California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services

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

§ 100000. The Political Reform Act, Government Code Sections 81000, et seg., 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 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

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.

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 for-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.

Chapter 1.1: EMS System Regulations

§ 100000.01 Appeal Proceedings to the Commission.
(a) Any proceeding by the Commission to hear an appeal of a local emergency medical services agency's (LEMSA) emergency medical services (EMS) plan, pursuant to Health and Safety Code, Section 1797.105, shall be conducted in accordance with the provisions of the Administrative Procedure Act, Government Code, Section 11500 et seq, and its associated regulations as contained in Title 1 of the California Code of Regulations.
(b) The Office of Administrative Hearings, using an administrative law judge, shall hold a public hearing and receive evidence according to the Administrative Procedures Act.
(c) The administrative law judge, in making a proposed decision to the Commission, shall only make a recommendation as described in Section 1797.105(d) of Division 2.5 of the Health and Safety Code to:
(1) sustain the determination of the authority, or
(2) overrule the determination of the authority and permit local implementation of the plan.
(d) Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote regarding the proposed decision at the next regularly scheduled Commission meeting.
(e) The Commission shall permit public comment concerning the proposed decision pursuant to the Bagley-Keene Open Meeting Act.
(f) The Commission's vote on the proposed decision is limited to the following:
(1) adopt the administrative law judge's proposed decision, or
(2) not adopt the administrative law judges proposed decision, or
(3) return the proposed decision to the office of Administrative Hearings for re-hearing.
(g) The decision by the Commission shall be by simple majority vote of a quorum of those members present at the meeting where the proposed decision is scheduled as an agenda item.
(h) Costs of the administrative hearing shall be borne equally by the parties. Costs shall not include attorney's fees.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.105 and 1797.254, Health and Safety Code; and Section 11517(c)(2)(D), Government Code.

Chapter 2. General Public Standards and Training
Chapter 2.1: Training Standards for Child Care Providers

Article 1: Definitions

§ 100015.01. 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, Health and Safety Code. Reference: Sections 1596.791, 1596.90, 1596.866 and 1597.30, Health and Safety Code.

§ 100015.02. Approved Training Programs.
“Approved Training Programs” means a program approved by the designated approving authority.
Note: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.90, 1596.791, 1596.866 and 1597.30, Health and Safety Code.

§ 100015.03. 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.

§ 100015.04. 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.

§ 100015.05. 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.

§ 100015.06. Child Care Facility.
"Child care facility" means a facility which provides nonmedical 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.

§ 100015.07. 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, Health and Safety Code. Reference: Sections 1596.791, 1596.90, 1597.30 and 1596.866, Health and Safety Code.
§ 100015.01. Child.

§ 100015.08. 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.

§ 100015.09. 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.

§ 100015.10. 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, Health and Safety Code. Reference: Sections 1596.78, 1596.866, 1597.44, 1597.465 and 1797.191, Health and Safety Code.

§ 100015.11. 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.

§ 100015.12. 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, Health and Safety Code. Reference: Sections 1596.866 and 1797.191, Health and Safety Code

§ 100015.13. 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.

§ 100015.14. 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, Health and Safety Code. Reference: Sections 1596.791, 1596.90, 1596.866 and 1597.30, Health and Safety Code.

§ 100015.15. Training Program Director.
"Training program director" means the person with the authority to oversee, make decisions, and provide oversight to ensure training program compliance.
Note: Authority cited: Sections 1797.107 and 1797.191, Health and Safety Code. Reference: Sections 1596.791, 1596.90, 1596.866 and 1597.30, Health and Safety Code.

§ 100015.16. 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, Health and Safety Code. Reference: Sections 1596.791, 1596.90, 1596.866 and 1597.30, Health and Safety Code.

Article 2: Training Requirements for Child Care Providers

§ 100016. 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 1596.866 and 1797.191, Health and Safety Code.

Article 3: Training Program Approval

§ 100017.01. 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-App100-1/95 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.

§ 100017.02. 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 100017.01 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.

§ 100017.03. 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 Procedure Act, Section 11500 et. Seq. of the Government Code. An approved training program shall have no more than thirty (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

§ 100018.01. 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 1596.750, 1596.866 and 1797.191, Health and Safety Code.

§ 100018.02. 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 100018.03 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.

§ 100018.03. 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 Section 100019.02(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, 1596.866, 1596.8661 and 1797.191, Health and Safety Code; and Section 3765, Business and Professions Code.

§ 100018.04. 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 100019.02(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 100018.05 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.

§ 100018.05. 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 100019.02(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.

§ 100018.06. 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.

§ 100018.07. 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 100018.03 and 100018.05.
(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.

§ 100018.08. 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

§ 100019.01. Course Hours and Class Size Requirements.

(a) The initial course of instruction shall consist of not 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 not 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.

§ 100019.02. 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 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 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; and Section 3765, Business and Professions Code.

§ 100019.03. 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.

§ 100019.04. 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

§ 100020.01. 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.

§ 100020.02. 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. 01/2024) 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, 1797.113 and 1797.191, Health and Safety Code. Reference: Sections 1596.866, 1797.113 and 1797.191, Health and Safety Code.

Article 7: Fees

§ 100021. Fees.
Each training program submitting an application (Forms EMS-App 100-1/95, 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 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.
(e) 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.

Chapter 2.2: First Aid Testing for School Bus Drivers

Article 1: Definitions

§ 100022.01. 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.

§ 100022.02. 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.

Article 2: General

§ 100023. 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.

Article 3: Examination Standards

§ 100024. 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.

Chapter 2.3: First Aid and CPR Standards and Training for Public Safety Personnel

Article 1: Definitions

§ 100025.01. 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 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100025.02 Cardiopulmonary Resuscitation.
“Cardiopulmonary resuscitation” (CPR) means establishing and maintaining an open airway, ensuring adequate respiration, and ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression, according to standards promulgated by the current American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC).
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.

§ 100025.03. 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.

§ 100025.04. Lifeguard.
“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, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.182, Health and Safety Code.

§ 100025.05. Peace Officer.
“Peace officer” means any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department or other peace officer required by law to complete the training specified in this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Section 1797.183, Health and

Safety Code; and Section 13518, Penal Code.

§ 100025.06. Primarily Clerical or Administrative.
“Primarily clerical or administrative” means the performance of clerical or administrative duties for ninety percent (90%) or more of the time worked within each pay period.

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.

§ 100025.07. 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 Sections 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.

§ 100025.08. Public Safety First Aid.
“Public safety first aid” means the recognition of and immediate care for injury or sudden illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.

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.

§ 100025.09. Regularly Employed.
“Regularly employed” means being given wages, salary, or other remuneration for the performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code.

Article 2: General Training Provisions

§ 100026.01. 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, CPR and use an AED according to the standards set forth in this Chapter:
(1) lifeguard;
(2) firefighter;
(3) 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.

§ 100026.02. 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 100028.01 of this Chapter within twenty-four (24) 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.

§ 100026.03. Time Limitation for Initial Training.
The initial training requirements specified in Section 100027.01 of 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 100026.01 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: Public Safety First Aid and CPR Training Standards

§ 100027.01. Public Safety First Aid and CPR Course Content.

(a) The initial course of instruction shall at a minimum consist of not less than twenty-one (21) hours in first aid and CPR.

(b) The course of instruction shall include, but need not be limited to, the following scope of courses as described in (c) below, which shall prepare personnel specified in Section 100026.01 of this Chapter to recognize the injury or illness of the individual and render assistance.

(c) The content of the training course shall include recognition and basic first aid level treatment of at least the following topics and shall be competency based:

(1) Role of the public safety first aid provider;

(A) Personal safety;

(i) Scene size-up.

(B) Body substance isolation, including removing contaminated gloves;

(C) Legal considerations;

(D) Emergency Medical Services (EMS) access;

(E) Integration with EMS personnel to include active shooter incidents;

(F) Minimum equipment and first aid kits.

(2) Heart attack and sudden cardiac arrest;

(A) Respiratory and circulatory systems;

(B) Heart attack;

(C) Sudden cardiac arrest and early defibrillation;

(D) Chain of survival.

(3) CPR and AED for adults, children, and infants, following current AHA Guidelines for CPR and ECC at the Healthcare provider level;

(A) Basic airway management;

(B) Rescue breathing;

(i) Mouth-to-mouth;

(ii) Mouth-to-mask;

(iii) Bag-valve-mask (BVM).

(C) Chest compressions and CPR/AED;

(i) Basic AED operation;

(ii) Using the AED;

(iii) Troubleshooting and other considerations.

(D) Single rescuer CPR/AED on adult, child and infant;

(E) Two rescuer CPR/AED on adult, child and infant;

(F) Recovery position.

(4) Management of foreign body airway obstruction on adults, children, and infants;

(A) Conscious patients;

(B) Unconscious patients.

(5) Recognition and identification of adult and pediatric patients for both medical and traumatic emergencies;

(A) Performing a primary assessment;

(B) Performing a secondary assessment;

(C) Obtaining a patient history.

(6) Medical emergencies;

(A) Pain, severe pressure, or discomfort in chest;

(B) Breathing difficulties, including asthma and COPD;

(C) Allergic reactions and anaphylaxis;

(D) Altered mental status;

(E) Stroke;

(F) Diabetic emergencies;

(i) Administration of oral glucose.

(G) Seizures;

(H) Alcohol and drug emergencies;

(i) Assisted naloxone administration and accessing EMS.

(I) Severe abdominal pain;

(J) Obstetrical emergencies.

(7) Burns;
(A) Thermal burns;
(B) Chemical burns;
(C) Electrical burns.
(8) Facial injuries;
(A) Objects in the eye;
(B) Chemical in the eye;
(C) Nosebleed;
(D) Dental emergencies.
(9) Environmental emergencies;
(A) Heat emergencies;
(B) Cold emergencies;
(C) Drowning.
(10) Bites and stings;
(A) Insect bites and stings;
(B) Animal and human bites;
(C) Assisted administration of epinephrine auto-injector and accessing EMS.
(11) Poisoning;
(A) Ingested poisoning;
(B) Inhaled poisoning;
(C) Exposure to chemical, biological, radiological, or nuclear (CBRN) substances;
(i) Recognition of exposure;
(ii) Scene safety.
(D) Poison control system.
(12) Identify signs and symptoms of psychological emergencies.
(13) Patient movement;
(A) Emergency movement of patients;
(B) Lifts and carries which may include: using soft litters and manual extractions including fore/aft, side-by-side, shoulder/belt.
(14) Tactical and rescue first aid principles applied to violent circumstances;
(A) Principles of tactical casualty care;
(i) Determining treatment priorities.
(15) Orientation to the EMS system, including:
(A) 9-1-1 access;
(B) Interaction with EMS personnel;
(C) Identification of local EMS and trauma systems.
(16) Trauma emergencies;
(A) Soft tissue injuries and wounds;
(B) Amputations and impaled objects;
(C) Chest and abdominal injuries;
(i) Review of basic treatment for chest wall injuries;
(ii) Application of chest seals.
(D) Head, neck, or back injury;
(E) Spinal immobilization;
(F) Musculoskeletal trauma and splinting;
(G) Recognition of signs and symptoms of shock;
(i) Basic treatment of shock;
(ii) Importance of maintaining normal body temperature.
(H) Internal bleeding;
(I) Control of bleeding, including direct pressure, tourniquet, hemostatic dressings, chest seals and dressings;
(i) Training in the use of hemostatic dressings shall result in competency in the application of hemostatic dressings. 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 and wound packing;
2. Types of hemostatic dressings.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.176, 1797.182,

1797.183 and 1797.193, Health and Safety Code; and Section 13518, Penal Code.

§ 100027.02. Authorized Skills for Public Safety First Aid Providers.

(a) A Public safety first aid provider, after completion of training and demonstration of competency to the satisfaction of the approved training provider for each skill listed in this section, is authorized to perform medical care while at the scene of an emergency including, but not limited to, CPR and AED and may do any of the following:

(1) Evaluate the ill and injured.

(2) Provide treatment for shock.

(3) Use the following techniques to support airway and breathing:

(A) Manual airway opening methods, including head-tilt chin-lift and/or jaw thrust;

(B) Manual methods to remove an airway obstruction in adults, children, and infants;

(C) Use the recovery position.

(4) Perform the following during emergency care:

(A) Spinal immobilization;

(B) Splinting of extremities;

(C) Emergency eye irrigation using water or normal saline;

(D) Assist with administration of oral glucose;

(E) Assist patients with administration of physician-prescribed epinephrine devices and naloxone;

(F) Assist in emergency childbirth;

(G) Hemorrhage control using direct pressure, pressure bandages, principles of pressure points, and tourniquets. Hemostatic dressings may be used from the list approved by the EMS Authority;

(H) Chest seals and dressings;

(I) Simple decontamination techniques and use of decontamination equipment;

(J) Care for amputated body parts;

(K) Provide basic wound care.

(b) The authorized skills of a public safety first aid provider shall not exceed those activities authorized in this section.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.176, 1797.182, 1797.183 and 1797.197, Health and Safety Code; and Section 13518, Penal Code.

§ 100027.03. Optional Skills.

(a) In addition to the activities authorized by Section 100027.02 of this Chapter, public safety personnel may perform any or all of the following optional skills specified in this section when the public safety first aid provider has been trained and tested to demonstrate competence following initial instruction, and when authorized by the Medical Director of the local EMS agency (LEMSA).

(b) A LEMSA shall establish policies and procedures that require public safety first aid personnel to demonstrate trained optional skills competency at least every two years, or more frequently as determined by the EMS quality improvement program (EMSQIP).

(c) Administration of epinephrine by auto-injector for suspected anaphylaxis.

(1) Training in the administration of epinephrine shall result in the public safety first aid provider being competent in the administration of epinephrine and managing a patient of a suspected anaphylactic reaction. The training shall include the following topics and skills:

(A) Common causative agents;

(B) Signs and symptoms of anaphylaxis;

(C) Assessment findings;

(D) Management to include but not be limited to:

1. Need for appropriate personal protective equipment and scene safety awareness.

(E) Profile of epinephrine to include, but not be limited to:

1. Class;

2. Mechanisms of drug action;

3. Indications;

4. Contraindications;

5. Dosage and route of administration;

6. Side/adverse effects.

(F) Administration of epinephrine by auto-injector including;

1. Site selection and administration;
2. Medical asepsis;
3. 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) Accessing 9-1-1 or advanced life support services for all patients suffering anaphylaxis or receiving epinephrine administration;
(D) Using universal precautions and body substance isolation procedures during medication administration;
(E) Demonstrating aseptic technique during medication administration;
(F) Demonstrate preparation and administration of epinephrine by auto-injector;
(G) Proper disposal of contaminated items and sharps.
(d) Supplemental oxygen therapy using a non-rebreather face mask or nasal cannula, and bag-valve-mask ventilation.
(1) Training in the administration of oxygen shall result in the public safety first aid provider being competent in the administration of supplemental oxygen and use of bag-valve-mask ventilation for a patient requiring oxygen administration and ventilation. The training shall include the following topics and skills:
(A) Integrating the use of supplemental oxygen by non-rebreather mask or nasal cannula based upon local EMS protocols;
(B) Assessment and management of patients with respiratory distress;
(C) Profile of Oxygen to include, but not be limited to:
1. Class;
2. Mechanism of Action;
3. Indications;
4. Contraindications;
5. Dosage and route of administration (mask, cannula, bag-valve-mask);
6. Side/adverse effects.
(D) Oxygen Delivery Systems;
1. Set up of oxygen delivery including tank opening, use of regulator and liter flow selection;
2. Percent of relative oxygen delivered by type of mask;
3. Oxygen delivery for a breathing patient, including non-rebreather mask and nasal cannula;
4. Bag-Valve-Mask and Oxygen delivery for a non-breathing patient.
(E) Safety precautions.
(2) At the completion of the training, the student shall complete a competency based written and skills examination for the administration of oxygen which shall include the topics listed above and:
(A) Assessment of when to administer supplemental oxygen and ventilation with a bag-valve-mask;
(B) Managing a patient before and after oxygen administration;
(C) Demonstrating preparation of the oxygen delivery system;
(D) Demonstrating application of supplemental oxygen by non-rebreather mask and nasal cannula on a breathing patient;
(E) Demonstrating use of bag-valve-mask on a non-breathing patient.
(e) Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care, when authorized by the Medical Director of a LEMSA, while working for a public safety provider.
(1) Training in the administration of auto-injectors containing atropine and pralidoxime shall result in the public safety first aid provider being competent in the administration of auto-injectors for nerve agent intoxication. The training shall include the following topics and skills:
(A) Integrating the use of auto-injectors for nerve agent intoxication based upon local EMS protocols;
(B) Assessment and recognition of patients with nerve agent intoxication;
(C) Management of patients with nerve agent exposure, including the need for appropriate personal protective equipment, decontamination principles, and scene safety awareness;
(D) Profile of atropine and pralidoxime chloride to include, but not be limited to:
1. Class;
2. Mechanism of action;
3. Indications;
4. Contraindications;

5. Dosage and route of administration;
6. Side/adverse effects.
(E) Auto-Injector delivery and types (i.e. Duo-Dote, Mark I);
1. Medical asepsis;
2. Site selection and administration;
3. Disposal of contaminated items and sharps;
4. Safety precautions.
(2) At the completion of the training, the student shall complete a competency based written and skills examination for the administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent intoxication which shall include the topics listed above and:
(A) Assessment of when to administer nerve agent auto-injector;
(B) Managing a patient before and after auto-injector administration;
(C) Accessing 9-1-1 or advanced life support services following administration of atropine and pralidoxime;
(D) Demonstrating preparation, site selection, and administration of the auto-injector;
(E) Demonstrating universal precautions and body substance isolation procedure during medication administration;
(F) Demonstrating aseptic technique during medication administration;
(G) Proper disposal of contaminated items and sharps.
(f) Administration of naloxone for suspected narcotic overdose.
(1) Training in the administration of naloxone shall result in the public safety first aid provider being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose. The training shall include 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.
(g) Use of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).
(1) Training in the use of OPAs and NPAs shall result in the public safety first aid provider being competent in the use of the devices and airway control and shall include 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 include manual and mechanical;
(D) The role of OPA and NPA airway adjuncts in the sequence of airway control;
(E) Indications and contraindications of OPAs and NPAs;
(F) The role of pre-oxygenation in preparation for OPAs and NPAs;
(G) OPA and NPA insertion and assessment of placement;
(H) Methods for prevention of basic skills deterioration;
(I) Alternatives to the OPAs and NPAs.

(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 OPAs and NPAs.
Note: Authority cited: Sections 1797.107 and 1797.197, Health and Safety Code. Reference: Sections 1797.182 and 1797.183, Health and Safety Code; and Section 13518, Penal Code.

§ 100027.04. Trial Studies.
Public safety personnel 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 100093.04, Chapter 3.3 (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 authorized skills for public safety personnel.
(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 authorized skills for public safety personnel.
(k) The Authority may require a trial study(ies) to cease after thirty-six (36) months.
Note: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code. Reference: Sections 1797.182, 1797.183 and 1797.221, Health and Safety Code.

§ 100027.05. Public Safety AED Service Provider.

A public safety AED service provider is an agency or organization that employs individuals as defined in Section 100026.01, 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 LEMSA, 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) Authorize personnel and maintain a listing of all public safety AED service provider authorized personnel and provide upon request to the LEMSA or the EMS Authority.

(d) An approved public safety AED service provider and its authorized personnel shall be recognized statewide.

Note: Authority cited: Sections 1797.107, 1797.182 and 1797.183, Health and Safety Code. Reference: Sections 1797.182, 1797.183 and 1797.190, Health and Safety Code; and Section 13518, Penal Code.

§ 100027.06. Public Safety First Aid and CPR Retraining Requirements.

(a) The retraining requirements of this Chapter shall be satisfied every two years by successful completion of:

(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 eight (8) hours of first aid and CPR including AED every two (2) years; or

(2) By maintaining current and valid licensure or certification as an EMR, EMT, Advanced EMT, Paramedic, Registered Nurse, Physician Assistant, Physician or by maintaining current and valid EMR, EMT, AEMT or Paramedic registration from the National Registry of EMTs; or

(3) Successful completion of 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 any approved training course, as defined in Section 100028.01, but in no event shall the retraining course including CPR and AED or pretest be offered less than once every two (2) years.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.182, 1797.183 and 1797.210, Health and Safety Code; and Section 13518, Penal Code.

Article 4: Public Safety First Aid and CPR Course Approval Requirements

§ 100028.01. Public Safety First Aid and CPR 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 in accordance with the course content contained in Section 100027.01 of this chapter:

(a) A course in public safety first aid, including CPR and AED, developed and/or authorized by the California Department of Forestry and Fire Protection (CAL FIRE) and approved by the EMS Authority; or

(b) A course in public safety first aid, including CPR and AED, authorized by the Commission on Peace Officer Standards and Training (POST) and approved by the EMS Authority. No later than 24-months from the adoption of these regulations, POST, in consultation with the Authority, shall develop the course curriculum and testing competency standards for these regulations as they apply to peace officers; or

(c) A course in public safety first aid, including CPR and AED, developed and authorized by the California

Department of Parks and Recreation (DPR) and approved by the EMS Authority; or
(d) A course in public safety first aid, including CPR and AED, developed and authorized by the Department of the California Highway Patrol (CHP) and approved by the EMS Authority; or
(e) The U.S. Department of Transportation's emergency medical responder (EMR) course which includes first aid practices and CPR and AED, approved by the LEMSA; or
(f) A course of at least 21 hours in first aid equivalent to the standards of the American Red Cross and healthcare provider level CPR and AED equivalent to the standards of the American Heart Association in accordance with the course content contained in Section 100027.01 of this chapter and approved by the LEMSA; or
(g) An EMT course which has been approved pursuant to Chapter 3.1 of this division; or
(h) An Advanced EMT (AEMT) course which has been approved pursuant to Chapter 3.2 of this division; or
(i) A Paramedic course which has been approved pursuant to Chapter 3.3 of this division; or
(j) An EMR course approved by the Authority, and developed and authorized by CAL FIRE, POST, DPR, CHP or other Statewide public safety agency, as determined by the 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.

§ 100028.02. Course Approval Process.

(a) For those courses requiring approval, the following shall be submitted to the approving authority as specified in Section 100028.01 of this chapter when requesting approval:
(1) Name of the sponsoring institution, organization, or agency;
(2) Detailed course outline;
(3) Final written examination with pre-established scoring standards; and
(4) Skill competency testing criteria, with pre-established scoring standards; and
(5) Name and qualifications of instructor(s).
(b) Course approval is valid for four (4) years from the date of approval, and shall be reviewed by the approving authority for approval every four (4) years, or sooner at the discretion of the approving authority.
(c) The approving authority may request additional materials or documentation as a condition of course approval.

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.

§ 100028.03. Training Program Notification.

(a) The approving authority shall notify the training program submitting its request for training program approval within twenty-one (21) 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 100028.01 and 100028.02 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 approving authority to the requesting training program within a reasonable period of time after receipt of all required documentation as specified by LEMSA policy.
(c) The approving authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
(d) 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, and program approval/ expiration date of program approval.

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.

§ 100028.04. 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 training program approving authority.

(b) Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:
(1) A training program approving authority shall notify the approved training program course director in writing, by registered mail, of the provisions of this Chapter with which the training program is not in compliance.
(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to the 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 training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved training program, the training program approving authority shall notify the Authority and the approved 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 training program approval.
(4) If the training program approving authority decides to suspend, revoke, or place an 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 training program approving authority's letter of decision to the Authority and the training program.

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.

§ 100028.05. Testing.

(a) The initial and retraining course of instruction shall include a written and skills examination which tests the ability to assess and manage all of the conditions, content and skills listed in Sections 100027.01 and 100027.02 of this Chapter.
(b) A passing standard shall be established by the training agency before administration of the examination and shall be in compliance with the standard submitted to and approved by the approving authority according to Sections 100028.01 and 100028.02.
(c) Public safety first aid and/or CPR training programs shall test the knowledge and skills specified in this chapter and have a passing standard for successful completion of the course and shall ensure competency of each skill.

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.

§ 100028.06. Training Instructor Requirements.

(a) Training in public safety first aid and CPR for the personnel specified in Section 100026.01 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) Validation of the instructor's qualifications shall be the responsibility of the agency whose training program has been approved by the approving authority pursuant to Sections 100028.01 and 100028.02 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.

§ 100028.07. Validation of Course Completion.

(a) Each trainee who successfully completes an approved course of instruction and successfully passes the competency based written and skills exams shall be given a certificate or written verification to that effect by the institution, organization or agency which provides the instruction.
(b) Each certificate or written verification of course completion shall include the following information:
(1) Indicate initial or refresher training and number of training hours completed;
(2) Date of issue;

(3) Date of expiration;
(i) Expiration of training shall be 2 years from the date of course completion.
(c) Each training program provider shall maintain a record of the names of trainees and the date(s) on which training courses have been completed for at least four (4) years.
(d) Such training records shall be made available for inspection by the LEMSA or approving authority 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.

§ 100028.08. Program Review.
(a) All course outlines, written tests, and competency testing criteria used in an approved program shall be subject to oversight and periodic review as determined by the approving authority.
(b) Program approval and renewal is contingent upon continued compliance with all required criteria and provisions described in this Chapter, and may be revoked by the approving authority as described in Section 100028.04 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.

Chapter 2.4: Lay Rescuer Epinephrine Auto-Injector Training Certification Standards

Article 1: Definitions

§ 100029.01. Anaphylaxis.
“Anaphylaxis” means a potentially life-threatening hypersensitivity or allergic reaction.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100029.02. Approved Training Programs.
“Approved Training Programs” means a program approved by the designated approving authority.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100029.03. Authorized Health Care Provider.
“Authorized Health Care Provider” means a currently licensed health care professional who is legally authorized in California to issue a prescription for or dispense an epinephrine auto-injector to an individual who meets the requirements of Section 100030.02 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100029.04. Authorized Training Provider.
“Authorized training provider” or “instructor” means an individual who is authorized by an approved training program to provide epinephrine auto-injector training as approved by the EMS Authority and who meets the requirements set forth in Section 100031.04 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100029.05. Automated External Defibrillator.
“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 1797.5, 1797.190, 1797.196, 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100029.06. Cardiopulmonary Resuscitation.

