

**NORTH CAROLINA ASSOCIATION OF RESCUE & EMERGENCY MEDICAL SERVICES, INC.**

**P.O. BOX 1914, GOLDSBORO, N.C. 27533-1914 TELEPHONE: 919/736-0506 FAX: 919/736-7759**

**E-MAIL: [ncarems@ncarems.org](mailto:ncarems@ncarems.org)**

**STATEMENT OF ELIGIBILITY**  
**MEDICAL RESPONDER UNIT**

\*\*\* PLEASE PRINT OR TYPE

NAME OF DEPARTMENT \_\_\_\_\_ DATE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ ST. ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_

DEPARTMENT EMAIL ADDRESS \_\_\_\_\_

COMM CENTER PHONE #( ) \_\_\_\_\_ BUSINESS PHONE #( ) \_\_\_\_\_

DEPARTMENT CELL PHONE #( ) \_\_\_\_\_ FAX # \_\_\_\_\_

CAPTAIN/CHIEF \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

WORK PHONE #( ) \_\_\_\_\_ HOME PHONE #( ) \_\_\_\_\_ CELL #( ) \_\_\_\_\_

SECRETARY \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

WORK PHONE #( ) \_\_\_\_\_ HOME PHONE #( ) \_\_\_\_\_ CELL #( ) \_\_\_\_\_

DOES YOUR SQUAD PROVIDE?

RESCUE ONLY \_\_\_ EMS ONLY \_\_\_ EMS/FIRE \_\_\_ EMS/RESCUE \_\_\_ EMS/FIRE/RESCUE \_\_\_ FIRE/RESCUE \_\_\_

**DOCUMENTS NEEDED TO CERTIFY & MUST ACCOMPANY THIS STATEMENT OF ELIGIBILITY:**

- 1) COPY OF STATE CHARTER**
- 2) AUTHORITY TO OPERATE WITH CITY/COUNTY**

# **AUTHORITY TO OPERATE**

## **TO BE SIGNED & NOTARIZED BY CITY OR COUNTY OFFICIAL**

THIS IS TO CERTIFY THAT \_\_\_\_\_  
Name of Department

IS AN ACTIVE OPERATING SERVICE, OPERATING IN \_\_\_\_\_ CITY  
OR COUNTY AND IS HEREBY AUTHORIZED TO PROVIDE **MEDICAL RESPONSE** IN THE ABOVE MENTIONED  
CITY OR COUNTY.

\_\_\_\_\_  
COUNTY OR CITY OFFICIAL PRINT NAME \_\_\_\_\_ SIGNED

\_\_\_\_\_  
TITLE

(NOTARY SEAL)

COUNTY OF \_\_\_\_\_ STATE OF \_\_\_\_\_

ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_, APPEARED BEFORE ME THE SAID INDIVIDUAL DESCRIBED  
HEREIN AND WHO EXECUTED THE FOREGOING INSTRUMENT, AND HE (OR SHE) DULY ACKNOWLEDGED TO ME THAT HE (OR SHE)  
EXECUTED SAME AND THAT THE STATEMENT THEREIN CONTAINED WERE TRUE TO THE BEST OF HIS (OR HER) KNOWLEDGE AND  
BELIEF.

MY COMMISSION EXPIRES: \_\_\_\_\_ NOTARY PUBLIC

## **TO BE SIGNED & NOTARIZED BY DEPARTMENT OFFICIAL**

THIS IS TO CERTIFY THAT \_\_\_\_\_  
Name of Department

IS AN ACTIVE OPERATING SERVICE, OPERATING IN \_\_\_\_\_ CITY  
OR COUNTY AND IS HEREBY AUTHORIZED TO PROVIDE **MEDICAL RESPONSE** IN THE ABOVE MENTIONED  
CITY OR COUNTY.

