# CHAPTER 41

# MOBILE INTENSIVE CARE PROGRAMS

**Authority**

N.J.S.A. 26:1A-15 and 26:2K-39 et seq.

**Source and Effective Date**

R.1993 d.202, effective June 21, 1993.
See: 24 N.J.R. 3255(b), 25 N.J.R. 2721(b).

**Executive Order No. 66(1978) Expiration Date**

Chapter 41, Mobile Intensive Care Programs, expires on June 21, 1998.

**Chapter Historical Note**

Chapter 41, Mobile Intensive Care Programs, became effective February 17, 1987 as R.1987 d.112. See: 18 N.J.R. 602(a), 19 N.J.R. 357(a). Pursuant to Executive Order No. 66(1978), Chapter 41 was readopted, with amendments, by R.1992 d.113, effective February 13, 1992, for a period of one year. See: 23 N.J.R. 3734(a), 24 N.J.R. 938(a). Chapter 41 expired on February 13, 1993. New rules were adopted by R.1993 d.202. See: Source and Effective Date.

See section annotations for additional rulemaking.

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APPENDIX A NEW JERSEY DEPARTMENT OF HEALTH OFFICE OF EMERGENCY MEDICAL SERVICES

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## SUBCHAPTER 1. AUTHORITY, SCOPE AND DEFINITIONS

### 8:41-1.1 Authority; delegation

These rules are promulgated pursuant to N.J.S.A. 26:1A-15 and 26:2K-17, which authorize the Commissioner of the State Department of Health to enact rules pertaining to the operation of mobile intensive care units, and the provision of prehospital advanced life support in general.

### 8:41-1.2 Scope and purpose

These rules shall apply to all hospitals, agencies, persons and authorized programs that operate mobile intensive care programs, or which are seeking authorization to do so. These rules serve to define the operational requirements of these programs, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to operate a mobile intensive care program.

### 8:41-1.3 Definitions

The following words and terms, as used in this chapter, shall have the following meaning, unless the context in which they are used clearly indicates otherwise.

"Advanced life support (ALS)" means an advanced level of prehospital, inter-hospital and emergency medical service care which includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care, and other techniques and procedures authorized by the Commissioner.

"Advanced life support ambulance" means a vehicle which is utilized for the delivery of advanced life support and for the purpose of emergency patient transportation, which serves as a mobile intensive care unit as defined by this chapter, and which serves as an emergency ambulance as defined by N.J.A.C. 8:40, Manual of Standards for Licensure of Invalid Coach and Ambulance Services.

"Authorized mobile intensive care unit" means a mobile intensive care unit authorized by the Department to provide advanced life support services to a specific population, geographic region, or political subdivision.

"Authorized" means approved by the Commissioner of the New Jersey State Department of Health, or his or her designee, in accordance with the provisions of this chapter.

"Available" means ready for immediate use (pertaining to equipment, vehicles and personnel); or, immediately accessible (pertaining to records).

"Base station physician" means any physician licensed by the Board of Medical Examiners of New Jersey who provides medical command to advanced life support personnel by radio, telephone or other direct means, as part of an authorized intensive care program.

"Basic life support (BLS)" means a basic level of prehospital care which includes patient stabilization, airway maintenance, cardiopulmonary resuscitation (to the standards of the American Heart Association), control of hemorrhage, initial wound care, fracture stabilization, victim extrication, and other techniques and procedures as defined in the United States Department of Transportation (U.S.D.O.T.) curriculum for Emergency Medical Technician-Ambulance (obtainable from the Superintendent of Government Documents, Washington, D.C. 20402) incorporated herein by reference and as promulgated by the Commissioner.

"Certified" means official confirmation that an individual has completed the requirements of an approved program and has demonstrated a competence in the subject matter to the satisfaction of the certifying agency.

"Chief Administrator" means the Chief Administrator of the Office of Emergency Medical Services of the New Jersey State Department of Health.

"Commissioner" means the Commissioner of Health of the State of New Jersey.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its toxic products from a reservoir to a susceptible host.

"Department" means the New Jersey State Department of Health.

"Didactic coordinator" means the person responsible for the didactic training, offered in conjunction with a college, in accordance with this chapter.

"Didactic training" means the classroom portion of the paramedic training program, as authorized by the Commissioner, and which meets, at a minimum, the requirements as outlined by the U.S. Department of Transportation curriculum for EMT-paramedic (obtainable from the Superintendent of Government Documents, Washington, D.C. 20402), incorporated herein by reference.

"Director" means the individual responsible for the general operation of a mobile intensive care program.

"Dispatch center" means a facility that provides coordinated dispatching of emergency services for a given area.

"Emergency medical services (EMS)" means a system for the provision of emergency care and transportation of individuals who are sick or injured.

"Emergency medical services (EMS) educator" means the individual responsible for the clinical training of paramedics, paramedic students, EMTs, nurses and physicians, as defined by, and required in, this chapter.

"Emergency Medical Technician—Ambulance (EMT–A)" means an individual trained and currently certified by the Commissioner, in accordance with the United States Department of Transportation (U.S.D.O.T.) EMT–A training course, as outlined in the standards established by the Federal Highway Safety Act of 1966, 23 U.S.C. 401 et seq. (as amended), to deliver basic life support services, and who has completed the national standard curriculum, as published by the U.S.D.O.T. for Emergency Medical Technicians–Ambulance.

"Governing body" means the organization or persons holding legal responsibility for the operation of a hospital, health care facility, business or other agency.

"Health care facility" means a facility so defined in the Health Care Facilities Planning Act, N.J.S.A. 26:2H–1.1 et seq.

"JEMS (Jersey Emergency Medical Services) Communication Plan" means the authorized communication plan for emergency medical services, as issued by the Department.

"Licensed vehicle" means a vehicle that has been licensed in accordance with this chapter for the purpose of providing prehospital advanced life support as a mobile intensive care unit.

"MED channels" means those specific radio frequencies designated by the Federal Communications Commission for the exclusive use in providing medical command to MICUs, as defined in 47 CFR 90.53(15)(i).

"Medical command" means medical supervision provided to prehospital advanced life support providers by a licensed physician via radio, telephone or other direct means of communication.

"Medical control" means the medical oversight provided to the operations of a mobile intensive care unit (MICU), including written protocols, quality assurance and other medical supervision of the MICUs operations.

"Medical director" means a physician who meets the requirements of this chapter and is responsible to provide medical oversight to the operations of the MICU.

"Medical record" means the documentation completed each time the MICU makes physical or verbal contact with a patient, in accordance with the requirements of this chapter.

"Mobile intensive care nurse (MICN)" means a registered professional nurse licensed by the New Jersey State Board of Nursing who has at least one year of emergency or critical care nursing experience, is currently certified in advanced cardiac life support and basic cardiac life support to the standards of the American Heart Association, is currently certified by the Commissioner as an EMT–A, is endorsed by the program's medical director, and is staffing an authorized mobile intensive care unit.

"Mobile Intensive Care Advisory Council" means the advisory council charged with advising the Commissioner on matters regarding the provision of prehospital advanced life support, as defined at N.J.S.A. 26:2K–16.

"National Registry (NREMT)" means the National Registry of Emergency Medical Technicians, P.O. Box 29233, Columbus, OH 43229.

"Office of Emergency Management (OEM)" means the Office of Emergency Management of the New Jersey State Police.

"Office of Emergency Medical Services (OEMS)" means the Office of Emergency Medical Services in the New Jersey State Department of Health, Division of Health Facilities Evaluation and Licensing.

"Paramedic" means a person who has completed a training program authorized by the Department and who is certified by the Commissioner pursuant to N.J.A.C. 8:41–4.

"Patient" means any person who is ill or injured, living or deceased and with whom the mobile intensive care unit has established physical or verbal contact.

"Physician" means a person who has earned the degree of M.D. or D.O. and who is licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

"Prehospital ALS provider" means a mobile intensive care paramedic as defined by N.J.S.A. 26:2K–7 et seq., who is certified in accordance with the provisions of this chapter, or a mobile intensive care nurse as defined by this chapter.

"Provide" means furnishing, conducting, maintaining, advertising, or in any way engaging in or professing to engage in any activity regulated by this chapter.

"Provider" means any person, agency or institution, public or private, that provides authorized mobile intensive care unit services.

"Radio failure," when applied to medical command, means circumstances that prevent prehospital advanced life support providers from communicating with their base station physician for medical command due to technical difficulties.

"Radio failure protocols" means the specific course of treatment to be followed by the prehospital advanced life support provider in the event contact with the base station cannot be made, and which is authorized by the Commissioner.

"Receiving hospital" means any hospital to which a patient is transferred following the provision of advanced life support services, including those patients evaluated but not treated by the MICU.

"Regional communications center" means a facility designated by the Department to coordinate communications of mobile intensive care units, including biomedical telemetry, radio and telephone services essential to dispatch and medical command.

"Revocation" and "revoked" mean the permanent removal of a license, certificate or endorsement, and shall have the effect of permanent debarment.

"Specific order" means an order by a licensed base station physician or other medical command physician with regard to the treatment of a patient, whether directly transmitted by the physician or relayed through a licensed registered professional nurse in accordance with this chapter.

"Standing orders" means specific treatment protocols that are authorized by the Commissioner, that relate to immediate life saving treatment of a patient and that occur without any communications with the base station physician.

"Suspended" means the temporary cancellation of any license, certificate, endorsement or privilege.

"Therapeutic agent" means any drug or agent which is used in the treatment of the sick or injured, including those authorized in accordance with N.J.A.C. 8:41–8.

"Unsafe vehicle" means, but is not limited to, any vehicle used as an MICU with any defect of the vehicle's exhaust, brakes, suspension, tires, and/or engine systems and any defect or fault in any required patient care equipment that poses a risk of harm, injury or death to patients, employees or passengers.

"Valid" means current, up-to-date, not expired, and in effect.

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## SUBCHAPTER 2. APPROVAL; LICENSING; PENALTIES

### 8:41–2.1 Approvals required

No person, institution or agency, public or private, shall provide mobile intensive care services in any form or manner unless the provider is approved by the Department to do so.

### 8:41–2.2 Certificate of need required

(a) No applicant shall be approved to provide mobile intensive care unit services unless approval is granted under the Department's Certificate of Need Program, pursuant to N.J.A.C. 8:33N and N.J.S.A. 26:2H–1.1 et seq.

(b) The terms and conditions set forth in the certificate of need and any subsequent conditions shall be binding upon the program. Failure to comply with any such condition shall be deemed cause for action against the program, in accordance with N.J.A.C. 8:41–2.7, 2.8 and 4.12.

### 8:41–2.3 Approval procedures

(a) Following their approval by the Certificate of Need program, any qualified applicant desiring to provide mobile intensive care services shall make application in accordance with the requirements of this chapter.

(b) No authorization, certificate or license issued by the Department shall be transferred or otherwise assigned to any other party. Any proposed change to the operations of the program as specified in the approval or Certificate of Need shall not occur prior to Department approval.

### 8:41–2.4 Surveys and inspections

(a) Authorized representatives of the Department shall conduct surveys and inspections to determine compliance with this chapter.

(b) Survey visits may be made by any authorized representative of the Department at any time to any location used or occupied by the program or its agents. The survey may also take place at any place where the vehicle is located. Such visits may include, but are not limited to, the review of all documents and patient records, and/or conferences with patients.

(c) The program and its employees shall permit authorized representatives of the Department to make such surveys as required by the Department.

**8:41–2.5 Report of unusual occurrences**

(a) The program shall notify the Department by telephone by the next business day, followed by written confirmation, of:

1. Any death or injury requiring hospitalization of an employee due to an on-the-job incident;

2. Any police reported motor vehicle accident in which the mobile intensive care unit was involved, regardless of injuries. The written report shall include a copy of the police report and shall be forwarded within 14 days of the accident;

3. Any event occurring on or within the licensee's vehicle(s) or place of business that results in damage to records as required by this chapter;

4. The loss of any controlled dangerous substance of Schedule I–V inclusive, as defined by N.J.S.A. 24:21–1 et seq. This does not relieve the provider of any responsibility for reporting as required by N.J.A.C. 8:65; or

5. Any instance when an interruption in service, as defined by the program's certificate of need, occurs for more than eight consecutive hours.

(b) All telephone reports of unusual occurrences shall be made to the Office of Emergency Medical Services on or before the next business day during regular business hours.

(c) The required written confirmation shall include any additional information known to the licensee, copies of any official reports and licensee's estimate of the degree of disruption of services. This confirmation shall be received by the Department no later than 14 days after the incident.

(d) Information received by the Department of Health through the inspection process authorized by N.J.S.A. 25:2H–1 et seq. shall not be disclosed to the public in such a way as to indicate the names of specific patients or hospital employees to whom the information pertains. The Department shall forward inspection reports to the MICU program hospital at least 30 days prior to public disclosure. In all cases where the hospital comments on the inspection report, the hospital comments and the inspection report shall be released simultaneously by the Department. In cases in which the Commissioner determines that the protection of public health and safety necessitates immediate public disclosure of information, inspection reports may be disclosed immediately.

(e) Notwithstanding (d) above, these rules shall not be construed to interfere with existing legislation or the established rights and privileges of the public prosecutor and litigants having access to hospital records, nor shall determinations herein be construed to interfere in any way with the orderly legal process of obtaining access to such records.

**8:41–2.6 Policy and personnel files**

No approval shall be issued unless the applicant has a policy and procedure manual that meets the requirements of N.J.A.C. 8:41–9 and has personnel files on each employee that consist of the employee's name, home address and documentation of current required certifications and continuing education units on personnel recertified by the program. No program shall develop policies that are contrary to public law or rule.

**8:41–2.7 Enforcement**

(a) The Office of Emergency Medical Services of the Department is empowered to act for the Commissioner and the Department to enforce the provisions of this chapter.

(b) Violation of any portion of this chapter by a program may be cause for action against the program, including, but not limited to, reprimand, suspension of approval or licensure, revocation of approval or licensure, fines, placing of conditions for continued operation of a program, the reassignment of medical command or any combination of these penalties. In addition to any action taken under this chapter, all matters of a criminal nature shall be forwarded to the appropriate authorities for disposition.

(c) Violation of any portion of this chapter by an individual may be cause for action against the individual, including, but not limited to, reprimand, probation, suspension of certification or privileges, revocation of certification or privileges, fines, or any combination of these. In addition to any action taken under this chapter, all matters of professional misconduct shall be referred to the appropriate licensing board(s). Matters of a criminal nature shall be forwarded to the appropriate authorities for disposition.

(d) The Chief Administrator of the Office of Emergency Medical Services may authorize action against a program which is utilizing an unsafe vehicle, as defined by this chapter, including:

1. Immediately placing the unsafe vehicle out of service;

2. Instituting a Departmental action against the program and/or provider responsible for the violation; and

3. Instituting other actions as allowed by law or rule.

### 8:41–2.8 Hearings

Except in circumstances deemed by the Commissioner to be a hazard to public health and safety, no penalty shall be assessed nor approval suspended or revoked without affording the program or accused individual an opportunity for a hearing. In the event of action which results in the suspension of a certificate, approval, license or endorsement, the hearing shall be held within 30 days unless an adjournment is requested by the program or accused individual. Unless otherwise required by this chapter, the procedures governing all hearings shall be in accordance with the Administrative Procedure Act (N.J.S.A. 52:14B–1 et seq.) and N.J.S.A. 26:2H–1 et seq., as well as the Uniform Administrative Rules of Practice N.J.A.C. 1:1.