“Cardiopulmonary resuscitation” (CPR) means ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression, establishing and maintaining an open airway, and ensuring adequate ventilation equivalent to current standards promulgated by the American Heart Association's (AHA) Guidelines for CPR and Emergency Cardiovascular Care (ECC) or the American Red Cross.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100029.07. Certification of Training.
“Certification of training” means the certification card issued by the EMS Authority to an individual who satisfies the requirements outlined in Section 100030.02.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100029.08. Epinephrine Auto-injector.
“Epinephrine auto-injector” means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering from anaphylaxis.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100029.09. Lay Rescuer.
“Lay rescuer” means any person who has met the training standards and other requirements of this Chapter but who is not otherwise licensed or certified to use an epinephrine auto-injector on another person.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100029.10. Prehospital Emergency Medical Care Person.
“Prehospital emergency medical care person” means any of the following: authorized registered nurse, mobile intensive care nurse, nurse practitioner, nurse midwives, clinical nurse specialist, nurse anesthetists, physician assistant, emergency medical technician, advanced emergency medical technician, paramedic, lifeguard, firefighter, peace officer, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, 1797.183, 1797.189, 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100029.11. Training Program Director.
“Training program director” means the person with the authority to oversee, make decisions, and provide oversight to ensure training program compliance.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Article 2: Certification Requirements

§ 100030.01. Application and Scope.
(a) Upon certification by the EMS Authority as defined in Section 100029.07 a lay rescuer, or off-duty prehospital emergency medical care personnel are authorized to administer an epinephrine auto-injector to treat a person who is suffering or reasonably believed to be suffering from anaphylaxis under the following conditions:
(1) The epinephrine auto-injector is legally obtained by prescription from an authorized health care provider who may issue a prescription for an epinephrine auto-injector to a person described in this subdivision for the purpose of rendering emergency care to another person upon presentation of current and valid certification card issued by the EMS Authority, and
(2) The epinephrine auto-injector is used on an individual, with the express or implied consent of that person, to treat anaphylaxis, and

(3) The epinephrine auto-injector is stored and maintained as directed by the manufacturer's instructions for that product, and
(4) The emergency medical services system is activated as soon as practical when an epinephrine auto-injector is used.
(b) Certified persons shall make, maintain, and make available to EMSA upon request a record for five years reflecting:
(1) Dates of receipt, use and destruction of each auto-injector dispensed, and
(2) The name of any person to whom epinephrine was administered by using an auto-injector, and
(3) The circumstances and manner of disposal of any auto-injectors.
(c) The training standards prescribed by this Chapter shall apply to lay rescuers and off duty prehospital emergency medical care personnel.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 4119.3, Business and Professions Code.

§ 100030.02. Certification Requirements.
(a) An individual who meets all of the following criteria shall be eligible for certification by the EMS Authority:
(1) Successful completion of training from an epinephrine auto-injector training program approved pursuant to Section 100031.01 of this Chapter, and
(2) Course completion document provided by the training program and signed by the class instructor and,
(3) Current certification in CPR and AED for infants, children and adults equivalent to the current standards of the American Red Cross and/or the AHA Guidelines for CPR and ECC and,
(4) Payment of all fees pursuant to Section 100032 of this Chapter and,
(5) Submit the State of California Epinephrine Certification Application form #1.9app (01/2024) herein incorporated by reference.
(b) Currently licensed California health care professionals including physician assistants, registered nurses, nurse practitioners, nurse midwives, clinical nurse specialists, nurse anesthetists, mobile intensive care nurses and currently licensed or certified California paramedics and advanced emergency medical technicians (AEMTs) shall be deemed to have met the requirement for training and are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using the State of California Epinephrine Certification Application form #1.9app (01/2024).
(c) California emergency medical technicians, lifeguards, firefighters and peace officers in this state who have current documentation of successfully completed training in the administration of epinephrine by auto-injector, approved by a local EMS agency or the EMS Authority, are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using the State of California Epinephrine Certification Application form #1.9app (01/2024).
(d) The effective date of the certification shall be the day the certification is issued by the EMS Authority.
(e) The certification card shall be valid for two (2) years from the last day of the month in which it was issued.
(f) The requirements and process for renewal of the certification are the same as that for the initial certification as described in Section 100030.02 (a)(1)-(5), (b) and (c).

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Article 3: Training Program Requirements

§ 100031.01. Procedures for Training Program Approval.
(a) Prospective training programs shall submit a written request for training program approval to the EMS Authority.
(b) The EMS Authority shall receive and review the following prior to program approval:
(1) A statement verifying that the course content meets the requirements set forth in Section 100031.02 of this Chapter, and
(2) An outline of course objectives, and
(3) A final written and skills competency examination, and
(4) The name and qualifications of the program director, and
(5) The training program address and phone number, and

(6) A copy of the training course curriculum including any workbooks, videos, textbooks, or handouts if used in the course, and
(7) The required fees for program review, and
(8) A copy of a course completion document to be provided to students who successfully complete training which shall contain all of the following elements:
(A) The name of the training program, and
(B) The name of the individual completing the course, and
(C) The course completion date, and
(D) A signature line for the class instructor, and
(E) Course name.
(c) All program materials and student records specified in this chapter shall be subject to periodic review, evaluation and monitoring by the EMS Authority.
(d) Any person or agency conducting a training program shall notify the EMS Authority in writing within thirty (30) calendar days of any change in program director, instructor, and change of address, phone number, and contact person.
(e) Any change to the curriculum once approved, shall be submitted for review and approval by the EMS Authority and shall include the requirements of Section 100031.02 Subsections (a) and (b) (1)-(12) and subsection (a)(2) of Section 100032
(f) The EMS Authority may request additional materials or documentation as a condition of course approval.
(g) The requirements and process for renewal of approval are the same as that for the initial approval.
(1) The training program shall submit an application for renewal at least sixty (60) calendar days before the expiration date of their approval in order to maintain continuous approval.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.02. Course Content Requirements.

(a) Training in the administration of epinephrine shall result in the lay rescuer demonstrating competency in the assessment, management and administration of epinephrine to an individual suspected of having an anaphylactic reaction.
(b) The following topics and skills shall be included in the training:
(1) Common causative agents,
(2) Recognition of symptoms of anaphylaxis,
(3) Recognition of signs of anaphylaxis,
(4) Acquisition and disposal of epinephrine auto-injectors,
(5) Maintenance and quality assessment of epinephrine auto-injectors,
(6) Emergency use of an epinephrine auto-injector
(A) Indications,
(B) Contraindications,
(C) Adverse effects,
(D) Administration by auto-injector,
(E) Dosing,
(F) Drug actions,
(G) Proper storage, handling and disposal of used/or expired injectors,
(7) Consent law,
(8) Good Samaritan law,
(9) Emergency Care Plans,
(10) Activation of the EMS system by calling 9-1-1,
(11) Commonly available models of epinephrine auto-injectors,
(12) Record keeping requirement as specified in Section 100030.01(b).
(c) At the completion of training, the student shall successfully complete a competency based written and skills examination which shall include all the course content requirements listed in subsection (b) of this Section.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.03. Director Requirements.

(a) Each training program shall have a program director that shall be qualified by education and experience in methods, materials, and evaluation of instruction.
(b) Duties of the program director shall include but not be limited to:
(1) Administering the training program, and
(2) Approving course content, and
(3) Approving all written examinations and the final skills examination, and
(4) Approving all instructor(s), and
(5) Assuring all aspects of the training program are in compliance with this Chapter and other related laws.
(6) Provide to the EMS Authority a list of all instructors at least every thirty (30) calendar days or,
(7) Notify the EMS Authority of any changes to the approved instructor list within fifteen (15) calendar days.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.04. Instructor Requirements.
(a) Each instructor shall:
(1) Be authorized by an approved training program, and
(2) Be approved by the training program director as qualified to teach by education and experience in methods, materials, and evaluation of instruction, and
(3) Possess current certification in first aid, CPR and AED.
(b) Upon completion of each epinephrine auto-injector course the instructor shall provide the individual with a signed course completion document.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.05. Notification of Program Approval.
(a) The EMS Authority shall notify the training program within twenty-one (21) working days of receiving its request that:
(1) The request has been received, and
(2) The request contains or does not contain the information requested in Section 100031.01 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 EMS Authority to the applying training program within sixty (60) 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 certificate of approval to the training program with the effective date and an expiration date.
(d) Program approval shall be for four (4) years from the last day of the month in which the approval is given and shall be reviewed by the EMS Authority for approval every four (4) years or sooner at the discretion of the EMS Authority.
(e) Approved training programs shall notify the EMS Authority in writing, and within thirty (30) calendar days of any change in name, address, phone number, hours of instruction, or program director.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.06. Withdrawal of Program Approval.
(a) 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.
(b) Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:
(1) The EMS Authority shall notify the approved training program course director in writing, by registered mail, of the provisions of this Chapter with which the training program is not in compliance.
(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to the EMS Authority one of the following:
(A) Evidence of compliance with 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 thirty (30) calendar days from the mailing date of the noncompliance notification the EMS Authority shall notify the approved 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 training program approval.
(4) If the EMS Authority decides to suspend, revoke, or place a training program on probation the notification specified in the subsection (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 shall not be less than sixty (60) calendar days from the date of the EMS Authority's letter of decision to the approved training program.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100031.07. Certification Card.
(a) The EMS Authority shall issue a certification card to each individual who satisfies the requirements of Section 100030.02
(b) The certification card shall contain all of the following:
(1) The name of the individual completing the course
(2) The course completion date
(3) Certification expiration date
(4) Certification number
(5) The title of the card shall be listed as: Epinephrine Auto-injector Certification.
(6) The signature of the certified Health and Safety Code Section 1797.197a Responder, affirming the statement: “I understand the scope of my authority and responsibilities as a trained Health and Safety Code Section 1797.197a Responder, and will possess and only employ epinephrine consistent with that Health and Safety Code Section 1797.197a training and applicable law, including activation of the Emergency Medical Services System and record keeping.”

Note: Authority cited: Sections 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Article 4: Fees

§ 100032. Fees.
(a) Each epinephrine training program submitting a written request for program approval shall include a fee of:
(1) Five hundred ($500) dollars for approval and re-approval of a training program.
(2) Two hundred and fifty ($250) dollars for any changes in the course content or curriculum occurring outside of the renewal period.
(b) Each individual submitting an application for certification, recertification, or request for a replacement card shall include a fee of:
(1) Fifteen ($15) dollars.
(c) All fees are nonrefundable.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Chapter 3. Professional Standards and Training
Chapter 3.1: Emergency Medical Technician

Article 1: Definitions

§ 100065.01. 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 LEMSA.

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.

§ 100065.02. Electronic Health Record.

"Electronic health record" (EHR) or "electronic patient care record" (ePCR) means real-time, patient centered records that make information available securely to authorized users in a digital format capable of being shared with other providers across more than one health care organization. Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.107, 1797.109, 1797.170, 1797.208 and 1797.227, Health and Safety Code.

§ 100065.03. 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 10 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.

§ 100065.04. Emergency Medical Technician Approving Authority.

(a) "Emergency Medical Technician (EMT) approving authority" means an agency or person authorized by this Chapter to approve an EMT training program, as follows:

(1) 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).

(2) Any other EMT training programs not included in subsection (a)(1) shall be approved by the local EMS agency (LEMSA) that has jurisdiction in the county where the training program is located.

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.

§ 100065.05. 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.

§ 100065.06. 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.

§ 100065.07. EMT Certifying Cognitive Examination.

"EMT Certifying Cognitive Examination" means the National Registry of Emergency Medical Technicians EMT Cognitive Examination to test an individual applying for certification as an EMT.

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.

§ 100065.08. EMT Certifying Psychomotor Examination.

“Certifying Psychomotor Examination” means the National Registry of Emergency Medical Technicians EMT Psychomotor Examination to test an individual applying for certification as an EMT.

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.

§ 100065.09. EMT Local Accreditation.

“Local Accreditation” or “accreditation” or “accreditation to practice” means authorization by the LEMSA to practice within that jurisdiction. Note: Authority cited: Sections 1797.107 and 1797.170, Health and Safety Code. Reference: Sections 1797.7, 1797.170, 1797.176, 1797.177, 1797.178, 1797.200, 1797.204, 1797.206, 1797.210 and 1797.214, Health and Safety Code.

§ 100065.10. 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 LEMSA medical director to be responsible for any of the skills that are listed in Sections 100066.02(b) and 100066.04 of this Chapter including medical control. Waiver of the board-certified requirement may be granted by the LEMSA 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.

§ 100065.11. High Fidelity Simulation.

“High Fidelity Simulation” means using computerized manikins that are operated by a technologist from another location to produce audible sounds and to alter, simulate and manage physiological changes within the manikin to include, but not be limited to, altering the heart rate, respirations, chest/lung sounds, blood pressure and saturation of oxygen. Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code.

§ 100065.12. 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.

Article 2: General Provisions

§ 100066.01 Application of Chapter.

(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 LEMSA, 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.
(d) The local EMS agency shall develop and implement policies for the medical control and medical accountability of care rendered by the EMT. This shall include, but not be limited to, basic life support protocols, policies and procedures and documentation, which may include completing an electronic health record (EHR) that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information Systems (NEMSIS) standards.
(e) Pursuant to Health and Safety Code section 1797.170, subdivision (b), a California-certified EMT shall be recognized as an EMT on a statewide basis.
(f) If an EMT or Advanced EMT certification card is lost, destroyed, damaged, or there has been a change in the name of the EMT, a duplicate certification card may be requested. The request shall be in writing to the certifying entity that issued the EMT certificate and include a statement identifying the reason for the request and, if due to a name change, include a copy of legal documentation of the change in name. The duplicate card shall bear the same certification number and date of expiration as the original card.
(g) An individual currently certified as an EMT by the provisions of this section may voluntarily deactivate his or her EMT certificate as long as the individual is not under investigation or disciplinary action by a LEMSA medical director for violations of Health and Safety Code Section 1798.200. An individual who has voluntarily deactivated his or her EMT certificate shall comply with the following:
(1) Discontinue all medical practice requiring an active and valid EMT certificate,
(2) Return the EMT certificate to the certifying entity, and
(3) Notify the LEMSA to whom the individual is accredited as an EMT that his or her certification is no longer valid.
(4) Reactivation of the EMT certificate shall be in accordance with the provisions of Section 100069.02 of this Chapter.
(5) This information shall be entered into the Central Registry by the certifying entity who issued the EMT certificate.
Note: Authority cited: Sections 1797.107, 1797.109, 1797.170, 1797.220 and 1797.227, Health and Safety Code. Reference: Sections 1797.160 and 1797.170, Health and Safety Code.

§ 100066.02. Basic 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 motion restriction or immobilization devices.
(8) Provide initial prehospital emergency care to patients, 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 motion restriction or immobilization;
(D) Seated spinal motion restriction or immobilization;
(E) Extremity splinting; and

(F) Traction splinting.
(G) Administer oral glucose or sugar solutions.
(H) Extricate entrapped persons.
(I) Perform field triage.
(J) Transport patients.
(K) Apply mechanical patient restraint.
(L) Set up for ALS procedures, under the direction of an Advanced EMT or Paramedic.
(M) Perform automated external defibrillation.
(N) 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 who is part of the organized EMS system and 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. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;
(2) 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;
(3) Administer naloxone or other opioid antagonist by intranasal and/or intramuscular routes for suspected narcotic overdose;
(4) Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma;
(5) Perform finger stick blood glucose testing; and
(6) Administer over the counter medications, when approved by the medical director, including, but not limited to:
(A) Aspirin.
(c) The scope of practice of an EMT shall not exceed those activities authorized in this Section, Section 100066.04, and Section 100066.05.
(d) During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained and authorized according to the policies and procedures established by the LEMSA within the jurisdiction where the EMT is employed as part of an organized EMS system.
Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.8, 1797.170, 1797.197 and 1797.221, Health and Safety Code.

§ 100066.03. EMT AED Service Provider.
An EMT AED service provider is an agency or organization that employs individuals as defined in Section 100065.05, 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.

§ 100066.04. EMT Optional Skills.

(a) In addition to the activities authorized by Section 100066.02 of this Chapter, a 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. Accreditation for EMTs to practice optional skills shall be limited to those whose EMT certificate is active and are employed within the jurisdiction of the LEMSA by an employer who is part of the organized EMS system.

(1) Use of perilaryngeal airway adjuncts.
(A) 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:
1. Anatomy and physiology of the respiratory system.
2. Assessment of the respiratory system.
3. Review of basic airway management techniques, which includes manual and mechanical.
4. The role of the perilaryngeal airway adjuncts in the sequence of airway control.
5. Indications and contraindications of the perilaryngeal airway adjuncts.
6. The role of pre-oxygenation in preparation for the perilaryngeal airway adjuncts.
7. Perilaryngeal airway adjuncts insertion and assessment of placement.
8. Methods for prevention of basic skills deterioration.
9. Alternatives to the perilaryngeal airway adjuncts.
(B) 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.
(C) 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 the EMSQIP.
(2) Administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma.
(A) Training in the administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma shall consist of no less than two (2) hours to result in the EMT being competent in the use and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe 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:
1. Names
2. Indications
3. Contraindications
4. Complications
5. Side/adverse effects
6. Interactions
7. Routes of administration
8. Calculating dosages
9. Mechanisms of drug actions
10. Medical asepsis
11. Disposal of contaminated items and sharps
12. Medication administration

(B) At the completion of this training, the student shall complete a competency based written and skills examination for the use and/or administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, which shall include:
1. Assessment of when to administer epinephrine,
2. Managing a patient before and after administering epinephrine,
3. Using universal precautions and body substance isolation procedures during medication administration,
4. Demonstrating aseptic technique during medication administration,
5. Demonstrating preparation and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, and
6. Proper disposal of contaminated items and sharps.
(3) Administer the medications listed in this subsection.
(A) Using prepackaged products, the following medications may be administered:
1. Atropine
2. Pralidoxime Chloride
(B) This training shall consist of no less than two (2) hours of didactic and skills laboratory training to result in competency. In addition, a basic weapons of mass destruction training is recommended. Training in the profile of medications listed in subsection (A) shall include, but not be limited to:
1. Indications
2. Contraindications
3. Side/adverse effects
4. Routes of administration
5. Dosages
6. Mechanisms of drug action
7. Disposal of contaminated items and sharps
8. Medication administration
(C) 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:
1. Assessment of when to administer these medications,
2. Managing a patient before and after administering these medications,
3. Using universal precautions and body substance isolation procedures during medication administration,
4. Demonstrating aseptic technique during medication administration,
5. Demonstrating the preparation and administration of medications by the intramuscular route, and
6. Proper disposal of contaminated items and sharps.
(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 (01/17), herein incorporated by reference, 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 100066.04(a)(4).
(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.
(b) 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 the EMSQIP.
(c) 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 100066.04(i).
(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.
(d) 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.
(e) 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.
(f) 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.
(g) An EMT accredited in an optional skill may assist in demonstration of competency and training of that skill.
(h) In order to be accredited to utilize an optional skill, an EMT shall demonstrate competency through passage, by preestablished 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.
(i) 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.

§ 100066.05. 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 judgement 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 100093.03, Chapter 3.3 (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

§ 100067.01. EMT 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 of Title 22 of the California Code of Regulations; 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.

§ 100067.02. 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 100067.04 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.

§ 100067.03. 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.

§ 100067.04. 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.

§ 100067.05. EMT Training Program Notification.

(a) 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.
(b) The EMT approving authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
(c) The EMT training program approval effective date shall be the day the approval is issued. The approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years subject to the procedure for program approval specified in this Chapter.
(d) 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.

§ 100067.06. Teaching Staff.

(a) 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:
(b) Each EMT training program shall have an approved program director who shall be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
(c) 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.
(d) 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).
(e) 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 with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction and shall meet the following qualifications:
(1) Be a Physician, Registered Nurse, Physician Assistant, or Paramedic currently licensed in California; or,
(2) Be an Advanced EMT or EMT who is currently certified in California.
(3) 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.
(4) 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 (e) of this Section.

(f) 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.

§ 100067.07. 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.

§ 100067.08. Withdrawal of EMT Training Program Approval.
(a) Failure to comply with the provisions of this Chapter may result in denial, probation, suspension or revocation of program approval by the EMT training program approving authority.
(b) The requirements for training program noncompliance notification and actions are as follows:
(1) An EMT training program approving authority shall provide notification of noncompliance with this Chapter to the EMT training program provider found in violation. The notification shall be in writing and sent by certified mail to the EMT training program course director.
(2) Within fifteen (15) working days from receipt of the noncompliance notification the approved EMT training program shall submit in writing, by certified 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 to comply 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 from receipt of the approved EMT training program's response, 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 issue a decision letter by certified mail to the Authority and the approved EMT training program. The letter shall identify the EMT training program approving authority's decision to take one or more of the following actions:
(A) Accept the evidence of compliance provided.
(B) Accept the plan for meeting compliance.
(C) Place the training program on probation.
(D) Suspend or revoke the training program approval.
(4) The decision letter shall also include, but not be limited to, the following:
(A) Date of the training program approving authority's decision;
(B) Specific provisions found noncompliant by the training program approving authority, if applicable;
(C) The probation or suspension effective and ending date, if applicable;
(D) The terms and conditions of the probation or suspension, if applicable; and
(E) The revocation effective date, if applicable.
(5) If the training program found noncompliant with this Chapter does not comply with subsection (2) of this Section, the EMT training program approving authority may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described in subsection (3) of this Section.
(6) The EMT training program approving authority shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described in subsection (3) of this Section.
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; and Section 11505, Government Code.

§ 100067.09. 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 final written and skills competency examinations to include all skills covered by course content listed in section 100067.11;
(3) A challenge examination; and
(4) A refresher course required for renewal or reinstatement.
(b) The approving authority 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.

§ 100067.10. EMT Training Program Required Course Hours.
(a) The EMT course shall consist of not less than one hundred seventy (170) hours. These training hours shall be divided into:
(1) A minimum of one hundred forty-six (146) 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.
(A) High fidelity simulation, when available, may replace up to six (6) hours of supervised clinical experience and may replace up to three (3) documented patient contacts.
(b) The minimum hours shall not include the examinations for EMT certification as specified in Sections 100065.07 and 100065.08 of this Chapter.
Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.170 and 1797.208, Health and Safety Code.

§ 100067.11. 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 100066.02 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 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 EMSA-approved hemostatic dressings;
(2) Review treatment of open chest wall injuries;
(3) Types of hemostatic dressings; and
(4) Importance of maintaining normal body temperature.
(c) Training in the administration of naloxone or other opioid antagonist shall result in the EMT being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose and shall include the following topics and skills:
(1) Common causative agents.
(2) Assessment findings.
(3) Management to include, but not be limited to:
(A) Need for appropriate personal protective equipment and scene safety awareness.
(4) Profile of Naloxone to include, but not be limited to:
(A) Indications.
(B) Contraindications.
(C) Side/adverse effects.
(D) Routes of administration.
(E) Dosages.
(F) Mechanisms of drug action.

(G) Calculating drug dosages.
(H) Medical asepsis.
(I) Disposal of contaminated items and sharps.
(J) Medication administration.
(d) Training in the administration of epinephrine for suspected anaphylaxis and/or severe asthma shall result in the EMT being competent in the use and administration of epinephrine by auto-injector and managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms. Included in the training shall be the following topics and skills:
(1) Common causative agents.
(2) Assessment findings.
(3) Management to include, but not be limited to:
(A) Need for appropriate personal protective equipment and scene safety awareness.
(4) Profile of epinephrine to include, but not be limited to:
(A) Indications
(B) Contraindications.
(C) Side/adverse effects.
(D) Mechanisms of drug action.
(5) Administration by auto-injector.
(6) Medical asepsis.
(7) Disposal of contaminated items and sharps.
(e) Training in the use of finger stick blood glucose testing shall result in the EMT being competent in the use of a glucometer and managing a patient with a diabetic emergency. Included in the training shall be the following topics and skills:
(1) Blood glucose determination.
(A) Assess blood glucose level.
(B) Indications.
1. Decreased level of consciousness in the suspected diabetic.
2. Decreased level of consciousness of unknown origin.
(C) Procedure for use of finger stick blood glucometer.
1. Medical asepsis.
2. Refer to manufacturer's instructions for device being used.
(D) Disposal of sharps.
(E) Limitations.
1. Lack of calibration.
(F) Interpretation of results.
(G) Patient assessment.
(H) Managing a patient before and after finger stick glucose testing.
(f) In addition to the above, the content of the training course shall include a minimum of four (4) hours of tactical casualty care (TCC) principles applied to violent circumstances with at least the following topics and skills, and shall be competency based:
(1) History and Background of Tactical Casualty Care:
(A) Demonstrate knowledge of tactical casualty care.
1. History of active shooter and domestic terrorism incidents.
2. Define roles and responsibilities of first responders including Law Enforcement, Fire and EMS.
3. Review of local active shooter policies.
4. Scope of practice and authorized skills and procedures by level of training, certification, and licensure zone.
(2) Terminology and definitions.
(A) Demonstrate knowledge of terminology.
1. Hot zone/warm zone/cold zone.
2. Casualty collection point.
3. Rescue task force.
4. Cover/concealment.
(3) Coordination Command and Control.
(A) Demonstrate knowledge of Incident Command and how agencies are integrated into tactical operations.
1. Demonstrate knowledge of team command, control and communication.
a. Incident Command System (ICS) /National Incident Management System (NIMS)

b. Mutual Aid considerations.
c. Unified Command.
d. Communications, including radio interoperability.
e. Command post.
i. Staging areas.
ii. Ingress/egress.
iii. Managing priorities.
(4) Tactical and Rescue Operations.
(A) Demonstrate knowledge of tactical and rescue operations.
1. Tactical Operations - Law Enforcement.
a. The priority is to mitigate the threat.
b. Contact Team.
c. Rescue Team.
2. Rescue Operations - Law Enforcement/EMS/Fire.
a. The priority is to provide life-saving interventions to injured parties.
b. Formation of Rescue Task Force (RTF).
c. Casualty collection points.
(5) Basic Tactical Casualty Care and Evacuation.
(A) Demonstrate appropriate casualty care at your scope of practice and certification.
1. Demonstrate knowledge of the components of the Individual First Aid Kit (IFAK) and/or medical kit.
a. Understand the priorities of Tactical Casualty Care as applied by zone.
(B) Demonstrate competency through practical testing of the following medical treatment skills:
1. Bleeding control.
a. Apply Tourniquet.
i. Self-Application.
ii. Application on others.
b. Apply Direct Pressure.
c. Apply Pressure Dressing.
d. Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved products.
2. Airway and Respiratory management.
a. Perform Chin Lift/Jaw Thrust Maneuver.
b. Recovery position.
c. Position of comfort.
d. Airway adjuncts.
3. Chest/torso wounds.
a. Apply Chest Seals vented preferred.
(C) Demonstrate competency in patient movement and evacuation.
1. Drags and lifts.
2. Carries.
(D) Demonstrate knowledge of local multi-casualty/mass casualty incident protocols.
1. Triage procedures (START or SALT).
2. CCP - Triage, Treatment and Transport.
(6) Threat Assessment.
(A) Demonstrate knowledge in threat assessment.
1. Understand and demonstrate knowledge of situational awareness.
a. Pre-assessment of community risks and threats.
b. Pre-incident planning and coordination
c. Medical resources available.

