background Checks for EMT and Advanced EMT.

§ 100347. Responsibility of the Initial and Recertification Applicant.

(a) Starting July 1, 2010, unless all the requirements and conditions as specified below in Section 100348 are met, the EMT and Advanced EMT initial applicant or recertification applicant shall do all of the following:

- (1) Submit a completed request for "Live Scan Applicant Submission Form, BCII 8016 (Rev 06/09)," to the California DOJ for a state and federal CORI search in accordance with the provisions of Section 11105 (p) (1) of the California Penal Code; and,
- (2) The CORI request shall include a subsequent arrest notification report in accordance with the provisions of Section 11105.2 of the California Penal Code; and,
- (3) The EMT and/or Advanced EMT applicant will designate that both the state and federal CORI search results and the subsequent arrest notification reports shall be reported to the certifying entity and the Authority.

(b) If the requirements specified in subsection (a) are fulfilled, the fee for recertification shall be as specified in subsection 100345(a)(1) of this Chapter.

NOTE: Authority Cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.117, 1797.118, and 1797.217, Health and Safety Code. Sections 11075, 11105.2, Penal Code.

§ 100348. Responsibility of Certifying Entity and/or Employers Prior to July 1, 2010.

(a) If prior to July 1, 2010, for the purposes of employment or EMT, Advanced EMT, or EMT-II certification/recertification, the certifying entity or an ambulance service permitted by the California Highway Patrol or a public safety agency that employs firefighters, lifeguards or peace officers (as defined in Chapter 1.5 of this Division) has fulfilled all the requirements specified within subsection 100348 (a)(1)(2)(3), then the condition stated in the second sentence of subsection 100348(a)(3) may apply. To qualify for that subsection 100348(a)(3) condition eligibility, the certifying entity and/or employer entity must:

- (1) Have conducted a previous state level CORI search on the EMT, Advanced EMT, or EMT-II certificate holder prior to July 1, 2010;
- (2) Be actively receiving subsequent arrest notification reports from the California DOJ prior to July 1, 2010 on the EMT, Advanced EMT, or EMT-II certificate holder, and must,
- (3) Verify in writing to the Authority that a state level CORI search, including subsequent arrest notification report, has been conducted and that nothing in the CORI search precluded the applicant from obtaining EMT, Advanced EMT, or EMT-II certification/recertification pursuant to Section 100214.3(c) of Chapter 6, of this Division. Upon receipt of this written notification by the Authority, the requirement specified in subsection 100347(a) shall be deemed fulfilled so long as active subsequent arrest reports for the EMT, Advanced EMT, or EMT-II certificate holder are being received by the certifying entity and/or employer.

(b) If the requirements specified in subsection (a) are fulfilled, the fee for recertification shall be as specified in subsection 100345(a)(2) of this Chapter.

NOTE: Authority Cited: Sections 1797.107 and 1797.118, Health and Safety Code. Reference: Sections 1797.117, 1797.118, 1797.216, and 1797.217, Health and Safety Code. Sections 11075, 11105.2, Penal Code.

§ 100349. Responsibility of Certifying Entity and/or Employer After Terminating Certification or Employment Relationship.

Certifying entities and/or employers that receive a CORI report, including a subsequent arrest notification report, that no longer certify/recertify or employ an EMT or an Advanced EMT shall notify the California DOJ using the "No Longer Interested Notification Form (BCII 8302, Rev 08/07)" within twelve months of the certification lapse that they no longer have a business need to receive the CORI on that individual.

NOTE: Authority Cited: Sections 1797.107 and 1797.118, Health and Safety Code. Reference: Sections 1797.117, 1797.210, and 1797.217, Health and Safety Code. Sections 11075, 11105.2, Penal Code.