### 8:41–2.9 Waiver

(a) The Commissioner or his or her designee may grant a waiver of parts of this chapter if, in his or her opinion, such a waiver would not:

1. Endanger the life, safety or health of any person who utilizes the services; or

2. Adversely affect the provision of the service.

(b) A program seeking a waiver of part(s) of this chapter shall apply in writing to:

Office of Emergency Medical Services
New Jersey State Department of Health
CN 367
Trenton, NJ 08625–0367

Amended by R.1994 d.35, effective January 18, 1994.
See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a).

### 8:41–2.10 Research proposals

(a) As used in this section, the following terms are defined as follows:

1. "Research" means a scientific investigation designed to establish facts and to analyze their significance, including:

i. Any study directed at systemizing data related to the causes, mechanisms, diagnosis and treatment of injuries;

ii. Data collection for purposes other than EMS management or evaluation; and

iii. Any other use of EMS client data, unless specifically authorized by this chapter;

2. "Principal investigator" means the person responsible for proposing and coordinating the research project;

3. "Human subject" means the person under consideration who is affected with a disease or condition which is being treated or observed with medical and surgical procedures and about whom the researcher obtains:

i. Historical data (for example, initial symptoms, circumstances surrounding the event, associated medical conditions) through intervention or interaction with the individuals or their family; and

ii. Identifiable private client data as recorded in the ED record, the hospital chart or the EMS prehospital run report;

4. "The Institutional Review Board (IRB)" means the board established by a licensed hospital to review biomedical and/or behavioral research using human subjects that is conducted at or supported by the hospital, in order to protect the rights of the human subject, and to approve said research; and

5. "Participating organizations" means volunteer, municipal or proprietary ambulance companies, licensed MICU programs, a receiving hospital and/or other specific EMS-related organization.

(b) No licensee shall engage in any prospective research activity involving drug trials or invasive procedures, unless first authorized to do so by the Commissioner.

(c) The procedure to request approval to conduct research projects shall be as follows:

1. The principal investigator shall first meet all requirements of the Federal regulations, including those in 42 U.S.C. 6a, III, G289;

2. The principal investigator shall obtain the approval of the IRB at the hospital sponsoring or endorsing the study;

i. If the principal investigator is not a member of the sponsoring institution's medical staff, the proposal shall include the name of the institution's principal investigator responsible for the conduct of the study;

3. The principal investigator shall obtain approval of the MICU's medical director. The MICU medical director has ultimate authority and responsibility for the conduct of the research project;

4. The application shall also include specification of any procedure or drug that is proposed that is not manifestly approved by this chapter;

5. If the proposal is directed to operational systems and is not directly related to human subjects, the principal investigator shall submit documentation that IRB approval is not necessary;

6. Forty copies of the proposal shall be submitted to the Department through the Office of Emergency Medical Services (OEMS) no later than 30 days before the scheduled meeting of the MICU Advisory Council at which the principal investigator wishes to present the proposal;

7. The proposal shall be reviewed at the MICU Advisory Council meeting or by a research subcommittee as appointed by the chair of the MICU Advisory Council. The Council or committee shall review the proposal, make any comments it deems necessary, and make a recommendation with regard to approval or disapproval of the proposal. The recommendation, comments and proposal shall be forwarded to the Commissioner by OEMS; and

8. The Commissioner shall have final authority in the approval or disapproval of all research studies. The Department shall notify the principal investigator of its determination via mail. The study shall not be started until approval is obtained from the Commissioner.

(d) The format of the proposal shall include:

1. Background information, including rationale and relevant literature;

2. Specific aims and objectives, which shall be clearly stated, including the hypothesis and data to be gathered or tested;

3. Significance, relevance, benefits of and justification of the research;

4. Details of the methods utilized, including research design, how results will be analyzed, number and type of clients, research tools utilized, amount of time necessary and any risks involved;

5. If patient procedures or drugs are needed, an explanation of the procedures, risks, frequency, duration and precautions in detail, and a summary of the competence of personnel performing the procedure and the time frames of the study;

6. A detailed description of the mechanisms of patient protection, including:

i. How confidentiality of client data will be maintained, including methods of safeguarding client-identifiable data; and

ii. If the research directly involves human subjects, how consent will be obtained and documented; and

7. Administrative details, including budget, facilities used, and personnel issues.

(e) The Commissioner retains the right to revoke or suspend approval for any research project, regardless of stage of the research, for violations of the terms of the approval, violations of any part of this chapter or applicable statute, violations of patient's rights or confidentiality or for reasons of patient safety.

(f) The principal investigator shall submit interim reports as required by the approval notice to the MICU Advisory Council. These reports shall include:

1. A brief summary of the project with the methodology of the study;

2. Objectives of the study;

3. Results of the study, to date;

4. Amount and type of work remaining; and

5. Any conclusions reached to date.

(g) The principal investigator shall submit a final report to the Commissioner, OEMS and the MICU Advisory Council, including a one page abstract.

(h) If the proposal involves a therapeutic agent not approved in accordance with N.J.A.C. 8:41–8, the Commissioner may authorize the use of said agent in his or her approval of the study. The Commissioner's approval shall specify the length of time the agent may be used, and shall be subject to the terms and conditions imposed in the approval notice. Thereafter, if the medication is to be continued, it must be added to N.J.A.C. 8:41–8 in accordance with the provisions of the Administrative Procedure Act. Only programs officially designated by the principal investigator and authorized by the Commissioner shall utilize any medication under study.

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## SUBCHAPTER 3. VEHICLES AND PERSONNEL

### 8:41–3.1 Vehicle license required

(a) No program shall utilize any vehicle as a primary or back-up MICU unless the vehicle is first inspected and licensed by the Department in accordance with this chapter. The Department shall make an inspection of new vehicles within five business days of the request.

(b) The vehicle license issued in accordance with this chapter shall be valid from July 1 through June 30 of the following year. All new vehicle licenses issued shall expire on June 30. The vehicle thereafter would be subject to the annual license period.

### 8:41–3.2 Inspections

(a) The Department shall conduct inspections on each vehicle approved under this chapter at least once every year. In addition, the Department shall conduct unannounced surveys and program inspections for compliance with this chapter.

(b) Unannounced surveys may be conducted by the Department at any time and at any place the vehicle is located, provided that patient care is not compromised. The scope of the survey shall be determined by the authorized representative of the Department conducting the survey, and may include, but not be limited to: an examination of patient records, equipment, personnel and staffing, vehicles and facility.

### 8:41–3.3 Vehicles

(a) Each program shall secure a sufficient number of vehicles in order to comply with the provisions of N.J.A.C. 8:33N with regard to back-up vehicles.

(b) No program shall allow the operation of any vehicle that is patently unsafe to drive, presents a hazard to personnel and/or bystanders, or has not passed New Jersey Division of Motor Vehicles (N.J.D.M.V.) inspection and does not display a valid inspection sticker.

(c) Each vehicle approved in accordance with this chapter shall be equipped with emergency warning devices, including red lights and a siren, so that it meets the definition of an emergency vehicle as defined by N.J.S.A. 39:1–1 et seq. and N.J.A.C. 13:24.

(d) Each vehicle approved in accordance with this chapter shall be registered and insured in accordance with applicable State law and rule.

(e) MICUs which provide transportation to patients shall meet the standards set forth for emergency ambulances in N.J.A.C. 8:40 as a condition of licensure as a MICU. These vehicles are subject to licensure only as MICU vehicles, in accordance with this chapter. In the event of a conflict between N.J.A.C. 8:40 and this chapter, the MICU shall meet the higher of the two standards.

### 8:41–3.4 Required vehicle markings

(a) Each vehicle licensed in accordance with this chapter shall bear the following markings:

1. The name of the program approved to provide the MICU service and, in the event the vehicle is operated by several hospitals, all participating hospitals named in the certificate of need shall be listed; and

2. The term "paramedics," "mobile intensive care unit," or "Advanced Life Support."

### 8:41–3.5 Required equipment

(a) Every vehicle licensed in accordance with this chapter as an MICU shall be equipped with the following items:

1. All communications equipment as required by this chapter;

2. A cardiac monitor that shall have a DC defibrillator that can provide both defibrillation and synchronized cardioversion, and shall have the capability of producing a paper recording of cardiac rhythms;

3. An external pacemaker;

4. Assorted needles, syringes and intravenous supplies to include:

i. Blood tubes for laboratory specimens;

ii. Intravenous (IV) tubing and catheters;

iii. Phlebotomy equipment; and

iv. Needle and syringe disposal containers;

5. Pediatric equipment to include:

i. Pediatric airway management materials including:

(1) Airways, endotracheal tubes and stylets;

(2) Pediatric and infant laryngoscope blades; and

(3) Pediatric and infant sized oxygen masks and bag-valve-masks;

ii. Pediatric-sized electrodes and paddles for the monitor/defibrillator;

iii. Pediatric and infant-sized IV catheters and/or winged infusion sets;

iv. Intraosseous infusion sets; and

v. Pediatric and infant sized blood pressure cuffs;

6. Adult airway management equipment to include:

i. Oropharyngeal and nasopharyngeal airways of various sizes;

ii. Laryngoscope blades, handles, endotracheal tubes, and stylets; and

iii. Oxygen masks, cannulas and bag-valve-masks;

7. Oxygen in a United States Department of Transportation (U.S.D.O.T.) approved cylinder that has a current hydrostatic testing date on it, in accordance with U.S.D.O.T. Regulations;

i. Each oxygen system shall have a flowmeter. Each flowmeter shall have a gauge or dial with a range of at least zero to 15 liters per minute (lpm) in calibrated increments. The flowmeter on portable systems shall be non-gravity dependent. Flowmeters shall be accurate to within one lpm when at a setting equal to or less than five lpm, 1.5 lpm when at a setting between six and 10 lpm and within two lpm when at a setting equal to or greater than 11 lpm. Non-dial type flowmeters must take at least one full turn to go from zero to 15 lpm. Indicators on dial-type flowmeters must be securely seated at each flow rate position;

ii. All bag-valve-masks shall be free from leaks, and shall be clean and free of contamination. The bags shall recycle at a rate of 20 times a minute for an adult unit, 30 times a minute for pediatric units and 40 times a minute for infant units, shall have an oxygen supply (reservoir) system and shall be capable of providing adequate resuscitation pressures. Any bag that has a "pop off valve" shall have a device to easily defeat the valve;

8. A portable suction unit that is capable of providing adequate suction to clear a patient's airway. In addition, each transport MICU shall be equipped with an on-board suction unit. All suction units shall meet the following standards:

i. All installed suction units on transporting MICUs shall be powered by the vehicle's electrical system and shall be securely mounted in a location to allow easy access to the patient on the stretcher, shall provide a flow rate of at least 30 liters per minute and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg;

ii. Each portable suction unit shall be powered by an integral battery or by gas. Each portable suction unit shall meet the requirements of the vehicle suction unit for flow and vacuum pressure as described above. It shall meet the standard both initially and after 20 minutes of continuous operation;

iii. Each suction unit shall be equipped with a non-breakable collection bottle, at least three feet of non-collapsible suction tubing and an assortment of adult and pediatric-sized suction catheters;

9. A sterile obstetrical delivery/emergency childbirth kit that contains four towels, 12 sterile gauze compresses (four inches by four inches), four sterile umbilical cord clamps, one sterile bulb syringe (aspirator), one receiving blanket, four pairs of sterile surgeons gloves, one pair of sterile scissors or a sterile scalpel and one set of eye protection. If these items are in a sealed sterile pack, the packet shall have a list of contents affixed to it. Items needed for this requirement may also be readily available on the vehicle if not included in the package;

10. Trauma supplies to allow adequate treatment of trauma and burn patients, to include:

i. Adult sized pneumatic anti-shock garment (PASG);

ii. Material for bandaging;

iii. Sterile dressings;

iv. Occlusive dressings;

v. Burn sheets or burn dressings;

vi. Blood pressure cuffs; and

vii. Equipment to perform needle chest decompression;

11. Only those medications listed in N.J.A.C. 8:41–8.1, and no others;

12. Nasogastric tubes and irrigation syringes;

13. Personnel protective gear to include helmets, goggles and gloves, protective outer garments to include at least two sets of full protective outer garments, disposable exam gloves, and personal protective isolation garments;

14. A current copy of the U.S. Department of Transportation (D.O.T.) Emergency Response Guidebook (obtainable from the Superintendent of Documents, Washington, D.C. 20402, or U.S.D.O.T., National Highway Traffic Safety Administration, 7th St. SW, Washington, D.C. 20590) and a copy of the program's approved radio failure protocols that is to be kept in each licensed vehicle;

15. Assorted sizes of rigid cervical collars;

16. A long spine board;

17. Back-up medications and other equipment needed to provide for uninterrupted service; and

18. A set of binoculars.

### 8:41–3.6 Optional equipment

(a) Each program may carry additional equipment it deems necessary for the provision of prehospital ALS, provided that equipment does not permit staff to render care beyond that allowed under this chapter. These may include:

1. An Esophageal Gastric Tube Airway, and other commercial airways;

2. A time-cycled resuscitator, provided the device meets ventilatory requirements of the American Heart Association;

3. Pulse-oximeters;

4. Positive pressure resuscitators ("demand valve" resuscitators). Each device shall provide 100 percent oxygen, have an instantaneous flow rate between 35 and 45 liters per minute, deliver an inspiratory pressure between 55 and 65 cm water and have a standard 15/22mm fitting;

5. A spinal immobilization device (for example, K.E.D.); and

6. Pediatric-sized pneumatic anti-shock garment (PASG).

### 8:41–3.7 Back-up vehicles

Back-up vehicles need not have the required equipment as listed in this subchapter at all times, provided that, when the vehicle is utilized as an MICU, all required equipment shall be in place and operational.

### 8:41–3.8 Vehicle out of service logs

Each vehicle approved under this chapter shall have a log kept which specifies out of service time, the cause of the problem and its resolution. Additionally, each program shall develop and maintain a program of preventive maintenance for each licensed vehicle.

### 8:41–3.9 Safety of operation

The responsibility for safe operation of each vehicle licensed under this chapter shall rest with the advanced life support personnel staffing that unit. No provider shall operate any vehicle licensed under this chapter without due regard for the safety of the general public or without adhering to all applicable statutes.

### 8:41–3.10 Storage of equipment

All equipment carried by a licensed MICU shall be stored in a manner not presenting a hazard to any vehicle occupant in the event of an accident or sudden change in vehicle speed or direction.

### 8:41–3.11 Biomedical equipment maintenance

(a) Each program shall develop and maintain a program of maintenance for its biomedical equipment in accordance with institutional policy, including, but not limited to, a maintenance program for cardiac monitor/defibrillators and external pacemakers.

(b) Each item of biomedical equipment shall be checked in accordance with institutional policy by a qualified biomedical engineer or service technician to determine accuracy and safety. The program shall maintain a record of the service of its biomedical equipment.

### 8:41–3.12 Sanitation

(a) Each vehicle licensed under this chapter shall be kept in a neat, clean, orderly fashion so as to permit easy access to equipment and supplies.