(g) Training programs in operation prior to the effective date of this subsection shall submit evidence of compliance with this Chapter to the appropriate approving authority as specified in Section 100065.04 of this Chapter within twelve (12) months after the effective date of this subsection.

Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.116, 1797.170 and 1797.173, Health and Safety Code.

§ 100067.12. 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 preestablished standards, developed and/or approved by the EMT approving authority pursuant to Section 100067.02 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.

§ 100067.13. 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) 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.

§ 100067.14. 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 100067.02 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 as 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

§ 100068. 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 cognitive examination and psychomotor examination specified in Sections 100065.07 and 100065.08 of this Chapter within two (2) years from the date of application for EMT certification and have a valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100067.02 of this Chapter issued within two (2) years of the date of application, or
(2) Pass the cognitive examination and psychomotor examination specified in Sections 100065.07 and 100065.08 of this Chapter within two (2) years from the date of application for EMT certification and have documentation of successful completion of an approved out-of-state initial EMT training course that meets the requirements of this Chapter issued within two (2) years of the date of application, or
(3) Pass the cognitive examination and psychomotor examination specified in Sections 100065.07 and 100065.08 of this Chapter within two (2) years from the date of application for EMT certification and have a current and valid out-of-state EMT certificate, or
(4) Possess a current and valid National Registry EMT, Advanced EMT or Paramedic registration certificate, or
(5) Possess a current and valid out-of-state Advanced EMT or Paramedic certificate, or
(6) Possess a current and valid California Advanced EMT certificate 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 6, Chapter 4.1 of this Division. The certifying entity shall receive the State and Federal criminal background check results before issuing an initial certification;
(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 prior and/or current certification, licensure, or accreditation actions:
(A) Against an EMT or Advanced EMT 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 denials and any active investigations; or
(D) Against any health-related license;
(5) Disclose any pending or current criminal investigations;
(6) Disclose any pending criminal charges;
(7) Disclose any prior convictions;
(8) Disclose each certifying entity or LEMSA to which the applicant has applied for certification in the previous 12 months; and
(9) 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 the last day of the month two (2) years from the effective date of the initial certification.
(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

§ 100069.01. EMT Certification Renewal.
(a) In order to renew certification, an EMT shall:
(1) Possess a current EMT Certification issued in California.
(2) Meet one of the following continuing education requirements:
(A) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program within the 24 months prior to applying for renewal, or
(B) Obtain at least twenty-four (24) hours of continuing education (CE), within the 24 months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in Chapter 3.5 of this Division.
1. CE hours may be used to renew multiple licensure/certification types as long as they are earned within the licensure/certification cycle being renewed and were not used in a previous cycle.
(3) Complete an application form and other processes as specified in Section 100068, subdivisions (b)(3)-(b)(9), of this Chapter.
(4) Complete the criminal history background check requirements as specified in Article 6, Chapter 4.1 of this Division when changing certifying entities. The certifying entity shall receive the State and Federal criminal background check results before issuing a certification.
(5) Submit a completed skills competency verification form, EMSA-SCV (01/17). Form EMSA-SCV (01/17) 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.
(6) Starting 24 months after the effective date of this subsection, an EMT renewing his or her certification for the first time shall submit documentation of successful completion of the following training by an approved EMT training program or approved CE provider:
(A) The use and administration of naloxone or other opioid antagonist that meets the standards and requirements of section 100067.11, subsection (c).
(B) The use and administration of epinephrine by auto-injector that meets the standards and requirements of section 100067.11, subsection (d).
(C) The use of a glucometer that meets the standards and requirements of section 100067.11, subsection (e).
(D) If an individual possesses a current California-issued paramedic license or California Advanced EMT certificate, then the individual need not comply with subsections (A)-(C), above.
(b) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100221.01, subdivisions (c) and (d), of Chapter 9 of this Division, within forty-five (45) days to eligible individuals who apply for EMT renewal and successfully complete the requirements of this Chapter.
(c) If the EMT renewal requirements are met within six (6) months prior to the current certification expiration date, the EMT Certifying entity shall make the effective date of renewal the date immediately following the expiration date of the current certificate. The certification will expire the last day of the month two (2) years from the day prior to the effective date.
(d) If the EMT renewal requirements are met greater than six (6) months prior to the expiration date, the EMT Certifying entity shall make the effective date of renewal 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.
(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 100069.01, subdivisions (a)(2)-(a)(5). In order to qualify for this exception, the individual shall:
(1) Submit proof of his or her membership in the Armed Forces of the United States, and
(2) Submit documentation of his or her deployment starting and ending dates.
(3) Continuing education credit may be given for documented training that meets the requirements of Chapter 3.5 of this Division while the individual was deployed on active duty.

(4) The continuing education 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.

§ 100069.02. Reinstatement of an Expired California EMT Certificate.

(a) The following requirements apply to individuals who wish to be eligible for reinstatement after their California EMT certificates have expired:

(1) For a lapse of less than six (6) months, the individual shall meet one of the following continuing education requirements:

(A) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program within the 24 months prior to applying for reinstatement, or

(B) Obtain at least twenty-four (24) hours of continuing education (CE), within the 24 months prior to applying for reinstatement, from an approved CE provider in accordance with the provisions contained in Chapter 3.5 of this Division.

1. CE hours may be used to renew multiple licensure/certification types.

(C) Complete an application form and other processes as specified in Section 100068, subdivisions (b)(3)-(b)(9), of this Chapter.

(D) Complete the criminal history background check requirements as specified in Article 6, Chapter 4.1 of this Division when the background check results are not on file with the certifying entity that is processing the reinstatement. The certifying entity shall receive the State and Federal criminal background check results before issuing a certification.

(E) Submit a completed skills competency verification form, EMSA-SCV (01/17). Form EMSA-SCV (01/17) 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.

(F) Starting 24 months after the effective date of this subsection, an EMT applying for reinstatement of his or her certification for the first time shall submit documentation of successful completion of the following training by an approved EMT training program or approved CE provider:

1. The use and administration of naloxone or other opioid antagonist that meets the standards and requirements of section 100067.11, subsection (c).

2. The use and administration of epinephrine by auto-injector that meets the standards and requirements of section 100067.11, subsection (d).

3. The use of a glucometer that meets the standards and requirements of section 100067.11, subsection (e).

4. If an individual possesses a current California-issued paramedic license or California Advanced EMT certificate, then the individual need not comply with subsections 1.-3., above.

(2) For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall meet one of the following continuing education requirements:

(A) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program, and twelve (12) hours of continuing education, within the 24 months prior to applying for reinstatement, or

(B) Obtain at least thirty-six (36) hours of continuing education (CE), within the 24 months prior to applying for reinstatement, from an approved CE provider in accordance with the provisions contained in Chapter 3.5 of this Division.

1. CE hours may be used to renew multiple licensure/certification types.

(C) Complete an application form and other processes as specified in Section 100068, subdivisions (b)(3)-(b)(9), of this Chapter.

(D) Complete the criminal history background check requirements as specified in Article 6, Chapter 4.1 of this Division when the background check results are not on file with the certifying entity that is processing the reinstatement. The certifying entity shall receive the State and Federal criminal background check results before issuing a certification.

(E) Submit a completed skills competency verification form, EMSA-SCV (01/17). Form EMSA-SCV (01/17) 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.
(F) Starting 24 months after the effective date of this subsection, an EMT applying for reinstatement of his or her certification for the first time shall submit documentation of successful completion of the following training by an approved EMT training program or approved CE provider:
1. The use and administration of naloxone or other opioid antagonist that meets the standards and requirements of section 100067.11, subsection (c).
2. The use and administration of epinephrine by auto-injector that meets the standards and requirements of section 100067.11, subsection (d).
3. The use of a glucometer that meets the standards and requirements of section 100067.11, subsection (e).
4. If an individual possesses a current California-issued paramedic license or California Advanced EMT certificate, then the individual need not comply with subsections 1.-3., above.
(3) For a lapse of twelve (12) months or more, the individual shall meet one of the following continuing education requirements:
(A) Successfully complete a twenty-four (24) hour refresher course from an approved EMT training program, and twenty-four (24) hours of continuing education, within the 24 months prior to applying for reinstatement, or
(B) Obtain at least forty-eight (48) hours of continuing education (CE), within the 24 months prior to applying for reinstatement, from an approved CE provider in accordance with the provisions contained in Chapter 3.5 of this Division.
1. CE hours may be used to renew multiple licensure/certification types.
(C) Complete an application form and other processes as specified in Section 100068, subdivisions (b)(3)-(b)(5), of this Chapter.
(D) Complete the criminal history background check requirements as specified in Article 6, Chapter 4.1 of this Division. The certifying entity shall receive the State and Federal criminal background check results before issuing a certification.
(E) Submit a completed skills competency verification form, EMSA-SCV (01/17). Form EMSA-SCV (01/17) 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.
(F) Starting 24 months after the effective date of this subsection, an EMT applying for reinstatement of his or her certification for the first time shall submit documentation of successful completion of the following training by an approved EMT training program or approved CE provider:
1. The use and administration of naloxone or other opioid antagonist that meets the standards and requirements of section 100067.11, subsection (c).
2. The use and administration of epinephrine by auto-injector that meets the standards and requirements of section 100067.11, subsection (d).
3. The use of a glucometer that meets the standards and requirements of section 100067.11, subsection (e).
4. If an individual possesses a current California-issued paramedic license or California Advanced EMT certificate, then the individual need not comply with subsections 1.-3., above.
(G) Pass the cognitive and psychomotor exams, as specified in Sections 100065.07 and 100065.08 of this Chapter, within two (2) years of the date of application for EMT reinstatement unless the individual possesses a current and valid EMT, AEMT or paramedic National Registry Certificate or a current and valid AEMT certificate or paramedic license.

(b) For individuals who meet the requirements of Section 100069.02, subdivision (a)(1), (a)(2), or (a)(3), the EMT certifying entity shall make the effective date of reinstatement 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.
(c) The EMT certifying entity shall issue a wallet-sized certificate card, pursuant to Section 100221.01, subdivisions (c) and (d), of Chapter 9 of this Division, within forty-five (45) days to eligible individuals who apply for EMT reinstatement 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

§ 100070.01. 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.

§ 100070.02. Fees.
A LEMSA may establish a schedule of fees for EMT training program review approval, EMT certification, EMT renewal and EMT reinstatement 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 1798.217, Health and Safety Code.

Chapter 3.2: Advanced Emergency Medical Technician

Article 1: Definitions

§ 100075.01. 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.

§ 100075.02. 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 LEMSA 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.

§ 100075.03. Advanced EMT Certifying Entity.

“Advanced EMT certifying entity” means the medical director of the LEMSA authorized to certify and recertify applicants for Advanced EMT. Note: Authority cited: Sections 1797.107, 1797.109, 1797.117, 1797.184(b) and 1797.184(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.

§ 100075.04. 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.

§ 100075.05. 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 10 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.

§ 100075.06. 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.

Article 2: General Provisions

§ 100076.01. 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 100079.01 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.

§ 100076.02. Advanced EMT Scope of Practice.
(a) An Advanced EMT may perform any activity identified in the scope of practice of an EMT in Chapter 3.1 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, needle or other cannula (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 100076.03.

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.

§ 100076.03. Advanced EMT Local Optional Scope of Practice.
(a) Advanced EMTs who were not certified as EMT-IIs 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 100076.02 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.

§ 100076.04. 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.

§ 100076.05. 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.

§ 100076.06. Advanced EMT Quality Improvement Program.

(a) The LEMSA shall establish a system-wide quality improvement program (EMSQIP) as defined in Section 100075.05 of this Chapter.
(b) Each Advanced EMT service provider, as defined in Section 100079.01 and each Advanced EMT base hospital as defined in Section 100079.02, 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

§ 100077.01. 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 post-secondary 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.

§ 100077.02. 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 examinations.
(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 of 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 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 the State of 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 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.

§ 100077.03. Advanced EMT Training Program Didactic and Skills Laboratory.
An approved Advanced EMT training program shall assure that no more than six (6) trainees are assigned to one (1) instructor/teaching assistant during the skills practice/laboratory sessions.
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.

§ 100077.04. 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.

§ 100077.05. 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 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.

§ 100077.06. Advanced EMT Training Program Approval.

(a) Eligible training programs as defined in Section 100077.01 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.

§ 100077.07. 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.

§ 100077.08. 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.

§ 100077.09. 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.

§ 100077.10. 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.

§ 100077.11. 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.

§ 100077.12. 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 performance of one or more of the skills specified in Section 100076.02(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 100076.02(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 100077.13 of this Chapter.
(4) Examination for Advanced EMT certification.

Note: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code. Reference: Sections 1797.82 and 1797.171, Health and Safety Code.

§ 100077.13. 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 100076.02 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: Sections 1797.82, 1797.171 and 1797.173, Health and Safety Code.

§ 100077.14. 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.

§ 100077.15. 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 within fifteen (15) working days of course completion.

Note: Authority cited: Sections 1797.107 and 1797.171, Health and Safety Code. Reference: Section 1797.82, 1797.171, 1797.208 and 1797.210, Health and Safety Code.

Article 4: Certification

§ 100078.01. 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 preestablished standards a competency based written and skills Advanced EMT certifying examination pursuant to Section 100075.04 of this Chapter.

(4) Beginning July 1, 2010, complete the criminal history background check requirements as specified in Article 6, Chapter 4.1 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 100076.03 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 100077.13 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 100076.03 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 100078.02(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 100078.03(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 100078.03(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 100077.13.
(2) Successfully complete five (5) documented ALS contacts in a prehospital field internship as specified in Section 100077.12 (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 100066.04 of chapter 3.1 of this Division may be given credit for training and experience for those topics and

scope of practice items contained in Section 100076.02 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 100221.01(c) of Chapter 9 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 9 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 100078.01(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.

§ 100078.02. 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 3.5 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 6, Chapter 4.1 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 100078.03 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 3.5, 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 100078.01(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.

§ 100078.03. 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 100078.02(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 100078.02(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 100078.02(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 100078.01(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 100078.01(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 100078.02(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 100221.01(c) of Chapter 9 of this Division.
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 and 1797.212, Health and Safety Code; and United States Code, Title 10, Subtitle A, Chapter 1, Section 101.

Article 5: Operational Requirements

§ 100079.01. 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 100076.06.
(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.

§ 100079.02. 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 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 prehospital 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.

§ 100079.03. 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 as specified in this Chapter.
(d) In circumstances where use of a base hospital as defined in Section 100079.02 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

§ 100080.01. 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 100079.03(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 LEMSA 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, 1797.173, 1797.200, 1797.202, 1797.204 and 1797.208, Health and Safety Code.

§ 100080.02. 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 an 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.

Chapter 3.3: Emergency Medical Technician-Paramedic

Article 1: Definitions

§ 100090.01. 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.

§ 100090.02. Cognitive Written Examination.
“Cognitive Written Examination” means the NREMT Paramedic Cognitive Written Examination to test an individual applying for licensure as a paramedic.
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.

§ 100090.03. 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 with the standards prescribed by this Chapter, has completed a training program as specified in Section 100092.07(c), holds a current certification as a CCP by the International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA in which their paramedic service provider is based.
Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and Safety Code.

§ 100090.04. Electronic Health Record.
“Electronic health record” (EHR) or “electronic patient care record” (ePCR) means real-time, patient centered records that make information available securely to authorized users in a digital format capable of being shared with other providers across more than one health care organization.
Note: Authority cited: Sections 1797.107, 1797.122 and 1797.227, Health and Safety Code. Reference: Sections 1797.107, 1797.122 and 1797.227, Health and Safety Code.
§ 100090.05. 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 10 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 and 1797.185, Health and Safety Code. Reference: Sections 1797.172 and 1797.204, Health and Safety Code.

§ 100090.06. Flight Paramedic.
A “Flight Paramedic” (FP) is an individual who is educated and trained in critical care transport, whose scope of practice is in accordance with the standards prescribed by this Chapter, has completed a training program as specified in Section 100092.07(c), holds a current certification as a FP by the International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC), has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA in which their paramedic service provider is based.
Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and Safety Code.

§ 100090.07. High Fidelity Simulation.
“High Fidelity Simulation” means using computerized manikins that are operated by a technologist from another location to produce audible sounds and to alter, simulate and manage physiological changes within the manikin to include, but not be limited to, altering the heart rate, respirations, chest/lung sounds, blood pressure and saturation of oxygen. Note: Authority cited: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code. Reference: Sections 1797.107, 1797.109 and 1797.170, Health and Safety Code.

§ 100090.08. Local Accreditation.
“Local Accreditation” or “accreditation” or “accreditation to practice” means authorization by the LEMSA to practice within that jurisdiction. 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.

§ 100090.09. 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.

§ 100090.10. 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.

§ 100090.11. Paramedic Training Program Approving Authority.
(a) “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:
(1) A paramedic training program and/or a CCP training program conducted by a qualified statewide public safety agency shall be approved by the director of the Authority.
(2) Any other paramedic training program and/or a CCP training program not included in subsection (1) shall be approved by the local EMS agency (LEMSA) that has jurisdiction in the county where the training program is located.
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.

§ 100090.12. Psychomotor Skills Examination.
“Psychomotor Skills examination” means the National Registry of Emergency Medical Technicians (NREMT) Paramedic Psychomotor Skills Examination to test the skills of an individual applying for

licensure as a paramedic.
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.

§ 100090.13. 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 100093.07.
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.

Article 2: General Provisions

§ 100091.01. 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.

§ 100091.02. Scope of Practice of Paramedic.
(a) A paramedic may perform any activity identified in the scope of practice of an EMT in Chapter 3.1 of this Division, or any activity identified in the scope of practice of an Advanced EMT (AEMT) in Chapter 3.2 of this Division without requiring a separate certification.
(b) A licensed 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 cannula (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. nitroglycerine preparations, except IV, unless permitted under (c)(2)(A) of this section;
24. ondansetron;
25. sodium bicarbonate;
26. tranexamic acid;
27. ketamine;
28. ketorolac;
29. acetaminophen IV.

(S) In addition to the approved paramedic scope of practice, the CCP or FP may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports, when approved by the LEMSA medical director.
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 by the medical director of the LEMSA, that have been approved by the Director of the Authority. Paramedics shall demonstrate competency in performing these procedures and administering these medications through training and successful testing.
(B) The medical director of the LEMSA shall submit a written request, Form #EMSA-0391, revised 01/17, incorporated herein by reference, to the Director of the Authority for approval of any procedures or medications proposed for use in accordance with Section 1797.172(b) of the Health and Safety Code prior to implementation.
(C) The Authority shall, within fourteen (14) days of receiving Form #EMSA-0391, revised 01/17, notify the medical director of the LEMSA that the 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 Services Medical Directors Association of California's (EMDAC) Scope of Practice Committee, shall approve or disapprove the request for additional procedures and/or administration of medications and notify the LEMSA medical director of the decision within ninety (90) days of receipt of the completed request. An approved status shall be in effect for a period of three (3) years. An approved status may be renewed for another three (3) year period, upon the authority's receipt of a written request that includes, but is not limited to, the following information: the utilization of the procedure(s) or medication(s), beneficial effects, adverse reactions or complications, statistical evaluation, and general conclusion.
(E) The Director of the Authority, in consultation with the EMDAC Scope of Practice Committee, 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, authorized registered nurse, or mobile intensive care nurse (MICN), provided that an EMSQIP is in place as specified in Chapter 10 of this Division.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.185, 1797.192, 1797.195 and 1797.214, Health and Safety Code. Reference: Sections 1797.56, 1797.172, 1797.178 and 1797.185, Health and Safety Code.

§ 100091.03. Paramedic Trial Studies.

A paramedic may perform any prehospital emergency medical care treatment procedures(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.

§ 100091.04. Responsibility of the LEMSA.
(a) The LEMSA that authorizes an ALS program shall establish policies and procedures approved by the medical director of the LEMSA that shall include:
(1) Approval, denial, revocation of approval, suspension, and monitoring of the ALS components of the EMS System such as training programs, base hospitals or alternative base stations, and paramedic service providers.
(2) Assurance of compliance with provisions of this Chapter.
(b) The LEMSA shall submit to the Authority, along with any changes to, the following paramedic training program information:
(1) Name of program director and/or program contact;
(2) Program address, phone number, email address, website address, and facsimile number;
(3) Date of program approval, date classes will begin, and date of program expiration.
(4) Date of Commission on Accreditation of Allied Health Education Programs (CAAHEP) approval;
(5) Date of Bureau of Private Post-Secondary Education (BPPE) approval for private post-secondary educational institutions;
(6) Issue date of Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) Letter of Review (LoR).
(c) 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.

(d) 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, 1797.218, 1798 and 1798.100, Health and Safety Code.

Article 3: Program Requirements for Paramedic Training Programs

§ 100092.01. Paramedic Approved Training Programs.

(a) An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in Section 100092.01(j) 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) All approved paramedic training programs shall be accredited and shall maintain current accreditation, or be in the process of receiving accreditation approval by CAAHEP upon the recommendation of CoAEMSP in order to operate as an approved paramedic training program.
(c) All approved paramedic training programs shall:
(1) Receive a Letter of Review (LoR) from CoAEMSP prior to starting classes; and
(2) Submit their application, fee, and Initial Self-Study Report (ISSR) to CoAEMSP for accreditation within six (6) months of the first class' graduation; and
(3) Receive and maintain CAAHEP accreditation no later than two (2) years from the date of the ISSR submission to CoAEMSP for accreditation.
(d) Paramedic training programs approved according to the provisions of this Chapter shall provide the following information in writing to all their paramedic training program applicants prior to the applicants' enrollment in the paramedic training program:
(1) The date the paramedic training program must submit their CAAHEP Request for Accreditation Services (RAS) form and ISSR or the date their application for accreditation renewal was sent to CoAEMSP.
(2) The date the paramedic training program must be initially accredited or the date its accreditation must be renewed by CAAHEP.
(e) Failure of the paramedic training program to maintain its LoR, submit their RAS form and ISSR to CoAEMSP, or obtain and maintain its accreditation with CAAHEP, as described in 100092.01(c), by the date specified shall result in withdrawal of program approval as specified in Section 100093.05 of this Chapter.
(f) Students graduating from a paramedic training program that fails to apply for, receive, or maintain CAAHEP accreditation by the dates required will not be eligible for state licensure as a paramedic.
(g) 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 RAS form, ISSR, and documents required for maintaining accreditation.
(h) Paramedic training programs shall submit to the Authority the date their initial RAS form was submitted to CoAEMSP and copies of documentation received from CoAEMSP and/or CAAHEP verifying accreditation.
(i) Approved paramedic training programs shall participate in the EMSQIP of their respective paramedic training program approving authority.
(j) 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 for Private Postsecondary Education.
(2) Medical training units of the United States Armed Forces or Coast Guard.
(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 of Title 22 of the California Code of Regulations;
(B) Provide continuing education (CE) to other health care professionals; and
(C) are accredited by a Centers for Medicare and Medicaid Services accreditation organization with 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.

§ 100092.02. Teaching Staff.
(a) Each training program shall have a program medical director who is a physician currently licensed in the State of California, has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:
(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 hospital clinical and field internship experience provisions.
(4) Approval of principal instructor(s).
(b) Each training program shall have a program director who is either a California licensed physician, a registered nurse who has a baccalaureate degree, or a paramedic who has a baccalaureate degree, or an individual who holds a baccalaureate degree in a related health field or in education. The program 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. Duties of the program director shall include, but not be limited to the following:
(1) Administration, organization and supervision of the educational program.
(2) In coordination with the program medical director, approve the principal instructor(s), 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 the preceptor(s) are trained according to the curriculum in subsection (h)(4).
(c) Each training program shall have a principal instructor(s), who is responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall meet the following criteria:
(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 January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 E, herein incorporated by reference; and
(3) Have six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree.
(4) Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
(d) A Principal Instructor may also be the program medical director or program director.
(e) Each CCP training program shall have a principal instructor(s) who is either licensed in California as a physician with knowledge in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or a flight paramedic (FP) certification from the International Board of Specialty Certification (IBSC) Board for Critical Care Transport Paramedic Certification (BCCTPC).
(f) Each training program may have a teaching assistant(s) who has training and experience to assist with teaching the course. The teaching assistant(s) shall be supervised by a principal instructor, the program director and/or the program medical director.
(g) Each training program may have a clinical coordinator(s) who is 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. Duties of the program clinical coordinator shall include, but need not be limited to, the following:
(1) The coordination and scheduling of students with qualified clinical preceptors in approved clinical settings as described in Section 100092.04.
(2) Ensuring adequate clinical resources exist for student exposure to the minimum number and type of patient contacts established by the program as required for continued CAAHEP accreditation.
(3) The tracking of student internship evaluation and terminal competency documents.
(h) Each paramedic training program shall have a field preceptor(s) who meets the following criteria:
(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 program director and/or the program medical director; and

(4) Have completed a field preceptor training program approved by the LEMSA in accordance with CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions (2015) which is hereby incorporated by reference. Training shall include a curriculum that will result in preceptor competency in the evaluation of paramedic students during the internship phase of the training program and the completion of the following:
(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 the 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 standards 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 procedures to address student injuries or exposure to illness, communicable disease or hazardous material.
(i) Each training program shall have a hospital clinical preceptor(s) who shall meet the following criteria:
(1) Be a physician, registered nurse or physician assistant currently licensed in the State of California.
(2) Have worked in emergency medical care services or areas of medical specialization for the last two (2) years.
(3) Be under the supervision of a principal instructor, the program director, and/or the program medical director.
(4) Receive training in the evaluation of paramedic students in clinical settings. Instructional tools may include, but need not be limited to, educational brochures, orientation, training programs, or training videos. Training shall include the following components of instruction:
(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 procedures for addressing student injuries or exposure to illness, communicable disease or hazardous material.
(i) Instructors of tactical casualty care (TCC) topics shall be qualified by education and experience in TCC methods, materials, and evaluation of instruction.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code. Reference: Sections 1797.116, 1797.172 and 1797.208, Health and Safety Code.