California Code of Regulations, Title 22

Chapter 11: EMS Continuing Education

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California Code of Regulations
Title 22. SOCIAL SECURITY
DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 11. EMS CONTINUING EDUCATION

Article 1 – Definitions

§ 100390. Emergency Medical Services (EMS) Continuing Education (CE) Provider

EMS Continuing Education Provider means an individual or organization approved by the requirements of this Chapter, to conduct continuing education courses, classes, activities or experiences and issue earned continuing education hours to EMS Personnel for the purposes of maintaining certification/licensure or re-establishing lapsed certification or licensure.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.1. EMS Service Provider

EMS Service Provider means an organization employing certified EMT-I, certified EMT-II or licensed paramedic personnel for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport, or during interfacility transfer.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.2. EMS System Quality Improvement Program

"Emergency Medical Services System Quality Improvement Program" or "QIP" means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process pursuant to Chapter 12 of Division 9, Title 22, California Code of Regulations.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.3. Continuing Education

Continuing education (CE) is a course, class, activity, or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of pre-hospital emergency medical care.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.4. Continuing Education Hour (CEH).

(a) One continuing education hour (CEH) is any one of the following:

(1) Every fifty minutes of approved classroom or skills laboratory activity.

- (2) Each hour of structured clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to this Division.
 - (3) Each hour of media based/serial production CE as approved by the CE provider approving authority.
 - (b) Continuing Education courses or activities shall not be approved for less than one hour of credit.
 - (c) For courses greater than one CEH, credit may be granted in no less than half hour increments.
 - (d) Ten CEHs will be awarded for each academic quarter unit or fifteen CEHs will be awarded for each academic semester unit for college courses in physical, social or behavioral sciences (e.g., anatomy, physiology, sociology, psychology).
 - (e) CE hours will not be awarded until the written and/or skills competency based evaluation, as required by Section 100391(c), has been passed.
- NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.5. CE Provider Approving Authority

- (a) Courses and/or CE providers approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS) or approved by EMS offices of other states are approved for use in California and need no further approval.
 - (b) Courses in physical, social or behavioral sciences offered by accredited colleges and universities are approved for CE and need no further approval.
 - (c) The local EMS agency shall be the agency responsible for approving EMS Continuing Education Providers whose headquarters are located within the geographical jurisdiction of that local EMS agency if not approved according to subsections (a) or (b) of this section.
 - (d) The EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved according to subsections (a) or (b) of this Section.
- NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.6. National Standard Curriculum.

National Standard Curriculum means the curricula developed under the auspices of the United States Department of Transportation, National Highway Traffic Safety Administration for the specified level of training of EMS Personnel which includes the following incorporated herein by reference: Emergency Medical Technician-Basic: National Standard Curriculum, DOT HS 808 149, August 1994; Emergency Medical Technician-Intermediate: National Standard Curriculum, DOT HS 809 016, December 1999; and Emergency Medical Technician-Paramedic: National Standard Curriculum DOT HS 808 862, March 1999. These curricula are incorporated herein by reference and can be accessed at the U.S. Department of Transportation, National Highway Traffic Safety Administration website www.nhtsa.dot.gov/people/injury/ems/products.htm.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and

1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100390.7. Pre-hospital Emergency Medical Care Personnel

For the purpose of this chapter, Pre-hospital Emergency Medical Care Personnel or EMS Personnel means EMT-I, EMT-II or EMT-Paramedic as defined in Health and Safety Code Sections 1797.80, 1797.82, and 1797.84, respectively.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

Article 2. Approved Continuing Education

§ 100391. Continuing Education Topics

(a) Continuing education for EMS personnel shall be in any of the topics contained in the respective National Standard Curricula for training EMS personnel, except as provided in Section 100391.1 (a) (8) of this Chapter.

(b) In lieu of completing the required CEH, EMT-I certification can be maintained by successfully completing an approved refresher course pursuant to Section 100080 of Chapter 2, Division 9, Title 22, California Code of Regulations.

(c) All approved CE shall contain a written and/or skills competency based evaluation related to course, class, or activity objectives.

(d) Approved CE courses shall be accepted statewide.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100391.1. Continuing Education Delivery Formats and Limitations

(a) Delivery formats for CE courses shall be by any of the following:

(1) Classroom – didactic and/or skills laboratory where direct interaction with instructor is possible.

(2) Organized field care audits of patient care records;

(3) Courses offered by accredited universities and colleges, including junior and community colleges;

(4) Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual.

(5) Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules).

