DEPARTMENT OF HEALTH SERVICES COUNTY OF LOS ANGELES

Department Emergency Coordination Program

PREHOSPITAL OR REQUEST FORM		Y WAIVER	REFEREN	CE NO. 1142.1
Hospital:				
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ing this Form:				
ation (Phone):				
ation (E-Mail):				
ERS: Check all tha	at apply.			
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ed Start Date:	/	/		
ed End Date:	/	/		
e: ency	Approve	ed	Denied	
		Name		Signature
not authorized to u paramedic and one	ıse 1:1 Staffin	g Configuration to	o operate with onl	
ed End Date:	/	/		
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ts:		Name		Signature
	REQUEST FORM Hospital: st: st: ting this Form: ation (Phone): ation (E-Mail): ERS: Check all that A.1. ALS Unit State with only one (1) per ed Start Date: ency e: ency et et et ency et	Hospital: st: ting this Form: ation (Phone): ation (E-Mail): ERS: Check all that apply. A.1. ALS Unit Staffing Waiver with only one (1) paramedic and ed Start Date: ency ency ency entative: B.1. ALS Unit Staffing Waiver and authorized to use 1:1 Staffing paramedic and one (1) emergenced Start Date: ed Start Date: // Approvered Ency ed End Date: // Approvered Ency ency ency ency ency ency ency ency e	Hospital: st: ting this Form: ation (Phone): ation (E-Mail): ERS: Check all that apply. A.1. ALS Unit Staffing Waiver – Allow ALS Unit with only one (1) paramedic and one (1) emerger and Start Date: ency ency entative: B.1. ALS Unit Staffing Waiver for Private Proventative: Approved Approved Approved Approved Approved Approved Approved Approved	Hospital: st: ting this Form: ation (Phone): ation (E-Mail): ERS: Check all that apply. A.1. ALS Unit Staffing Waiver – Allow ALS Units to respond to Alwith only one (1) paramedic and one (1) emergency medical technical ed Start Date: ed End Date: ed End Date: ency test: B.1. ALS Unit Staffing Waiver for Private Providers – Allow ALS units to respond to Alwith only one (1) paramedic and one (1) emergency medical technical technical ed End Date: b. Approved B.1. ALS Unit Staffing Waiver for Private Providers – Allow ALS unit authorized to use 1:1 Staffing Configuration to operate with only paramedic and one (1) emergency medical technician (EMT). and Start Date: d. Approved Denied Denied Denied Denied

EFFECTIVE DATE: 03-12-20

REVISED: 04-01-24 SUPERCEDES: 07-01-22 SUBJECT:

PREHOSPITAL CARE POLICY WAIVER REFERENCE NO. 1142.1

REQUEST FORM

Requested Start Date:	/	/	
Anticipated End Date:	/	/	
EMS Agency Response: EMS Agency Representative:	Approve	ed	Denied
Comments:		Name	Signature
		-	ovider (ALS and BLS) to eater than 15 minutes from
incident location.	orgonoy dopa.	unoni located git	
Requested Start Date:	/	/	
Anticipated End Date:		/	
EMS Agency Response: EMS Agency Representative:	Approve	ed	Denied
Comments:		Name	Signature
Comments.			
C.3. Patient Destir			to designated alternate site the hospital's campus.
C.3. Patient Destir			to designated alternate site the hospital's campus.
C.3. Patient Desting (other than the emeter start Date: Anticipated End Date:			
C.3. Patient Desting (other than the emean sequested Start Date:		ment) located on / /	