§ 100092.03. 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: 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.

§ 100092.04. 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 100092.06(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 LEMSA 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.

§ 100092.05. Field Internship.

(a) A field internship shall provide emergency medical care training and experience to paramedic students under continuous supervision, instruction, and evaluation by an authorized preceptor and shall promote student competency in medical procedures, techniques, and the administration of medications as specified in Section 100091.02, 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) that provide field internship services to students. This agreement shall include provisions to ensure compliance with this Chapter.

(c) The medical director of the LEMSA where the internship is located shall have medical control over the paramedic intern.

(d) The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency.

(1) The assignment of a student to a field preceptor shall be limited to duties associated with the student's training or the student training program.

(e) If the paramedic service provider is located outside the jurisdiction of the paramedic training program approving authority, the paramedic training program shall do the following:

(1) Ensure the student receives orientation in collaboration with the LEMSA where the field internship will occur. The orientation shall include that LEMSA's local policies, procedures, and treatment protocols,

(2) Report to the LEMSA, where the field internship will occur, the name of the paramedic intern, the name of the field internship provider, and the name of the preceptor.

(3) Ensure the field preceptor has the experience and training as required in Section 100092.02(h)(1)-(4).
(f) The paramedic training program shall enroll only the number of students it is able to place in field internships within ninety (90) days of completion of their hospital clinical education and training phase of the training program. The training program director and a student may agree to start the field internship at a later date in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.). This agreement shall be in writing.
(g) The internship, regardless of the location, shall be monitored by the training program staff, in collaboration with the assigned field preceptor.
(h) Training program staff shall, upon receiving input from the assigned field preceptor, document the progress of the student. Documentation shall include the identification of student deficiencies and strengths and any training program obstacles encountered by, or with, the student.
(i) Training program staff shall provide documentation reflecting student progress to the student at least twice during the student's internship.
(j) No more than one (1) 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.

§ 100092.06. Required Course Hours.

(a) The total paramedic training program shall consist of not less than one thousand and ninety-four (1094) hours. These training hours shall be divided into:
(1) A minimum of four-hundred and fifty-four (454) hours of didactic instruction and skills laboratories that shall include not less than four (4) hours of training in tactical casualty care principles as provided in Section 100092.07(b);
(2) The hospital clinical training shall consist of no less than one-hundred and sixty (160) hours;
(3) 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) documented ALS patient contacts during the field internship as specified in Section 100092.05. 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.
(1) When available, up to ten (10) of the required ALS patient contacts may be satisfied through the use of high fidelity adult simulation patient contacts as defined in Section 100090.07.
(2) Students shall document patient contacts utilizing an EHR system under supervision of the preceptor.
(c) The student shall have a minimum of twenty (20) documented experiences performing the role of team lead during the field internship. A team lead shall be defined as a student who, with minimal to no prompting by the preceptor, successfully takes charge of EMS operation in the field including, at least, the following:
(1) Lead coordination of field personnel,
(2) Formulation of field impression,
(3) Comprehensively assessing patent conditions and acuity.
(4) Directing and implementing patient treatment,
(5) Determining patient disposition, and
(6) Leading the packaging and movement of the patient.
(d) 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 100092.07 of this Chapter.
(4) Examination for paramedic licensure.
(e) 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 100092.04(b) of this Chapter.
(f) For at least half of the ALS patient contacts specified in Section 100092.06(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 transfer of care to hospital personnel.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172 and 1797.173, Health and Safety Code.

§ 100092.07. Required Course Content.
(a) The content of a paramedic course shall meet the objectives contained in the January 2009 U.S. Department of Transportation (DOT) National Emergency Medical Services Education Standards, DOT HS 811 077E, and be consistent with the paramedic basic scope of practice specified in Section 100091.02(a) of this Chapter. The DOT HS 811 077 E can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the National Highway Traffic Safety Administration http://www.nhtsa.gov/.
(b) In addition to the above, the content of the training course shall include a minimum of four (4) hours of tactical casualty care (TCC) principles applied to violent circumstances with at least the following topics and skills and shall be competency based:
(1) History and Background of Tactical Casualty Care
(A) Demonstrate knowledge of tactical casualty care
1. History of active shooter and domestic terrorism incidents
2. Define roles and responsibilities of first responders including Law Enforcement, Fire and EMS
3. Review of local active shooter policies
4. Scope of Practice and Authorized Skills and procedures by level of training, certification, and licensure zone
(2) Terminology and definitions
(A) Demonstrate knowledge of terminology
1. Hot zone/warm zone/cold zone
2. Casualty collection point
3. Rescue task force
4. Cover/concealment
(3) Coordination, Command and Control
(A) Demonstrate knowledge of Incident Command and how agencies are integrated into tactical operations.
1. Demonstrate knowledge of team command, control and communication
a. Incident Command System (ICS) /National Incident Management System (NIMS)
b. Mutual Aid considerations
c. Unified Command
d. Communications, including radio interoperability
e. Command post
f. Staging areas
g. Ingress/egress
h. Managing priorities
(4) Tactical and Rescue Operations
(A) Demonstrate knowledge of tactical and rescue operations
1. Tactical Operations - Law Enforcement
a. The priority is to mitigate the threat
b. Contact Team
c. Rescue Team
2. Rescue Operations - Law Enforcement/EMS/Fire
a. The priority is to provide life-saving interventions to injured parties
b. Formation of Rescue Task Force (RTF)
c. Casualty collection points
(5) Basic Tactical Casualty Care and Evacuation
(A) Demonstrate appropriate casualty care at your scope of practice and certification
1. Demonstrate knowledge of the components of the Individual First Aid Kit (IFAK) and/or medical kit.
2. Understand the priorities of Tactical Casualty Care as applied by zone.
3. Demonstrate competency through practical testing of the following medical treatment skills:
a. Bleeding control
b. Apply Tourniquet
i. Self-Application
ii. Application on others
c. Apply Direct Pressure
d. Apply Pressure Dressing
e. Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved products
2. Airway and Respiratory management

a. Perform Chin Lift/Jaw Thrust Maneuver
b. Recovery position
c. Position of comfort
d. Airway adjuncts
3. Chest/torso wounds
a. Apply Chest Seals, vented preferred
4. Demonstrate competency in patient movement and evacuation.
a. Drags and lifts.
b. Carries
5. Demonstrate knowledge of local multi-casualty/mass casualty incident protocols.
a. Triage procedures (START or SALT).
b. Casualty Collection Point.
c. Triage, Treatment and Transport.
(6) Threat Assessment.
(A) Demonstrate knowledge in threat assessment.
1. Understand and demonstrate knowledge of situational awareness.
2. Pre-assessment of community risks and threats.
3. Pre-incident planning and coordination.
4. Medical resources available.
(c) 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 in 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. Bronchodilaters
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. Infections 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
(d) Training programs in operation prior to the April 1, 2020 shall submit evidence of compliance with this Chapter to the appropriate approving authority as specified in Section 100060.11 of this Chapter no later than April 1, 2021.
Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code. Reference: Sections 1797.116, 1797.172, 1797.173, 1797.185 and 1797.213, Health and Safety Code.

§ 100092.08. Required Testing.
(a) Approved paramedic and CCP training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.
(b) Documentation of successful student clinical and field internship performance 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.

Article 4: Applications and Examinations

§ 100093.01. Course Completion Record.
(a) A tamper resistant course completion record shall be issued 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 the student successfully completes the paramedic 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 training program 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 a paramedic license.”
(8) For paramedic training, a list of the approved optional scope of practice procedures and/or medications taught in the course pursuant to subsection (c)(2)(A)-(D) of Section 100091.02.
(9) For CCP training, a list of the approved procedures and medications taught in the course pursuant to subsection (c)(1)(S)(1-10) of Section 100091.02.
Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code. Reference: Section 1797.172, Health and Safety Code.

§ 100093.02. 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 Advanced-EMT 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.

§ 100093.03. Procedure for Training Program Approval.

(a) Eligible training institutions, as defined in Section 100092.01(j), shall submit a written request for training program approval to the paramedic training program approving authority.

(b) The paramedic training program approving authority shall receive and review the following documentation 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 811 077 E January 2009.

(2) An outline of course objectives.

(3) Performance objectives for each skill.

(4) The names and qualifications of the training program director, program medical director, and principal instructors.

(5) 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.

(6) Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.

(7) The location at which the courses are to be offered and their proposed dates.

(8) 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.

(9) Written contracts or agreements between the paramedic training program and a provider agency (ies) for student placement for field internship training.

(10) A copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.

(11) Samples of written and skills examinations administered by the training program.

(12) Samples of a final written examination(s) administered by the training program.

(13) Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.

(14) CCP programs shall submit a statement verifying the CCP training program course content complies with the requirements of subsection 100092.07(c) of this Chapter and documentation listed in subsections (b)(2)-(5) and (b)(7)-(8) of this Section, if applicable.

(c) 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.

(d) Paramedic training programs will be approved by meeting all requirements in subsection (b) of this section. Notification of program approval or deficiencies with the application shall be made in writing by the paramedic training program approving authority to the requesting training program in a time period not to exceed ninety (90) days.

(e) The paramedic training program approving authority shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

(f) Paramedic training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years subject to the procedure for program approval specified in Section 100093.03(a)-(d).

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.

§ 100093.04. Program Review and Reporting.

(a) All program materials specified in this Chapter shall be subject to review by the paramedic training program approving authority and shall also be made available for review upon request by the Authority.

(b) All programs shall be subject to 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 provide written notification of changes to the paramedic training program approving authority of course objectives, hours of instruction, program director,

program medical director, principal instructor, provisions for hospital clinical experience, or field internship. Written notification shall be provided in advance, when possible, and no later than thirty (30) days after a change(s) has been identified.
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.

§ 100093.05. Withdrawal of Program Approval.
(a) Failure to comply with the provisions of this Chapter may result in denial, probation, suspension or revocation of program approval by the paramedic training program approving authority.
(b) The requirements for training program noncompliance notification and actions are as follows:
(1) A paramedic training program approving authority shall provide written notification of noncompliance with this Chapter to the paramedic training program provider found in violation. The notification shall be in writing and sent by certified mail to the paramedic training program director.
(2) Within fifteen (15) days from receipt of the noncompliance notification, 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 to comply 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 from receipt of the approved training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the approved paramedic training program, the paramedic training program approving authority shall issue a decision letter by certified mail to the Authority and the approved paramedic training program. The letter shall identify the paramedic training program approving authority's decision to take one or more of the following actions:
(A) Accept the evidence of compliance provided.
(B) Accept the plan for meeting compliance provided.
(C) Place the training program on probation.
(D) Suspend or revoke the training program approval.
(4) The decision letter shall also include, but need not be limited to, the following information:
(A) Date of the program training approval authority's decision;
(B) Specific provisions found noncompliant by the training approval authority, if applicable;
(C) The probation or suspension effective and ending date, if applicable;
(D) The terms and conditions of the probation or suspension, if applicable;
(E) The revocation effective date, if applicable;
(5) The paramedic training program approving authority shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described in subsection (3) of this Section.

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.

§ 100093.06. Cognitive Written and Psychomotor 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 psychomotor skills examination specified in Section 100090.12 of this chapter upon successful completion of didactic and skills laboratory. Students shall be eligible to take the cognitive written examination specified in Section 100090.02 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.

§ 100093.07. Date and Filing of Applications.

(a) The Authority shall notify the applicant within forty-five (45) calendar 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 the applicant may be required to submit to the Authority, are as follows:
(1) Initial In-State Paramedic License Application, (California Graduate), Form #L-01, revised 01/2024 herein incorporated by reference, for California paramedic program graduates.
(2) Initial Out-of-State Paramedic License Application Form #L-01A revised 01/2024, herein incorporated by reference, for Out-of-State applicants who are registered with the National Registry of Emergency Medical Technicians as a paramedic.
(3) Initial Challenge Paramedic License Application, Form #CL-01A revised 01/2024, herein incorporated by reference.
(4) Renewal Paramedic License Form #RL-01, revised 01/2024, herein incorporated by reference.
(5) Audit Renewal Paramedic License Application, Form #AR-01, revised 01/2024, herein incorporated by reference.
(6) Reinstatement Paramedic License Applications(s):
(A) Reinstatement Paramedic License Application Lapsed Less than One Year, Form #RLL-01A, revised 01/2024, herein incorporated by reference.
(B) Reinstatement Paramedic License Application Lapsed One Year or More, Form #RLL-01B, revised 01/2024, herein incorporated by reference.
(7) Applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Rev 05/2018), submitted to the California Department of Justice (DOJ), for a state and federal criminal history report provided by the Department of Justice in accordance with the provisions of section 11105 et seq. of the Penal Code.
(8) Request for Licensure/Certification Verification, Form #VL-01, revised 01/2024.
(b) Applications for renewal of license shall be complete and postmarked, hand delivered, or otherwise received by the Authority at least thirty (30) calendar days prior to the expiration date of the current license. Applications postmarked, hand delivered or otherwise received by the Authority less than thirty (30) calendar days prior to the expiration date of the current license will require the applicant to pay a $50 late fee, as specified in Section 100097.02(b)(4) of this Chapter.
(c) Eligible out-of-state applicants as defined in section 100094.01(a)(2) and eligible applicants as defined in section 100094.01(a)(3) of this Chapter who have applied to challenge the paramedic licensure training requirements shall be notified by the Authority within forty-five (45) calendar 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 all 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.

Article 5: Licensure

§ 100094.01. Licensure.
(a) In order to be eligible for initial paramedic licensure an applicant shall meet at least one of the following requirements:
(1) Provide documentation of a California paramedic training program course completion record as specified in Section 100093.01 of this Chapter or other documented proof of successful completion of a California approved paramedic training program and shall meet the following requirements:
(A) Complete and submit the appropriate Initial In-State Paramedic License application form as specified in Section 100093.07.

(B) Provide documentation of successful completion of the paramedic licensure cognitive written and psychomotor skills examinations within the previous two (2) years as specified in sections 100090.12 and 100090.02, or possess a current NREMT paramedic registration.
(C) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code.
(D) Pay the established fees pursuant to Section 100097.02.
(2) Provide documentation of a paramedic license or a paramedic training program course completion issued from an approved training program outside the State of California and meet the following requirements:
(A) Complete and submit the Initial Out-of-State Paramedic License application form as specified in Section 100093.07.
(B) Provide documentation of a current paramedic NREMT registration or proof of passing the paramedic licensure cognitive written and psychomotor skills exams within the last two (2) years.
(C) Provide documentation of successful completion of an approved paramedic field internship as defined in Section 100092.05(a), provided by an approved paramedic program director, consisting of no less than 40 advanced life support patient contacts as defined in section 100092.06(b), or a letter on official letterhead by an applicant's employer, training program director, or medical director verifying applicant's successful completion of 40 ALS patient contacts.
(D) An individual who is currently or was previously paramedic certified/licensed out-of-state shall submit a completed Request for License/Certification Verification, Form # VL-01 01/2024.
(E) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code.
(F) Pay the established fees pursuant to Section 100097.02.
(3) A physician, authorized registered nurse, mobile intensive care nurse (MICN), or physician assistant currently licensed shall be eligible to challenge the required paramedic training for initial paramedic licensure upon meeting the following requirements:
(A) If licensed as a physician, authorized registered nurse, MICN or physician assistant outside the state of California, provide documentation that their training is equivalent to the DOT HS 811 077 E specified in Section 100092.07, or
(B) If licensed as a physician, authorized registered nurse, MICN or physician assistant in the state of California, provide a copy of their current license, and
(C) Complete and submit the Initial Challenge Paramedic License application form as specified in Section 100093.07.
(D) Provide documentation of successful completion of no less than 40 advanced life support patient contacts during an approved paramedic training program field internship, as specified in Section 100092.05(a), or a letter on official letterhead by a paramedic employer, training program director, or medical director verifying applicant's successful completion of 40 ALS patient contacts as defined in section 100092.06(b), in an approved paramedic service provider field environment.
(E) Pay the established fees pursuant to Section 100097.02.
(F) Submit a completed Request for Licensure/Certification Verification Form # VL-01 01/2024, if applicable.
(G) Provide documentation of a current paramedic NREMT registration or proof of passing the paramedic licensure cognitive written and psychomotor skills exams within the last two (2) years.
1. If a letter of support is required by the NREMT to take the paramedic licensure cognitive written or psychomotor skills exams, the applicant shall notify the Authority. The Authority shall review an applicant's completed and signed application for eligibility to provide a letter of support to NREMT.
(H) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code
(b) If a letter of support is required by the NREMT to take the paramedic licensure cognitive written or psychomotor skills exams, the applicant shall be required to submit the appropriate application as identified in section 100094.01(a) and at least one of the following to the Authority:
(1) Documentation showing the applicant is currently licensed as an out-of-state paramedic.
(2) Documentation showing proof of completion of a state, or country, approved or CAAHEP accredited paramedic training program within the past two (2) years.

(3) Documentation showing applicant's training program course content is equivalent or surpasses the content and hours of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077E.
(c) 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.
(d) The Authority shall issue within forty-five (45) calendar days of receipt of a completed application as specified in Section 100093.07(e) a wallet-sized license to eligible individuals who apply for a license and successfully complete the licensure requirements.
(e) The initial paramedic license's effective date shall be the day the license is issued. The license shall be valid for a period of two (2) years; beginning on the effective date through the last day of the approval month in the second year.
(f) The paramedic shall be responsible for notifying the 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.
(g) 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.
(h) An individual currently licensed as a paramedic by the provision of this section may function as an EMT and/or an AEMT, except when the paramedic license is under suspension, with no further testing or certification process required. If a separate EMT or AEMT certificate is sought the certifying entity shall follow the EMT, or AEMT certification/recertification provisions as specified in Chapters 3.1 and 3.2 of this Division.
(i) 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 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 100095 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 1797.56, 1797.63, 1797.172, 1797.175, 1797.177, 1797.185, 1797.194 and 1798.200, Health and Safety Code; and Section 15376, Government Code.

§ 100094.02. 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 100097.02.
(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 100096.01.
(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 Renewals, License Audit Renewals and License Reinstatements

§ 100095. License Renewal, License Audit Renewal, and License Reinstatement.

(a) In order to be eligible for renewal of a non-lapsed paramedic license, an individual shall comply with the requirements in subdivisions (1) through (5) below:
(1) Possess a current paramedic license issued in California.
(2) Complete forty-eight (48) hours of CE pursuant to the provisions of Chapter 3.5 of this Division.
(3) Complete and submit the Renewal Paramedic License Application, Form #RL-01, revised 01/2024.
(4) If applicant is selected for audit, submit to the Authority a signed and completed Audit Renewal Paramedic License Application, Form #AR-01, revised 01/2024.
(A) Applicants selected for audit shall submit documentation of forty-eight (48) hours of CE completion, as specified in (a)(2) of this section.
(5) Pay the appropriate fees as specified on the application in accordance with Section 100097.02 of this Chapter.
(6) EMSA will send a renewal reminder notification by mail to the paramedic, approximately five (5) months prior to their paramedic license expiration date.
(b) In order for an individual whose license has lapsed to be eligible for license reinstatement, the following requirements shall apply:
(1) For a license lapsed less than six (6) months, the individual shall submit:
(A) Forty-eight (48) hours of CE pursuant to the provisions of Chapter 3.5 of this Division with copies of the CE Certificates.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100097.02 of this Chapter.
(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed Less than 1 year, specified in Section 100093.07(a)(6)(A),
(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 01/2024, shall be submitted to the Authority for each state or country the applicant was licensed/certified.
(2) For a license lapsed six (6) months or more, but less than twelve (12) months, the individual shall:
(A) Submit sixty (60) hours of CE pursuant to the provisions of Chapter 3.5 of this Division, with copies of the CE Certificates.
(B) Pay the appropriate fees as specified on the application in accordance with Section 100097.02 of this Chapter.
(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed less than 1 year, as specified in Section 100093.07(a)(6)(A).
(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 01/2024, shall be submitted to the Authority for each state or country the applicant was licensed/certified.
(3) For a license lapsed twelve (12) months or more, but less than twenty-four (24) months, the individual shall:
(A) Provide documentation of passing the licensure examinations within the past two (2) years as specified in Sections 100090.12 and 100090.02 or provide documentation of a current paramedic registration issued by the NREMT,
(B) Submit seventy-two (72) hours of CE pursuant to the provisions of Chapter 3.5 of this Division, with copies of the CE Certificates.
(C) Pay the appropriate fees as specified on the application in accordance with Section 100097.02 of this Chapter,
(D) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code
(E) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed 1 year or more, specified in Section 100093.07(a)(6)(B),
(F) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 01/2024, shall be submitted to the Authority for each state or country the applicant was licensed/certified.
(4) For a lapse of twenty-four (24) months or more, the individual shall:
(A) Provide documentation of passing the licensure examinations within the past two (2) years as specified in Sections 100090.12 and 100090.02 or provide documentation of a current paramedic registration issued by the NREMT.
(B) Pay the appropriate fees as specified on the application in accordance with Section 100097.02 of this Chapter.
(C) Submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Form, BCII 8016 (Rev 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code.
(D) Submit a signed and completed Reinstatement Paramedic License Application, lapsed 1 year or more, specified in Section 100093.07(a)(6)(B).
(E) Documentation of seventy-two (72) hours of CE that shall include completion of the following courses, or their equivalent:
1. Advanced Cardiac Life Support,
2. Pediatric Advanced Life Support,
3. Prehospital Trauma Life Support or International Trauma Life Support,
4. CPR.
(F) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 01/2024, shall be submitted to the Authority for each state or country the applicant was licensed/certified.
(c) Renewal of a license shall be for two (2) years. If the renewal requirements are met within six (6) months 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) Reinstated licenses shall be valid for a period of two (2) years beginning on the date of issuance through the last day of the approved month in the second year.
(e) Within forty-five (45) calendar days of receiving the application, the Authority shall notify the applicant that the application has been approved or specify what information, if any, is missing.
(f) An individual, who is a member of the Armed Forces of the United States, whose paramedic license expires during the time the individual is on active duty or license expires 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 following 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 100095(a)(2) through (a)(5) of this Chapter, except the individual will not be subject to the $50 late renewal application fee specified in Section 100097.02(b)(4).
(3) Provide documentation showing the CEs were received no sooner 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 months from the date of deactivation/release from active duty.
(A) Individuals whose active duty required them to use their paramedic skills may be given credit for documented training that meets the requirements of Chapter 3.5, 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

§ 100096.01. 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 10 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.

§ 100096.02. 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 local 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.

§ 100096.03. 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, is treated on scene without transport, or when the patient refuses care or transport.
(6) Requirements for the initiation, completion, review, evaluation, and retention of an electronic health record (EHR) as specified in this Chapter. These requirements shall address but not be limited to:
(A) Initiation of an electronic health 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, authorized registered nurse, 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, authorized registered nurse, 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.
(5) Ensuring the EMSQIP methods of evaluation 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 10 of this Division.
(d) In circumstances where use of a base hospital as defined in Section 100096.02 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 1797.106, 1797.107, 1797.172 and 1797.176, Health and Safety Code. Reference: Sections 1204, 1206, 1797.56, 1797.90, 1797.114, 1797.172, 1797.202, 1797.220, 1797.227, 1798, 1798.2, 1798.3, 1798.101 and 1798.105, Health and Safety Code; and Section 5404, Welfare and Institutions Code.

Article 8: Record Keeping and Fees

§ 100097.01. 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 program 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, program 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, in a timely manner, the electronic health record referenced in Section 100096.03(a)(6) compliant with the current versions of the National EMS Information System and the California EMS Information System, 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 or date of birth;
(C) Gender;
(D) Weight, if necessary for treatment;
(E) Address;
(F) Chief complaint; and
(G) Vital signs.
(7) Appropriate physical assessment.
(8) Primary Provider Impression.
(9) The emergency care rendered and the patient's response to such treatment.
(10) Patient disposition.
(11) The time of departure from scene.
(12) The time of arrival at receiving facility (if transported).
(13) Time patient care was transferred to receiving facility.
(14) The name of receiving facility (if transported).
(15) The name(s) and unique identifier number(s) of the paramedics.
(16) Signature(s) of the paramedic(s).
(f) A LEMSA shall establish policies for the collection, utilization, storage and secure transmission of interoperable electronic health records.
(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures.
(h) The LEMSA shall submit the electronic health record data to the Authority within seventy-two (72) hours after completion of the patient encounter, or at longer intervals if established by written agreement between the LEMSA and the Authority.

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, 1797.208 and 1797.227, Health and Safety Code.

§ 100097.02. 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 nonrefundable licensing fees established by the Authority:
(1) The Initial In-State Paramedic License application fee shall be two hundred fifty ($250) dollars.
(A) Effective July 1, 2020 through June 30, 2021, the Initial In-State Paramedic License application fee shall be two hundred seventy-five ($275) dollars.
(B) Effective July 1, 2021 and thereafter the Initial In-State Paramedic License application fee shall be three hundred ($300) dollars.
(2) The Initial Out-of-State Paramedic License application fee shall be three hundred ($300) dollars.
(A) Effective July 1, 2020 through June 30, 2021, the Initial Out-of-State Paramedic License application fee shall be three hundred twenty-five ($325) dollars.
(B) Effective July 1, 2021 and thereafter the Initial Out-of-State Paramedic License application fee shall be three hundred fifty ($350) dollars.
(3) The Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100093.07(b) of this Chapter, shall be two hundred dollars ($200) .
(A) Effective July 1, 2020 through June 30, 2021, the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100093.07(b) of this Chapter, shall be two hundred twenty-five ($225) dollars.
(B) Effective July 1, 2021 and thereafter the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100093.07(b) of this Chapter, shall be two hundred fifty ($250) dollars.
(4) The fee for failing to submit a complete application for renewal, as specified in Section 100093.07(e), within the timeframe specified in Section 100093.07(b) shall be a late fee in the amount of fifty dollars ($50.00).
(5) The fee for state and criminal history records shall be in accordance with the schedule of fees established by the California DOJ and the Federal Bureau of Investigations.
(6) The fee for a duplicate or replacement of a license shall be ten dollars ($10).
(7) The fee for approval and re-approval of a CE provider shall be two thousand five hundred ($2,500) dollars.
(8) The fee for administration of the provisions of Section 17520 of the Family Code shall be five dollars ($5); which is incorporated into the fees specified commencing with Section 100097.02(b)(1).
(9) The Reinstatement Paramedic License Application fee shall be two hundred fifty dollars ($250).
(A) Effective July 1, 2020 through June 30, 2021, the Reinstatement Paramedic License Application fee shall be two hundred seventy-five ($275) dollars.
(B) Effective July 1, 2021 and thereafter the Reinstatement Paramedic License Application fee shall be three hundred ($300) dollars.
(10) The Initial Challenge Paramedic License Application fee shall be three hundred dollars ($300).
(A) Effective July 1, 2020 through June 30, 2021, the Initial Challenge Paramedic License Application fee shall be three hundred twenty-five ($325) dollars.
(B) Effective July 1, 2021 and thereafter the Initial Challenge Paramedic License Application fee shall be three hundred fifty ($350) dollars.
(11) The fee for dishonored checks shall be twenty-five dollars ($25).