(6) Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by an EMS training program, an EMS service provider, a hospital or alternate base station approved according to this Division. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider, hospital or alternate base station must be a CE provider approved according to this Chapter. CE for precepting can only be given for actual time spent precepting a student or EMS personnel and must be issued by the EMS training program, EMS service provider, hospital or alternate base station that has an agreement or contract with the hospital clinical preceptor or with the preceptor's employer.

(7) Precepting EMS students or EMS personnel as a field preceptor, as assigned by an EMS training program or an EMS service provider approved according to this Division. CE for precepting can only be given for actual time precepting a student and must be issued by the EMS training program or EMS service provider that has an agreement or contract with the field preceptor or with the preceptor's employer. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider must be a CE provider approved according to this Chapter.

(8) Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care (e.g. surgical airway procedures).

(9) At least fifty percent of the required CE hours must be in a format that is instructor based, which means that instructor resources are readily available to the student to answer questions, provide feedback, provide clarification, and address concerns (e.g., on-line CE courses where an instructor is available to the student). This provision shall not include precepting or magazine articles for CE credit. The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.

(10) During a certification or licensure cycle, an individual may receive credit, one time only, for service as a CE course, class, or activity instructor. Credit received shall be the same as the number of CE hours applied to the course, class, or activity.

(11) During a certification or licensure cycle, an individual may receive credit, one time only, for service as an instructor for one of the following, an approved EMT-I, EMT-II, or paramedic training program, except that the hours of service shall not exceed fifty percent of the total CE hours required in a single certification or licensure cycle.

(12) When guided by the EMS service provider's QIP, an EMS service provider that is an approved CE provider may issue CEH for skills competency demonstrations to address any deficiencies identified by the service provider's QIP. Skills competency demonstration shall be conducted in accordance with the respective National Standard Curriculum skills outline or in accordance with the policies and procedures of the local EMS agency medical director.

(b) An individual may receive credit for taking the same CE course, class, or activity no more than two times during a single certification or licensure cycle.

(c) Local EMS agencies may not require additional continuing education hours for accreditation.

(d) If it is determined through a QIP that EMS personnel working in a local EMS system need remediation or refresher in an area of the individual's knowledge and/or skills, a local EMS agency medical director or an EMS service provider may require the EMS personnel to take an approved CE course with learning objectives that addresses the remediation or refresher needed, as part of the individual's required hours of CE for maintaining certification or licensure.

(e) Because paramedic license renewal applications are due to the EMS Authority thirty days prior to the expiration date of a paramedic license, a continuing education course(s) taken in the last month of a paramedic's licensure cycle, may be applied to the paramedic's subsequent licensure cycle, if that CE course(s) was not applied to the licensure cycle during which the CE course(s) was taken.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

Article 3. Continuing Education Records

§ 100392 Continuing Education Records

(a) In order for CE to satisfy the requirements for maintaining EMS personnel certification or licensure, CE shall be completed during the current certification/licensure cycle, except as provided in Section 100391.1(e) of this Chapter, and shall be submitted to the appropriate certifying/licensing authority.

(b) In order for CE to satisfy the requirements for renewal of a lapsed certificate/license, CE shall be valid for a maximum of two years prior to the date of a completed application for certificate/license renewal.

(c) EMS personnel shall maintain for four years CE certificates issued to them by any CE provider.

(d) CE certificates may be audited for cause by the certifying/licensing authority or as part of the certifying/licensing authority's continuing education verification process.

(e) Approved CE provider record requirements are contained in Section 100395, sub-sections (b) and (l) of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

Article 4. CE Provider Approval Process.

§ 100393. Application for Approval

(a) In order to be an approved CE provider, an organization or individual shall submit an application packet for approval to the appropriate CE approving authority, along with the fee specified by that authority.

(1) The fee assessed by the EMS Authority is specified in Section 100171 (b) (7) of Chapter 4, Division 9, Title 22, California Code of Regulations.

(b) The application packet shall include, but may not be limited to:

(1) Name and address of the applicant;

(2) Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;

(3) The type of entity or organization requesting approval; and,

(4) The resumes of the program director and the clinical director.

(c) The CE approving authority shall, within fourteen working days of receiving a request for approval, notify the CE provider that the request has been received, and shall specify what information, if any, is missing.