(b) Each vehicle shall be free from blood or other bodily fluids and noxious odors.

(c) All patient care equipment shall be kept in a clean, sanitary condition free from noxious odors, bodily fluids or other contaminants.

(d) Non-disposable patient care equipment shall be decontaminated after each patient use in a manner consistent with the hospital's requirements for equipment decontamination. No airway, tube, catheter or other similar device shall be used on more than one patient unless sterilized in accordance with manufacturer's recommendations.

(e) No vehicle shall carry any medication, solution or other equipment beyond the expiration date posted on it.

(f) Each vehicle and cabinet or other storage place for medications shall be sufficiently climate controlled so that the medications and solutions are kept within the temperature range recommended by the manufacturer.

### 8:41–3.13 Director

(a) Every program approved under this chapter shall have a director who shall be responsible for all activities of the mobile intensive care program.

(b) No person shall be appointed as the director unless that person is either a certified paramedic or a currently licensed registered nurse with at least one year of critical care experience or who has demonstrated by education or experience the ability to manage health care organizations.

(c) Each program shall notify the Department in writing of any change of director within 14 days after the change.

### 8:41–3.14 Minimum staffing

No program shall operate a mobile intensive care unit unless that unit is staffed by a minimum of two prehospital ALS providers as defined in this chapter.

### 8:41–3.15 Hours of operations

(a) Each MICU authorized under this chapter shall operate 24 hours a day, seven days a week, unless otherwise restricted by the program's certificate of need. In the event the program is unable to meet this requirement and coverage is interrupted, the program shall:

1. Assure that the service area is covered by another approved mobile intensive care program to the level of service that would normally be provided; when there is an interruption in service of greater than eight hours; and

2. Notify the Office of Emergency Medical Services by telephone on the next business day during regular business hours, followed by written confirmation if there is an interruption in service of greater than eight hours.

### 8:41–3.16 Addition of temporary MICU vehicles

(a) A program approved in accordance with this chapter may place a temporary MICU vehicle in service if public safety concerns necessitate additional coverage for a limited period of time. This shall include:

1. Events where a large number of people are expected to gather;

2. A temporary change in the accessibility of the service area (for example, bridge or road closures);

3. A mass casualty incident (MCI), disaster, an emergency situation, as a part of an organized emergency preparedness action or drill; and/or

4. Other situations that are not covered by this section, but which have been approved in advance by the Office of Emergency Medical Services (OEMS) of the Department.

(b) No program shall operate a temporary MICU without obtaining prior approval from OEMS, excluding the situations listed (a)3 above. The procedure for obtaining approval shall be as follows:

1. The program shall make application to OEMS in writing. Each application shall include:

i. Details of the special event, including the reason for an additional MICU(s);

ii. Documentation that the program's primary service area coverage will not be affected; and

iii. If the site of the proposed vehicle is not within the program's primary service area, an agreement signed by the program that is the primary provider for MICU services at that location;

2. If circumstances arise that leave insufficient time for the program to apply in writing, the program may apply by telephone during regular business hours, Monday through Friday (9:00 A.M. to 5:00 P.M.), provided that written application is made as soon as is practical; and

3. If additional units are placed into service due to the situations listed under (a)3 above, the program shall notify OEMS by phone on or before the next business day during regular business hours (Monday through Friday, 9:00 A.M. to 5:00 P.M.).

(c) OEMS will review all applications and, when appropriate, issue approvals in consideration of specific circumstances and in the interest of public health and safety. These approvals shall set forth the number of additional vehicles approved, hours of operation and the duration of the approval. Each program operating the additional units shall adhere to the terms and conditions of the approval.

(d) Nothing in this section shall be construed to permit the operation of part-time or seasonal vehicles. Such units are subject to the certificate of need process as set forth in the Health Care Facilities Planning Act (N.J.S.A. 26:2H–1 et seq.).

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## SUBCHAPTER 4. TRAINING AND CERTIFICATION OF ADVANCED LIFE SUPPORT PERSONNEL

### 8:41–4.1 Paramedic student selection

(a) No person shall be enrolled as a paramedic student in any program, nor shall any person be eligible to be certified as a paramedic, unless that person:

1. Has reached his or her 18th birthday;

2. Has a high school diploma or its equivalent;

3. Is currently certified by the Commissioner as an Emergency Medical Technician–Ambulance (EMT–A), or Intermediate (EMT–I) in accordance with the standards established by the United States Department of Transportation pursuant to 23 U.S.C. 401 et seq. and incorporated herein by reference and maintains certification as at least an EMT–A throughout the training and until either certification as a paramedic or termination from the training program;

4. Maintains current certification in cardiopulmonary resuscitation to the level of professional rescuer, in accordance with the standards of the American Heart Association, and maintains the certification throughout the training and until either certification as a paramedic or termination from the training program;

5. Is physically capable of performing all required skills of a paramedic student; and

6. Has not been convicted of any crime, or an offense involving moral turpitude or drugs.

i. An applicant may apply for a waiver of this requirement from the Commissioner or designee, in accordance with N.J.A.C. 8:41–2.9.

Amended by R.1994 d.35, effective January 18, 1994.
See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a).

### 8:41–4.2 Didactic sites

(a) No person, group, program or agency, whether public or private, shall offer, or claim to offer, paramedic didactic or clinical training unless authorized by the Department to do so.

(b) Any New Jersey college accredited by the Department of Higher Education may seek to sponsor a didactic program through application to the Office of Emergency Medical Services of the Department. Applications shall include proposed lesson plans, affiliated clinical sites and other information as deemed necessary by the Department, including, but not limited to, instructional staff, physical plant and course content. Approval of new sites shall be based on system needs as determined by the Department. No classes shall be offered until approval is granted by the Department, subsequent to the Department's evaluation of the current supply of trained personnel, as it relates to need for such personnel.

(c) All paramedic didactic programs shall include, as a minimum, the curriculum as set forth in the United States Department of Transportation Emergency Medical Technician–Paramedic National Standard Curriculum, incorporated herein by reference. While additional material may be presented, all topics of the curriculum shall be covered.

(d) The Department, through the Office of Emergency Medical Services, shall conduct audits and inspections to insure compliance with the provisions of this subchapter. Authorized didactic sites shall submit reports to the Depart-

ment as required, including, but not limited to, course schedules, students registered and attending on the first night of class and final grade reports of students enrolled.

**8:41–4.3 Authorized clinical training sites**

(a) Any hospital approved to provide mobile intensive care unit services may seek to offer a paramedic clinical training program. The hospital shall make application to the Department's Office of Emergency Medical Services. Applications shall include clinical resources, training objectives, didactic affiliations, the name of the medical director responsible for overseeing the training, and other such information as required by the Department of a specific applicant. No students may be sponsored for didactic training unless the sponsoring program is approved by the Department to provide clinical training in accordance with this chapter.

(b) The Department, through the Office of Emergency Medical Services, shall conduct such audits and inspections as required to insure compliance with the provisions of this subchapter. Authorized clinical training sites shall submit student rosters to the Department as needed to monitor the programs for compliance with this chapter.

(c) All paramedic clinical sites shall conduct their programs in compliance with the clinical training objectives of the Office of Emergency Medical Services as delineated at N.J.A.C. 8:41–11. All clinical training sites shall maintain accurate records of the students' progress, documenting satisfactory completion of all completed clinical objectives. These records shall be presented to the Department for inspection upon demand.

**8:41–4.4 Emergency medical services (EMS) educator**

Every clinical training program offered under this chapter shall employ a qualified individual who shall be an advanced life support provider, as defined by this chapter, to coordinate the training activities. The EMS educator shall also ensure that the records required by this subchapter are maintained. The EMS educator shall insure that the trainee performs and demonstrates competence in all skills authorized to be performed in accordance with this chapter, prior to endorsing the candidate for certification by exam.

**8:41–4.5 Evaluations**

The EMS educator shall provide each student at least four periodic written and verbal assessments. These evaluations shall be signed by both the EMS educator and the student.

**8:41–4.6 Timespan allowed**

(a) All clinical training requirements shall be completed within 18 calendar months of the completion of the didactic program. Candidates are eligible to request a three-month extension to complete the clinical training requirements. The requests shall be made to the Department and shall:

1. Be made in writing by the EMS educator responsible for the student and received no later than 30 days before the expiration of the clinical training period;

2. Include the candidate's name, didactic training site, didactic completion date, and clinical sponsor;

3. Include an explanation of the need for the extension; and

4. Contain an endorsement of the request by the EMS educator and a statement reaffirming clinical sponsorship.

(b) Candidates shall be advised, through their EMS educator, of the outcome of their request within 30 days of receipt by the Department. Only one clinical training extension will be granted per candidate. Candidates who receive an extension shall enter the examination process as defined by this subchapter by the first certification examination offered after the extension expires.

(c) Any student failing to complete clinical training within the time span allowed by (a) above shall be required to complete a didactic course of study equivalent to the U.S.D.O.T. refresher curriculum for paramedics, the balance of the clinical time required and any additional time the EMS educator deems necessary to demonstrate competence in the required clinical training objectives. In no instance shall the total training period exceed 36 months from the beginning of the didactic training program.

(d) Paramedic students shall not transfer clinical sponsorship during the course of the training unless the change is endorsed by both the original sponsor and the intended sponsor.

**8:41–4.7 Preceptor orientation**

(a) The EMS educator shall insure that all personnel providing clinical preceptorship to students who are being trained in accordance with this chapter:

1. Are clinically competent to provide the necessary training; and

2. Have received formal orientation to the training program.

**8:41–4.8 Certification examinations**

(a) Certification examinations for paramedics shall be scheduled a minimum of four times per calendar year.

(b) No person, except as otherwise permitted by this chapter, shall be permitted to take the paramedic certification examination unless the person shall have first completed the approved training program specified in this chapter.

(c) Application for the certification examination shall be made on forms prescribed by the Department, which shall bear the endorsement of both the EMS educator and medical director of the clinical training site. All signatures shall be original.

(d) All applications shall be received by the Department by the announced closing date to be considered for the examination. If the application is received after the closing date, it shall be returned to the candidate with an explanation of his or her ineligibility for that examination.

(e) All examinations shall be conducted in accordance with the rules established by the Department, as well as any procedural requirements set forth by any testing agency utilized by the Department for the purpose of paramedic certification.

(f) Upon successful completion of the certification examination, candidates shall be certified by the Department for a period of two years. Expiration dates shall be either on June 30 or December 31, as determined by the Department with regard to the examination date.

(g) Only the Department shall be permitted to administer the examination or any parts thereof. Evaluators shall administer the examination in a manner consistent with the rules and policies of the Department and any agency authorized to administer the examination. Failure to do so shall be cause for revocation of evaluator status, as well as any other action permitted by this chapter.

**8:41–4.9 Paramedic certification**

(a) Any person who has successfully completed the examination process or has been granted full reciprocity by the Department in accordance with N.J.A.C. 8:41–4.15 shall be deemed certified as a mobile intensive care paramedic by the Commissioner for a period of two years. Expirations of all permanent certifications shall be on June 30 or December 31, dependent on the date of initial certification. All certifications shall remain valid and in force unless suspended, revoked or otherwise cancelled in accordance with this chapter.

(b) Each paramedic certified by the Department under this chapter shall provide to the Department his or her full name, permanent mailing address and other information as required by the Department and law. This information shall be maintained by the Department permanently and shall be used to meet the requirements of N.J.S.A. 26:2K–7 et seq. Any paramedic certified in accordance with this chapter shall notify the Department of any change of address or name and shall provide appropriate documentation as required by the Department.

**8:41–4.10 Paramedic recertification**

(a) Every paramedic certified in accordance with this chapter shall document successful completion of continuing education requirements as listed in this chapter, on a form to be submitted to the Department. These continuing education hours shall be accumulated over a two-year period. In the case of a paramedic, these credits shall be accumulated during the period of certification as issued by the Department.

(b) All paramedics shall maintain current certification in:

1. Advanced Cardiac Life Support (ACLS) to the standards of the American Heart Association; and

2. Cardiopulmonary Resuscitation (CPR) to the professional rescuer level to the standards of the American Heart Association.

(c) No person shall be recertified unless documentation of the required certifications, as specified in (b) above, accompanies the recertification application.

(d) Paramedics shall practice ALS only when in compliance with the certification requirements of this chapter.

(e) A minimum of 48 hours of advanced level continuing education shall be accrued by prehospital advanced life support personnel over the two year period specified by (a) above, in accordance with the following:

1. The continuing education hours shall cover a minimum of three of the six divisions of the United States Department of Transportation National Standard Curriculum for Paramedics;

2. A minimum of 36 hours shall cover divisions two through six. No more than 12 hours shall be applied to division one; and

3. The Department may evaluate standard courses (for example, New Jersey State Police HAZ–MAT courses) and college and professional (for credit) courses to determine applicability to paramedic recertification. The Department shall provide information on approvals to interested parties.

(f) In addition to required continuing education, paramedics shall demonstrate to their medical director proficiency in all skills approved for prehospital care, as specified by N.J.A.C. 8:41–7.2. Proficiency may be demonstrated based on actual observation, field performance, or other methods as deemed necessary by the medical director. The medical director shall complete the forms required by this section and submit them to the Department attesting to the level of proficiency of each paramedic seeking recertification. Such forms shall reflect whether the skill level is satisfactory and shall bear the original signature of the medical director. The director or EMS educator shall keep records to allow the completion of such forms that may be required for recertification.

(g) Each paramedic shall perform a basic life support skills review on a biennial basis. These reviews shall be

under the direction of a New Jersey State Certified EMT–A instructor for those skills which are a component of the U.S.D.O.T. curriculum for Emergency Medical Technicians including but not limited to, KED, HARE, MAST. In addition, the EMS educator shall designate qualified persons (for example, a Prehospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS) instructor or an EMT–A instructor with proficiency in the area) to oversee the review of rapid takedown and standing long backboard skills and other advanced concepts that are considered to be basic life support skills. Each EMS educator shall maintain a record of the required BLS review on a form prescribed by the Department in this section.

(h) Each paramedic seeking recertification shall have the endorsement of an approved program, prior to application for recertification. The Director or EMS educator of the program endorsing the paramedic shall verify that all portions of these requirements have been met and that the paramedic is physically capable of performing his or her duties and shall forward all required documentation to the Department. The director or EMS educator shall sign the endorsement.

**8:41–4.11 Mobile intensive care nurses**

(a) No licensee shall utilize a nurse in the capacity of a prehospital ALS provider unless:

1. The nurse is currently licensed as a registered nurse by the New Jersey Board of Nursing;

2. The nurse has completed at least one year in the provision of nursing care in hospital critical care units or emergency departments, as defined in N.J.A.C. 8:43G–9 and 8:43G–12;

3. The nurse is currently certified in advanced cardiac life support to the standards of the American Heart Association;

4. The nurse is currently certified as an Emergency Medical Technician—Ambulance (or greater) by the Commissioner;

5. The nurse is currently certified in cardiopulmonary resuscitation to the level of professional rescuer to the standards of the American Heart Association;

6. The nurse has successfully completed at least a 100–hour field internship on an approved mobile intensive care program's vehicle and has demonstrated proficiency in prehospital advanced life support to the satisfaction of the program's medical director;

7. The nurse is sponsored by an approved mobile intensive care program; and

8. The nurse is physically capable of performing the duties of a mobile intensive care nurse.

(b) Once the mobile intensive care nurse candidate has successfully met the qualifications as required by this section the physician medical director shall endorse the nurse as a mobile intensive care nurse. This endorsement shall include a statement attesting to the competency to perform all skills allowed for prehospital advanced life support personnel as defined by this chapter. This endorsement shall be forwarded to the Department as soon as practical after completion of all requirements. If the candidate is not endorsed after training, the candidate shall be entitled to a hearing as defined in N.J.A.C. 8:41–2.