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; Section 11105, Penal Code; and Section 1719, Civil Code.

Chapter 3.4: Emergency Medical Technician:

Article 1: Personnel

§ 100098. 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 1797.170, 1797.171, 1797.172, 1797.175, 1797.176, 1797.178, 1797.214, 1797.218, 1798 and 1798.6, Health and Safety Code.

Chapter 3.5: EMS Continuing Education

Article 1: Definitions

§ 100099.01. 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.

§ 100099.02. 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.

§ 100099.03. Continuing Education Hour (CEH).
(a) One continuing education hour (CEH) is any one of the following:
(1) Every fifty (50) 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 (1) 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 (15) 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 100100.01(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.

§ 100099.04. 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.

§ 100099.05. EMS Service Provider.

"EMS Service Provider" means an employer or organization with the oversight and administration of certified EMT-I, certified EMT-II, licensed paramedic, and public safety 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.

§ 100099.06. 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 10 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.

§ 100099.07. 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.

§ 100099.08. 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

§ 100100.01. 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 100100.02(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 100069.01 of chapter 3.1, 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.

§ 100100.02. 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 (50) 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 (50) 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

§ 100101. 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 100100.02(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 100104, 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

§ 100102.01. 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 100097.02 of Chapter 3.3, 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.

§ 100102.02. 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 100104 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

§ 100103. 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

§ 100104. 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 100102.01(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.

Chapter 4. Discipline

Chapter 4.1: EMT and Advanced EMT Disciplinary Action

Article 1: Definitions

§ 100105.01. 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.

§ 100105.02. 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: Sections 1797.204 and 1798.200, Health and Safety Code.

§ 100105.03 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.

§ 100105.04. 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.

§ 100105.05. 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) of the Health and Safety 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.

§ 100105.06. Discipline.
“Discipline” means either a disciplinary plan taken by a relevant employer pursuant to Section 100105.05 of this Chapter or certification action taken by a medical director pursuant to Section 100105.08 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: Sections 1797.61, 1798.200 and 1798.204, Health and Safety Code.

§ 100105.07. 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.

§ 100105.08. Medical Director.
For the purposes of this Chapter, “medical director” means the medical director of the LEMSA, 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.

§ 100105.09. 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: Sections 1797.61, 1798.200 and 1798.204, Health and Safety Code.

§ 100105.10. 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.

§ 100105.11. 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, 179.176, 1797.184 and 1798.204, Health and Safety Code. Reference: Sections 1797.61, 1798.200 and 1798.204, Health and Safety Code.

Article 2: General Provisions

§ 100106.01. 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 Chapters 3.2 and 3.4 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.

§ 100106.02. 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 judgement 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.

§ 100106.03. 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.

§ 100106.04. 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 entering the information 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

§ 100107.01. 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.

§ 100107.02. 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; and Sections 3250 and 27727, Government Code. Reference: Sections 1797.90, 1797.176, 1797.202, 1797.220 and 1798.204, Health and Safety Code.

§ 100107.03. 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

§ 100108.01. 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 100106.04 (c) of this Chapter, it shall take effect upon the date the notice required by Section 100108.02 of this Chapter is mailed to the certificate holder.

(d) For all other certification actions, the effective date shall be thirty (30) 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.

§ 100108.02. 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 100108.06 (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, 1798.100, 1798.200 and 1798.204, Health and Safety Code.

§ 100108.03. 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 100107.03 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: Authority cited: Section 1797.184, Health and Safety Code. Reference: Section 1798.200, Health and Safety Code.

§ 100108.04. Placement of a Certificate Holder on Probation.
Pursuant to Section 100106.01, 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, 1797.184, 1797.202, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

§ 100108.05. 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.

§ 100108.06. 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 100107.01(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.
Note: Authority cited: Sections 1797.107, 1797.176, 1797.184 and 1798.204, Health and Safety Code; and Section 11522, Government Code. Reference: Sections 1797.61, 1797.62, 1797.118, 1797.176, 1797.202, 1797.216, 1797.220, 1798, 1798.200 and 1798.204, Health and Safety Code.

§ 100108.07. 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

§ 100109.01. 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.

§ 100109.02. 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.

Article 6: Background Checks for EMT and Advanced EMT

§ 100110.01. Responsibility of the Initial and Recertification Applicant.
(a) Starting July 1, 2010, unless all the requirements and conditions as specified below in Section 100110.02 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 100221.02(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; and Sections 11075 and 11105.2, Penal Code.

§ 100110.02. 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 2.3 of this Division) has fulfilled all the requirements specified within subsection 100110.02(a)(1)(2)(3), then the condition stated in the second sentence of subsection 100110.02(a)(3) may apply. To qualify for that subsection 100110.02(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 100108.06(c) of chapter 4, of this Division. Upon receipt of this written notification by the Authority, the requirement specified in subsection 100110.01(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 100221.02(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; and Sections 11075 and 11105.2, Penal Code.

§ 100110.03. 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; and Sections 11075 and 11105.2, Penal Code.

Chapter 4.2 Paramedic Discipline

Article 1: Discipline and Reinstatement of License

§ 100111.01. 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.

§ 100111.02. 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.

§ 100111.03. 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 judgement 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.

§ 100111.04. 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.

Article 2: Paramedic Scope of Practice, Accreditation, and Discipline.

§ 100112.01. Paramedic Scope of Practice, Accreditation, and Discipline.

(a) Scope of Practice. A community paramedic or triage paramedic shall utilize the paramedic scope of practice, approved LEMSA local optional scope as identified in section 100091.02 of this division, and trial study scope identified in section 100091.03 of this Division. This includes utilizing their general paramedic scope and other approved scopes while transporting to alternate destinations, providing care to discharged patients, providing vaccinations, and through other conditions as identified in approved community paramedicine and triage to alternate destination programs.

(b)Community Paramedic Accreditation to Practice.

(1) A community paramedic shall only utilize community paramedicine skills when accredited by the LEMSA as a community paramedic within that LEMSA jurisdiction and when associated with that LEMSA’s overseen EMSA approved Community Paramedicine Program(s).

(2) The LEMSA shall register the community paramedic accreditation in the Central Registry public look-up database within five (5) business days of the community paramedic accreditation application being approved.

(3) An initial community paramedic accreditation is deemed effective when recorded in the Central Registry public look-up database.

(4) An initial community paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation.
(5) Community paramedic accreditation shall require renewal every two (2) years by the LEMSA that oversees EMSA approved community paramedic program(s) in the jurisdiction in which the community paramedic is associated.
(c) Initial Community Paramedic Accreditation Application Requirements and Process.
(1) To be community paramedic accredited, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:
(A) Proof of an active, unrestricted California issued paramedic license,
(B) Social Security Number or Individual Tax Identification Number,
(C) LEMSA approved community paramedicine course completion certificate, and
(D) Proof of passing the IBSC community paramedic examination for community paramedics within the last two (2) years of the date of application submission.
(2) The LEMSA shall review the submitted eligibility criteria for community paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
(A) The submission is incomplete or illegible and requires corrective action, or
(B) The accreditation request has been approved and the accreditation data has been entered into the Central Registry public look-up database, or
(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.
(d) Renewal Community Paramedic Accreditation Requirements and Process.
(1) To be eligible for renewal, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:
(A) Proof of a current, unrestricted California issued paramedic license, and either,
(i) Show proof of completion of eight (8) hours approved community paramedicine related continuing education (CE) every two (2) years, or
(ii) Show proof of continued active, unrestricted IBSC.
(2) The LEMSA shall review the submitted eligibility criteria for community paramedicine accreditation renewal and notify the applicant in writing within thirty (30) business days from the date of submission that:
(A) The submission is incomplete or illegible and required corrective action, or
(B) The accreditation request has been approved and renewal data is updated in the Central Registry public look-up database.
(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.
(e) Reinstatement Community Paramedic Accreditation Requirements and Process.
(1) To be eligible for reinstatement of a community paramedic accreditation that has expired for a period of twelve (12) months or less, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:
(A) Proof of a current, unrestricted California issued paramedic license, and either,
(i) Proof of completion of eight (8) hours of approved local community paramedicine related CE, or
(ii) Show proof of continued active, unrestricted IBSC.
(2) To be eligible for reinstatement of a community paramedic accreditation that has expired more than twelve (12) months, the applicant shall submit to the community paramedic program(s) LEMSA the following eligibility criteria for review:
(A) Proof of an active, unrestricted California issued paramedic license,
(B) Proof of successful completion of a LEMSA approved community paramedicine course within the last two (2) years from the submission date of the reinstatement application, and
(C) Proof of passing the IBSC Community Paramedic examination within the last two (2) years from the submission date of the reinstatement application.
(3) The LEMSA shall review the community paramedic accreditation application and notify the applicant in writing within thirty (30) business days from the date of submission that the application is:
(A) Incomplete or illegible and requires corrective action, or
(B) The accreditation application has been approved and the accreditation data entered in the Central Registry public look-up database, or
(C) The accreditation request has been denied; including the reason for the denial and notification of the applicant's right to appeal.
(f) Triage Paramedic Accreditation to Practice.

(1) A triage paramedic shall only utilize triage to alternate destination skills when accredited by the LEMSA as a triage paramedic within that LEMSA's jurisdiction and when associated with that LEMSA's approved triage to alternate destination service program(s).
(2) The LEMSA shall register the triage paramedic accreditation in the Central Registry public look-up database within five (5) business days of the triage paramedic accreditation application being approved.
(3) An initial triage paramedic accreditation is deemed effective when recorded in the Central Registry public look-up database.
(4) An initial triage paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation.
(5) Triage paramedic accreditation shall require renewal every two (2) years by the LEMSA that oversees EMSA approved triage to alternate destination service program(s) in the jurisdiction in which the triage paramedic is associated.
(g) Initial Triage Paramedic Accreditation Application Requirements and Process.
(1) To be triage paramedic accredited, the applicant shall submit to the triage program(s) LEMSA the following eligibility criteria for review:
(A) Proof of an active, unrestricted California issued paramedic license,
(B) Social Security Number or Individual Tax Identification Number, and
(C) LEMSA approved triage paramedicine course completion certificate.
(2) The LEMSA shall review the submitted eligibility criteria for triage paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
(A) The submission is incomplete or illegible and requires corrective action, or
(B) The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database, or
(C) The accreditation request has been denied; including the reason for the denial and notification of the applicant's right to appeal.
(h) Renewal Triage Paramedic Accreditation Requirements and Process.
(1) To be eligible for renewal, the applicant shall submit to the triage Paramedicine program(s) LEMSA the following eligibility criteria for review:
(A) Proof of a current, unrestricted California issued paramedic license, and
(B) Proof of completion of four (4) hours of approved local triage paramedicine related CE.
(2) The LEMSA shall review the submitted eligibility criteria for triage paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
(A) The submission is incomplete or illegible and required corrective action, or
(B) The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.
(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.
(i) Reinstatement Triage Paramedic Accreditation Requirements and Process.
(1) To be eligible for reinstatement of a triage paramedic accreditation that has expired twelve (12) months or less, the applicant shall submit to the triage paramedic program(s) LEMSA the following eligibility criteria for review:
(A) Proof of a current, unrestricted California issued paramedic license, and
(B) Proof of completion of four (4) hours of approved local triage paramedic related CE.
(2) To be eligible for reinstatement of a triage paramedic certification that has been expired more than twelve (12) months, the applicant shall submit to the triage paramedicine program(s) LEMSA the following eligibility criteria for review:
(A) Proof of a current, unrestricted California issued paramedic license, and
(B) Proof of successful completion of a LEMSA approved triage to alternate destination training course within the last year from the submission date of the reinstatement application.
(3) The LEMSA shall review the submitted eligibility criteria for triage paramedic accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
(A) The submission is incomplete or illegible and required corrective action, or
(B) The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.
(C) The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

(j) A LEMSA that authorizes community paramedicine or triage paramedic personnel, shall be responsible for submission of a summary data report of authorized personnel to the Authority no later than the thirtieth (30th) calendar day of January, April, July, and October.
(k) The disciplinary procedures for a community paramedic or triage paramedic shall be consistent with subsection (d) of Section 1797.194 of the Health and Safety Code.
Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1797.117, 1797.194, 1830, 1831, 1843, 1852, 1853, and 1854, Health and Safety Code.

Chapter 5. Community Paramedicine and Triage to Alternate Destination

Article 1: Definitions

§ 100115.01. Alternate Destination Facility
“Alternate destination facility” means a treatment location that is an authorized mental health facility, as defined in Section 1812 of the Health and Safety Code or an authorized sobering center as defined in Section 1813 of the Health and Safety Code. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.02. Authorized Mental Health Facility
“Authorized mental health facility” means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subsection (a) or (b) of Section 1250 of the Health and Safety Code, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, or licensed health facility, or certified crisis stabilization unit. An authorized mental health facility may also be a psychiatric health facility licensed by the State Department of Health Care Services. The facility shall be staffed at all times with at least one registered nurse. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.03. Authorized Sobering Center
“Authorized sobering center” a non-correctional facility that is staffed at all times with at least one registered nurse, that provides a safe, supportive environment for intoxicated individuals to become sober, that is identified as an alternate destination in a plan developed pursuant to Section 1843 of the Health and Safety Code, and that meets any of the following requirements:
(1) The facility is a federally qualified health center, including a clinic described in subsection (b) of Section 1206 of the Health and Safety Code.
(2) The facility is certified by the State Department of Health Care Services, Substance Use Disorder Compliance Division to provide outpatient, nonresidential detoxification services.
(3) The facility has been accredited as a sobering center under the standards developed by the National Sobering Collaborative. Facilities granted approval for operation by Office of Statewide Health Planning and Development (OSHPD) before November 28, 2017, under the Health Workforce Pilot Project No. 173, may continue operation until one year after the National Sobering Collaborative accreditation becomes available.
Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.04. Community Paramedic
“Community paramedic” means a paramedic licensed under Division 2.5 of the Health and Safety Code who has completed the curriculum for community paramedic training, has received certification in one or more of the community paramedicine program specialties described in Section 1815 of the Health and Safety Code, and is accredited to provide community paramedic services by a local EMS agency (LEMSA) as part of an approved community paramedicine program. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.05. Community Paramedic Training Program

“Community paramedic training program” means a training program approved by the LEMSA to provide certification of completion of didactic education and clinical experience in this area. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.06. Community Paramedicine Program

“Community paramedicine program” means a program developed by a LEMSA and approved by the Emergency Medical Services Authority (the Authority or EMSA) to provide community paramedicine services consisting of one or more of the program specialties described in Section 1815 of the Health and Safety Code under medical protocols developed by the LEMSA that are consistent with the minimum medical protocols established by the Authority. Community paramedicine program specialties include:

(1) Providing directly observed therapy (DOT) to persons with tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease.

(2) Providing case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.07. Community Paramedicine Provider

“Community paramedicine provider” means an advanced life support (ALS) provider authorized by a LEMSA to provide ALS services who has entered into a contract to deliver community paramedicine services as described in Section 1815 of the Health and Safety Code as part of an approved community paramedicine program developed by a LEMSA and approved by the Authority. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.08. Public Agency

“Public agency” means a city, county, city and county, special district, or other political subdivision of the state that proves first response services, including emergency medical care. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.09. Triage Paramedic

“Triage paramedic” means a paramedic licensed under this Division who has completed the curriculum for triage paramedic services adopted pursuant to paragraph (2) of subsection (d) of Section 1830 of the Health and Safety Code and has been accredited by a LEMSA in one or more of the triage paramedic specialties described in Section 1819 of the Health and Safety Code as part of an approved triage to alternate destination program. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.10. Triage Paramedic Training Program

“Triage paramedic training program” means a training program approved by LEMSA to provide certification of completion of didactic and clinical experience and that includes a final comprehensive competency-based exam to test the knowledge and skills specified in this Chapter to provide triage paramedic services. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.11. Triage to Alternate Destination Program

“Triage to alternate destination program” means a program developed by a LEMSA and approved by the Authority to provide triage paramedic assessments under triage and assessment protocols developed by the LEMSA that are consistent with the minimum triage and assessment protocols established by the Authority in one or more specialties including:

(1) Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's hospice agency until the hospice nurse arrives to treat the patient.
(2) Providing patient with ALS triage and assessment by a triage paramedic and transportation to an alternate destination facility, as defined in Section 1811 of the Health and Safety Code.
(3) Providing transport services for patients who identify as veterans and desire to transport to a local veteran's administration emergency department for treatment, when appropriate. Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

§ 100115.12. Triage to Alternate Destination Provider
"Triage to alternate destination provider" means an advanced life support provider authorized by a LEMSA to provide ALS triage paramedic assessments as part of an approved triage to alternate destination program specialty as described in Section 1819 of the Health and Safety Code.
Note: Authority cited: Sections 1797.107 and 1830, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, and 1820, Health and Safety Code.

Article 2: General Provisions

§100116.01. General Provisions
(a) A LEMSA that elects to implement a community paramedicine or triage to alternate destination program pursuant to Section 1840 of the Health and Safety Code shall develop and, prior to implementation, submit a plan for that program to the Authority for review and approval.
(b) If a LEMSA within the county elects to develop a community paramedicine or triage to alternate destination program pursuant to Section 1840 of the Health and Safety Code, the county board of supervisors, or in the case of a city and county, the mayor, shall establish an emergency medical care committee to advise the LEMSA on the development of the program and other matters relating to emergency medical services (EMS). Where a committee is already established for the purposes described in this article, the county board of supervisors or the mayor, shall ensure that the membership meets or exceeds the requirements of Section 1797.273, subsection (b) of the Health and Safety Code.
(c) No person or organization shall offer a community paramedicine or triage paramedic training program or hold themselves out as offering a community paramedicine or triage paramedic training program or hold themselves out as providing ALS services utilizing community paramedic personnel for the delivery of community paramedicine care unless that person or organization is authorized by the LEMSA to provide those services as part of a community paramedicine or triage to alternate destination program approved by the Authority in accordance with Section 1835 of the Health and Safety Code.
Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1797.259, 1797.273, 1815, 1830, 1840, and 1851, Health and Safety Code.

§ 100117.01. Program Requirements and Minimum Standards
(a) A LEMSA that elects to develop a community paramedicine or triage to alternate destination program shall do all the following:
(1) Integrate the proposed community paramedicine or triage to alternate destination program into the LEMSA's EMS plan described in Article 2 (commencing with Section 1797.250) of Chapter 4 of the Health and Safety Code.
(2) Provide medical control and oversight for the program(s).
(3) Approve, annually review, and facilitate any necessary agreements with one or more community paramedicine or triage to alternate destination providers for the delivery of community paramedicine or triage to alternate destination services within the LEMSA's jurisdiction.
(4) Prohibit triage and assessment protocols or a triage paramedic's decision to authorize transport to an alternate destination facility from being based on, or affected by, a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subsection (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.
(5) Facilitate funding discussions between a community paramedicine provider, triage to alternate

destination provider, or incumbent emergency medical transport provider and public or private health system participants to support the implementation of the LEMSA's community paramedicine or triage to alternate destination program.
(6) Coordinate, review, and approve any agreements necessary for the provision of community paramedicine specialties as described in Section 1815 of the Health and Safety Code consistent with all the following:
(A) Provide a first right of refusal to the public agency or agencies within the jurisdiction of the proposed program area to provide the proposed program specialties for community paramedicine. If the public agency or agencies agree to provide the proposed program specialties for community paramedicine, the LEMSA shall review and approve any written agreements necessary to implement the program with those public agencies.
(B) Review and approve agreements with community paramedicine providers that partner with a private provider to deliver those program specialties.
(C) If a public agency declines to provide the proposed program specialties pursuant to paragraph (A) or (B), the LEMSA shall develop a competitive process held at periodic intervals to select community paramedicine providers to deliver the program specialties.
(7) Establish a process to verify training and accreditation of community paramedics in each of the proposed community paramedicine program specialties described in subsections (a) and (b) of Section 1815 of the Health and Safety Code, and a process to verify and training and accreditation of triage paramedics in each of the areas described in Section 1819 of the Health and Safety Code.
(8) A LEMSA may exclude an existing ALS provider from the plan if it determines that the provider's participation will negatively impact patient care. If a LEMSA elects to exclude an ALS provider, the LEMSA shall do both of the following:
(A) Report to the Authority at the time the program is submitted for approval, the specific reasons for excluding an ALS provider.
(B) Inform the ALS provider of the reasons for exclusion.
(9) Facilitate any necessary agreements to ensure continuity of care and efficient transfer of care between the triage to alternate destination provider and the existing emergency medical transport provider to ensure transport to the appropriate facility.
(10) At the discretion of the LEMSA medical director, develop additional triage and assessment protocols commensurate with the need of the local programs authorized under this Chapter.
(11) Secure an agreement with the alternate destination facility that requires the facility to notify the LEMSA within twenty-four (24) hours if there are changes in the status of the facility with respect to protocols and the facility's ability to care for patients.
(12) Secure an agreement with the alternate destination facility that requires the facility to operate in accordance with Section 1317 of the Health and Safety Code. The agreement shall provide that failure to operate in accordance with Section 1317 of the Health and Safety Code shall result in the immediate termination of use of the facility as part of the triage to alternate destination program.
(13) In implementing a triage to alternate destination program specialties described in Section 1819 of the Health and Safety Code, continue to use, and coordinate with, any emergency medical transport providers operating within the jurisdiction of the local LEMSA pursuant to Section 1797.201 or 1797.224 of the Health and Safety Code. The LEMSA shall not in any manner eliminate or reduce the services of the emergency medical transport providers.
(14) Establish a process for training and accreditation of triage paramedics in each of the proposed triage to alternate destination program's specialties described in Section 1819 of the Health and Safety Code.
(15) Approve and annually review community paramedicine and triage to alternate destination training programs.
(16) Coordinate community paramedic personnel and training program(s).
(17) Notify the Authority of any reported complaints or unusual occurrences for any approved community paramedicine or triage to alternate destination program within seventy-two (72) hours of receiving them along with any supporting or explanatory documentation.
(b) The LEMSA shall write into program policy and ensure through program oversight that any patient who meets the triage criteria for transport to an alternate destination facility, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.
(c) The LEMSA shall require in policy that a patient who is transported to an alternate destination facility and, upon assessment, is found to no longer meet the criteria for admission to an alternate destination

facility, be immediately transported to the emergency department of a general acute care hospital.
(d) For any patient requiring secondary transfer from an alternate destination facility to an emergency department, the LEMSA shall require alternate destination facilities to send with each patient at the time of transfer or, in the case of an emergency, as promptly as possible, copies of all medical records related to the patient's transfer. To the extent practicable and applicable to the patient's transfer, the medical records shall include current medical findings, diagnosis, laboratory results, medications provided prior to transfer, a brief summary of the course of treatment provided prior to transfer, ambulation status, nursing and dietary information, name and contact information for the treating provider at the alternate destination facility, and, as appropriate, pertinent administrative and demographic information related to the patient, including name and date of birth. The requirements in this paragraph do not apply if the alternate destination facility has entered into a written transfer agreement with a local hospital that provides for the transfer of medical records.
(e) The LEMSA shall ensure that facilities participating in the triage to alternate destination program shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.
Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830, 1831, 1841, 1842, and 1843, Health and Safety Code.

§ 100118.01.Community Paramedicine, Triage to Alternate Destination, and Alternate Destination Facility Providers Program Requirements, Oversight and Withdrawal
(a) LEMSAs that approve a community paramedicine, triage to alternate destination, or alternate destination facility provider. shall annually conduct a review of community paramedicine, triage to alternate destination, or alternate destination facility providers programs to ensure compliance with all requirements.
(b) A community paramedicine, triage to alternate destination, or alternate destination facility providers program's failure to comply with the provisions of statute, regulation, and/or any additional LEMSA requirements may result in denial, probation, suspension, or revocation of approval by the LEMSA. Not complying with this subsection is considered noncompliance.
(c) The procedure for notifying a community paramedicine, triage to alternate destination, or alternate destination facility providers programs of noncompliance shall be as follows:
(1) Within ten (10) days of a LEMSA finding noncompliance by a community paramedicine, triage to alternate destination, or alternate destination facility provider, the LEMSA shall provide a written notification of noncompliance to the community paramedicine, triage to alternate destination, or alternate destination facility provider, including the specific requirements they failed to meet. The notification shall be sent by certified mail to the director.
(2) Within fifteen (15) days from receipt of the notification, the community paramedicine, triage to alternate destination, or alternate destination facility provider shall submit, in writing and by certified mail, to the LEMSA one of the following:
(A) Evidence of compliance, or
(B) A plan to comply within sixty (60) days from the day of receipt of the notification of noncompliance.
(3) Within fifteen (15) days from receipt of the community paramedicine, triage to alternate destination, or alternate destination facility provider's response, or within thirty-five (35) days from the mailing date of the notification of noncompliance if no response is received from the community paramedicine, triage to alternate destination, or alternate destination facility provider, the LEMSA shall issue a decision letter by certified mail to the Authority and the community paramedicine, triage to alternate destination, or alternate destination facility provider. The letter shall identify the LEMSA's decision to take one or more of the following actions based on relevant factors such as severity of noncompliance, actual or potential harm to public health, safety, and welfare, or history of compliance or noncompliance as provided in subsection (b) of this section:
(A) Accept the evidence of compliance provided.
(B) Accept the plan for meeting compliance provided.
(C) Place the community paramedicine, triage to alternate destination, or alternate destination facility provider on probation.
(D) No sooner than five (5) days after the LEMSA's decision suspend or revoke the community paramedicine, triage to alternate destination, or alternate destination facility provider.
(4) The decision letter shall also include, but not be limited to, the following information:
(A) Date of the LEMSA's decision,
(B) Specific requirements that LEMSA found the community paramedicine, triage to alternate destination, or alternate destination facility provider failed to meet,

(C) The probation or suspension effective and ending date, if applicable,
(D) The terms and conditions of the probation or suspension, if applicable, and
(E) The revocation effective date, if applicable.
(5) The LEMSA that approves a community paramedicine, triage to alternate destination, or alternate destination facility provider shall establish the probation, suspension, or revocation effective dates no sooner than five (5) days after the date of the community paramedicine provide community paramedicine, triage to alternate destination, or alternate destination facility provider had been notified under subsection (c)(3) of this Section.
(6) EMSA retains authority to take any necessary action against a community paramedicine, triage to alternate destination, or alternate destination facility provider for failure to meet the requirements of this Chapter or the community paramedicine or triage to alternate destination program requirements of the LEMSA. Such action may be taken in addition to any actions taken by the LEMSA and may include immediate suspension or revocation.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1811, 1812, 1813, 1830, 1831, 1832, 1840, 1841, and 1842, Health and Safety Code.