(d) The CE approving authority shall approve or disapprove the CE request within sixty calendar days of receipt of the completed request.

(e) If the CE request is approved, the CE approving authority shall issue a CE provider number according to the standardized sequence developed by the EMS Authority.

(f) The CE approving authority may approve CE providers for up to four years, and may monitor the compliance of CE providers to the standards established by the CE approving authority.

(g) When a CE provider is approved by either a local EMS agency or the EMS Authority, the CE provider is approved to conduct CE courses statewide.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

§ 100393.1. Application for Renewal

(a) The CE provider shall submit an application for renewal at least sixty calendar days before the expiration date of their CE provider approval in order to maintain continuous approval.

(b) All CE provider requirements shall be met and maintained for renewal as specified in Section 100395 of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

Article 5. CE Provider Denial/Disapproval Process

§ 100394. CE Provider Disapproval

(a) Noncompliance with any criterion required for CE provider approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in denial, probation, suspension or revocation of CE provider approval by the CE approving authority.

(b) Notification of noncompliance and action to place on probation, suspend or revoke shall be carried out as follows:

(1) A CE approving authority shall notify the approved CE provider program director in writing, by certified mail, of the provision of this Chapter with which the CE provider is not in compliance.

(2) Within fifteen days of receipt of the notification of noncompliance, the approved CE provider shall submit in writing, by certified mail, to the approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty days from the date of receipt of the notification of noncompliance.

(3) Within fifteen days of receipt of the response from the approved CE provider, or within thirty days from the mailing date of the noncompliance notification if no response is received from the approved CE provider, the CE approving authority shall notify the EMS Authority and the approved CE provider in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, or place on probation, suspend or revoke the CE provider approval.

(4) If the CE provider approving authority decides to place on probation, suspend or revoke the CE provider's approval, the notification specified in sub-section (b) (3) of this section shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty days from the date of the CE approving authority's letter of decision to the EMS Authority and the CE provider.

(c) If CE provider status is suspended or revoked, approval for CE credit shall be withdrawn for all CE programs scheduled after the date of action.

(d) The CE approving authority shall notify the EMS Authority of each CE provider approved, placed on probation, suspended or revoked within its jurisdiction within thirty calendar days of action.

(e) The EMS Authority shall maintain a list of all CE providers that are approved, placed on probation, suspended or revoked and shall post the listing on the EMS Authority's website.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code, and Section 15376, Government Code.

Article 6. CE Providers for EMS Personnel

§ 100395. CE Provider Requirements

(a) In order to be approved as an EMS continuing education provider, the provisions in this Section shall be met.

(1) The applicant shall submit an application packet as specified in Section 100393 (b) of this Chapter and any required fee to the approving authority at least sixty calendar days prior to the date of the first educational activity.

(b) An approved CE provider shall ensure that:

(1) The content of all CE is relevant, designed to enhance the practice of EMS emergency medical care, and be related to the knowledge base or technical skills required for the practice of emergency medical care.

(2) Records shall be maintained for four years and shall contain the following:

(A) Complete outlines for each course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance;

(B) Record of time, place, and date each course is given and the number of CE hours granted;

(C) A curriculum vitae or resume for each instructor;

(D) A roster signed by course participants, or in the case of media based/serial production courses, a roster of course participants, to include name and certificate or license number of EMS personnel taking any CE course, class, or activity and a record of any course completion certificate(s) issued.

(c) The CE approving authority shall be notified within thirty calendar days of any change in name, address, telephone number, program director, clinical director or contact person.

(d) All records shall be made available to the CE approving authority upon request. A CE provider shall be subject to scheduled site visits by the approving authority.

(e) Individual classes, courses or activities shall be open for scheduled or unscheduled visits by the CE approving authority and/or the local EMS agency in whose jurisdiction the CE course, class or activity is being offered.

(f) Each CE provider shall provide for the functions of administrative direction, medical quality coordination and actual program instruction through the designation of a program director, a clinical director and instructors. Nothing in this section precludes the same individual from being responsible for more than one of these functions.