SUBJECT: **PREHOSPITAL CARE POLICY WAIVER** REFERENCE NO. 1142.1

D.1. Hospital Designated Service Area Boundary Waiver – Suspend Service

REQUEST FORM

Requested Start Date:	/	/	
Anticipated End Date:	/	/	-
EMS Agency Response: EMS Agency Representative:	Approve		Denied
Comments:		Name	Signature
on Internal Disast	er when hospit nospital reques	als report via R st for Internal Di	Alert Center may place hospit eddiNet that their Service Leve saster diversion must be
Anticipated End Date:			-
		,	-
Response: EMS Agency	Approve	ed	Denied
EMS Agency Response: EMS Agency Representative: Comments:	Approve	ed Name	Denied Signature
Response: EMS Agency Representative: Comments: F.1. 30-Minute Sponses	pecialty Care (Name Center Transpand BLS Units to	Signature
Response: EMS Agency Representative: Comments: F.1. 30-Minute Sponses	pecialty Care (Name Center Transpand BLS Units to	Signature ort Waiver (i.e., Trauma, STE to transport to a more distant
Response: EMS Agency Representative: Comments: F.1. 30-Minute Sponse Stroke, Pediatric specialty care centered.	pecialty Care (Name Center Transpand BLS Units to	Signature ort Waiver (i.e., Trauma, STE to transport to a more distant
Response: EMS Agency Representative: Comments: F.1. 30-Minute Sponse Stroke, Pediatric specialty care centered Start Date:	pecialty Care (Name Center Transpand BLS Units to the 30-minut /	Signature ort Waiver (i.e., Trauma, STE to transport to a more distant

SUBJECT: **PREHOSPITAL CARE POLICY WAIVER** REFERENCE NO. 1142.1 **REQUEST FORM**

G.1. Out of County and Ambulance Operator License Exemption – Allow

within Los Angele		ot licensed in Los	Angeles County to operate
Requested Start Date:	/	/	
Anticipated End Date:	/	/	
EMS Agency Response: EMS Agency Representative:	Approve		Denied
Comments:		Name	Signature
•	ider to dispatcl	h and provide trar	ust obtain consent from 9-1-1 nsportation services within the
<u>-</u>	/	/	
Anticipated End Date: EMS Agency Response: EMS Agency Representative:	/ Approve	/ ed	Denied
Anticipated End Date: EMS Agency Response: EMS Agency	/ Approve	ed Name	Denied Signature
Anticipated End Date: EMS Agency Response: EMS Agency Representative: Comments: H.1. Specialty Care Tror one (1) Respire	are (Nurse/RC ansport Units t atory Care Pra	Name P) Transport Un to operate with on ctitioner.	
Anticipated End Date: EMS Agency Response: EMS Agency Representative: Comments: H.1. Specialty Care Tror one (1) Respirations (1) Respirati	are (Nurse/RC	Name P) Transport Un to operate with on	Signature it Staffing Waiver – Allow
Anticipated End Date: EMS Agency Response: EMS Agency Representative: Comments: H.1. Specialty Care Tror one (1) Respire	are (Nurse/RC ansport Units t atory Care Pra	Name EP) Transport Un to operate with on ctitioner. /	Signature it Staffing Waiver – Allow

SUBJECT: **PREHOSPITAL CARE POLICY WAIVER** REFERENCE NO. 1142.1

REQUEST FORM

I.1. Waiver to Refer 9-1-1 Type Calls to the 9-1-1 Jurisdictional Provider –
Waive the requirement that private ambulance operators must refer any call that
would normally be considered an emergency 9-1-1 call to the authorized
emergency transportation provider for that geographical area.

	/	/		
Anticipated End Date:	/	/		
EMS Agency Response: EMS Agency Representative:	Approved		Denied	
Comments:		Name	Signature	
J.1. Emergency requirements.	Response Rec	quest Waiver – V	Vaive minimum response time	
Requested Start Date:	/	/		
Anticipated End Date:	/	/		
EMS Agency Response: EMS Agency Representative:	Approve	ed	Denied	
·		Name	Signature	
Commente:				
Comments:				
K.1. Sponsorshi Accreditation req	uirement for pa . Paramedics p	ramedics licensed racticing under the	les County Paramedic d in California and practicing in his waiver must adhere to the e.	
K.1. Sponsorshi Accreditation req a different county Los Angeles Cou	uirement for pa . Paramedics p	ramedics licensed racticing under the	d in California and practicing in iis waiver must adhere to the	

REQUEST FORM

Prior to approval, the EMS Agency will contact the requesting EMS Provider/Hospital for additional requirements as each waiver request will be evaluated on a case-by-case basis.

Submit the completed Waiver Request Form to the EMS Agency:

Attention: Chief, Prehospital Care Section

FAX: (562) 941-2306

E-Mail: <u>DWells@dhs.lacounty.gov</u> and <u>Cclare@dhs.lacounty.gov</u>