(c) Each mobile intensive care nurse endorsed to act as a prehospital ALS provider shall be required to renew the endorsement every two years. Each mobile intensive care nurse shall meet the requirements listed in N.J.A.C. 8:41–4.10 in order to have the endorsement renewed. A copy of verification of compliance with N.J.A.C. 8:41–4.10 shall accompany the medical director's endorsement.

(d) Mobile intensive care nurses shall practice on an MICU only when in compliance with the certification requirements of this chapter.

(e) Notwithstanding the provisions of N.J.A.C. 8:41–4.1, a mobile intensive care nurse endorsed in accordance with this chapter shall be eligible to sit for certification as a paramedic upon meeting other requirements needed to enter the examination process as required by the National Registry of EMTs.

(f) Provided that the requirements for recertification as a prehospital ALS provider are met in accordance with N.J.A.C. 8:41–4.10, the EMT–A certification of the mobile intensive care nurse shall be renewed for a period of two years from the date of the expiration of the previous EMT–A card.

**8:41–4.12 Denial of recertification or renewal of endorsement**

(a) If a program or medical director does not recommend recertification or a renewal of an endorsement of any prehospital ALS provider, an accompanying statement shall be forwarded to the Department documenting why such action is being taken. Such documentation shall include a plan for remediation, if applicable. The Department shall review this information and will notify the prehospital ALS provider of the recommendation of the program's medical director. Individuals denied recertification or renewal of endorsement shall be entitled to a hearing in accordance with N.J.A.C. 8:41–2. No certification or endorsement shall be suspended, revoked or denied, except for just cause.

(b) If a program determines that a prehospital advanced life support provider, as defined by this chapter, may not be eligible to be recertified or re-endorsed, the program shall notify the Department and the prehospital ALS provider by certified mail at least 60 days prior to the expiration of the certification or endorsement.

### 8:41–4.13 Recertification extensions

(a) Any advanced life support provider who has not been able to meet recertification or endorsement renewal requirements due to personal illness or injury may request a one-year extension of his or her certification or endorsement. Such request shall be made to the Department and shall contain:

1. The reasons for the extension;

2. Medical documentation from a licensed physician; and

3. A letter of endorsement from an approved MICU program.

(b) The length of the extension shall equal the period of disability, but shall not exceed one year.

(c) The Department shall notify the applicant of its decision within 30 days of receipt of the request.

(d) Causes other than medical reasons will be reviewed on a case by case basis by the Commissioner or his or her designee.

### 8:41–4.14 Paramedics with expired certifications

(a) A paramedic formerly certified by the Department whose certification has expired is eligible to enter the retraining process provided:

1. He or she is currently certified by the Commissioner as an EMT–A, EMT–D or EMT–I; and

2. He or she is currently certified in cardiopulmonary resuscitation to the standards of the American Heart Association (AHA), National Center, 7320 Greenville Ave., Dallas, TX 75231.

(b) A paramedic with an expired certification who seeks to obtain a valid certification shall obtain the sponsorship of an approved clinical training site, in accordance with the provisions of this chapter.

(c) Candidates for retraining shall forward an application to the Department through their EMS educator. This application shall contain such information as required by the Department, including but not limited to, name, address, demographic information and sponsoring hospital.

(d) Each candidate shall complete a didactic training program equivalent to the U.S.D.O.T. refresher curriculum for paramedics. Prior to the completion of the didactic training program, the candidate shall become certified in advanced cardiac life support to the standards of the American Heart Association and in prehospital trauma life support to the standards of the National Association of EMTs, and shall complete any other training required to enter the examination process as determined by the testing agency, such as the National Registry of EMTs.

(e) Following the completion of the requirements listed in (d) above, each candidate shall enter into a period of clinical training that shall consist of 200 hours. These hours shall be completed within one calendar year of entering into the program. No hours may be completed until the candidate is notified by the Department that he or she has been admitted into the program.

(f) The areas covered by the training shall be determined by the educator, based on the needs of the candidate, and shall be scheduled at the discretion of the EMS educator.

(g) In addition to the 200 hours of clinical training, the candidate shall submit documentation as required by the designated testing agency, including but not limited to, certification and medical director endorsement.

(h) During retraining, the candidate shall have the same status as a paramedic student, and shall not act independently to provide prehospital advanced life support.

(i) Once the candidate has met the requirements of this chapter, he or she shall be permitted to take the certification examination as provided for in this section.

(j) Once the candidate has successfully completed the examination process, he or she shall be issued a certification, bearing the candidate's previous certification number, valid for a period of two years.

(k) A paramedic who has his or her certification expire shall be issued an EMT–A certification card valid for one year from the date of the expiration of the paramedic certification.

### 8:41–4.15 Reciprocity

(a) Individuals who are currently certified by another jurisdiction as a paramedic, and who have completed a course of study equivalent to or greater than that required of New Jersey paramedics, which adheres to the U.S.D.O.T. curriculum for paramedics, shall be deemed eligible for reciprocity. If training hours are below what is required, the sponsoring site may provide any additional clinical experience needed to complete this requirement.

(b) A paramedic currently certified by another jurisdiction seeking New Jersey certification shall seek affiliation with an approved MICU program. The candidate and MICU program shall jointly apply for reciprocity for the candidate. All requests shall be made in writing, and shall be in a form and manner specified by the Department, including, but not limited to, certifications currently held and demographic and identifying information.

(c) The Department shall verify all requests for reciprocity in a timely manner. The Department shall obtain written verification as to the candidate's status from the certifying agency under which he or she is certified.

(d) Only currently certified paramedics in other jurisdictions shall be eligible for reciprocity, provided the certification period is less than two years from the date it was issued (for example, the certificate is not in the third year of a four-year certification period).

(e) Once all information is verified, and the Department determines the candidate is eligible for reciprocity, a temporary certification shall be issued. This certificate shall be valid for a one-year period or the duration of the current certification, whichever is the lesser amount of time, which shall be deemed a probationary period, in accordance with this chapter.

(f) Individuals who are not currently registered by the National Registry of EMTs as a paramedic shall enter the first New Jersey advanced level certification examination after the issuance of a temporary certification, and successfully complete the certifying examination process as specified in this section prior to the expiration of their temporary certification.

(g) Any person who has taken the test, but has not passed, and has his or her certification expire, may seek to have his or her temporary certification extended until the next available examination. Only one extension shall be granted.

(h) If a candidate fails to gain full certification at the expiration of the temporary certification, he or she shall be ineligible for certification in New Jersey, unless he or she successfully completes the training program as specified in this chapter for paramedics with expired certifications.

(i) Upon successfully completing the certification exam, or at the end of the probationary period (as applicable), the candidate shall be certified in accordance with this chapter.

(j) Any reciprocity candidate who is currently registered as a paramedic by the National Registry of EMTs shall be eligible for full certification, after at least six months of temporary certification, upon endorsement of the sponsoring MICU program.

**8:41–4.16 Probationary periods**

(a) Any prehospital ALS provider who is placed on probationary status by the Department shall be monitored for performance by the program's medical director and the Department.

(b) Probationary providers shall operate only when under the supervision of an approved prehospital life support provider or physician. Under no circumstances may a probationary provider act independently or in conjunction with another probationary provider on the same MICU vehicle.

(c) The EMS educator or director of the approved MICU program shall monitor the progress of the probationer, and shall forward to the Department a progress report at the end of the probationary period, or as required by the Department.

(d) The Department shall have the right to restrict or otherwise limit the scope of practice of the probationer. Failure to meet such conditions or any terms of the probationary period shall be deemed cause for revocation of certification or endorsement and/or other such action the Department deems appropriate.

**8:41–4.17 Scope of practice; limitations**

(a) No paramedic shall engage in any activity independent of an approved mobile intensive care program that would require him or her to perform as a prehospital ALS provider as defined by law or rule, unless otherwise authorized by law or this chapter.

(b) All prehospital ALS providers operating on a licensed mobile intensive care unit shall operate within the scope of practice as defined by this chapter. This requirement shall not apply to physicians licensed in New Jersey by the State Board of Medical Examiners.

**8:41–4.18 Disciplinary action; suspensions, revocation and penalties for prehospital ALS providers**

(a) The Department may suspend, revoke or refuse to issue or reissue the certification or cancel an endorsement of any prehospital ALS provider upon receipt of a complaint and subsequent investigation for the following:

1. Demonstrated incompetence or inability to provide adequate services as required by this chapter;

2. Deceptive or fraudulent procurement of certification or endorsement credentials;

3. Willful or negligent practice beyond that which is specifically authorized by this chapter;

4. Abuse or abandonment of a patient;

5. Rendering of services while under the influence of alcohol or drugs;

6. Operation of an emergency vehicle in a reckless manner or while under the influence of alcohol or drugs;

7. Unauthorized disclosure of medical or other confidential information;

8. Willful preparation or filing of false medical reports, or the inducement of others to do so;

9. Destruction of medical or other records required to be maintained by this chapter;

10. Refusal to respond to a call or to render emergency medical care because of a patient's race, sex, creed, national origin, sexual preference, age, disability, medical condition or ability to pay;

11. Failure to comply with any part of these rules;

12. Failure to comply with the patient reporting requirements of this chapter;

13. Failure to complete continuing education and performance standards as required by this chapter;

14. Conviction of a crime, including any crime involving moral turpitude, or conviction of any offense resulting from action as a prehospital ALS or BLS provider. Conviction shall mean a finding of guilt by a judge or jury, a guilty plea, a plea of nolo contendere or non-vult or entry into a pre-trial intervention program;

15. Misuse or misappropriation of drugs, medications or controlled equipment;

16. Willful obstruction of any official of the Department or other agency empowered to enforce the provisions of this chapter or New Jersey law;

17. The authority to engage in prehospital care has been suspended or revoked or had action taken by any other state, agency or authority for reasons consistent with this chapter; and

18. Any other action deemed by the Department to pose a threat to public health and safety.

(b) Suspension of certification or endorsement shall have the effect of prohibiting the prehospital ALS provider from operating in that capacity on any MICU licensed in the State. The suspension shall last for a specified period, and may be followed by a probationary period. No person shall serve on any MICU while suspended by the Commissioner.

(c) No person shall serve on any licensed MICU, once his or her certification or endorsement is revoked. No person shall be enrolled as a student, nor shall he or she seek endorsement as a MICN if his or her paramedic certification or MICN endorsement has been revoked, without specific authorization by the Commissioner.

(d) A prehospital ALS provider may be suspended by the Department during the course of an investigation of allegations, if the Department demonstrates that public safety and health require such an interim suspension. All persons who are suspended in such a manner shall be afforded the right to an immediate hearing in accordance with this chapter and New Jersey law.

(e) No provider shall have any action taken against his or her certification or endorsement, excluding an emergent situation as described by (d) above, unless that person shall have been afforded a hearing in accordance with this chapter.

(f) The Department may seek to impose a probationary period, a fine or both in lieu of any suspension or revocation. Action taken against an individual does not preclude any action that may be taken against a program for the same infraction. Any action taken under this section shall be separate from any civil, criminal or other judicial proceeding, including actions against licenses of health care professionals issued by other Departments or Boards.

(g) The Department shall notify all programs by mail of any disciplinary actions taken under this section.

**8:41–4.19 Report of unlawful or prohibited conduct**

Every prehospital ALS provider authorized to operate under this chapter shall report in a timely manner to the Department's Office of Emergency Medical Services (OEMS) any and all incidents or series of incidents which, upon objective evaluation, leads to the good faith belief that the conduct is in violation of any law or rule. The Department shall investigate all reports in a timely manner.

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## SUBCHAPTER 5. COMMUNICATIONS

**8:41–5.1 Dispatch of mobile intensive care units**

Each program operating mobile intensive care units, as defined by this chapter, shall be dispatched by a regional dispatch center approved by the Department, in accordance with this chapter.

**8:41–5.2 Dispatch centers; criteria**

(a) Approved dispatch centers shall be capable of providing:

1. Coordinated dispatch activity among various mobile intensive care units, basic life support units and first responders;

2. Dispatching of mobile intensive care units that is in compliance with the service area designations as determined by the certificate of need;

3. Adequate radio coverage to the mobile intensive care units the dispatch center serves;

4. Other emergency services that may be required, including coordination of mass casualty incidents and disasters; and

5. Record retention, including a log of all requests received for service, times as recorded by the dispatch center, the unit assigned to the request, requests not assigned to the primary unit for that area due to the vehicle being unavailable, and tape recording, either digital or analog, of required frequencies as determined by the dispatch center and the Department.

(b) Dispatch centers may be consortium-based or by county.

(c) Each mobile intensive care program shall furnish documentation to the Department that it has secured the services of an approved dispatch center prior to the issuance of an approval, in accordance with this chapter. The Department shall be informed of any proposed change in the dispatch arrangement prior to any such changes. All proposed dispatch agreements shall be subject to approval by the Department.

**8:41–5.3 Communication equipment required**

(a) Every mobile intensive care vehicle licensed under this chapter shall have communication equipment that will allow the prehospital advanced life support personnel to:

1. Directly contact the approved dispatch agency;

2. Directly contact any hospital emergency room via use of the HEAR system (155.340 mHz);

3. Directly contact the mobile intensive care units that operate in the area immediately bordering the vehicle's territory;

4. Directly contact the base hospital's medical command physician while away from the vehicle and to send telemetered electrocardiograms when required via the approved MED channels;

5. Interface with appropriate disaster control agencies in accordance with local and county emergency plans; and

6. Directly contact the dispatch agency while away from the vehicle.

(b) Each program and dispatch center approved under this chapter shall not operate on any frequency in violation of any law, regulation or rule, including those of the Federal Communications Commission.

(c) Each approved program operating under this chapter shall develop and maintain a communications plan. This plan shall be consistent with the JEMS Communication Plan or other plans promulgated by either the Federal Communications Commission or the Department. The Department shall review each plan, and if appropriate, will approve the plan in accordance with this subsection or with N.J.A.C. 8:41–2.9 (Waiver).

**8:41–5.4 Biomedical telemetry; communications**

(a) Each program approved by the Department shall insure that each mobile intensive care vehicle has operational biomedical telemetry and other such communications as may be required to meet the requirements of N.J.S.A. 26:2K–10 and this chapter.

(b) Each program approved in accordance with this chapter shall assure that there is a working communications base station at each approved medical command site that will permit the receiving of voice communications as well as telemetered electrocardiograms. Such base station shall be positioned in the emergency department and shall be readily accessible to the medical command physician.

(c) Each approved program shall have the capability of providing a recording of both transmitted and received voice communications, as well as any telemetered electrocardiograms. Tape recordings shall be maintained in accordance with the provisions of this chapter and shall be produced upon the demand of an authorized member of the Department.