(g) Each CE provider shall have an approved program director, who is qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:

(1) California State Fire Marshal (CSFM) "Fire Instructor 1A and 1B"; or

(2) National Fire Academy (NFA) "Fire Service Instructional Methodology" course; or

(3) a training program that meets the U. S. Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the EMS Educator Course of the National Association of EMS Educators.

(4) Individuals with equivalent experience may be provisionally approved for up to two years by the approving authority pending completion of the above specified requirements. Individuals with equivalent experience who teach in geographic areas where training resources are limited and who do not meet the above program director requirements may be approved upon review of experience and demonstration of capabilities.

(h) The duties of the program director shall include, but not be limited to:

(1) Administering the CE program and ensuring adherence to state regulations and established local policies.

(2) Approving course, class, or activity, including instructional objectives, and assigning CEH to any CE program which the CE provider sponsors; approving all methods of evaluation, coordinating all clinical and field activities approved for CE credit; approving the instructor(s) and signing all course, class, or activity completion records and maintaining those records in a manner consistent with these guidelines. The responsibility for signing course, class, or activity completion records may be delegated to the course, class, or activity instructor.

(i) Each CE provider shall have an approved clinical director who is currently licensed as a physician, registered nurse, physician assistant, or paramedic. In addition, the clinical director shall have had two years of academic, administrative or clinical experience in emergency medicine or EMS care within the last five years. The duties of the clinical director shall include, but not be limited to, monitoring all clinical and field activities approved for CE credit, approving the instructor(s), and monitoring the overall quality of the EMS content of the program.

(j) Each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

(k) Continuing education credit shall be assigned on the following basis:

(1) Classes or activities less than one CEH in duration will not be approved.

(2) For courses greater than one CEH, credit may be granted in no less than half hour increments.

(l) Each CE provider shall maintain for four years:

(1) Records on each course, class, or activity including, but not limited to, title, objectives, outlines, qualification of instructors, dates of instruction, location, participant rosters, sample tests or other methods of evaluation, and records of course, class, or activity completions issued.

(2) Summaries of test results, or other methods of evaluation. The type of evaluation used may vary according to the instructor, content of program, number of participants and method of presentation.

(m) Providers shall issue to the participant a tamper resistant document or certificate of proof of successful completion of a course, class, or activity within thirty calendar days of completion of the course, class, or activity. The CE certificate or documentation of successful completion must contain the name of participant, certificate or license number, class title, CE provider name and address, date of course, class, or activity and signature of program director or class instructor. A digitally reproduced signature of the program director or class instructor is acceptable for media

based/serial production CE courses. In addition, the following statements shall be printed on the certificate of completion with the appropriate information filled in:

"This course has been approved for (number) hours of continuing education by an approved California EMS CE Provider and was (check one)____ instructor-based,____ non-instructor based". "This document must be retained for a period of four years"

"California EMS CE Provider # _____ - _____"

(n) Information disseminated by CE providers publicizing CE must include at a minimum the following:

(1) CE provider's policy on refunds in cases of nonattendance by the registrant or cancellation by provider;

(2) a clear, concise description of the course, class or activity content, objectives and the intended target audience (e.g. paramedic, EMT-II, EMT-I, First Responder or all);

(3) CE provider name, as officially on file with the approving authority; and

(4) specification of the number of CE hours to be granted. Copies of all advertisements disseminated to the public shall be sent to the approving authority and the local EMS agency in whose jurisdiction the course, class, or activity is conducted prior to the beginning of the course, class, or activity. However, the approving authority or the local EMS agency may request that copies of the advertisements not be sent to them.

(o) When two or more CE providers co-sponsor a course, class, or activity, only one approved CE provider number will be used for that course, class, or activity and the CE provider, whose number is used, assumes the responsibility for meeting all applicable requirements of this Chapter.

(p) An approved CE provider may sponsor an organization or individual that wishes to provide a single course, class or activity. The approved CE provider shall be responsible for ensuring the course, class, or activity meets all requirements and shall serve as the CE provider of record. The approved CE provider shall review the request to ensure that the course, class, or activity complies with the minimum requirements of this Chapter.

NOTE: Authority cited: Sections 1797.107, 1797.172, 1797.174, 1797.175, 1797.185, and 1797.194 Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, and 1797.214 Health and Safety Code.