§ 100119.01. Documentation and Data Submission
(a) Community paramedics and triage paramedics shall complete and submit electronic patient care records in accordance with Title 22 California Code of Regulations Section 100097.01.
(b) Community paramedics and triage paramedics providers shall document destination facility with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS).
(c) Community paramedicine or triage to alternate destination programs shall exchange electronic patient health information (HIE) between community paramedicine or triage to alternate destination providers and health providers and facilities. The Authority may grant a one-time temporary waiver based on the proposed plan and timeline to achieve Electronic HIE functionality, not to exceed five (5) years of this requirement for alternate destination facilities that are unable to immediately comply with the electronic patient health information requirement. A plan to establish HIE shall accompany any request for a waiver.
(d) Community paramedicine programs shall submit to the LEMSA at minimum a quarterly summary of patient outcomes, which are due by January 30, April 30, July 30, and October 30 each year, in an EMSA provided template with the following data:
(1) For programs which provide directly observed therapy (DOT) to persons with Tuberculosis:
(A) Total patients enrolled who completed therapy successfully.
(B) Total patients enrolled who are still in the treatment program.
(C) Total number of patients enrolled who did not complete treatment successfully.
(2) For programs which provide case management services to EMS high utilizers, a summary of the reduction in EMS utilization, and any other impacts of the program.
(e) Alternate destination facilities shall submit to the LEMSA at minimum a quarterly summary of patient outcomes with an EMSA provided template, the following data:
(1) Total number of patients evaluated who were transported by EMS.
(2) Total number of these patients who were treated and released
(3) Total number of these patients who were transferred to an acute care emergency department.
(4) Total number of these patients admitted to another care facility.
(5) Total number of these patients who experienced an adverse event resulting from services provided under this program.
(f) LEMSAs shall submit quarterly data reports to the Authority to include:
(1) Quarterly ambulance patient offload times (APOT) for every alternate destination facility.
(2) Quarterly total EMS transports to every alternate destination facility.
(3) Quarterly total number of patients turned away or diverted from every alternate destination facility.
(4) Quarterly total number of patients who require subsequent transfer to an emergency department from an alternate care facility.
(5) A summary of the primary reasons for turning away, diverting, or transferring patients to emergency departments from alternate care facilities.
(6) A summary of feedback about the program from the Emergency Medical Care Committee.
(7) Community paramedicine program summary of outcomes (noted in subsection (d) above).
(8) Alternate destination facility summary of patient outcomes (noted in subsection (e) above).
(g) LEMSAs shall submit a once annual summary, due to EMSA January 30 each year, of all alternate destination facilities that certifies each facility maintains adequate licensed medical and professional staff,

facilities, and equipment pursuant to the Authority's regulations and the provisions of this Chapter, which shall include all the following:
(1) Identification of qualified staff to care for the degree of a patient's injuries and needs.
(2) Certification of standardized medical and nursing procedures for nursing staff.
(3) Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1797.227, 1830, 1831, and 1833, Health and Safety Code.

§ 100120.01. Quality Improvement

"Quality Improvement" or "QI" is the process of making system-level changes in clinical, operational, administrative, processes with a continuous reassessment to improve the delivery of high-quality pre-hospital care.

Note: Authority cited: Section 1797.107, 1830, and 1831, Health and Safety Code. Reference: Section 1830 and 1831, Health and Safety Code.

§ 100121.01. Approval of Community Paramedic and Triage to Alternate Destination Training Programs

(a) The LEMSA is responsible for approval of training programs within its geographic area. As the approver, the LEMSA has oversight authority to conduct onsite visits, inspect, investigate, and discipline the training program for any violations of this Division or for failure to fulfill any additional requirements established by the LEMSA through denial, probation, suspension, or revocation of the approval.
(b) The LEMSA shall develop policies and procedures for the submission of program applications and requirements based on patient population and EMS system needs.
(c) Eligible training programs shall submit a written request for training program approval to the LEMSA.
(d) The LEMSA shall receive and review the following documentation prior to program approval:
(1) A statement verifying that the course content meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National EMS Education Standards as required by Section 1831(c)(2) of the Health and Safety Code.
(2) An outline of course objectives.
(3) Performance objectives for each skill.
(4) The names and qualifications of the training program director, program medical director, and instructors.
(5) If the training program includes supervised clinical training, then provisions for supervised clinical training including student evaluation criteria and standardized forms for evaluating community paramedic students; and monitoring of preceptors by the training program shall be included.
(6) If the training program includes supervised field internship, then provisions for supervised field internship including community paramedic student evaluation criteria and standardized forms for evaluating students; and monitoring of preceptors by the training program shall be included.
(7) The proposed location(s) and date(s) for courses.
(8) Written contract or agreements between the training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.
(9) Written contracts or agreements between the training program and a provider agency(ies) for student placement for field internship training.
(10) Samples of written and skills examinations administered by the training program.
(11) Evidence that training program facilities, equipment, examination securities, and student record keeping are compliant with the provisions of statute, regulation, and LEMSA requirements.
(e) The LEMSA shall approve and establish the effective date of program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.
(f) Notification of program approval or deficiencies with the application shall be made in writing by the LEMSA to the requesting training program within ninety (90) days of receiving the training program's request for approval.
(g) Training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years.
(h) The LEMSA shall notify the Authority in writing of the training program approval, including the name and contact information of the program director, medical director, and effective date of the program.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections

1830 and 1831, Health and Safety Code.

§ 100122.01. Oversight of Training Programs
(a) The LEMSA has oversight authority to conduct onsite visits, inspect, investigate, and discipline approved training programs for any violations of this Division or for failure to fulfill any additional requirements established by the LEMSA through denial, probation, suspension, or revocation of the approval.
(b) The requirements of training program noncompliance notification and actions are as follows:
(1) A LEMSA shall provide written notification of noncompliance with this Division and/or local standards and requirements to the training program provider. The notification shall be in writing and sent by certified mail to the training program director.
(2) Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing, by certified mail, to the LEMSA one of the following:
(A) Evidence of compliance with the provisions of this Division and/or the local standards and requirements, as applicable, or
(B) A plan to comply with the provisions of this Division and/or the local standards and requirements, as applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.
(3) Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the LEMSA shall issue a decision letter by certified mail to the Authority and the training program. The letter shall identify the LEMSA's decision to take one or more of the following actions:
(A) Accept the evidence of compliance provided.
(B) Accept the plan for meeting compliance provided.
(C) Place the training program on probation.
(D) Suspend or revoke the training program approval.
(4) The decision letter shall also include, but need not be limited to, the following information:
(A) Date of the LEMSA's decision,
(B) Specific provisions found noncompliant by the LEMSA, if applicable,
(C) The probation or suspension effective and ending date, if applicable,
(D) The terms and conditions of the probation or suspension, if applicable, and
(E) The revocation effective date, if applicable.
(5) The LEMSA shall establish the probation, suspension, or revocation effective dates.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830 and 1831, Health and Safety Code.

§100123.01. Community Paramedic and Transportation to Alternate Destination Training Programs Administration and Faculty Requirements
(a) Each training program shall have a program medical director who is a board certified or board eligible emergency medical physician currently licensed in the State of California, who has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:
(1) Review and approve educational content, standards, and curriculum; including training objectives and local protocols and policies 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 hospital clinical and field internship experience provisions.
(4) Approval of instructor(s).
(5) The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.
(b) Each training program shall have a program director who shall meet the following requirements:
(1) Has knowledge or experience in local EMS protocol and policy,
(2) Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and
(3) Has education and experience in methods, materials, and evaluation of instruction including:
(A) A minimum of one (1) year experience in an administrative or management level position, and
(B) A minimum of three (3) years academic or clinical experience in prehospital care education.
(c) Duties of the program director shall include, but not be limited to the following:

(1) Administration, organization, and supervision of the educational program.
(2) In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.
(3) Ensure training program compliance with this chapter and other related laws.
(4) Ensure that all course completion records include a signature verification.
(5) Ensure the preceptor(s) are trained according to the subject matter being taught.
(d) Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:
(1) Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,
(2) Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and
(3) Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and
(4) Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and
(5) Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
(6) An instructor may also be the program medical director or program director.
(e) Required course content:
(1) The community paramedicine training program medical director and training program director will be required to certify that all delineated education standards are met. In addition, the Authority and the authorizing LEMSA shall assure that each training program curriculum meets the minimum educational standards set forth in this Division and is focused on the knowledge and skills needed to successfully complete the International Board of Specialty Certification (IBSC) examination.
(2) The triage to alternate destination training program medical director shall certify that all delineated triage to alternate destination education standards are met. In addition, the Authority and the authorizing LEMSA shall assure that each training program has a curriculum that meets the minimum educational standards set forth in this division.
(f) Minimum training and curriculum requirements, triage paramedic training:
(1) Triage paramedic training curriculum shall include at a minimum the following:
(A) Screening and responding to mental health and substance use crisis intervention, including co-occurring mental health and substance use disorders to be provided by a licensed physician, surgeon, or licensed addiction medicine specialist with experience in the emergency department of a general acute care hospital.
(B) Mental health conditions.
(C) Assessment and treatment of intoxicated patients.
(D) The prevalence and causes of substance use disorders and associated public health impacts.
(E) Suicide risk factors.
(F) Alcohol and substance use disorders.
(G) Triage and transport parameters.
(H) Health risks and interventions in stabilizing acutely intoxicated patients.
(I) Common medical conditions and infections with presentations similar to psychosis and intoxication which require medical testing and treatment.
(J) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use and other substance use disorders.
(K) LEMSA policies for the triage, treatment, transport, and transfer of care, of patients to an alternate destination facility.
(L) The Emergency Medical Treatment and Labor Act (EMTALA) law as it pertains to psychiatric, and substance use disorder-related emergencies.
(2) LEMSAs shall verify that the participating triage paramedic has completed training in all the following topics:
(A) Psychiatric disorders.
(B) Neuropharmacology.
(C) Alcohol and substance abuse.
(D) Patient consent.

(E) Patient documentation.
(F) Medical quality improvement.
(g) Minimum training and curriculum requirements, community paramedic training:
(1) Foundations of community paramedicine.
(A) Subjects and theories to be learned:
(i) Overview of the United States and California healthcare systems and reimbursement.
(ii) Overview of public health.
(iii) Effect of the Affordable Care Act on development of community paramedicine nationally and in California.
(iv) Roles of the community paramedic.
(v) Community paramedic scope of practice.
(vi) Legal and ethical issues in client- and community-centered care.
(vii) Chronic disease management.
(viii) Subacute disease management.
(ix) Personal safety and wellness.
(x) International Board of Specialty Certification (IBSC).
(xi) Research in evidence-based practice.
(B) Knowledge and abilities acquired include:
(i) Understanding the relationship of the system of care as a community paramedic within public health.
(ii) Advocating for the client and the health care team through an equity lens.
(iii) Maintaining a healthy workplace stressor balance.
(2) Cultural humility, equity and access within community paramedicine and healthcare.
(A) Subjects and theories to be learned:
(i) Social determinants of health.
(ii) Biomedical ethics.
(iii) Equity versus equality.
(iv) Implicit bias in healthcare.
(v) Disparities in healthcare access and health outcomes by age, race, gender, ethnicity, language, ability status, socioeconomic status, mental health, and community.
(vi) Cultural humility as a framework for public health and community paramedic practice.
(vii) Roles of the culturally effective community paramedic.
(viii) Trauma-informed care.
(B) Knowledge and abilities acquired should include:
(i) Examination of potential biases toward clients and/or communities.
(ii) Application of evidence-based tools and models for practicing cultural humility in client-centered care.
(iii) Connect with culturally diverse/aware community partners.
(iv) Application of culturally effective community paramedic as community advocate.
(v) Access qualified interpreter services for language access and communication with clients and community.
(3) Interdisciplinary collaboration and systems of care navigation.
(A) Subjects and theories to be learned:
(i) Healthcare coordination.
(ii) Systems of care navigation.
(iii) Outreach and advocacy for target and at-risk populations.
(iv) Client referral.
(v) Documentation across disciplines.
(vi) Overview of the subject areas of nutrition, palliative care, hospice care, end of life care, home health vs. home care, mental health care, and substance use care.
(B) Knowledge and abilities acquired include:
(i) Collegial communications with interdisciplinary team members.
(ii) Appreciative inquiry with care team members.
(iii) Interdependent relationships with team members.
(iv) Appropriate referrals and system navigation.
(4) Client-centered Care.
(A) Subjects and theories to be learned:
(i) Client approach and the biopsychosocial assessment, including embedding cultural humility practices in client case management.

(ii) Motivational interviewing.
(iii) Interventional techniques.
(iv) Crisis intervention.
(v) Client assessment, referral, and education.
(vi) Creating a care plan.
(vii) Implementing a care plan.
(viii) Resources for client case management.
(ix) Service coordination and client counseling.
(x) Documentation and follow up.
(B) Knowledge and abilities acquired include:
(i) Core proficiency in health assessment, referral, health education, service coordination, and client-centered counseling.
(ii) Create resource map and examine webs of resources.
(iii) Create outreach strategies to connect client/community to resources.
(5) Community and public health.
(A) Subjects and theories to be learned:
(i) Population based care.
(ii) Health equity across populations.
(iii) Epidemiology.
(iv) Public health mission.
(v) Community health/needs assessment.
(vi) Public health disaster response.
(vii) Prevention.
(viii) Isolation and quarantine.
(ix) Public education.
(x) Interagency communications.
(B) Knowledge and abilities acquired include:
(i) Engages in public health planning and implementation.
(ii) Develops resources that aid in public health responses.
(iii) Coordinates and manages mass events.
(h) Community Paramedicine and Triage Paramedic Required Testing:
(1) ISBC community paramedic exam approved paramedic training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this chapter.
(2) Triage paramedic approved programs shall include a minimum of one (1) final comprehensive competency-based examination to test the knowledge and skills specified in this chapter.
(3) Documentation of successful student clinical and field internship performance, if applicable.

Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1801, 1830, 1831, 1842, and 1843, Health and Safety Code.

§ 100124.01. Community Paramedicine or Triage to Alternate Destinations Program Approval Process
(a) A LEMSA shall submit a written request to the Authority for approval of a community paramedicine or triage to alternate destination program, which shall include the following:
(1) Identification of the community need and recommended solutions.
(2) All program medical protocols and policies to include but not limited to, data collection, transport, patient safety, and quality assurance/improvement process.
(3) All program service provider approval documentation, including written agreements, if any.
(4) All relevant alternate destination facility approval documentation, including agreements, if any.
(5) All relevant documentation outlining policy for collaboration with public health or community resource entities for DOT and EMS high utilizer programs.
(6) Curriculum for program focused training.
(b) The Authority shall review a LEMSA's proposed community paramedicine or triage to alternate destination program using procedures consistent with Section 1797.105 of the Health and Safety Code and review the LEMSA's program protocols to ensure compliance with the statewide minimum protocols developed under Section 1832 of the Health and Safety Code.
(c) The Authority shall impose conditions as part of the approval of a community paramedicine or triage to alternate destination program that the LEMSA is required to incorporate into its program to achieve

consistency with the Authority's regulations and statute.
(d) The Authority shall approve or deny in writing the proposed community paramedicine or triage to alternate destination program no later than 30 days after it is submitted by the LEMSA.
(e) Approval of community paramedicine or triage to alternate destination program shall be for twelve (12) months from the date of approval. Renewal of the program shall be completed annually through submission of the Community Paramedicine Annex of the EMS plans process found in Section 100117.01 of this Division.
Note: Authority cited: Section 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830, 1831, 1832, 1835, and 1836, Health and Safety Code.

§ 100125.01. Review, Withdrawal, and Revocation of a Community Paramedicine or Triage to Alternate Destination Program
A LEMSA shall immediately terminate from participation in the program any alternate destination facility, community paramedicine, or triage to alternate destination provider if it fails to operate in accordance with subsection (b) of Section 1317 of the Health and Safety Code.
Note: Authority cited: Sections 1797.107, 1830, and 1831, Health and Safety Code. Reference: Sections 1830 and 1831, Health and Safety Code.

§ 100126.01. Fees
A LEMSA may establish a schedule of fees for community paramedic and or triage paramedic initial, renewal and reinstatement accreditation in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.112 and 1797.172, Health and Safety Code.

Chapter 6. Specialty Programs

Chapter 6.1: Trauma Care Systems

Article 1: Definitions

§ 100135.01. 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.

§ 100135.02. Immediately Available.
"Immediately available" means: (a) Unencumbered by conflicting duties or responsibilities and (b) responding without delay upon receiving notification and either (c) being physically available to the specified area of the hospital when the patient is delivered in accordance with local EMS agency policies and procedures or (d) available by a direct incoming telephone system to the public and health professionals within the poison control center service area. Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100135.03. Implementation.
"Implementation" or "implemented" or "has implemented" means putting the decision or plan into effect.
Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100135.04. 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.

§ 100135.05. On-Call.
"On call" means being able to be contacted and respond 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.

§ 100135.06. 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.

§ 100135.07. Qualified Specialist.
“Qualified specialist” means a physician licensed in California who is board certified or board eligible in the corresponding specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100135.08. 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.

§ 100135.09. 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.

§ 100135.10. 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 100135.09 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.

§ 100135.11. 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: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1798.161, Health and Safety Code.

§ 100135.12. 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 100136.04 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.

§ 100135.13. 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.

§ 100135.14. 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 1798.161, Health and Safety Code.

§ 100135.15. 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 1798.161, Health and Safety Code.

§ 100135.16. 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.

§ 100135.17. 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 considerations, physiologic and/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

§ 100136.01. 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 100136.03 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 themselves 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 1798.257, 1798.161, 1798.163 and 1798.166, Health and Safety Code.

§ 100136.02. 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 Level 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.

§ 100136.03. 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.

§ 100136.04. 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 100136.02, 100136.03 and 100136.05 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 100136.03 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 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.

§ 100136.05. 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 100080.01 of the EMT-II regulations and Section 100111.04 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.

§ 100136.06. 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 100138.

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

§ 100137.01 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 100137.02. 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 specialities, 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 specialities, 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 100135.10 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. cardiolthoracic;
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 100135.10 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 or Level 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 Care 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;

(4) Written interfacility transfer agreements with referring and specialty hospitals;

(5) 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.

§ 100137.02. 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.

§ 100137.03. 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 100137.04. 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 specialists 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 100135.10 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 speciality 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 speciality 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.

§ 100137.04. 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 specialist 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 anaesthetists 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.

§ 100137.05. 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 speciality 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.

§ 100137.06. 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

§ 100138. Trauma 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) A detailed audit of all trauma-related deaths, major complications and transfers (including interfacility transfer);
(b) A multidisciplinary trauma peer review committee that includes all members of the trauma team;
(c) Participation in the trauma system data management system;
(d) Participation in the local EMS agency trauma evaluation committee; and
(e) 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.
(f) 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: Section 1798.161, Health and Safety Code.

Article 5: Transfer of Trauma Patients

§ 100139. 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 which 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.

Chapter 6.2: ST-Elevation Myocardial Infarction Critical Care System

Article 1: Definitions

§ 100146.01. Cardiac Catheterization Laboratory.
“Cardiac catheterization laboratory” or “Cath lab” means the setting within the hospital where diagnostic and therapeutic procedures are performed on patients with cardiovascular disease.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.02. Cardiac Catheterization Team.
“Cardiac catheterization team” means the specially trained health care professionals that perform percutaneous coronary intervention. It may include, but is not limited to, an interventional cardiologist, mid-level practitioners, registered nurses, technicians, and other health care professionals.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.03. Clinical Staff.
“Clinical staff” means individuals that have specific training and experience in the treatment and management of ST-Elevation Myocardial Infarction (STEMI) patients. This includes, but is not limited to, physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.04. Emergency Medical Services Authority.
“Emergency Medical Services Authority” or “EMS Authority” or “EMSA” or "Authority" means the department in California responsible for the coordination and integration of all state activities concerning EMS.
Note: Authority cited: Sections 1797.1, 1797.107 and 1797.54, Health and Safety Code. Reference: Sections 1797.100 and 1797.103, Health and Safety Code.

§ 100146.05. Immediately Available.
“Immediately available” means: (a) Unencumbered by conflicting duties or responsibilities and (b) responding without delay upon receiving notification and either (c) being physically available to the specified area of the hospital when the patient is delivered in accordance with local EMS agency policies and procedures or (d) available by a direct incoming telephone system to the public and health professionals within the poison control center service area.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.06. Implementation.
"Implementation" or "implemented" or "has implemented" means putting the decision or plan into effect.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.07. Interfacility Transfer.
"Interfacility transfer" means the transfer of a patient from one medical facility to another in order to ensure the patient has access to the appropriate level of care.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1798.170, Health and Safety Code.

§ 100146.08. Local Emergency Medical Services Agency.
“Local emergency medical services agency” or “local EMS agency” means the agency, department, or office having primary responsibility for administration of emergency medical services in a county or region and which is designated pursuant Health and Safety Code commencing with section 1797.200.
Note: Authority cited: Sections 1797.107, 1797.200 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.09. Percutaneous Coronary Intervention (PCI).
“Percutaneous coronary intervention” or “PCI” means a procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart, usually done on an emergency basis for a STEMI patient.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.10. Quality Improvement.
“Quality Improvement” or "QI" is the process of making system-level changes in clinical, operational, administrative, processes with a continuous reassessment to improve the delivery of high-quality pre-hospital care.
Note: Authority cited: Sections 1797.103, 1797.107, 1797.174, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.174, 1797.202, 1797.204, 1797.220 and 1798.175, Health and Safety Code.

§ 100146.11. ST-Elevation Myocardial Infarction (STEMI).
“ST-Elevation Myocardial Infarction” or “STEMI” means a clinical syndrome defined by symptoms of myocardial infarction in association with ST-segment elevation on Electrocardiogram (ECG).
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.12. STEMI Care.
“STEMI care” means emergency cardiac care, for the purposes of these regulations.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.13. STEMI Critical Care System.
“STEMI critical care system” means a critical care component of the EMS system developed by a local EMS agency that links prehospital and hospital care to deliver treatment to STEMI patients.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.14. STEMI Medical Director.
“STEMI medical director” means a qualified board-certified physician by the American Board of Medical Specialties (ABMS) as defined by the local EMS agency and designated by the hospital that is responsible for the STEMI program, performance improvement, and patient safety programs related to a STEMI critical care system.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.15. STEMI Patient.
“STEMI patient” means a patient with symptoms of myocardial infarction in association with ST-Segment Elevation in an ECG.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100146.16. STEMI Program.
“STEMI program” means an organizational component of the hospital specializing in the care of STEMI patients.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.17. STEMI Program Manager.
“STEMI program manager” means a registered nurse or qualified individual as defined by the local EMS agency, and designated by the hospital responsible for monitoring, coordinating and evaluating the

STEMI program.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100146.18. STEMI Receiving Center (SRC).
"STEMI receiving center" or "SRC" means a licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to Section 100149.01 of this Division and is able to perform PCI.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100146.19. STEMI Referring Hospital (SRH).
"STEMI referring hospital" or "SRH" means a licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to Section 100149.02 of this Division.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100146.20. STEMI Team.
"STEMI team" means clinical personnel, support personnel, and administrative staff that function together as part of the hospital's STEMI program.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

Article 2: Local EMS Agency STEMI Critical Care System Requirements

§ 100147.01. STEMI Critical Care System Plan.
(a) The local EMS agency may develop and implement a STEMI critical care system.
(b) The local EMS agency implementing a STEMI critical care system shall have a STEMI Critical Care System Plan approved by the EMS Authority prior to implementation.
(c) A STEMI Critical Care System Plan submitted to the EMS Authority shall include, at a minimum, all of the following components:
(1) The names and titles of the local EMS agency personnel who have a role in a STEMI critical care system.
(2) The list of STEMI designated facilities with the agreement expiration dates.
(3) A description or a copy of the local EMS agency's STEMI patient identification and destination policies.
(4) A description or a copy of the method of field communication to the receiving hospital specific to STEMI patient, designed to expedite time-sensitive treatment on arrival.
(5) A description or a copy of the policy that facilitates the inter-facility transfer of a STEMI patient.
(6) A description of the method of data collection from the EMS providers and designated STEMI hospitals to the local EMS agency and the EMS Authority.
(7) A policy or description of how the local EMS agency integrates a receiving center in a neighboring jurisdiction.
(8) A description of the integration of STEMI into an existing quality improvement committee or a description of any STEMI specific quality improvement committee.
(9) A description of programs to conduct or promote public education specific to cardiac care.
(d) The EMS Authority shall, within 30-days of receiving a request for approval, notify the requesting local EMS agency in writing of approval or disapproval of its STEMI Critical Care System Plan. If the STEMI Critical Care System Plan is disapproved, the response shall include the reason(s) for the disapproval and any required corrective action items.
(e) The local EMS agency shall provide a corrected plan to the EMS Authority within 60 days of receipt of the disapproval letter.
(f) The local EMS agency currently operating a STEMI critical care system implemented before the effective date of these regulations, shall submit to the EMS Authority a STEMI Critical Care System Plan

as an addendum to its next annual EMS plan update, or within 180-days of the effective date of these regulations, whichever comes first.

(g) After approval of the STEMI Critical Care System Plan, the local EMS agency shall submit an update to the plan as part of its annual EMS update, consistent with the requirements in Section 100147.02.

(h) No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with a STEMI critical care system or a STEMI center unless they have been so designated by the local EMS agency, in accordance with this chapter.

Note: Authority cited: Sections 1797.107, 1797.103, 1797.105, 1797.250, 1797.254 and 1798.150, Health and Safety Code. Reference: Sections 1797.176 and 1797.220, Health and Safety Code.

§ 100147.02. STEMI Critical Care System Plan Updates.