(d) Each time the mobile intensive care unit calls the base station for medical command, a tape recording of the call shall be made. This shall be done regardless of whether the means of communication is radio (including HEAR), telephone or any other approved means.

(e) Each program shall be able to retrieve an auditable tape recording for at least 90 percent of the calls where medical command is contacted.

**8:41–5.5 MED channels**

(a) Each mobile intensive care unit and each base station shall be capable of utilizing any of the 10 MED Channels, as defined by 47 CFR 90.53, and shall engage in coordinated usage of these channels by use of a regional coordinating center. These regional coordinating centers shall be as currently designated by the Department, in accordance with the certificate of need application process.

(b) MED Channels 1 through 8 are to be utilized only for the purpose of medical command, as defined in N.J.A.C. 8:41–1.

(c) MED Channels 9 and 10 shall be utilized for frequency coordination and other administrative types of communication as may be needed and as assigned by the JEMS Communication Plan.

(d) No person, agency or program shall engage in any activity that could interfere with the legitimate medical command functions outlined by this chapter.

**8:41–5.6 Alternative communications**

(a) Any program seeking to provide medical command by means other than the MED Channels described in this chapter shall make application to the Department prior to utilizing any alternative device or means. No change shall be effected until approval is obtained from the Department nor shall any program cease to participate in regional coordination of MED channels.

(b) The Department shall review each application to determine compliance with this chapter and shall approve or deny the application.

(c) The Department may impose any conditions on the approval deemed necessary to insure the requirements of this chapter are met, including trial periods, restrictions and/or other actions.

(d) The program shall provide the Department with such reports, as required by any waiver(s) granted, to monitor the progress of alternative communications systems.

(e) Any alternative communication system shall meet the 90 percent requirement for the production of an auditable tape of the event, including a recording of both voice and telemetered ECG.

### 8:41–5.7 Performance standards

(a) All communications equipment authorized under this chapter for the purpose of medical command shall:

1. Provide for clear, concise voice communication between the base physician and the advanced life support personnel and shall produce an auditable tape of conversation and ECG at least 90 percent of the time; and

2. Provide adequate coverage, as in (a)1 above, to the service area of the mobile intensive care program.

(b) All back-up equipment used for obtaining medical command shall meet the standards of N.J.A.C. 8:41–5.4 in regard to the production of tapes and the ability to send telemetered ECG.

(c) Each program shall provide for the repair and maintenance of all communications equipment. In the event that medical communication or dispatch equipment fails, the program shall:

1. Immediately provide alternate communications equipment to allow contact with medical command or arrange for another authorized medical command site to provide medical command to the unit; and

2. Notify the Department if the outage lasts longer than eight hours.

### 8:41–5.8 Radio failure; protocols

(a) Radio failure exists only when:

1. Standard biotelemetry communications equipment fails;

2. Back-up biotelemetry equipment fails, including cellular telephones;

3. The MICU cannot access any approved medical command site by these means;

4. The advanced life support personnel cannot access any approved medical command site by the HEAR system; and

5. Telephone service is not available or is inoperative.

(b) Each program shall develop and maintain radio failure protocols that are to be followed in the event of radio failure. These protocols shall bear the approval signature of the program's medical director and shall be approved by the Department prior to implementation, in accordance with the requirements of this chapter and those of the U.S.D.O.T. and the American College of Emergency Physicians.

(c) In the event that radio failure protocols are utilized, the prehospital advanced life support provider who utilized the protocols shall prepare a report indicating the call on which the protocols were utilized, treatment rendered, a description of the radio problems, a list of alternate means attempted, problems encountered, and attempts to remedy the problem. This report shall be forwarded to the program's director within 24 hours of the incident.

(d) The director shall maintain a file of all radio failure reports, and shall present the file to an authorized representative of the Department upon demand.

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## SUBCHAPTER 6. MEDICAL CONTROL; ADMINISTRATION

### 8:41–6.1 Medical director required

(a) Every approved mobile intensive care program shall have a medical director who shall be responsible for all medical matters that affect the program.

(b) No person shall serve in the capacity of medical director unless he or she first:

1. Is licensed as a physician by the New Jersey Board of Medical Examiners;

2. Is currently certified in Advanced Cardiac Life Support to the standards of the American Heart Association;

3. Has successfully completed the Advanced Trauma Life Support course to the standards of the American College of Surgeons; and

4. Is experienced in provision of emergency care.

(c) Any licensed physician who is serving in the capacity of program medical director on June 21, 1993 shall continue in that capacity, regardless of compliance with (b)2 through 4 above.

(d) Individuals who are board certified in emergency medicine need not be certified in Advanced Trauma Life Support or Advanced Cardiac Life Support.

(e) The medical director shall oversee the general medical direction provided to the prehospital advanced life support providers by base station physicians. The medical director shall be responsible for overseeing the quality control activities of the program as required by this chapter, as well as overseeing both medical control and medical command activities.

(f) The medical director is responsible for determining the competence of all prehospital advanced life support providers who are performing under the program's authority and shall submit such reports attesting to the individual's competency as required by the Department, in accordance with N.J.A.C. 8:41–4.

(g) Upon any change of the medical director, the program shall notify the Department within 30 days of the change, stating that the designated individual meets the requirements for a medical director as defined in this chapter.

**8:41–6.2 Medical command of advanced life support personnel**

(a) The provision of prehospital advanced life support by advanced life support personnel on licensed mobile intensive care vehicles is deemed a delegated medical practice. The physician providing medical command provides the authority for such personnel to act.

(b) Except as provided for in the event of radio failure or standing orders authorized by this chapter, no prehospital advanced life support provider shall perform any skill or procedure, administer any pharmaceutical agent or engage in any other activity patently within the scope of practice of a prehospital advanced life support provider, unless that person has received the direct and specific order of a physician.

(c) All orders given to advanced life support personnel shall be specific with regard to treatments ordered or medications and dosages to be given and the sequence in which the treatment is to be performed.

(d) Each prehospital advanced life support provider shall provide the base station physician with an appropriate report of patient assessment, patient condition and any other information required by the physician.

(e) Communication with the prehospital advanced life support personnel shall be done directly by the physician controlling the call unless prevented by emergent patient care duties in the emergency department. In that case, a licensed registered nurse may relay the report and orders if:

1. The nurse is currently certified in advanced cardiac life support to the standards of the American Heart Association;

2. The nurse has been trained in proper operation of the base station; and

3. The nurse personally relays the report to the physician and any orders or direction to the prehospital advanced life support personnel. All orders shall be prefaced with the name of the base station physician ordering the treatment.

(f) No physician shall order a prehospital ALS provider to perform any treatment or administer any medication not specifically authorized by this chapter.

(g) The physician providing medical control shall review the medical record form and affix his or her signature to it, in accordance with established institutional policies, but not later than 30 days after providing the medical direction. The physician shall inform the medical director of any discrepancies in the medical record.

(h) In an instance where patient care is provided in accordance with approved radio failure protocols as defined by this chapter, the authority for such treatment shall be deemed to emanate from the medical director.

(i) In every instance that a mobile intensive care unit has treated a patient, the medical command physician who provided the medical direction to the MICU shall ensure that the receiving facility is notified as soon as possible after providing medical command. The report shall be relayed to either a physician or licensed registered nurse at the facility, and shall contain:

1. The patient's chief complaint and presenting signs and symptoms;

2. Treatment ordered for the patient; and

3. The estimated time of arrival of the patient.

**8:41–6.3 Base station physicians**

(a) No person shall provide medical command to any prehospital advanced life support provider unless that person:

1. Is currently licensed as a physician by the New Jersey Board of Medical Examiners or is a permit holder as defined in N.J.A.C. 8:43G–16.2(f);

2. Is currently certified in Advanced Cardiac Life Support to the standards of the American Heart Association unless board certified as described in this subchapter; and

3. Has received instruction in the proper use of the base station and the provision of medical command to prehospital advanced life support providers.

(b) Each base station physician shall provide medical command to mobile intensive care units in a timely fashion, without undue delay.

(c) In the event that a mobile intensive care unit not affiliated with the program should seek medical command from the base station physician, the physician shall provide medical control as if the unit was one of the program's own.

**8:41–6.4 Protocols**

Each program approved by the Department in accordance with this chapter shall develop and maintain written medical protocols that cover most common emergencies. These treatment protocols shall be kept at the base station immediately accessible to all physicians and shall be reviewed at least yearly. These protocols shall serve as a guide to the physicians, but shall not be deemed to restrict the treatment ordered in the best judgment of the physicians and within the scope of the practice of a prehospital ALS provider.

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## SUBCHAPTER 7. PROCEDURES; TREATMENTS; MODALITIES

**8:41–7.1 Basic life support functions**

Nothing in this chapter shall be construed to prohibit any prehospital advanced life support provider from providing any care or treatment that is construed to be a basic life support function. This shall include all skills and procedures incorporated in the U.S. D.O.T. Curriculum for Emergency Medical Technician–Ambulance or Emergency Medical Technician–Defibrillator as adopted by the Department as part of this chapter. These functions may be performed prior to and without the order of a physician.

**8:41–7.2 Approved skills and procedures**

(a) The following skills and procedures are approved to be performed by prehospital advanced life support personnel, paramedic students and MICN candidates operating under this chapter:

1. Venipuncture for the purpose of obtaining blood samples (excluding blood alcohol levels drawn solely for legal purposes);

2. Institution of intravenous therapy, either by direct infusion or by intravenous catheter plug;

3. Administration of any medication authorized by N.J.A.C. 8:41–8;

4. Endotracheal intubation (oral and nasal) and nasogastric tube insertion and aspiration;

5. Administration of oxygen therapy, including nebulizer treatments in accordance with N.J.A.C. 8:41–8, and the provision of ventilatory support, using approved equipment as specified in this chapter;

6. ECG monitoring, including taking of 12–lead ECG;

7. Cardiac defibrillation, synchronized cardioversion and transthoracic cardiac pacing;

8. Use of telemetry and proper radio procedures in the field, as defined by the Federal Communications Commission and good professional practice;

9. Intraosseous infusion and pleural chest decompression (needle thoracentesis); and

10. Any other procedure approved and promulgated by the Commissioner, provided that such procedure is published within six months of the approval date as part of these rules.

(b) In addition to the procedures in (a) above, a program's medical director may elect to have the following procedures performed on that program's MICUs, subject to approval by the Department:

1. The insertion of esophageal airways;

2. Access of established central venous catheters; and

3. Access of AV fistulas or shunts.

**8:41–7.3 Supervision of students, candidates and probationary personnel**

(a) All students and candidates operating on a mobile intensive care vehicle licensed in accordance with this chapter may perform any of the skills permitted by this chapter, provided they are directly supervised by an approved preceptor in accordance with these rules (see N.J.A.C. 8:41–4.7). Student paramedics or MICN candidates shall not be utilized to meet the minimum staffing requirements specified in this chapter.

(b) Probationary prehospital advanced life support providers may perform any of the skills permitted by this chapter, provided they are under the direct supervision of a prehospital advanced life support provider authorized by this chapter.

**8:41–7.4 Paramedics in the emergency department**

(a) Currently certified paramedics who are operating on a licensed MICU vehicle may perform any of the approved skills authorized by N.J.A.C. 8:41–7, in the emergency department of any licensed hospital provided that:

1. The paramedic is performing under the direct order of a physician;

2. The paramedic records the treatment on the patient's chart and signs the chart in compliance with institutional policy; and

3. The skills provided do not exceed what is allowable for a paramedic to perform, in accordance with the provisions of this chapter.

(b) No hospital shall utilize a paramedic to perform duties routinely assigned to any other health care professionals, nor shall any hospital utilize any prehospital advanced life support provider in any manner regardless of capacity if such utilization would delay that provider's response to a dispatch.

(c) Notwithstanding any portion of these rules, a paramedic shall not be considered to meet any staffing requirement for in-hospital purposes as required by N.J.A.C. 8:43G.

**8:41–7.5 Pronouncement of death**

(a) All pronouncements of death shall be made in accordance with rules promulgated by the State Board of Medical Examiners and with the physician's medical judgment.

(b) No paramedic shall act as an independent agent for the purpose of making pronouncements of death.

(c) All patients who are presented to the mobile intensive care unit and who appear dead shall be monitored for electrocardiac activity and given an examination, and then the advanced life support provider shall contact the base physician and relay all findings. These findings shall include a telemetered electrocardiogram sent when requested by the base station physician unless the condition of the patient precludes the application of ECG leads.

(d) No standing orders for the pronouncement of death shall be authorized. In the event of radio failure, no pronouncement shall be made.

(e) No mobile intensive care unit shall be taken out of service or be deemed unavailable for response to an emergency call for the purpose of performing a pronouncement of death.

**8:41–7.6 Patient triaged to basic life support**

(a) Patients with whom the prehospital advanced life support providers make physical or verbal contact shall be evaluated by the prehospital advanced life support staff to determine the nature of their illness and/or injury. This exam shall be detailed enough to provide:

1. At least one complete set of vital signs;

2. Documentation of chief complaint, past history and medications;

3. A clinical picture of the patient's status; and

4. Information enough to provide a brief narrative on the patient.

(b) For every patient who presents to the mobile intensive care unit staff, there shall be a medical record completed. This chart shall contain the same information that an advanced life support completed call would contain, including any basic life support treatment rendered by the unit or other responders.

(c) In the event the physician should order the patient released to BLS, the staff shall indicate that the physician had released the patient on the patient's medical record, and the physician shall affix his or her signature to that medical record.

(d) The program medical director shall review at least 10 percent of the calls triaged to BLS to ensure compliance with this chapter and to achieve quality assurance goals.

**8:41–7.7 Blood alcohol levels for legal purposes**

(a) No prehospital advanced life support provider operating on a licensed MICU shall draw a patient's blood for the purpose of determining blood alcohol levels to be solely used for legal purposes. No blood drawn by the MICU shall be provided to any law enforcement agency, except under the order of a court of competent jurisdiction.

(b) No prehospital ALS provider shall perform phlebotomy for the purpose of collecting a blood specimen to determine the alcohol content solely for legal purposes in the emergency department, nor shall any prehospital ALS provider draw any blood sample to be utilized for law enforcement purposes.

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## SUBCHAPTER 8. ADMINISTRATION OF MEDICATIONS

**8:41–8.1 Approved drug list for mobile intensive care units**

(a) The following is an alphabetical list of generic therapeutic agents authorized for administration by prehospital advanced life support providers:

Adensosine
Acetylsalicylic acid
Aminophylline
Albuterol
Atropine sulfate
Bretylium tosylate
Calcium chloride
Dextrose, 50 percent
Dextrose, 5 percent in water
Dextrose in water
Dextrose, 5 percent in water and normal saline 0.45 percent
Dexamethasone sodium phosphate
Diazepam
Diphenhydramine HCL
Dopamine HCL
Epinephrine
Flumazenil
Furosemide
Glucagon
Ipecac syrup
Isoetharine HCL
Isoproterenol HCL
Lidocaine HCL
Magnesium sulfate (with Commissioner's approval only)
Metaproterenol sulfate

Morphine sulfate
Naloxone HCL
Nifedipine
Nitroglycerine (excluding intravenous administration)
Normal saline
Oxygen
Procainamide HCL
Ringer's lactate
Sodium bicarbonate
Terbutaline sulfate
Thiamine HCL
Verapamil HCL

Amended by R.1990 d.473, effective September 17, 1990.
See: 22 N.J.R. 1980(a), 22 N.J.R. 3013(a).
Added acetylsalicylic acid, albuterol, magnesium sulfate, nifedipine; deleted nalbuphine HCL.
Amended by R.1991 d.12, effective January 7, 1991.
See: 22 N.J.R. 3104(a), 23 N.J.R. 61(b).
Adenosine added to (a).
Amended by R.1992 d.113, effective March 16, 1992.
See: 23 N.J.R. 3734(a), 24 N.J.R. 938(a).
Any form nitroglycerine allowed; any concentration dextrose in water also allowed.