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California Code of Regulations, Title 22

Chapter 12: EMS System Quality Improvement

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**California Code of Regulations
TITLE 22. SOCIAL SECURITY
DIVISION 9. PRE-HOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 12. EMS System Quality Improvement**

Article 1. Definitions

100400. Emergency Medical Services System Quality Improvement Program.

"Emergency Medical Services System Quality Improvement Program" or EMS QI Program means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.

NOTE: Authority cited: Sections 1797.103, 1797.107, 1797.174, and 1797.176 Health and Safety Code. Reference: Sections 1797.174, 1797.202, 1797.204, 1797.220, and 1798.175 Health and Safety Code.

100401. EMS Service Provider.

"EMS Service Provider" means an organization employing certified EMT-I, certified EMT-II or licensed paramedic personnel for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport, or during interfacility transfer.

NOTE: Authority cited: Sections 1797.107, 1797.174, and 1797.176 Health and Safety Code. Reference: Section 1797.174 Health and Safety Code.

Article 2. EMS Service Provider

100402. EMS Service Provider Responsibilities.

(a) An EMS service provider shall:

(1) Develop and implement, in cooperation with other EMS system participants, a provider-specific written EMS QI program, as defined in Section 100400 of this Chapter. Such programs shall include indicators, as defined in Section III and Appendix E of the Emergency Medical Services System Quality Improvement Program Model Guidelines, which address, but are not limited to, the following:

(A) Personnel

(B) Equipment and Supplies

(C) Documentation

(D) Clinical Care and Patient Outcome

(E) Skills Maintenance/Competency

(F) Transportation/Facilities

(G) Public Education and Prevention

(H) Risk Management

(2) Review the provider-specific EMS QI Program annually for appropriateness to the operation of the EMS provider and revise as needed.

(3) Participate in the local EMS agency's EMS QI Program that may include making available mutually agreed upon relevant records for program monitoring and evaluation.

(4) Develop, in cooperation with appropriate personnel/agencies, a performance improvement action plan when the EMS QI Program identifies a need for improvement. If the area identified as needing improvement includes system clinical issues, collaboration is required with the provider medical director and the local EMS agency medical director or his/her designee if the provider does not have a medical director.

(5) Provide the local EMS agency with an annual update, from date of approval and annually thereafter, on the provider EMS QI Program. The update shall include, but not be limited to, a summary of how the EMS provider's EMS QI Program addressed the program indicators.

(b) The EMS provider EMS QI Program shall be in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines (Rev. 3/04), incorporated herein by reference, and shall be approved by the local EMS agency. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMS QI program.

(c) The provider EMS QI Program shall be reviewed by the local EMS agency at least every five years.

NOTE: Authority cited: Sections 1797.103, 1797.107, 1797.174 and 1797.176 Health and Safety Code. Reference: Sections 1797.174 and 1797.220 Health and Safety Code.

Article 3. Paramedic Base Hospital

100403. Paramedic Base Hospital and Alternate Base Station Responsibilities.

(a) A paramedic base hospital and alternate base station shall:

(1) Develop and implement, in cooperation with other EMS system participants, a hospital-specific written EMS QI program, as defined in Section 100400 of this Chapter. Such programs shall include indicators, as defined in Section III and Appendix E of the Emergency Medical Services System Quality Improvement Program Model Guidelines, which address, but are not limited to, the following:

(A) Personnel

(B) Equipment and Supplies

(C) Documentation

(D) Clinical Care and Patient Outcome

(E) Skills Maintenance/Competency

(F) Transportation/Facilities

(G) Public Education and Prevention

(H) Risk Management

(2) Review hospital-specific EMS QI Program annually for appropriateness to the operation of the base hospital or alternative base station and revise as needed.

(3) Participate in the local EMS agency's EMS QI Program that may include making available mutually agreed upon relevant records for program monitoring and evaluation.

(4) Develop, in cooperation with appropriate personnel/agencies, a performance improvement action plan when the base hospital or alternative base station EMS QI Program identifies a need for improvement. If the area identified as needing improvement includes system clinical issues, collaboration with the base hospital medical director or his/her designee or alternate base station medical director or his/her designee is required.