(a) The local EMS agency shall submit an annual update of its STEMI Critical Care System Plan, as part of its annual EMS plan submittal, which shall include, at a minimum, all the following:

(1) Any changes in a STEMI critical care system since submission of the prior annual plan update or a STEMI Critical Care System Plan addendum.

(2) The status of a STEMI critical care system goals and objectives.

(3) The STEMI critical care system quality improvement activities.

(4) The progress on addressing action items and recommendations provided by the EMS Authority within the STEMI Critical Care System Plan or status report approval letter if applicable.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1797.254, 1798.150 and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1797.222 and 1798.170, Health and Safety Code.

Article 3: Prehospital STEMI Critical Care System Requirements

§ 100148. EMS Personnel and Early Recognition.

(a) The local EMS agency with an established STEMI critical care system shall have protocols for the identification and treatment of STEMI patients, including paramedic performance of a 12-lead ECG and determination of the patient destination.

(b) The findings of 12-lead ECG shall be assessed and interpreted through one or more of the following methods:

(1) Direct paramedic interpretation.

(2) Automated computer algorithm.

(3) Wireless transmission to facility followed by physician interpretation or confirmation.

(c) Notification of prehospital ECG findings of suspected STEMI patients, as defined by the local EMS agency, shall be communicated in advance of the arrival to the STEMI centers according to the local EMS agency's STEMI Critical Care System Plan.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.114, 1797.176, 1797.206, 1797.214 and 1798.150, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798, 1798.150 and 1798.170, Health and Safety Code.

Article 4: STEMI Critical Care Facility Requirements

§ 100149.01. STEMI Receiving Center Requirements.

(a) The following minimum criteria shall be used by the local EMS agency for the designation of a STEMI receiving center:

(1) The hospital shall have established protocols for triage, diagnosis, and Cath lab activation following field notification.

(2) The hospital shall have a single call activation system to activate the Cardiac Catheterization Team directly.

(3) Written protocols shall be in place for the identification of STEMI patients.

(A) At a minimum, these written protocols shall be applicable in the intensive care unit/coronary care unit, Cath lab and the emergency department.

(4) The hospital shall be available for treatment of STEMI patients twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year.

(5) The hospital shall have a process in place for the treatment and triage of simultaneously arriving

STEMI patients.

(6) The hospital shall maintain STEMI team and Cardiac Catheterization Team call rosters.

(7) The Cardiac Catheterization Team, including appropriate staff determined by the local EMS agency, shall be immediately available.

(8) The hospital shall agree to accept all STEMI patients according to the local policy.

(9) STEMI receiving centers shall comply with the requirement for a minimum volume of procedures for designation required by the local EMS agency.

(10) The hospital shall have a STEMI program manager and a STEMI medical director.

(11) The hospital shall have job descriptions and organizational structure clarifying the relationship between the STEMI medical director, STEMI program manager, and the STEMI team.

(12) The hospital shall participate in the local EMS agency quality improvement processes related to a STEMI critical care system.

(13) A STEMI receiving center without cardiac surgery capability on-site shall have a written transfer plan and agreements for transfer to a facility with cardiovascular surgery capability.

(14) A STEMI receiving center shall have reviews by local EMS agency or other designated agency conducted every three years.

(b) A STEMI center designated by the local EMS agency prior to implementation of these regulations may continue to operate. Before re-designation by the local EMS agency at the next regular interval, STEMI centers shall be re-evaluated to meet the criteria established in these regulations.

(c) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.220, 1798.150, 1798.167 and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798, 1798.150 and 1798.170, Health and Safety Code.

§ 100149.02. STEMI Referring Hospital Requirements.

(a) The following minimum criteria shall be used by the local EMS agency for designation of a STEMI referring hospital:

(1) The hospital shall be committed to supporting the STEMI Program.

(2) The hospital shall be available to provide care for STEMI patients twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year.

(3) Written protocols shall be in place to identify STEMI patients and provide an optimal reperfusion strategy, using fibrinolytic therapy.

(4) The emergency department shall maintain a standardized procedure for the treatment of STEMI patients.

(5) The hospital shall have a transfer process through interfacility transfer agreements, and have pre-arranged agreements with EMS ambulance providers for rapid transport of STEMI patients to a SRC.

(6) The hospital shall have a program to track and improve treatment of STEMI patients.

(7) The hospital must have a plan to work with a STEMI receiving center and the local EMS agency on quality improvement processes.

(8) A STEMI referring hospital designated by the local EMS agency shall have a review conducted every three years.

(b) A STEMI center designated by the local EMS agency prior to implementation of these regulations may continue to operate. Before re-designation by the local EMS agency at the next regular interval, STEMI centers shall be re-evaluated to meet the criteria established in these regulations.

(c) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.220, 1798.150, 1798.167 and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798.150 and 1798.170, Health and Safety Code.

Article 5: Data Management, Quality Improvement and Evaluations

§ 100150.01. Data Management.

(a) The local EMS agency shall implement a standardized data collection and reporting process for a STEMI critical care system.

(b) The system shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency.

(c) The prehospital STEMI patient care elements selected by the local EMS agency shall be compliant with the most current version of the California EMS Information Systems (CEMSIS) database, and the National EMS Information System (NEMSIS).
(d) All hospitals that receive STEMI patients via EMS shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures.
(e) The prehospital care record and the hospital data elements shall be collected and submitted to the local EMS agency, and subsequently to the EMS Authority, on no less than a quarterly basis and shall include, but not be limited to, the following:
(1) The STEMI patient data elements:
(A) EMS ePCR Number.
(B) Facility.
(C) Name: Last, First.
(D) Date of Birth.
(E) Patient Age.
(F) Patient Gender.
(G) Patient Race.
(H) Hospital Arrival Date.
(I) Hospital Arrival Time.
(J) Dispatch Date.
(K) Dispatch Time.
(L) Field ECG Performed.
(M) 1st ECG Date.
(N) 1st ECG Time.
(O) Did the patient suffer out-of-hospital cardiac arrest.
(P) CATH LAB Activated.
(Q) CATH LAB Activation Date.
(R) CATH LAB Activation Time.
(S) Did the patient go to the CATH LAB.
(T) CATH LAB Arrival Date.
(U) CATH LAB Arrival Time.
(V) PCI Performed.
(W) PCI Date.
(X) PCI Time.
(Y) Fibrinolytic Infusion.
(Z) Fibrinolytic Infusion Date. (AA)
Fibrinolytic Infusion Time. (BB)
Transfer.
(CC) SRH ED Arrival Date.
(DD) SRH ED Arrival Time.
(EE) SRH ED Departure Date.
(FF) SRH ED Departure Time.
(GG) Hospital Discharge Date.
(HH) Patient Outcome:
(II) Primary and Secondary Discharge Diagnosis.
(2) The STEMI System data elements:
(A) Number of STEMIs treated.
(B) Number of STEMI patients transferred.
(C) Number and percent of emergency department STEMI patients arriving by private transport (non-EMS).
(D) The false positive rate of EMS diagnosis of STEMI, defined as the percentage of STEMI alerts by EMS which did not show STEMI on ECG reading by the emergency physician.
Note: Authority cited: Sections 1791.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1798.150 and 1798.172, Health and Safety Code. Reference: Sections 1797.220, 1797.222 and 1797.204, Health and Safety Code.

§ 100150.02. STEMI Quality Improvement and Evaluation Process.

(a) Each STEMI critical care system shall have a quality improvement process that shall include, at a minimum:
(1) Evaluation of program structure, process, and outcome.
(2) Review of STEMI-related deaths, major complications, and transfers.
(3) A multidisciplinary STEMI Quality Improvement Committee, including both prehospital and hospital members.
(4) Participation in the QI process by all designated STEMI centers and prehospital providers involved in the STEMI critical care system.
(5) Evaluation of regional integration of STEMI patient movement.
(6) Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected STEMI cases.
(b) The local EMS agency shall be responsible for on-going performance evaluation and quality improvement of the STEMI critical care system.
Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1797.250, 1797.254, 1798.150 and 1798.172, Health and Safety Code. Reference: Sections 1797.104, 1797.176, 1797.204, 1797.220, 1797.222 and 1798.170, Health and Safety Code.

Chapter 6.3: Stroke Critical Care System

Article 1: Definitions

§ 100156.01. Acute Stroke Ready Hospital.
"Acute stroke-ready hospitals" or "Satellite stroke centers" means a hospital able to provide the minimum level of critical care services for stroke patients in the emergency department, and are paired with one or more hospitals with a higher level of stroke services.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

§ 100156.02. Board-certified.
"Board-certified" means a physician who has fulfilled all the Accreditation Council for Graduate Medical Education (ACGME) requirements in a specialty field of practice, and has been awarded a certification by an American Board of Medical Specialties (ABMS) approved program.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100156.03. Board-eligible.
"Board-eligible" means a physician who has applied to a specialty board examination and has completed the requirements and is approved to take the examination by ABMS. Board certification must be obtained within the allowed time by ABMS from the first appointment.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100156.04. Clinical Stroke Team.
"Clinical stroke team" means a team of healthcare professionals who provide care for the stroke patient and may include, but is not limited to, neurologists, neuro-interventionalists, neurosurgeons, anesthesiologists, emergency medicine physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100156.05. Comprehensive Stroke Center.
"Comprehensive stroke center" means a hospital with specific abilities to receive, diagnose and treat all stroke cases and provide the highest level of care for stroke patients.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections

1797.94, 1797.103 and 1797.176, Health and Safety Code.

§ 100156.06. Emergency Medical Services Authority.

“Emergency Medical Services Authority” or “EMS Authority” or “EMSA” or "Authority" means the department in California responsible for the coordination and integration of all state activities concerning EMS.

Note: Authority cited: Sections 1797.1, 1797.107 and 1797.54, Health and Safety Code. Reference: Sections 1797.100 and 1797.103, Health and Safety Code.

§ 100156.07. Local Emergency Medical Services Agency.

“Local emergency medical services agency” or “local EMS agency” means the agency, department, or office having primary responsibility for administration of emergency medical services in a county or region and which is designated pursuant Health and Safety Code commencing with section 1797.200.

Note: Authority cited: Sections 1797.107, 1797.200 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100156.08. Primary Stroke Center.

“Primary stroke center” means a hospital that treats acute stroke patients, and identifies patients who may benefit from transfer to a higher level of care when clinically warranted.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

§ 100156.09. Protocol.

“Protocol” means a predetermined, written medical care guideline, which may include standing orders.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.10. Quality Improvement.

Quality Improvement or "QI" is the process of making system-level changes in clinical, operational, administrative, processes with a continuous reassessment to improve the delivery of high-quality pre-hospital care.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.174, 1797.202, 1797.204, 1797.220 and 1798.175, Health and Safety Code.

§ 100156.11. Stroke.

“Stroke” means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction, most commonly through vascular occlusion or hemorrhage.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100156.12. Stroke Call Roster.

“Stroke call roster” means a schedule of licensed health professionals available twenty-four (24) hours a day, seven (7) days a week for the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.220, Health and Safety Code

§ 100156.13. Stroke Care.

“Stroke care” means emergency transport, triage, diagnostic evaluation, acute intervention and other acute care services for stroke patients that potentially require immediate medical or surgical intervention treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.14. Stroke Critical Care System.
“Stroke critical care system” means a subspecialty care component of the EMS system developed by a local EMS agency. This critical care system links prehospital and hospital care to deliver optimal treatment to the population of stroke patients.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.15. Stroke Medical Director.
“Stroke medical director” means a board-certified physician in neurology or neurosurgery or another board with sufficient experience and expertise dealing with cerebrovascular disease as determined by the hospital credentialing committee that is responsible for the stroke service, performance improvement, and patient safety programs related to a stroke critical care system.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.16. Stroke Program Manager.
“Stroke program manager” means a registered nurse or qualified individual designated by the hospital with the responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.17. Stroke Program.
“Stroke program” means an organizational component of the hospital specializing in the care of stroke patients.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.18. Stroke Team.
“Stroke team” means the personnel, support personnel, and administrative staff that function together as part of the hospital's stroke program.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100156.19. Telehealth.
“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code; and Section 2290.5, Business and Professions Code.

§ 100156.20. Thrombectomy-Capable Stroke Center.
“Thrombectomy-capable stroke center” means a primary stroke center with the ability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.
Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

Article 2: Local EMS Agency Stroke Critical Care System Requirements

§ 100157.01. Stroke Critical Care System Plan.
(a) The local EMS agency may develop and implement a stroke critical care system.
(b) The local EMS agency implementing a stroke critical care system shall have a Stroke Critical Care

System Plan approved by the EMS Authority prior to implementation.

(c) The Stroke Critical Care System Plan submitted to the EMS Authority shall include, at a minimum, all of the following components:

(1) The names and titles of the local EMS agency personnel who have a role in a stroke critical care system.

(2) The list of stroke designated facilities with the agreement expiration dates.

(3) A description or a copy of the local EMS agency's stroke patient identification and destination policies.

(4) A description or a copy of the method of field communication to the receiving hospital-specific to stroke patients, designed to expedite time-sensitive treatment on arrival.

(5) A description or a copy of the policy that facilitates the inter-facility transfer of stroke patients.

(6) A description of the method of data collection from the EMS providers and designated stroke hospitals to the local EMS agency and the EMS Authority.

(7) A policy or description of how the Local EMS agency integrates a receiving center in a neighboring jurisdiction.

(8) A description of the integration of stroke into an existing quality improvement committee or a description of any stroke-specific quality improvement committee.

(9) A description of programs to conduct or promote public education specific to stroke.

(d) The EMS Authority shall, within 30 days of receiving a request for approval, notify the requesting local EMS agency in writing of approval or disapproval of its Stroke Critical Care System Plan. If the Stroke Critical Care System Plan is disapproved, the response shall include the reason(s) for the disapproval and any required corrective action items.

(e) The local EMS agency shall provide an amended plan to the EMS Authority within 60 days of receipt of the disapproval letter.

(f) The local EMS agency currently operating a stroke critical care system implemented before the effective date of these regulations, shall submit to the EMS Authority a Stroke Critical Care System Plan as an addendum to its next annual EMS plan update, or within 180 days of the effective date of these regulations, whichever comes first.

(g) Any stroke center designated by the local EMS agency before implementation of these regulations may continue to operate. Before re-designation by the local EMS agency at the next regular interval, stroke centers shall be re-evaluated to meet the criteria established in these regulations.

(h) No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with a stroke critical care system or a stroke center unless they have been designated by the local EMS agency, in accordance with this chapter.

Note: Authority cited: Sections 1797.105, 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.105, 1797.173, 1797.176, 1797.220, 1797.250, 1798.170 and 1798.172, Health and Safety Code.

§ 100157.02. Stroke Critical Care System Plan Updates.

(a) The local EMS agency shall submit an annual update of its Stroke Critical Care System Plan, as part of its annual EMS plan submittal, which shall include, at a minimum, all the following:

(1) Any changes in a stroke critical care system since submission of the prior annual plan update or the Stroke Critical Care System Plan addendum.

(2) The status of the Stroke Critical Care System Plan goals and objectives.

(3) Stroke critical care system performance improvement activities.

(4) The progress on addressing action items and recommendations provided by the EMS Authority within the Stroke Critical Care System Plan or status report approval letter, if applicable.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.254 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, 1797.220, 1797.222, 1797.250, 1798.170 and 1798.172, Health and Safety Code.

Article 3: Prehospital Stroke Critical Care System Requirements

§ 100158. EMS Personnel and Early Recognition.

(a) The local EMS agency shall establish prehospital care protocols related to the early recognition, assessment, treatment, and transport of stroke patients for prehospital emergency medical care personnel as determined by the local EMS agency.

(b) The local EMS agency shall require the use of a validated prehospital stroke-screening algorithm for early recognition and assessment.
(c) The local EMS agency's protocols for the use of online medical direction shall be used to determine the most appropriate stroke center to transport a patient in cases of confusing or complex findings.
(d) The prehospital treatment policies for stroke-specific basic life support (BLS), advanced life support (ALS), and limited advanced life support (LALS) shall be developed according to the scope of practice and local accreditation.
(e) Notification of prehospital findings of suspected stroke patients shall be communicated in advance of the arrival to the stroke centers according to the local EMS agency's Stroke Critical Care System Plan.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.92, 1797.103, 1797.176, 1797.189, 1797.206, 1797.214, 1797.220, 1798.150 and 1798.170, Health and Safety Code.

Article 4: Hospital Stroke Care Requirements and Evaluations

§ 100159.01. Comprehensive Stroke Care Centers.
(a) Hospitals designated as a comprehensive stroke center by the local EMS agency shall meet the following minimum criteria:
(1) Satisfy all the requirements of a thrombectomy-capable and primary stroke center as provided in this chapter.
(2) Neuro-endovascular diagnostic and therapeutic procedures available twenty-four (24) hours a day, seven (7) days a week.
(3) Advanced imaging, available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include but not be limited to:
(A) All imaging requirements for thrombectomy-capable centers.
(B) Diffusion-weighted magnetic resonance imaging (MRI) and computed tomography (CT) perfusion imaging.
(4) Transcranial Doppler (TCD) shall be available in a timeframe that is clinically appropriate.
(5) Intensive care unit (ICU) beds with licensed independent practitioners with the expertise and experience to provide neuro-critical care twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five days (365) days per year.
(6) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.
(7) A stroke patient research program.
(8) Satisfy all the following staff qualifications:
(A) A neurosurgical team capable of assessing and treating complex stroke and stroke- like syndromes.
(B) A qualified neuro-radiologist, board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
(C) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.
(D) Written call schedule for attending neurointerventionalist, neurologist, neurosurgeon providing availability twenty-four (24) hours a day seven (7) days a week.
(9) Provide comprehensive rehabilitation services either on-site or by written transfer agreement with another health care facility licensed to provide such services.
(10) Written transfer agreements with primary stroke centers in the region to accept the transfer of patients with complex strokes when clinically warranted.
(11) A comprehensive stroke center shall at a minimum, provide guidance and continuing stroke-specific medical education to hospitals designated as a primary stroke center with which they have transfer agreements.
(b) Additional requirements may be stipulated by the local EMS agency medical director.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.220, 1797.222 and 1798.172, Health and Safety Code.

§ 100159.02. Thrombectomy-Capable Stroke Centers.
(a) Hospitals designated as a thrombectomy-capable stroke center by the local EMS agency shall meet the following minimum criteria:

(1) Satisfy all the requirements of a primary stroke center as provided in this chapter.
(2) The ability to perform mechanical thrombectomy for the treatment of ischemic stroke twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.
(3) Dedicated neuro-intensive care unit beds to care for acute ischemic stroke patients twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.
(4) Satisfy all the following staff qualifications:
(A) A qualified physician, board certified by the American Board of Radiology, American osteopathic Board of Radiology, American Board of Psychiatry and Neurology, or the American osteopathic Board of Neurology and Psychiatry, with neuro-interventional angiographic training and skills on staff as deemed by the hospital's credentialing committee.
(B) A qualified neuro-radiologist, board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
(C) A qualified vascular neurologist, board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or with appropriate education and experience as defined by the hospital credentials committee.
(D) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.
(5) The ability to perform advanced imaging twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include, but not be limited to, the following:
(A) Computed tomography angiography (CTA).
(B) Diffusion-weighted MRI or CT Perfusion.
(C) Catheter angiography.
(D) Magnetic resonance angiography (MRA).
(E) And the following modalities available when clinically necessary:
(i) Carotid duplex ultrasound.
(ii) Transesophageal echocardiography (TEE).
(iii) Transthoracic Echocardiography (TTE).
(6) A process to collect and review data regarding adverse patient outcomes following mechanical thrombectomy.
(7) Written transfer agreement with at least one comprehensive stroke center.
(b) Additional requirements may be stipulated by the local EMS agency medical director.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.220, 1797.222 and 1798.172, Health and Safety Code.

§ 100159.03. Primary Stroke Centers.

(a) Hospitals designated by the local EMS agency as a primary stroke center shall meet all the following minimum criteria:
(1) Adequate staff, equipment, and training to perform rapid evaluation, triage, and treatment for the stroke patient in the emergency department.
(2) Standardized stroke care protocol/order set.
(3) Stroke diagnosis and treatment capacity twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.
(4) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.
(5) Continuing education in stroke care provided for staff physicians, staff nurses, staff allied health personnel, and EMS personnel.
(6) Public education on stroke and illness prevention.
(7) A clinical stroke team, available to see in person or via telehealth, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke.
(A) At a minimum, a clinical stroke team shall consist of:
(i) A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee.
(ii) A registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients

that has been designated by the hospital who may serve as a stroke program manager.

(8) Written policies and procedures for stroke services which shall include written protocols and standardized orders for the emergency care of stroke patients. These policies and procedures shall be reviewed at least every three (3) years, revised as needed, and implemented.

(9) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.

(10) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year, such that imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

(11) CT scanning or equivalent neuro-imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

(12) Other imaging shall be available within a clinically appropriate timeframe and shall, at a minimum, include:

(A) MRI.

(B) CTA and / or Magnetic resonance angiography (MRA).

(C) TEE or TTE.

(13) Interpretation of the imaging.

(A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.

(B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival.

(i) For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

(ii) For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(iii) For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

(14) Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that services may be performed within forty-five (45) minutes following emergency department arrival.

(15) Neurosurgical services shall be available, including operating room availability, either directly or under an agreement with a thrombectomy-capable, comprehensive or other stroke center with neurosurgical services, within two (2) hours following the arrival of acute stroke patients to the primary stroke center.

(16) Acute care rehabilitation services.

(17) Transfer arrangements with one or more higher level of care centers when clinically warranted or for neurosurgical emergencies.

(18) There shall be a stroke medical director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery or another board-certified physician with sufficient experience and expertise dealing with cerebral vascular disease as determined by the hospital credentials committee.

(b) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.254 and 1798.150, Health and Safety Code. Reference: Sections 1797.102, 1797.103, 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1797.250, 1798.170 and 1798.172, Health and Safety Code.

§ 100159.04. Acute Stroke Ready Hospitals.

(a) Hospitals designated by the local EMS agency as an acute stroke ready hospital shall meet all the following minimum criteria:

(1) A clinical stroke team available to see, in person or via telehealth, a patient identified as a potential acute stroke patient within twenty (20) minutes following the patient's arrival at the hospital's emergency department.

(2) Written policies and procedures for emergency department stroke services that are reviewed, revised as needed, and implemented at least every three (3) years.

(3) Emergency department policies and procedures shall include written protocols and standardized orders for the emergency care of stroke patients.
(4) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.
(5) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that imaging shall be performed and reviewed by a physician within forty-five (45) minutes following emergency department arrival.
(6) Neuro-imaging services shall, at a minimum, include CT or MRI, or both.
(7) Interpretation of the imaging.
(A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.
(B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival.
(i) For the purpose of this subsection, a qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
(ii) For the purpose of this subsection, a qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
(iii) For the purpose of this subsection, a qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.
(8) Laboratory services shall, at a minimum, include blood testing, electrocardiography and x-ray services, and be available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, and able to be completed and reviewed by physician within sixty (60) minutes following emergency department arrival.
(9) Neurosurgical services shall be available, including operating room availability, either directly or under an agreement with a thrombecotomy-capable, primary or comprehensive stroke center, within three (3) hours following the arrival of acute stroke patients to an acute stroke-ready hospital.
(10) Provide IV thrombolytic treatment and have transfer arrangements with one or more thrombectomy-capable, primary or comprehensive stroke center(s) that facilitate the transfer of patients with strokes to the stroke center(s) for care when clinically warranted.
(11) There shall be a medical director of an acute stroke-ready hospital, who may also serve as a member of a stroke team, who is a physician or advanced practice nurse who maintains at least four (4) hours per year of educational time in cerebrovascular disease;
(12) Clinical stroke team for an acute stroke-ready hospital at a minimum shall consist of a nurse and a physician with training and expertise in acute stroke care.
(b) Additional requirements may be stipulated by the local EMS agency medical director.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.220, 1797.222 and 1798.172, Health and Safety Code.

§ 100159.05. EMS Receiving Hospitals (Non-designated for Stroke Critical Care Services).
(a) An EMS receiving hospital that is not designated for stroke critical care services shall do the following, at a minimum and in cooperation with stroke receiving centers and the local EMS agency in their jurisdictions:
(1) Participate in the local EMS agency's quality improvement system, including data submission as determined by the local EMS agency medical director.
(2) Participate in the inter-facility transfer agreements to ensure access to a stroke critical care system for a potential stroke patient.
Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.88, 1797.103, 1797.176, 1797.220, 1798.100, 1798.150, 1798.170 and 1798.172, Health and Safety Code.

Article 5: Data Management, Quality Improvement and Evaluation

§ 100160.01. Data Management Requirements.

(a) The local EMS agency shall implement a standardized data collection and reporting process for stroke critical care systems.
(b) The system shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency.
(c) The prehospital stroke patient care elements shall be compliant with the most current version of the California EMS Information Systems (CEMSIS) database and the National EMS Information System (NEMSIS) database.
(d) The hospital stroke patient care elements shall be consistent with the U.S. Centers for Disease Control and Prevention, Paul Coverdell National Acute Stroke Program Resource Guide, dated October 24, 2016, which is hereby incorporated by reference.
(e) All hospitals that receive stroke patients via EMS shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures.
(f) The prehospital care record and the hospital data elements shall be collected and submitted by the local EMS agency, and subsequently to the EMS Authority, on no less than a quarterly basis.
Note: Authority cited: Sections. 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Section 1797.102, 1797.103, 1797.204, 1797.220, 1797.222, 1797.227 and 1798.172, Health and Safety Code.

§ 100160.02. Stroke Quality Improvement and Evaluation Process.
(a) Each stroke critical care system shall have a quality improvement process that shall include, at a minimum:
(1) Evaluation of program structure, process, and outcome.
(2) Review of stroke-related deaths, major complications, and transfers.
(3) A multidisciplinary Stroke Quality Improvement Committee, including both prehospital and hospital members.
(4) Participation in the QI process by all designated stroke centers and prehospital providers involved in the stroke critical care system.
(5) Evaluation of regional integration of stroke patient movement.
(6) Participation in the stroke data management system.
(7) Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected stroke cases.
(b) The local EMS agency shall be responsible for on-going performance evaluation and quality improvement of the stroke critical care system.
Note: Authority cited: Sections 1797.107, 1797.176, 1797.254 and 1798.150, Health and Safety Code. Reference: Section 1797.102, 1797.103, 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1797.250, 1798.170 and 1798.172, Health and Safety Code.