### 8:41-8.2 Applicability of laws and regulations

(a) Mobile intensive care programs and prehospital advanced life support providers shall be subject to all applicable laws, rules and regulations regarding the control and administration of medications, controlled dangerous substances, syringes, needles and medical waste.

(b) Policies and procedures regarding the storage, use, and disposition of hypodermic needles and syringes shall be in accordance with the New Jersey State Board of Pharmacy rules, N.J.A.C. 8:43G, N.J.A.C. 8:65 and the Controlled Dangerous Substances Act and amendments thereto.

### 8:41-8.3 Medication controls, inventory, and recordkeeping required

(a) Each designated mobile intensive care program shall devise a plan for maintaining inventory control over medications, including all substances in Schedule II and III of the Controlled Dangerous Substances Act and amendments thereto, and syringes used in the program. The following information shall be recorded:

1. Name of the patient receiving the medication;

2. Name of the prescribing physician;

3. Name and strength of the drug;

4. Date the mobile intensive care unit received the drug for each Schedule I through V (inclusive) drug received by the MICU program;

5. Date the drug was administered;

6. Dosage administered;

7. Method of administration;

8. Signature of the paramedic or mobile intensive care nurse administering the drug;

9. Amount of medication wasted, if any; and

10. The co-signature of the prehospital ALS provider witnessing the waste.

(b) A verifiable record system shall be maintained of the acquisition, storage, and disposal of hypodermic needles and syringes in accordance with the rules of the New Jersey Board of Pharmacy, N.J.A.C. 8:43G and institutional policy.

(c) Medical records on the administration of any therapeutic agent shall be maintained by the paramedic or mobile intensive care nurse on a written log, setting forth the date, time, drugs or therapeutic agents administered, directions for administering, quantity and strengths to be indicated where appropriate. All entries shall be typewritten or written in ink, legible, dated and signed by the paramedic or mobile intensive care nurse. All orders are to be countersigned and dated by the physician who directed the call in accordance with institutional policy, but no later than 30 days after providing medical command, as specified in N.J.A.C. 8:41-6.2.

(d) All medications, syringes and needles are to be kept in a locked storage box or compartment when not under the direct control of a prehospital advanced life support provider as defined by this chapter. All substances in Schedules I through V, inclusive, of the Controlled Dangerous Substances Act, and amendments thereto, shall be kept under a double lock system that requires two separate keys for access, except when under the direct control of a prehospital advanced life support provider responsible for their custody. Medications for external use are to be kept in a separate section from medications for internal use. Keys to the medications box or compartment shall be available only to authorized prehospital advanced life support providers or as allowed by law.

(e) Student paramedics and MICN candidates shall have access to any narcotic or drug listed in Schedule I through V, inclusive, only while in the presence of an authorized prehospital advanced life support provider. All student/candidate signatures shall be countersigned by an authorized prehospital advanced life support provider.

(f) In the event that controlled dangerous substances, as defined by N.J.A.C. 8:65 and syringe inventories to a particular mobile intensive care unit cannot be verified or drugs are lost, contaminated or destroyed, a report of such incident is to be written and signed by the paramedics or mobile intensive care nurses involved and any witnesses present. This report is in addition to any other reports required by law, rule or regulation. Copies of the report shall be sent for review to the director and medical director of the program. Copies of the report shall be forwarded to the Office of Emergency Medical Services (OEMS) in the event of loss of medications of Schedule I through V, inclusive.

(g) If any employee, student or other person affiliated with the approved MICU program is relieved of duty due to improper handling of any medication or CDS, the MICU program shall notify the Office of Emergency Medical Services (OEMS). The notification shall be made by telephone during regular business hours on or before the next business day, followed by written confirmation within 14 days of the action.

(h) All voice or telemetered orders between the hospital and mobile intensive care units shall be monitored by recording tape and retained by the hospital for a period of at least three years.

Amended by R.1990 d.473, effective September 17, 1990.
See: 22 N.J.R. 1980(a), 22 N.J.R. 3013(a).
Date drug given changed to date received in (a)4.

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## SUBCHAPTER 9. POLICIES; RECORDS; QUALITY ASSURANCE

### 8:41-9.1 Personnel records

(a) Each program operating a mobile intensive care unit shall maintain a personnel file on every advanced life support provider who operates on that unit. Such file shall contain, at a minimum:

1. The name and address of the provider;

2. Copies of the provider's current paramedic certification and/or a verification of a valid nursing license by the program director;

3. Copies of the individual's current certification in CPR and Advanced Cardiac Life Support as required by this chapter;

4. Documentation of continuing education hours and skills for the previous recertification period as required by this chapter provided the individual is recertified by the program; and

5. Any official correspondence received by the program with regard to the provider's status (for example, notice of completion of probationary period).

(b) The program shall maintain personnel files at the place of business as specified on the license in a readily accessible manner. Personnel files shall be produced upon demand of an authorized representative of the Department.

(c) No person shall file any record that is falsified, fraudulent or untrue. No person shall knowingly verify a falsified, fraudulent or untrue document that is submitted or maintained in compliance with this chapter.

### 8:41-9.2 Policy and procedure manual

(a) Every program operating a mobile intensive care unit in accordance with this chapter shall develop and maintain a policy and procedure manual. The policy and procedure manual shall reflect the methods of daily operation, and shall not be inconsistent with the provisions of this chapter.

(b) The policy and procedure manual shall contain policies that include, but are not limited to:

1. Staff functions in the emergency department;

2. Narcotic control, storage and procurement;

3. Drug, needle and syringe storage (both vehicle and station);

4. Pronouncement of death;

5. Aeromedical utilization;

6. Triage to specialty centers, including trauma triage policies;

7. Hospital diversion;

8. HAZMAT incidents;

9. Mass Casualty Incidents, which shall include a copy of the Emergency Operating Plan (EMS Annex);

10. Physician and nurse orientation to the base station curriculum;

11. A current copy of this chapter;

12. The quality assurance plan developed in accordance with this chapter;

13. Vehicle maintenance, including vehicle out-of-service procedures;

14. The required reporting of certain events, including child abuse or neglect; and

15. Any other information that is required by the Department to assist the program staff in the performance of their duties, given the unique situation of each program.

(c) This policy manual shall be immediately available to all members of the MICU staff, and shall be presented upon demand to an authorized representative of the Department.

### 8:41-9.3 Didactic records

(a) Each approved didactic site shall maintain such records on its students as required by the college and the Department. These records shall include, but not be limited to:

1. Identifying data on each student including, but not limited to, name, address, phone number, date of birth and social security number;

2. Records of progress, including grades on examinations and skill performance;

3. Anecdotal records, as needed; and

4. Clinical site affiliation.

(b) The didactic coordinator shall provide periodic reports to the clinical coordinator at the sponsoring site reporting the student's progress.

(c) The didactic program shall present a student's records to an authorized representative of the Department upon demand.

**8:41–9.4 Student/candidate clinical training records**

(a) Each approved MICU clinical training program sponsoring paramedic students and/or MICN candidates shall maintain records of the training and progress of the students. These records shall include:

1. Copies of current certifications in CPR, EMT–A and ACLS and as required by this chapter;

2. Documentation of successful completion of didactic training;

3. Copy of the didactic training schedule;

4. Original documentation of completion of clinical training objectives, including sign-off sheets;

5. Clinical training schedules;

6. Anecdotal records, as needed;

7. Copies of the required evaluations; and

8. Copies of the endorsement to take the certification exam, if appropriate.

(b) Paragraphs (a)2, 3 and 8 above do not apply to MICN candidates.

(c) The program shall produce the files in (a) above upon demand of an authorized representative of the Department.

**8:41–9.5 Medical records**

(a) Every program operating a mobile intensive care unit in accordance with this chapter shall develop a medical record form to be utilized to document each instance when physical or verbal contact is made with a patient. This record shall be completed for each patient with whom the pre-hospital ALS providers make physical or verbal contact. At such time as the Department promulgates a standardized, Statewide report form that form shall be used.

(b) Every program shall develop and maintain a means for recording cancelled or recalled calls, missed calls, and other activity that does not result in patient contact, but did result in a dispatch.

(c) Each medical record form shall contain the following:

1. The name of the patient (if known);

2. The home address of the patient;

3. The location of the call;

4. Statistical information to include sex, age and weight;

5. Information as to patient's chief complaint, prior medical history, medications and allergies, findings obtained during the physical exam, treatment rendered, time the treatment was rendered and any response to treatment;

6. ECG documentation attached by the provider;

7. Any other information the program deems necessary, including insurance information;

8. Tape recording number, if applicable;

9. Date and times as follows:

i. Time of dispatch;

ii. Time the vehicle is en route;

iii. Time vehicle arrives at the scene;

iv. Time patient is enroute to the hospital; and

v. Time patient arrives at the hospital;

10. Crew information including certification number(s);

11. Any treatment rendered to the patient prior to the arrival of the MICU;

12. Unit identifying information to include the vehicle number, BLS squad name and vehicle number, type of communications used for medical command and printed name of medical command physician;

13. The printed name and signature of the medical command physician;

14. The receiving hospital or facility;

15. The receiving hospital's disposition of the patient to include admitting or discharge diagnosis and type of admission (for example, critical care floor);

16. A section to record the medication dosage, route and time of administration (flow sheet); and

17. The signature of the preparer of the record.

(d) The prehospital ALS providers in attendance with the patient shall prepare the medical record.

(e) A copy of the medical record shall be given to the physician or licensed registered nurse accepting the patient at the receiving facility. No additions to the chart shall be made once it is given, unless such changes are initialed and dated by the person making the change, and the receiving facility is notified.

(f) A copy of the medical record that has been signed by the medical command physician shall be retained by the program at the place of business and shall be available for inspection. Reports shall be presented to an authorized representative of the Department upon demand.

(g) If a patient should present to the MICU staff and should refuse care, the prehospital ALS providers shall complete a medical record for that patient and shall attempt to obtain the signature of the patient (or guardian) on a refusal of care statement.

(h) The program shall keep a record of all calls answered by the unit and shall track the destination, diagnosis and disposition of each patient evaluated by the unit. The emergency department of a licensed hospital receiving a patient evaluated by an approved MICU shall provide the information needed to comply with this section.

**8:41-9.6 Quarterly reports**

(a) Each program shall file a report with the Department stating the activity of the unit for that quarter. These reports shall be made on a form and in the manner specified by the Department (see Appendix A, incorporated herein by reference) and shall be received in the Office of Emergency Medical Services (OEMS) on or before the due date. The reporting period and due dates are:

| Period | Due |
|---|---|
| Jan. 1-Mar. 31 | Apr. 30 |
| Apr. 1-June 30 | July 31 |
| July 1-Sept. 30 | Oct. 31 |
| Oct. 1-Dec. 31 | Jan. 31 |

(b) The Department shall keep the data on file and shall generate a yearly report reflecting the activities of the MICU programs. Yearly reports shall be made available to the programs and general public for inspection at OEMS.

**8:41-9.7 Quality assurance; roles and responsibilities**

(a) The program medical director shall review at least 10 percent of all calls that were evaluated by the MICU, excluding cancelled calls. The method of determining which 10 percent of the calls will be reviewed shall be at the discretion of the medical director. The review shall determine:

1. Consistency with accepted treatment and triage protocols;

2. Consistency of the record with the tape recording of the call-in by the MICU;

3. Appropriateness of orders received by the MICU from the physician; and

4. Completeness of the medical record.

(b) The program director shall ensure that all medical records produced by the program meet standards, with regard to:

1. Completeness of the medical record;

2. Adherence to policies regarding treatment and triage of patients;

3. Compliance with the requirements of this chapter;

4. Documentation of excessive scene times based on the nature of the call, deviations from established protocols, unsuccessful procedures, radio failure, and other unusual incidents; and

5. The conditions set forth in (a) above.

**8:41-9.8 Quality assurance; compliance with standards**

(a) Each program approved under this chapter shall develop and maintain a quality assurance plan in accordance with N.J.A.C. 8:43G-27.1 and 27.2.

(b) Each program shall identify an individual responsible for the coordination of all aspects of the quality assurance program.

(c) There shall be an ongoing process of monitoring patient care. Evaluation of patient care on the MICU shall be criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(d) The quality assurance individual shall be available to provide ongoing consultation to the program, including assistance with the development of specific indicators used to evaluate service outcomes on the MICU.

(e) The program shall follow up on its findings to assure that effective corrective action is taken, including, at a minimum, policy revisions, procedural changes, educational activities and follow-up on recommendations, or shall establish that additional actions are no longer indicated or needed.

(f) The quality assurance program shall identify and establish indicators of quality care specific to the MICU that are monitored and evaluated which encompass:

1. Medical calls;

2. Trauma calls;

3. Pediatric calls;

4. Cardiac/respiratory arrest incidents;

5. Patients triaged to BLS;

6. Use of radio failure protocols;

7. Use of standing orders;

8. On-scene times;

9. Use of special procedures;

10. Triage to specialty care facilities; and

11. Other areas the medical director finds necessary to track in this manner.

(g) The quality assurance review must encompass at least 10 percent of all calls the mobile intensive care unit(s) handle, excluding cancelled calls.

(h) The program shall keep written records of medical director reviews and shall produce them on demand to an authorized member of the Department. Medical director reviews shall include the comments of the medical director.

**8:41–9.9 Additional reports**

Nothing in this chapter shall be deemed to prevent a program from gathering other information it deems necessary, providing such information is not otherwise restricted by law or rule. Other information gathered may include that which is necessary to process billing claims and insurance information. A receiving emergency department of a licensed hospital shall make such billing information available to the MICU staff.

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## SUBCHAPTER 10. STANDING ORDERS

**8:41–10.1 Standing orders for cardiac arrest**

(a) The following cardiac dysrhythmias and treatment protocols shall be considered standing orders in cardiac arrest:

1. For ventricular fibrillation or ventricular tachycardia (without pulse):

i. Defibrillate 200 Joules;

ii. Defibrillate 300 Joules;

iii. Defibrillate 360 Joules;

iv. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

v. Intubate, if possible; and

vi. Administer Epinephrine 1.0 mg, either intravenously or endotracheally.

2. For asystole:

i. If rhythm is unclear and possibly ventricular fibrillation, defibrillate as for ventricular fibrillation as in (a)1 above;

ii. Continue CPR;

iii. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

iv. Intubate if possible; and

v. Administer Epinephrine 1.0 mg, either intravenously or endotracheally.