(5) Provide the local EMS agency with an annual update, from date of approval and annually thereafter, on the hospital EMS QI Program. The update shall include, but not be limited to, a summary of how the base hospital/alternate base station's EMS QI Program addressed the program indicators.

(b) The base hospital/alternate base station EMS QI Program shall be in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines (Rev. 3/04), incorporated herein by reference, and shall be approved by the local EMS agency. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMS QI program.

(c) The base hospital/alternate base station EMS QI Program shall be reviewed by the local EMS agency at least every five years.

NOTE: Authority cited: Sections 1797.103, 1797.107, 1797.174, and 1797.176 Health and Safety Code. Reference: Sections 1797.174, 1797.220, and 1798.2, Health and Safety Code.

Article 4. Local EMS Agency

100404. Local EMS Agency.

(a) The local EMS agency shall:

(1) Develop and implement, in cooperation with other EMS system participants, a system-wide written EMS QI program, as defined in Section 100400 of this Chapter. Such programs shall include indicators, as defined in Section III and Appendix E of the Emergency Medical Services System Quality Improvement Program Model Guidelines, which address, but are not limited to, the following:

(A) Personnel

(B) Equipment and Supplies

(C) Documentation

(D) Clinical Care and Patient Outcome

(E) Skills Maintenance/Competency

(F) Transportation/Facilities

(G) Public Education and Prevention

(H) Risk Management

(2) Review system-wide EMS QI Program annually for appropriateness to the system and revise as needed.

(3) Develop, in cooperation with appropriate personnel/agencies, a performance improvement action plan when the EMS QI Program identifies a need for improvement. If the area identified

as needing improvement includes system clinical issues, collaboration is required with the local EMS agency medical director.

(4) Provide the EMS Authority with an annual update , from date of approval and annually thereafter, on the local EMS Agency's EMS QI Program. The update shall include, but not be limited to, a summary of how the local EMS Agency's EMS QI Program addressed the program indicators.

(b) The local EMS Agency EMS QI Program shall be in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines (Rev. 3/04), incorporated herein by reference, and shall be approved by the EMS Authority. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMS QI program.

(c) The local EMS Agency EMS QI Program shall be reviewed by the EMS Authority at least every five years.

NOTE: Authority cited: Sections 1797.103, 1797.107, 1797.174 and 1797.176 Health and Safety Code. Reference: Sections 1797.94, 1797.174, 1797.202, 1797.204, 1797.220, and 1798 Health and Safety Code.

Article 5. EMS Authority

100405. EMS Authority.

(a) The EMS Authority shall:

(1) Develop and implement, in cooperation with other EMS system participants, a state-wide written EMS QI program, as defined in Section 100400 of this Chapter. Such programs shall include indicators, as defined in Section III and Appendix E of the Emergency Medical Services

System Quality Improvement Program Model Guidelines, which address, but are not limited to, the following:

- (A) Personnel
- (B) Equipment and Supplies
- (C) Documentation
- (D) Clinical Care and Patient Outcome
- (E) Skills Maintenance/Competency
- (F) Transportation/Facilities
- (G) Public Education and Prevention
- (H) Risk Management

(2) Review state-wide EMS QI Program annually for appropriateness to the state and revise as needed.

(3) Develop, in cooperation with appropriate personnel/agencies, a performance improvement action plan when the EMS QI Program identifies a need for improvement. If the area identified as needing improvement includes system clinical issues, collaboration is required with the EMS Authority medical consultant.

(4) Provide the local EMS Agencies with an annual update on the EMS Authority's EMS QI Program. The update shall include, but not be limited to, a summary of how the EMS Authority's EMS QI Program addressed the state indicators.

(b) The EMS Authority EMS QI Program shall be in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines (Rev. 3/04), incorporated herein by reference. This is a model program which will develop over time and is to be tailored to the individual organization's quality improvement needs and is to be based on available resources for the EMS QI program.

NOTE: Authority cited: Sections 1797.103, 1797.107, 1797.174 and 1797.176 Health and Safety Code. Reference: Sections 1797.54 and 1797.174 Health and Safety Code.