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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00987B (05/2015) | | | | | **STATE OF WISCONSIN**  [Wis. Stat. § 256](http://docs.legis.wi.gov/statutes/statutes/256/Title)  [Adm. Code Chapter DHS 110](http://docs.legis.wi.gov/code/admin_code/dhs/110/110/Title)  608-266-1568 | | | | |
| **EMS SERVICE OPERATIONAL PLAN ADVANCED SKILLS ADDENDUM** | | | | | | | | | |
| Updating and maintaining a current operational plan with the Department of Health Services (DHS) is required s. 256 Wisconsin Statutes and Chapter DHS 110, Wisconsin Administrative Code. Failure to complete, submit and obtain approval of an EMS Operational Plan may result in denial, revocation or suspension of an EMS provider license or other disciplinary action as allowed by law. **Please scan and email the completed document to the appropriate EMS Program Coordinator.** | | | | | | | | | |
| **EMS Provider Information** | | | | | | | | | |
| Name of Service | | | | Service License No. | | | Service Level | | Date |
| Enter text | | | | Enter text | | | Advanced EMT | | Choose date |
| Contact Person (submitting plan) | | | | Contact Telephone No. | | | Contact Email Address | | |
| Enter text | | | | Enter xxx-xxx-xxxx | | | Enter text | | |
| **Service will** Choose an item.**?**  **Yes**  **No** | | | | | | | | | |
| **Proposed Effective Date:** | | Choose date (Note that review and approval may take up to 60 business days.) | | | | | | | |
| **Protocol:** **Is approved by our service medical director and is attached.** | | | | | | | | | |
| **Training Description** | | Date of Training: | Click here to enter a date. | | | | | | |
| The course outline and instructional materials that will be used are attached. Each student will have a chance to practice this advanced skill as taught. Knowledge and skill competency will be tested via a written exam and/or a competency based skills evaluation. Attendance and training records will be maintained by the ambulance service provider. | | | | | | | | | |
| Identify the training instructor and his/her qualifications: Enter text | | | | | | | | | |
| How will the new member be trained in this advanced skill? Enter text | | | | | | | | | |
| **Continued Competency:** Continued competency will be achieved by  annual or  biennial review (check box). Review and practice will also be accomplished periodically throughout the year as needed based on local utilization of the skill and quality assurance. Records of recertification will be kept on file with the service for a period of no less than five years. | | | | | | | | | |
| **Staffing** (check one)**:** | | | | | | | | | |
|  | All EMS personnel credentialed with this service have been trained on this protocol to allow our service to be fully staffed with individuals trained in this advanced skill. | | | | | | | | |
|  | A number of this service’s EMS personnel have been trained in this advanced skill. Scheduling will be accomplished so that at least one person per shift has already been trained and certified. | | | | | | | | |
|  | Other (describe): Enter text | | | | | | | | |
| **CERTIFICATION** | | | | | | | | | |
| I certify that the named EMS service will operate in conformance with s. 256 Wisconsin Statutes and Chapter DHS 110, Wisconsin Administrative Code and this amended operational plan. | | | | | | | | | |
| **SIGNATURE** – Service Director | | | | | |  | | Date Signed | |
| **SIGNATURE** – Service Medical Director | | | | | |  | | Date Signed | |