3. For Pulseless Electrical Activity (PEA):

i. Continue CPR;

ii. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

iii. Intubate, if possible; and

iv. Administer Epinephrine 1.0 mg, either intravenously or endotracheally.

(b) General guidelines are as follows:

1. Check pulse and rhythm after each shock. If Ventricular Fibrillation recurs after transiently converting to another rhythm, use whatever energy level was previously successful on the patient and defibrillate again.

2. Paramedics shall initiate radio communication with their base station physician as soon as the above treatments have been completed. At no time should initial communication with the medical control physician be delayed due to difficulty in intubating the patient and/or initiating an intravenous line.

3. The program medical director shall determine the type of fluids to be used in each of the above cases.

4. Each case utilizing these standing orders shall be documented on the run form and reviewed by the program director or EMS educator. Cases which do not follow these protocols as promulgated or where contact is never made with the base station physician shall be forwarded to the program medical director for a mandatory review.

5. Initial standing orders shall not replace communication with a base station physician and should not be considered as instructions for total treatment of the patient.

Amended by R.1994 d.35, effective January 18, 1994.
See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a).

**8:41–10.2 Standing orders for multiple trauma patients**

(a) The following treatment protocols shall be considered standing orders, to be used when treating multiple trauma patients.

1. Provide Basic Life Support as necessary;

2. Provide airway management with cervical spine precautions;

3. Assist ventilation, providing highflow oxygen at 100 percent by non rebreather mask and/or performing intubation utilizing cervical spine precautions when indicated;

4. Apply pneumatic anti-shock garment and inflate if applicable;

5. Transport as soon as possible;

6. Enroute to the hospital establish two large bore intravenous lines of Ringer's lactate. Attempt to draw

blood. In adult patients obtain two full red top tubes. If patient is less than five years old, use two pediatric red top tubes;

7. Paramedics shall initiate radio communication with their base physician as soon as the above treatments have been completed. Transportation shall not be delayed due to difficulty in intubating the patient and/or initiating an intravenous line, except at the specific direction of the medical control physician; and

8. Each case utilizing these standing orders shall be documented on the run form and monitored in accordance with the standard in N.J.A.C. 8:41–10.1(b)4.

**8:41–10.3 Standing orders for endotracheal intubation**

(a) The protocols contained in this section shall be considered standing orders for endotracheal intubation.

(b) Endotracheal intubation may be performed prior to contacting medical control if the patient presents:

1. In respiratory arrest;

2. In respiratory failure with associated inadequate spontaneous ventilatory volume; and/or

3. Unconscious with absent protective gag reflex.

(c) Advanced interventions should only be attempted after all basic life support interventions have been instituted. The patient may be intubated either by the orotracheal or nasotracheal route; however, nasotracheal intubation shall be withheld in children less than 12 years old.

(d) It is imperative that the MICU staff initiate contact with their base station physician as soon as possible after the above treatment has been rendered. These procedures should not delay the transportation of a patient in the event of a difficult intubation; nor should contact with the base physician be delayed by a difficult intubation.

(e) Each case utilizing these standing orders shall be documented on the run form and shall be monitored in accordance with the standards established in N.J.A.C. 8:41–10.1(b)4.

**8:41–10.4 Standing orders for the establishment of intravenous therapy**

(a) The protocols contained in this section shall be considered standing orders for the initiation of intravenous therapy prior to contacting the base physician, without existing radio failure.

(b) In cases where an emergent or potentially emergent condition exists and current advanced life support treatment protocols require the initiation of intravenous therapy, mobile intensive care unit staff may begin an intravenous line at keep vein open rate or establish intravenous access with a saline port prior to contacting a base physician.

(c) Mobile intensive care unit staff shall contact the base physician as soon as possible after the initiation of the intravenous line. Contact with the base physician shall not be delayed by, or as a result of, unsuccessful intravenous attempts in the field.

(d) The time of the initiation of intravenous therapy and the time of base station contact shall be recorded on the patient run form.

**8:41–10.5 Applicability of standing orders**

(a) The standing orders established in N.J.A.C. 8:41–10.6 through 10.15, inclusive, may be adopted in their entirety by the medical director of an approved MICU program, after notification to the Office of Emergency Medical Services (OEMS). The standing orders shall not be altered or abbreviated or enhanced in any manner.

(b) The protocols established in N.J.A.C. 8:41–10.6 through 10.13 are initial treatment protocols which may be utilized by prehospital advanced life support providers operating on an approved MICU. These protocols apply only to patients over 12 years old, and may be utilized prior to physician contact. In the event the implementation of these standing orders is delayed for any reason, the base station physician shall be contacted immediately.

(c) Any situation other than those specifically identified in these rules requires the prehospital advanced life support provider to contact the base station physician for medical command before providing any advanced life support treatment not authorized under N.J.A.C. 8:41–10.1 through 10.4, inclusive.

(d) These protocols shall not be interpreted as a requirement to administer advanced life support therapy prior to base station physician contact. The prehospital advanced life support providers may elect to contact the base station physician at any time during the provision of therapy, in accordance with this subchapter. Standing orders cease to be operative once base station physician contact is made.

(e) These standing orders shall not be considered to represent total patient management. Medical command shall be established after the protocols are utilized.

(f) The presence of an allergy to any medication in these rules shall be deemed to be a contraindication to the administration of that agent, and said agent shall not be administered under these protocols.

(g) Each case utilizing these standing orders shall be reviewed in accordance with the standards established by N.J.A.C. 8:41–10.1(b)4.

**8:41–10.6 Sustained ventricular tachycardia**

(a) The following standing orders are authorized in the event a patient presents with a stable (systolic blood pressure greater than or equal to 120 mmHg) ventricular tachycardia:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Perform patient assessment, including medical history and allergies;

4. Administer Lidocaine HCL at a dose of 1mg/kg IV push, if the patient is not allergic to it;

5. Continue to assess the patient and monitor the cardiac rhythm; and

6. Contact the base station physician.

(b) The following standing orders are authorized in the event a patient presents with an unstable (unconscious or hemodynamic compromise) ventricular tachycardia:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Cardiovert the patient at 100 joules. Check the pulse and monitor after the cardioversion;

4. If the rhythm fails to convert, cardiovert the patient at 200 joules. Check the pulse and monitor after the cardioversion;

5. If the rhythm fails to convert, cardiovert the patient at 300 joules. Check the pulse and monitor after the cardioversion;

6. If the rhythm fails to convert, cardiovert the patient at 360 joules. Check the pulse and monitor after the cardioversion;

7. If the rhythm is converted at any point, administer Lidocaine one mg/kg, if there is no history of allergy to the drug; and

8. Contact the base station physician for medical command.

**8:41–10.7 Bradycardia**

(a) The following standing orders are authorized in the case of bradycardia if the patient is symptomatic and/or hemodynamically unstable:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer Atropine Sulfate one mg IV; and

4. Contact the base station physician for medical command.

**8:41–10.8 Pulmonary Edema/Congestive Heart Failure; systolic blood pressure greater than or equal to 120 mmHg**

(a) The following standing orders are authorized in the case of pulmonary edema/congestive heart failure, with systolic blood pressure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer nitroglycerin (0.4 mg) sublingually;

4. Administer Furosemide one mg/kg IV; and

5. Contact the base station physician for medical command.

**8:41–10.9 Suspected myocardial infarction/chest pain: systolic blood pressure greater than or equal to 120 mmHg**

(a) The following standing orders are authorized in the case of suspected myocardial infarction/chest pain, with systolic blood pressure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer nitroglycerin (0.4 mg) sublingually; and

4. Contact the base station physician for medical command.

**8:41–10.10 Unstable paroxysmal supraventricular tachycardia: unconscious and hemodynamically unstable**

(a) The following standing orders are authorized in the case of unstable paroxysmal supraventricular tachycardia, with unconscious and hemodynamically unstable patient:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Perform a synchronized cardioversion at 50 joules. Check the patient's pulse and cardiac rhythm after the shock;

4. If the rhythm fails to convert perform a synchronized cardioversion at 100 joules. Check the patient's pulse and cardiac rhythm after the shock;

5. If the rhythm fails to convert perform a synchronized cardioversion at 200 joules. Check the patient's pulse and cardiac rhythm after the shock;

6. If the rhythm fails to convert perform a synchronized cardioversion at 300 joules. Check the patient's pulse and cardiac rhythm after the shock;

7. If the rhythm fails to convert perform a synchronized cardioversion at 360 joules. Check the patient's pulse and cardiac rhythm after the shock; and

8. Contact the base station physician for medical command.

**8:41-10.11 Anaphylactic shock**

(a) This standing order shall apply when the patient exhibits signs of acute respiratory distress and/or hypotension (systolic blood pressure of less than 90 mmHg).

1. Provide appropriate airway management;

2. Establish an intravenous line of 0.9 percent normal saline and give a 300cc fluid bolus;

3. Administer Epinephrine 1:1000 sol. at a dose of 0.5 mg subcutaneously;

4. Administer 50 mg of Diphenhydramine HCL IV; and

5. Contact the base station physician for medical command.

**8:41-10.12 Bronchospasm**

(a) The standing order shall apply in the case of bronchospasm:

1. Provide appropriate airway management;

2. Administer albuterol 2.5 mg via nebulizer;

i. A program's medical director may elect to substitute metaproterenol or isoetharine for albuterol. This substitution shall be declared at the time these standing orders are authorized by the medical director and approved by the Department.

3. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4; and

4. Contact the base station physician for medical command.

**8:41-10.13 Unconscious person**

(a) The treatment of an unconscious person shall be directed by the suspected etiology of the event. The following standing orders shall apply:

1. Provide appropriate airway management;

2. Draw a blood sample using a red-top tube;

3. Evaluate a blood glucose reagent strip, if available;

4. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4;

5. Administer Naloxone 2 mg IV;

6. Administer Thiamine 100 mg IV;

7. Administer 25 gm of 50 percent dextrose in water IV; and

8. Contact the base station physician for medical command.

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## SUBCHAPTER 11. PARAMEDIC CLINICAL TRAINING OBJECTIVES

**Authority**

N.J.S.A. 26:1A-15 and 26:2K-17.

**Source and Effective Date**

R.1994 d.35, effective January 18, 1994.
See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a).

**8:41-11.1 Category I; Skills Division**

(a) Upon the successful completion of the laboratory, or other designated clinical area, the student will be able to:

1. Identify the proper equipment and materials for venipuncture and blood collection;

2. Identify the proper sites for venipuncture and prepare the patient for the procedure;

3. Perform a minimum of 20 venipunctures utilizing proper aseptic technique and the appropriate blood collection equipment;

4. In accordance with hospital policy, document the procedure performed on the patient's record; and

5. Document all procedures performed on the appropriate clinical sign off sheet.

(b) Upon successful completion of the intravenous therapy experience, the student will be able to:

1. Prepare the patient for the procedure;

2. Select the appropriate site for the procedure and prepare the necessary equipment to accomplish the orders. This includes selecting and preparing the solution, tubing and other associated equipment and calculate the correct rate of infusion;

3. Perform a minimum of 20 successful intravenous infusions. All infusions will be performed utilizing proper aseptic technique and be performed in less than five minutes. Completion of the hospital intravenous therapy certification program may be substituted for this requirement. Prior to completion of the clinical training program, the student will have successfully initiated a minimum of 50 intravenous infusions or cannulations and have demonstrated clinical competency in the skill;

4. In accordance with hospital policy, document all procedures on the patient record; and

5. Document all procedures performed, using the appropriate clinical sign off sheet.

(c) Upon successful completion of the respiratory therapy experience, or other designated clinical areas, the student will be able to:

1. Identify breath sounds on a minimum of 20 patients utilizing proper ausculatory technique. Prior to the conclusion of clinical training, the student will have identified and documented breath sounds on a minimum of 10 patients with rales, rhonchi and wheezing;

2. Demonstrate the correct application of the nasopharyngeal airway, oropharyngeal airway, esophageal obturator airway, esophageal gastric tube airway and the endotracheal tube. The student will perform these skills utilizing appropriate equipment, techniques and sites. All airway insertions will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet. These skills will be evaluated by both observation and skill testing by the EMS Educator;

3. Demonstrate, utilizing appropriate equipment, the proper technique for suctioning orally, nasally, tracheally and endotracheally. Prior to the conclusion of clinical training, the student will have suctioned a minimum of five patients with an endotracheal tube in place. All suctioning will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet;

4. Identify the desired effect for medications administered by the respiratory therapist;

5. Prepare and administer a minimum of 10 nebulized medications. Only approved MICU medications are to be administered by the student. The student will perform this skill utilizing appropriate technique and dosage. All nebulized medication administrations will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet;

6. Observe patients on ventilators. The student will be able to identify the various ventilator controls and settings. The student will be able to explain the rationale for the use of the ventilator; and

7. Optional Experiences: Observation of pulmonary function tests and bronchoscopy.

(d) Upon successful completion of the operating room, or other designated clinical area for intubation, the student will be able to:

1. Perform successful endotracheal intubation. The student will perform this skill utilizing appropriate equipment and techniques. This includes the appropriate preoxygenation, reoxygenation and verification of tube placement by inspection and auscultation. All endotracheal intubations will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet; and

2. Prior to the conclusion of clinical training, the student will have successfully endotracheally intubated a minimum of five patients. It is recommended that the majority of these be performed in the prehospital environment.

(e) Upon successful completion of the E.K.G., or other designated clinical area, the student will be able to:

1. Perform a minimum of five 12–lead electrocardiograms. A copy of each will be retained by the student for interpretation at a later date with the EMS educator; and

2. Identify the effects of medications and electrolyte imbalances on the interpreted electrocardiograms; and

3. As an optional experience, observe stress tests, echocardiograms, application of Holter monitors and cardiac catheterizations.

(f) Each clinical training program shall develop an evaluation mechanism covering all the objectives of the Category I clinical training objectives. Each student shall take and pass this examination prior to proceeding to Category II.