Chapter 6.4: Emergency Medical Services for Children

Article 1: Definitions

§ 100161.01. California Emergency Medical Services Information System (CEMSIS). “California emergency medical services information system” or “CEMSIS” means the secure,standardized, and centralized electronic information and data collection system administered by the California EMS Authority which is used to collect statewide emergency medical services (EMS) and trauma data.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.102 and 1799.204, Health and Safety Code.

§ 100161.02. Emergency Medical Services Authority.
“Emergency Medical Services Authority” or “EMS Authority” or “EMSA” or "Authority" means the department in California responsible for the coordination and integration of all state activities concerning EMS.
Note: Authority cited: Sections 1797.1, 1797.107 and 1797.54, Health and Safety Code. Reference: Sections 1797.100 and 1797.103, Health and Safety Code.

§ 100161.03. Emergency Medical Services for Children (EMSC) Program.

“Emergency medical services for children program” or “EMSC program” means the prehospital and hospital pediatric care components integrated into an existing local EMS agency's EMS Plan for pediatric emergency care.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.04. Interfacility Transfer.
"Interfacility transfer" mean the transfer of a patient from one medical facility to another in order to ensure the patient has access to the appropriate level of care.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1798.170, 1798.172 and 1799.204, Health and Safety Code.

§ 100161.05. Local Emergency Medical Services Agency.
“Local emergency medical services agency” or “local EMS agency” means the agency, department, or office having primary responsibility for administration of emergency medical services in a county or region and which is designated pursuant Health and Safety Code commencing with section 1797.200.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.06. National EMS Information System (NEMSIS).
“National EMS information system” or “NEMSIS” means the national repository used to store secure, standardized, and centralized electronic EMS data from every state in the nation.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.07. Pediatric Emergency Care Coordinator (PECC).
“Pediatric emergency care coordinator” or “PECC” means a physician or registered nurse who is qualified in the emergency care of pediatric patients pursuant to section 100163.01(b).
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 1799.204, Health and Safety Code.

§ 100161.08. Pediatric Experience.
“Pediatric experience” means demonstrated competency through experience to care for children of all ages within their specialty as determined by hospital staff credentialing.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 1799.204, Health and Safety Code.

§ 100161.09. Pediatric Intensivist.
“Pediatric intensivist” means a physician who is board-certified or board-eligible in pediatric critical care medicine as recognized by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Board of Medical Specialties.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.10. Pediatric Patient.
“Pediatric patient” means a person who is less than 14 years of age, consistent with Title 22, Division 5, Chapter 1, Article 6, section 70537 of the California Code of Regulations.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.11. Pediatric Receiving Center (PedRC).
“Pediatric Receiving Center” or “PedRC” means a licensed general acute care hospital with, at a minimum, a permit for standby, basic, or comprehensive emergency services that has been formally designated as one of four types of PedRCs pursuant to sections 100163.01 through 100163.05, by the

local EMS agency for its role in an EMS system.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.67, 1797.88 and 1799.204, Health and Safety Code.

§ 100161.12. Qualified Emergency Specialist.

“Qualified emergency specialist” means a physician who is licensed in California, board certified or board eligible in emergency medicine or pediatric emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialties, or a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.13. Qualified Pediatric Specialist.

“Qualified pediatric specialist” means a physician who is licensed in California, board certified or board eligible in a pediatric specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797107 and 1799.204, Health and Safety Code.

§ 100161.14. Qualified Specialist.

“Qualified specialist” means a physician licensed in California who is board certified or board eligible in the corresponding specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.15. Quality Improvement.

Quality Improvement or "QI" is the process of making system-level changes in clinical, operational, administrative, process with a continuous reassessment to improve the delivery of high-quality pre-hospital care.
Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1798.150 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100161.16. Telehealth.

“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 2290.5, Business and Professions Code; and Section 1799.204, Health and Safety Code.

Article 2: Local EMS Agency EMSC Program Requirements

§ 100162.01. EMSC Program Approval.

(a) A local EMS agency may develop and implement an EMSC program.
(b) A local EMS agency implementing a new EMSC program shall have the EMSC component of an EMS plan approved by the EMS Authority prior to implementation.
(c) The EMSC component of an EMS plan submitted to the EMS Authority shall include, at a minimum, the following:
(1) EMSC program goals and objectives.
(2) The names and titles of the local EMS agency personnel who have a role in the planning, implementation, and management of an EMSC program.

(3) Injury and illness prevention planning that includes coordination, education, and data collection.
(4)(A) Policies for care and services rendered to pre-hospital EMS pediatric patients:
1. First response non-transport.
2. Transport.
3. Interfacility Transfer.
4. Critical Care.
(B) This shall include, but not be limited to:
1. Pediatric-specific personnel training.
2. Pediatric ambulance equipment.
(5) A quality improvement plan containing process-outcome measures as referenced in section 100164.02 of this Chapter.
(6) A list of facilities providing pediatric critical care and pediatric trauma services.
(7) List of designated hospitals with agreements to participate in the EMSC system of care.
(8) A list of facilities providing pediatric physical rehabilitation resources.
(9) Copies of the local EMS agency's EMSC pediatric patient destination policies.
(10) A description of the method of field communication to the receiving hospital specific to the EMSC patient.
(11) A description of the method of data collection from the EMS providers and designated EMSC hospitals to the local EMS agency and the EMS Authority.
(12) A policy or description of how the local EMS agency integrates a PedRC in a neighboring jurisdiction.
(13) Pediatric surge planning.
(d) The EMS Authority shall, within 30 days of receiving a request for approval, notify the requesting local EMS agency in writing of approval or disapproval of its EMSC program. If the EMSC program is disapproved, the response shall include the reason(s) for the disapproval and any required corrective action items.
(e) The local EMS agency shall provide an amended plan to the EMS Authority within 60 days of receipt of the disapproval letter.
(f) A local EMS agency currently operating an EMSC program implemented prior to the effective date of these regulations, shall submit, to the EMS Authority, an EMSC component of an EMS plan as an addendum to its annual EMS plan update, or within 180 days of the effective date of these regulations, whichever comes first.
(g) No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with an EMSC program or PedRC unless they have been designated by the local EMS agency, in accordance with this Chapter.
Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1797.220, 1797.250, 1798.150 and 1799.204, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1797.254, 1798.170, 1798.172 and 1799.204, Health and Safety Code.

§ 100162.02. Annual EMSC Program Update.
(a) The local EMS agency shall submit an annual update to its EMSC program as part of its annual EMS plan submittal, which shall include, at a minimum, all the following:
(1) Any changes in the EMSC program since submission of the prior annual EMS plan.
(2) The status of EMSC program goals and objectives.
(3) A summary of the EMSC program performance improvement activities.
(4) Progress on addressing action items and recommendations provided by the EMS Authority within the EMSC program or Status Report approval letter, if applicable.
Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1798.150 and 1799.204, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1797.254, 1798.172 and 1799.204, Health and Safety Code.

Article 3: Pediatric Receiving Centers

§ 100163.01. All PedRC Requirements.
(a) All PedRCs shall meet the following facility requirements:
(1) All PedRCs shall have an interfacility transfer plan for pediatric patients in accordance with Title 22, Division 9, Chapter 6, Article 5, section 100139.

(2) Establish a process for obtaining and providing consultation via phone, telehealth, or onsite for emergency care and stabilization, transfer, and transport.

(b) All PedRCs shall meet the following personnel requirements:

(1) All physician PECCs shall be licensed in California and meet all the following minimum requirements:

(A) Be a qualified emergency specialist, or

(B) Be a qualified specialist in Pediatrics or Family Medicine, and

(C) Shall have competency in resuscitation of pediatric patients of all ages from neonates to adolescents.

(2) All nurse PECCs shall be licensed in California and meet all the following minimum requirements:

(A) Have at least two (2) years of experience in pediatric or emergency nursing within the previous five (5) years.

(B) Shall have competency in resuscitation of pediatric patients of all ages from neonates to adolescents through American Heart Association Pediatric Advanced Life Support or American College of Emergency Physicians sponsored Advanced Pediatric Life Support.

(3) The designated PECC shall be responsible for all of the following:

(A) Provide oversight of the emergency department pediatric quality improvement program.

(B) Liaison with appropriate hospital-based pediatric care committees.

(C) Liaison with other PedRCs, the local EMS agency, base hospitals, prehospital care providers, and neighboring hospitals.

(D) Facilitate pediatric emergency department continuing education and competency evaluations in pediatrics for emergency department staff.

(E) Coordinate pediatric disaster preparedness.

(F) Ensure family centered care practices are in place.

(4) All PedRCs shall have personnel available for consultation to the emergency department through live interactive telehealth or other means determined by the local EMS agency including, but not limited to:

(A) A qualified pediatric specialist.

(B) A pediatric intensivist.

(C) Support services, including respiratory care, laboratory, radiology, and pharmacy shall include staff and equipment to care for the pediatric patient.

(D) Respiratory care specialists who respond to the emergency department.

1. Respiratory care specialists shall verify their competence to support oxygenation and ventilation of pediatric patients to the Director of Respiratory Services. This verification may include, but is not limited to:

a. Current completion of the American Heart Association Pediatric Advanced Life Support Course, or

b. The American Academy of Pediatrics and American College of Emergency Physicians sponsored Advanced Pediatric Life Support Course, or

c. Continuing education courses specific to resuscitation of pediatric patients.

(c) The pediatric equipment, supplies, and medications in all PedRCs, for pediatric patients from neonates to adolescents, shall include, but not be limited to:

(1) A length-based resuscitation tape, medical software, or other system available to assure proper sizing of resuscitation equipment and proper dosing of medication.

(2) Portable resuscitation supplies, such as a crash cart or bag, with a method of verification of contents on a regular basis.

(3) Equipment for patient and fluid warming, patient restraint, weight scale (in kilograms) and pain scale tools for all ages of pediatric patients.

(4) Monitoring equipment appropriate for pediatric patients including, but not limited to, blood pressure cuffs, doppler device, electrocardiogram monitor/defibrillator, hypothermia thermometer, pulse oximeter, and end tidal carbon dioxide monitor.

(5) Respiratory equipment and supplies appropriate for pediatric patients including, but not limited to, clear oxygen masks, bag-mask devices, intubation equipment, supraglottic airways, oral and nasal airways, nasogastric tubes, and suction equipment.

(6) Vascular access supplies and equipment for pediatric patients including, but not limited to, intravenous catheters, intraosseous needles, infusion devices, and Intravenous solutions.

(7) Fracture management devices for pediatric patients including extremity splints and spinal motion restriction devices.

(8) Medications for the care of pediatric patients requiring resuscitation.

(9) Specialized pediatric trays or kits which shall include, but not be limited to:

(A) Lumbar puncture tray.

(B) Difficult airway kit with devices to assist intubation and ventilation.
(C) Tube thoracostomy tray including chest tubes in sizes for pediatric patients of all ages.
(10) Newborn delivery kit to include, but not limited to, the following:
(A) Towel,
(B) Clamps and scissors for cutting the umbilical cord,
(C) Bulb suction,
(D) Warming pad, and
(E) Neonatal bag-mask ventilation device with appropriate sized masks.
(F) Urinary catheter tray including urinary catheters for pediatric patients of all ages.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1798.150 and 1799.204, Health and Safety Code.

§ 100163.02. Basic PedRC Requirements.

(a) A hospital may be designated as a Basic PedRC by the local EMS agency upon meeting all the following criteria:
(1) All designated Basic PedRCs shall be licensed as a general acute care hospital with a basic or standby Emergency Department permit.
(2) Emergency Department services may include physician staffing 24 hours a day, 7 days a week or a physician available for consultation.
(3) At minimum, one licensed registered nurse or advanced care practitioner per shift in the emergency department shall have current completion of the American Heart Association Pediatric Advanced Life Support, Advanced Pediatric Life Support, completion of an Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care nursing course, as determined by the local EMS agency.
(4) The emergency department in the hospital shall be able to stabilize critically ill or injured infants, children, and adolescents prior to admission to the pediatric intensive care unit (PICU) or transfer to a Comprehensive PedRC facility.
(5) Establish agreements with at least one Comprehensive PedRC, as approved by the local EMS agency, for education, consultation, and transfer of critical pediatric patients.
(6) Establish agreements with an Advanced or General PedRC, as approved by the local EMS agency, for consultation and transfer of pediatric patients.
(7) Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a Comprehensive, Advanced or General PedRC, such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.
(8) All Basic PedRCs shall have a physician and/or nurse PECC which may be shared with other PedRCs.
(b) Additional requirements may be stipulated by the local EMS agency medical director.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172 and 1799.204, Health and Safety Code.

§ 100163.03. General PedRC Requirements.

(a) A hospital may be designated as a General PedRC by the local EMS agency upon meeting all the following criteria:
(1) All designated General PedRCs shall be licensed as a general acute care hospital with a basic or comprehensive Emergency Department permit.
(2) Participate with a Comprehensive and/or Advanced PedRC for pediatric emergency education for hospital staff and emergency care providers consistent with the local EMS agency plan for ongoing pediatric education.
(3) The emergency department in the hospital shall be able to stabilize critically ill or injured infant, children, and adolescents prior to admission to the PICU or transfer to a Comprehensive PedRC facility.
(4) Establish agreements with Comprehensive and/or Advanced PedRCs as approved by the local EMS agency, for education, consultation, and transfer.
(5) Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a Comprehensive, Advanced or General PedRC, such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.
(6) All designated General PedRCs shall have a physician and/or nurse PECC which may be shared with other PedRCs.

(7) All designated General PedRCs shall meet the following additional equipment requirements:
(A) Neonatal resuscitation equipment, including:
1. Pediatric laryngoscope with Miller 0 and 00 blades,
2. Size 2.5 and 3.0 endotracheal tubes, and
3. Umbilical vein catheters.

(b) Additional requirements may be stipulated by the local EMS agency medical director.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172 and 1799.204, Health and Safety Code.

§ 100163.04. Advanced PedRC Requirements.

(a) A hospital may be designated as an Advanced PedRC by the local EMS agency upon meeting the following criteria:
(1) All designated Advanced PedRCs shall be licensed by the Department of Health Services (DHS), Licensing and Certification Division, under California Code of Regulations (CCR), Title 22, Division 5, Chapter 1, as follows:
(A) As an acute care hospital pursuant to Article 1, sections 70003 and 70005.
(B) For pediatric service pursuant to Article 6, section 70535 et seq.
(C) For basic or comprehensive emergency medical services pursuant to Article 6, section 70411, et seq.
(D) For social services pursuant to Article 6, section 70535 et seq
(E) Community neonatal intensive care unit (NICU) or as an Intermediate NICU if it meets the following requirements, as per:
1. Article 6, Section 70545 et seq., for the provision of perinatal services and licensed by DHS, Licensing and Certification Division as a perinatal service;
2. Article 6, Section 70481 et seq., for the provision of neonatal intensive care services and licensed by DHS, Licensing and Certification Division as an Intensive Care Newborn Nursery (ICNN)
(F) If the hospital has a PICU then it shall be licensed by DHS, Licensing and Certification Division for intensive care services, and meet the requirements for the provision of intensive care services pursuant to CCR Title 22, Division 5, Chapter 1, Article 6, Section 70491 et seq.
(G) The emergency department in the hospital shall be able to stabilize critically ill or injured infant, children, and adolescents prior to admission to the PICU or transfer to a Comprehensive PedRC facility.
(2) Establish agreements with a minimum of one Comprehensive PedRC as approved by the local EMS agency, for consultation.
(3) Participate with a Comprehensive PedRC for pediatric emergency education for emergency care providers consistent with the local EMS agency plan for ongoing pediatric education.
(4) Establish transfer agreements with a Comprehensive PedRC to transfer pediatric patients for stabilization, ensuring the highest level of care.
(5) Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a Comprehensive, Advanced or General PedRC, such as trauma, burn, spinal cord injury, and rehabilitation and behavioral health.
(b) All Advanced PedRCs shall meet the following personnel requirements:
(1) Advanced PedRCs shall have a physician and nurse Pediatric Emergency Care Coordinator (PECC).
(2) Respiratory care service in the pediatric service department and emergency department provided by respiratory care practitioners (RCPs) who are licensed in the state of California and who have completed formal training in pediatric respiratory care which includes clinical experience in the care of children.
(3) Social work services in the pediatric service department provided by a medical social worker (MSW) holding a master's degree in social work who has expertise in the psychosocial issues affecting the families of seriously ill infants, children, and adolescents.
(4) Behavioral health specialists with pediatric experience to include, but not be limited to, psychiatrists, psychologists, and nurses.
(5) The following specialties shall be on-call, and available for consultation to the ED or NICU within 30 minutes by telephone and in-person within one hour:
(A) Neonatologist.
(B) General Surgeon with pediatric experience.
(C) Anesthesiologist with pediatric experience.
(D) Pediatric Cardiologist.
(6) The following specialties shall be on-call, and available to the NICU or ED either in-person, by phone, or

by telehealth, within 30 minutes:
(A) Radiologist with pediatric experience.
(B) Otolaryngologist with pediatric experience.
(C) Mental health professional with pediatric experience.
(D) Orthopedist with pediatric experience.

(7) The following qualified specialists shall be available twenty-four (24) hours a day, 7 days a week, for consultation which may be met through a transfer agreement or telehealth:
(A) Pediatric Gastroenterologist.
(B) Pediatric Hematologist/Oncologist.
(C) Pediatric Infectious Disease.
(D) Pediatric Nephrologist.
(E) Pediatric Neurologist.
(F) Pediatric Surgeon.
(G) Cardiac Surgeon with pediatric experience.
(H) Neurosurgeon with pediatric experience.
(I) Obstetrics/Gynecologist with pediatric experience.
(J) Pulmonologist with pediatric experience.
(K) Pediatric Endocrinologist.
(8) The hospital or LEMSA may require additional specialists or more rapid response times.

(c) The pediatric equipment, supplies, and medications in all Advanced PedRCs for pediatric patients from neonates to adolescents shall include all General PedRC equipment, and:

(1) Crash carts with pediatric resuscitation equipment that shall be standardized and available on all units, including but not limited to, the emergency department, radiology suite, and inpatient pediatric service.

(d) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172 and 1799.204, Health and Safety Code.

§ 100163.05. Comprehensive PedRC Requirements.

(a) A hospital may be designated as a Comprehensive PedRC by the local EMS agency upon meeting all criteria of an Advanced PedRC, as well as the following facility requirements:

(1) All designated Comprehensive PedRCs shall be licensed as a general acute care hospital with a basic or comprehensive Emergency Department permit and have full, provisional, or conditional California Children's Services (CCS) approval by the Department of Health Care Services as a tertiary hospital, or meet CCS criteria as a tertiary hospital as approved by the local EMS agency.

(2) Can provide comprehensive specialized pediatric medical and surgical care to any acutely ill or injured child.

(3) Inpatient resources including a neonatal intensive care unit (NICU) and a pediatric intensive care unit (PICU).

(4) Provide ongoing outreach and pediatric education for Community, General and Basic PedRCs, and prehospital care providers, in collaboration with the local EMS agency.

(5) Establish transfer agreements or serve as a regional referral center for specialized care, such as trauma, burn, spinal cord injury, and rehabilitation and behavioral health, of pediatric patients.

(6) Emergency department services include a separate pediatric emergency department or a designated area for emergency care of pediatric patients within an emergency department, with physician staff who are qualified specialists in emergency medicine or pediatric emergency medicine.

(7) All designated Comprehensive PedRCs shall meet the equipment requirements of Advanced PedRCs.

(b) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.173 and 1799.204, Health and Safety Code.

Article 4: Data Management, Quality Improvement and Evaluations

§ 100164.01. Data Management Requirements.

(a) The local EMS agency shall implement a standardized data collection and reporting process for EMSC program.

(1) The EMSC program shall include the collection of both prehospital and hospital patient care data, as

determined by the local EMS agency.
(2) The prehospital EMSC patient care elements selected by the local EMS agency shall be compliant with the most current version of the CEMSIS and the NEMSIS databases.

(b) All PedRCs shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures.
(c) Following approval of the EMSC program, PedRCs shall submit data to the local EMS agency which shall include, but not be limited to:
(1) Baseline data from pediatric ambulance transports, including, but not limited to:
(A) Arrival time/date to the emergency department.
(B) Date of birth.
(C) Mode of arrival.
(D) Gender.
(E) Primary impression.
(2) Basic outcomes for EMS quality improvement activities, including but not limited to:
(A) Admitting hospital name if applicable.
(B) Discharge or transfer diagnosis.
(C) Time and date of discharge or transfer from the Emergency Department.
(D) Disposition from the Emergency Department.
(E) External cause of injury.
(F) Injury location.
(G) Residence zip code.
(d) Pediatric data shall be integrated into the local EMS agency and the EMS Authority data management systems through data submission on no less than a quarterly basis.
Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 1799.204, Health and Safety Code.

§ 100164.02. EMSC Quality Improvement and Evaluation Process.
(a) Each local EMS agency shall have a quality improvement program in collaboration with all PedRCs.
(b) All PedRCs shall have a quality improvement program. This process shall include, at a minimum:
(1) Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure protected review of selected pediatric cases.
(2) A process that integrates emergency department quality improvement activities with the prehospital, trauma, inpatient pediatrics, pediatric critical care and hospital-wide quality improvement activities.
(3) A process to integrate findings from quality improvement audits and reviews into education and clinical competency evaluations of staff.
(4) Each PedRC will complete an online or paper assessment of the National Pediatric Readiness Project self-assessment and share the results with the local EMS agency every three years at minimum.
(5) A multidisciplinary pediatric quality improvement committee to review prehospital, emergency department, and inpatient care which shall include, but not be limited to:
(A) Cardiopulmonary or respiratory arrests.
(B) Child maltreatment cases.
(C) Deaths.
(D) Intensive care unit admissions.
(E) Operating room admissions.
(F) Transfers.
(G) Trauma admissions.
(c) The local EMS agency is responsible for:
(1) Ongoing performance evaluations of the local or regional EMSC programs.
(2) Ensuring the designated PedRCs, other hospitals that provide care to pediatric patients, and prehospital providers involved in the EMSC program, participate in the quality improvement program contained in this section.
Note: Authority cited: Sections 1797.107, 1797.176, 1798.150 and 1799.204, Health and Safety Code. Reference: Sections 1797.103, 1797.104, 1797.220 and 1799.204, Health and Safety Code.

Chapter 7: Prehospital EMS Aircraft Regulations

Article 1: Definitions

§ 100166.01. 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.

§ 100166.02. Advanced Life Support Rescue Aircraft.
“Advanced life support Rescue aircraft” or “ALS rescue aircraft” as used in this Chapter means a 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.

§ 100166.03. 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.

§ 100166.04. 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.

§ 100166.05. 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.

§ 100166.06. 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.

§ 100166.07. 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.

§ 100166.08. 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 100166.10.

Note: Authority cited: Sections 1797.1 and 1797.107, Health and Safety Code. Reference: Section 1797.103, Health and Safety Code.

§ 100166.09. 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 100066.02, 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.

§ 100166.10. 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 100067.10(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.

§ 100166.11. 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 100167(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.

§ 100166.12. 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 a 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.

§ 100166.13. 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.

§ 100166.14. 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 1797.94, 1797.103, 1797.204, 1797.206, 1797.218, 1797.222 and 1797.250, Health and Safety Code.

§ 100166.15. Medical Flight Crew.

“Medical flight crew” as used in this Chapter means the individual(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.

§ 100166.16. 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.

Article 2: General Provisions

§ 100167. 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 100167(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: System Operation

§ 100168. 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 maybe 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 4: Equipment and Supplies, Aircraft Specifications

§ 100169. 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 a 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.

Chapter 8: Poison Control Center Regulations

Article 1: Definitions

§ 100200.01. Immediately Available.

“Immediately available” means: (a) Unencumbered by conflicting duties or responsibilities and (b) responding without delay upon receiving notification and either (c) being physically available to the specified area of the hospital when the patient is delivered in accordance with local EMS agency policies and procedures or (d)available by a direct incoming telephone system to the public and health professionals within the poison control center service area.

Note: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code. Reference: Section 1798.180, Health and Safety Code.

§ 100200.02. On-Call.

"On call" means being able to be contacted and respond 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.

§ 100200.03. 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 100201.03.

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.

§ 100200.04. 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.

§ 100200.05. 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.

§ 100200.06. 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 100201.01(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.

§ 100200.07. Temporary Designation.
"Temporary designation" shall be for one (1) year and may begiven to a facility that meets the provisions of Section 100201.01(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

§ 100201.01. 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.

§ 100201.02. 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 100201.03(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 100201.05 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 100201.04.
Note: Authority cited: Sections 1797.1, 1797.107 and 1798.180, Health and Safety Code. Reference: Section 1797.97 and 1798.180, Health and Safety Code

§ 100201.03. 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 100201.02(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 100201.04;
(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 100201.02(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 100201.02(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 100201.05; 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.

§ 100201.04. 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.

§ 100201.05. 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

§ 100202.01. 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 100201.02(a)(1) through 100201.02(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 ten (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.

§ 100202.02. 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.

Chapter 9: California Central Registry

Article 1: Definitions

§ 100220.01. Advanced EMT Certifying Entity.
"Advanced EMT certifying entity" means the medical director of the LEMSA authorized to certify and recertify applicants for Advanced EMT. Note: Authority cited: Sections 1797.107, 1797.109, 1797.117, 1797.184(b) and 1797.184(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.

§ 100220.02. 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.

§ 100220.03. 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; and Section 11075, Penal Code.

§ 100220.04. 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: Section 1797.62, Health and Safety Code.

§ 100220.05 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 and 1797.118, Health and Safety Code. Reference: Section 1797.117, Health and Safety Code; and Sections 11075, 11105 and 11105.2, Penal Code.

§ 100220.06. 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; and Section 11105.2(a), Penal Code.

Article 2: General Provisions

§ 100221.01. Registry Requirements.

(a) All EMT and Advanced EMT certifying entities shall enter certification and recertification information, as specified in Section 100222.01, 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) LEMSA 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.

§ 100221.02. 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

§ 100222.01. 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 4.1 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.

§ 100222.02. 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.

Chapter 10: Data and Quality Assurance

Article 1: Definitions

§ 100250.01. 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.

§ 100250.02. EMS Service Provider.
EMS Provider Agency means an employer or organization with the oversight and administration of certified EMT-I, certified EMT-II, licensed paramedic, and public safety 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

§ 100251. 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 100250.01 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 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

§ 100252. 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 in EMS QI program, as defined in Section 100250.01 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 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

§ 100253. 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 100250.01 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

§ 100254. 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 100250.01 of the 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 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 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.