**8:41–11.2 Category II; Specialty Care Division**

(a) Upon successful completion of the clinical training experience in the Intensive Care Unit, Coronary Care Unit, Emergency Department and Mobile Intensive Care Unit, or designated clinical area, the student will be able to:

1. Document the performance of 20 complete patient histories/assessments using the appropriate clinical sign off sheet. These histories/assessments will include a minimum of 5 neurological and 5 trauma assessments;

2. Demonstrate medication administration by the intramuscular, subcutaneous, sublingual, topical and intravenous routes. Use of appropriate medication administration equipment and the correct drug calculations are required. The student will document all medication administrations performed on the patient record, as per hospital policy and on the appropriate clinical sign off sheet. Only New Jersey approved MICU medications may be administered;

3. Identify the actions, indications, normal dosage range, side effects and contraindications of all medications administered;

4. Submit one case study from each patient care area. This will include the chief complaint, patient history, past medical history, current medications, clinical presentation, treatment modalities, response to care and patient outcome;

5. Prepare a minimum of 10 medication cards on medication other than those approved for use by par-

amedics, as defined by Subchapter 8 of these rules, and which were identified during the student's critical care experience. Each card will include the generic and trade names, actions, indications, contraindications, dosage range, routes of administration and adverse reactions;

6. Demonstrate the proper application and use of an external cardiac pacemaker;

7. Document a rhythm strip from every monitored patient displaying a dysrhythmia and/or abnormal EKG in each clinical care area. Each strip will be interpreted and the treatment modalities documented on the appropriate clinical sign off sheet;

8. Document the participation and/or observation of a minimum of one cardiac arrest on the appropriate clinical sign off sheet. Prior to the conclusion of the clinical training experience, the student will have participated in a minimum of five cardiac arrest resuscitations;

9. Demonstrate the appropriate technique and situations for the application of defibrillation and cardioversion. By the end of the clinical training experience, the student will have performed a minimum of five defibrillations and/or synchronized cardioversions;

10. Demonstrates appropriate treatment modalities for the patient in cardiac arrest utilizing the Advanced Cardiac Advanced Life Support guidelines of the American Heart Association;

11. Document the insertion, or observation of the insertion, of a nasogastric tube on the appropriate clinical sign off sheet. If the student has inserted the nasogastric tube, document the insertion on the patient record, in accordance with hospital policy. If the student has performed the insertion, the student shall document the proper use of equipment and technique during the procedure;

12. Demonstrate the application of and discuss the principles of use of the PASG;

13. Identify etiologies, clinical presentation and treatment modalities of the following: Angina Pectoris, Acute Myocardial Infarction, Congestive Heart Failure, Ventricular and Aortic Aneurysm, Cardiogenic Shock, Myocardial Trauma, Acute Hypertensive Crisis, Diabetic Emergencies, Poisonings and Overdoses, Hypovolemic Shock, Acute Respiratory Failure, Chronic Obstructive Pulmonary Diseases (COPD), Asthma, Pneumonia, Head Injury and Coma, Cerebral Vascular Accident, Seizures, Burns, Infectious Diseases, Acute Abdomen, Renal Failure, Fractures, Septic Shock, Neurogenic Shock, Pulmonary Edema, Pulmonary Embolism and Anaphylaxis; and

14. As an optional experience, review and demonstrate, the use of Doppler, Infusion Pumps, and the observation of the insertion of internal pacemakers.

(b) Upon successful completion of the clinical training experience in the obstetrical department, or other designated clinical area, the student will be able to:

1. Document the observation of a minimum of five vaginal deliveries on the appropriate clinical sign off sheet;

2. Identify the normal stages of labor;

3. Assist in the care of a newborn infant and the post partum mother. Document the experiences on the appropriate clinical sign off sheet;

4. Identify the etiologies, clinical presentations and treatment modalities for abnormal and common complications of deliveries; and

5. Optional Experience: Neonatal Intensive Care Unit.

(c) Upon successful completion of the pediatric clinical training objective, or the designated clinical area, the student will be able to:

1. Document a minimum of 5 pediatric patient histories/assessments on the appropriate clinical sign off sheet. These histories/assessments should be done at various stages of development;

2. Identify normal vital signs for each developmental milestone of childhood;

3. Identify the correct procedure for the administration of medications and intravenous fluids to the pediatric patient;

4. Identify the correct pediatric drug dosages for all approved MICU medications;

5. Submit one pediatric patient case study; and

6. As an optional experience, review/demonstrate the operation of a Pediatric Intensive Care Unit, Well Baby Clinic, and Apnea Monitor.

(d) Upon the successful completion of the clinical training objectives in the Psychiatry Department, or other designated clinical training area, the student will be able to:

1. Document the observation of any crisis interviews and/or interventions on the appropriate clinical sign off sheet. If this experience is unavailable to the student, the EMS Educator may orient the student to the procedures followed during these activities;

2. Submit one case study after observing a crisis interview or intervention. If the required experience is not available, the EMS Educator may substitute the requirement of having the student write a synopsis of the procedures followed during a crisis interview or intervention; and

3. Prepare a minimum of five medication cards on psychiatric drugs. These cards are to include the generic and trade name, actions, indications, contraindications, dosage range, routes of administration and adverse reactions.

(e) Each clinical training program shall develop an evaluation mechanism covering all the objectives of the Category II clinical training objectives. Each student shall take and pass this examination prior to proceeding to Category III.

**8:41–11.3 Category III; Field Internship**

(a) Upon the successful completion of the Field Internship and all other clinical training objectives, the student will be able to:

1. Perform adequate patient assessments, communicate via telemetry and correctly document on the approved patient run report on a minimum of 20 patients. Copies of all run reports are to be submitted to the EMS Educator for review. A treatment call record will be completed on every patient the student treats or assesses. This record will be used by the EMS Educator to evaluate the types of patients the student has had experience with;

2. Submit a field observation report, completed by the field preceptor, according to the schedule established by the EMS educator;

3. Demonstrate the ability to use and troubleshoot all equipment, including the vehicle, radio and adjunct equipment;

4. Demonstrate knowledge of safe driving habits in accordance with hospital policy and the regulations of the New Jersey Division of Motor Vehicles;

5. Demonstrate the ability to promote or demonstrate positive interpersonal skills with squads, hospital employees and the patients and their families;

6. Function both independently and as a member of the team;

7. Demonstrate the ability to assume responsibility in the field. This includes the ability to set priorities, organize patient care and maintain control of the emergency scene;

8. Demonstrate clinical competency in the following skills: chest decompression, intraosseous infusion, external cardiac pacing, central venous access and AV shunt; and

9. Demonstrate knowledge and competence in the application of the approved standing order protocols as established by this subchapter.

**8:41–11.4 Program requirements**

(a) The program shall document a minimum of 600 hours of clinical training for each student. No clinical training area shall be entered until all didactic material has been presented that is necessary for the student to meet the clinical training objectives of that area. A minimum of 200 hours of field experience shall be documented after the completion of the didactic program. Hours of training in the following areas are mandated by the United States Department of Transportation National Standard Curriculum for Paramedics and the Department:

| | | |
|---|---|---|
| 1. | Emergency department | 100 hours |
| 2. | Intensive/coronary care units | 40 hours |
| 3. | Operating/recovery room | 24 hours |
| 4. | Intravenous team, if available | 8 hours |
| 5. | Pediatric unit | 24 hours |
| 6. | Labor/delivery/newborn nursery | 24 hours |
| 7. | Psychiatric unit or crisis center | 8 hours |
| 8. | Morgue | 4 hours |

i. The morgue experience may be obtained either by the student attending actual autopsies, or by attendance at a program provided by the Department.

(b) Clinical training shall also be required in the following areas:

| | | |
|---|---|---|
| 1. | Laboratory | 4 hours |
| 2. | Respiratory Therapy | 24 hours |

(c) Minimum hour requirements for other clinical areas may be determined by the EMS Educator.

(d) Each clinical training program shall develop a final evaluation mechanism covering all the objectives of these clinical training objectives. Each student shall take and pass this examination prior to receiving endorsement to take the State certification examination.

(e) The student shall provide the EMS Educator with the appropriate completed clinical sign off sheets documenting successful completion of all clinical training objectives.

(f) The student shall provide and maintain documentation of current certification in EMT–A, BCLS and ACLS. Certification must remain current throughout clinical training. ACLS certification shall be completed before the student enters Category III.

(g) If a student fails to meet any of the minimum numbers for the performance of the required skills listed in this subchapter, the clinical EMS educator responsible for the student's training may make application to the Chief Administrator of OEMS for a waiver of that requirement in accordance with the provisions for waivers in N.J.A.C. 8:41–2.

# APPENDIX A

NEW JERSEY DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

MICU Quarterly Report Quarter Ending________________

(Quarterly reports are due by the 30th of April, July, October, January)

Program Name

ADDRESS Telephone Number ( )

Person Completing Report Cost Per Completed ALS Call

Coordinator Medical Director

SECTION ONE—SYSTEM WIDE MICU INFORMATION

1. MICU dispatches ____
2. MICU calls cancelled (patient not seen) ____
3. MICU requested and unable to respond ____
4. Patients evaluated by MICU (total) ____
5. Patients triaged to BLS (total) ____
6. Patients triaged to BLS and admitted to critical care (total) ____
7. Patients refusing ALS ____
8. Patients treated by MICU as completed ALS calls ____

Age Ranges

9. 0 to 1 year ____
10. 2 to 8 year ____
11. 9 to 20 year ____
12. 21 to 45 year ____
13. 46 to 65 year ____
14. > 65 year ____
15. ALS Field pronouncements (by Medical control physician) ____
16. Total ALS patients admitted to a hospital ____
17. Total ALS patients treated and released from emergency department ____
18. ALS patients transported by volunteer ambulances ____
19. ALS patients transported by licensed ambulances ____
20. ALS patients transported by aeromedical service ____
21. ALS patients transported by transport MICU ____
22. ALS patients transported by other means (explain each situation below) ____
23. ALS patients treated and left at the scene ____
24. Transport delayed due to lack of available BLS transport vehicle ____

MATCHING TOTALS

15, 16 17 must = Item 8
9, 10, 11, 12, 13, 14 must = Item 8
18, 19, 20, 21, 22, 23 must = Item 8

Comments:

1 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM__________

QUARTER ENDING__________

SECTION TWO—INDIVIDUAL VEHICLE SITE DISPATCH INFORMATION

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

25. MICU dispatches ____
26. MICU calls cancelled (patient not seen) ____
27. MICU requested and unable to respond ____
28. Patients treated by MICU as completed ALS calls ____
29. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

30. MICU dispatches ____
31. MICU calls cancelled (patient not seen) ____
32. MICU requested and unable to respond ____
33. Patients treated by MICU as completed ALS calls ____
34. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

35. MICU dispatches ____
36. MICU calls cancelled (patient not seen) ____
37. MICU requested and unable to respond ____
38. Patients treated by MICU as completed ALS calls ____
39. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

40. MICU dispatches ____
41. MICU calls cancelled (patient not seen) ____
42. MICU requested and unable to respond ____
43. Patients treated by MICU as completed ALS calls ____
44. Number of out-of-service hours (explain) ____

Comments:

2 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM__________

QUARTER ENDING__________

SECTION TWO CONTINUED—INDIVIDUAL VEHICLE SITE DISPATCH INFORMATION

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

45. MICU dispatches ____
46. MICU calls cancelled (patient not seen) ____
47. MICU requested and unable to respond ____
48. Patients treated by MICU as completed ALS calls ____
49. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

50. MICU dispatches ____
51. MICU calls cancelled (patient not seen) ____
52. MICU requested and unable to respond ____
53. Patients treated by MICU as completed ALS calls ____
54. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

55. MICU dispatches ____
56. MICU calls cancelled (patient not seen) ____
57. MICU requested and unable to respond ____
58. Patients treated by MICU as completed ALS calls ____
59. Number of out-of-service hours (explain) ____

Comments:

VEHICLE SITE__________ VEHICLE RECOGNITION NUMBER/NAME__________

60. MICU dispatches ____
61. MICU calls cancelled (patient not seen) ____
62. MICU requested and unable to respond ____
63. Patients treated by MICU as completed ALS calls ____
64. Number of out-of-service hours (explain) ____

Comments:

3 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM____________________

QUARTER ENDING____________________

SECTION THREE—PATIENT CLASSIFICATION
Place each ALS patient in only one of the categories below

**Cardiac**

65. General Cardiac ____
66. Cardiopulmonary arrest (resuscitation attempted) ____
67. Cardiac Cases Total ____

**Trauma**

68. Blunt trauma ____
69. Burns/Electric Shock ____
70. Head injury ____
71. Penetrating injury ____
72. Spinal cord injury ____
73. Trauma codes ____
74. Other (explain) ____
75. Trauma Total ____

Mechanism of injury ____

76. MVA ____
77. Stab/gunshot ____
78. Falls ____
79. Assault ____
80. Other (explain) ____
81. Trauma patient admitted to Level I trauma center ____
82. Trauma patient admitted to Level II trauma center ____

**General Medical**

83. Alcohol/Drug abuse ____
84. Anaphylaxis ____
85. CVA/Vascular ____
86. Dehydration/Sepsis ____
87. Diabetic ____
88. Drowning/Near drowning ____
89. Gastrointestinal problems ____
90. Heat/Cold exposure ____
91. OB/GYN problems ____
92. Poisoning ____
93. Pronouncements not resuscitated ____
94. Psychiatric problems ____
95. Respiratory problems ____
96. Seizures ____
97. Syncope ____
98. Unconscious (etiology unknown) ____
99. Weakness/Malaise ____
100. Other (explain) ____
101. Medical Total ____

MATCHING TOTALS

67, 75, 101 must = Item 8
76, 77, 78, 79, 80 must = Item 75
68, 69, 70, 71, 72, 73 74 must = Item 75

Comments:

4 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM________________

QUARTER ENDING________________

## SECTION FOUR—PROCEDURES

| | | | |
|---|---|---|---|
| 102. AV fistula/shunt access | ____ | 110. MAST inflation | ____ |
| 103. Central venous access | ____ | 111. Nasogastric tube insertion | ____ |
| 104. Chest decompression | ____ | 112. Patients cardioverted | ____ |
| 105. Esophageal obturator airway insertion | ____ | 113. Patients defibrillated | ____ |
| 106. Ext. cardiac pacing | ____ | 114. Patients participated in a prehospital research project | ____ ____ |
| 107. Intraosseous infusion | ____ | 115. Tracheal intubation | ____ |
| 108. Intravenous catheter plug | ____ | 116. 12 lead EKG | ____ |
| 109. IV therapy initiated (number of patients) | ____ | | |

Comments:

## SECTION FIVE—PRIMARY COMMUNICATIONS WITH MEDICAL CONTROL

Enter each patient only once

| | | | |
|---|---|---|---|
| 117. UHF (telemetry) | ____ | 121. Radio failure | ____ |
| 118. VHF (HEAR) | ____ | 122. Other communications (explain) | ____ |
| 119. Cellular Phone | ____ | | |
| 120. Telephone | ____ | | |

MATCHING TOTALS
Section Five totals must = Item 8

Comments:

## SECTION SIX—PAYMENT SOURCE

Enter each patient only once

| | | | |
|---|---|---|---|
| 123. Medicare | ____ | 127. Other commercial insurance | ____ |
| 124. Medicaid | ____ | 128. No fault | ____ |
| 125. Blue Cross/Blue Shield | ____ | 129. Workman's Compensation | ____ |
| 126. Self pay | ____ | 130. Other (list) | ____ |

MATCHING TOTALS
Section Six totals must = Item 8

Comments:

5 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM________________________

QUARTER ENDING________________________

SECTION SEVEN—DESTINATIONS

Record the number of ALS patients taken to each hospital

131.

| Hospital name and code # | Number of patients | Hospital name and code # | Number of patients |
|---|---|---|---|
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MATCHING TOTALS
Item 131 Total must = Item 8

Comments:

6 (OEMS 9/91)

MICU QUARTERLY REPORT—Continued

PROGRAM________________

QUARTER ENDING________________

SECTION EIGHT—ORIGINATION OF CALL

List incorporated municipalities and municipality codes.
Do not use subdivision names.

Record in 133 the number of dispatches (by municipality) for your program vehicles. In 134 record the number of completed ALS calls originating in each town.

| 132. Town | Municipality Code | 133. Dispatches | 134. Completed ALS calls |
|---|---|---|---|
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MATCHING TOTALS
Total of 133 must = Item 1
Total of 134 must = Item 8

Comments:

7 (OEMS 9/91)