\_\_\_\_\_  
DEPARTMENT OFFICIAL PRINT NAME \_\_\_\_\_ SIGNED

\_\_\_\_\_  
TITLE

(NOTARY SEAL)

COUNTY OF \_\_\_\_\_ STATE OF \_\_\_\_\_

ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_, APPEARED BEFORE ME THE SAID INDIVIDUAL  
DESCRIBED HEREIN AND WHO EXECUTED THE FOREGOING INSTRUMENT, AND HE (OR SHE) DULY ACKNOWLEDGED TO ME THAT HE (OR  
SHE) EXECUTED THE SAME AND THAT THE STATEMENTS THEREIN CONTAINED WERE TRUE TO THE BEST OF HIS (OR HER) KNOWLEDGE  
AND BELIEF.

MY COMMISSION EXPIRES: \_\_\_\_\_ NOTARY PUBLIC

## **BOTH SIGNATURES ARE REQUIRED**

**MINIMUM STANDARD REQUIREMENTS - NCAR&EMS**

**MEDICAL RESPONDER UNIT**

**1. MINIMUM PERSONNEL / ORGANIZATION REQUIREMENTS:**

NUMBER OF PERSONNEL WITH CERTIFICATION

(ENTER NUMBER OF PERSONNEL WITH EACH CERTIFICATION)

FIRST RESPONDER - \_\_\_\_\_ MEDICAL RESPONDER - \_\_\_\_\_ EMT - \_\_\_\_\_

EMT-I - \_\_\_\_\_ EMT-P - \_\_\_\_\_ RESCUE CERTIFIED - \_\_\_\_\_ RN/MICN - \_\_\_\_\_

**A MINIMUM OF EIGHT (8) PERSONNEL WHO ARE AT LEAST 18 YEARS OF AGE, SHALL BE CERTIFIED AS NCOEMS MEDICAL RESPONDERS OR HIGHER AS SPECIFIED BY THE AHJ PRIOR TO CERTIFICATION IN THIS AREA. Note: If certification is less than NCOEMS Medical Responder the AHJ shall certify this is their approved level of service.**

**2. TYPE OF RESCUE TO PERFORM:**

AS SPECIFIED BY THE CONTRACT WITH THE AHJ

**3. VEHICLE:**

VEHICLE(S) SHALL BE CAPABLE OF TRANSPORTING RESCUE PERSONNEL AND EQUIPMENT TO AN INCIDENT SAFELY AND CANNOT EXCEED THE VEHICLE'S TOTAL GVWR, INCLUDING THE CHASSIS, BODY, AND MEDICAL CARE EQUIPMENT WHEN LOADED. ALL EQUIPMENT SHALL BE LOADED ON APPARATUS AND RESPONSE READY.

**4. MINIMUM REQUIRED EQUIPMENT:      DEPT. NAME \_\_\_\_\_**

NCAR&EMS, INC.,  
REPRESENTATIVE \_\_\_\_\_ DATE: \_\_\_\_\_

APPROVED:      \_\_\_\_\_ YES      \_\_\_\_\_ NO INSPECTOR'S SIGNATURE: \_\_\_\_\_

**YOU MUST HAVE EACH OF THE FOLLOWING ITEMS TO MEET ELIGIBILITY REQUIREMENTS FOR CERTIFICATION.**

- \_\_\_\_\_ B/P CUFFS, 1-ADULT & 1-CHILD
- \_\_\_\_\_ STETHOSCOPE, 1-ADULT & 1-CHILD
- \_\_\_\_\_ EXAM GLOVES
- \_\_\_\_\_ 1 POCKET MASK
- \_\_\_\_\_ 1 PAIR SCISSORS 5 1/2"
- \_\_\_\_\_ 4 5" X 9" ABD PADS
- \_\_\_\_\_ 4 3" X 8" ADAPTIC PADS (VASELINE GAUZE OR ASHERMAN CHESTSEALS)
- \_\_\_\_\_ 10 BAND AIDS
- \_\_\_\_\_ 4 2" KLING
- \_\_\_\_\_ 4 4" KLING
- \_\_\_\_\_ 3 ROLLS 1" TAPE
- \_\_\_\_\_ 4 TRIANGULAR BANDAGES
- \_\_\_\_\_ 12 4"X4" BANDAGES
- \_\_\_\_\_ 1 BOTTLE STERILE WATER 500 ML
- \_\_\_\_\_ 1 EACH PORTABLE SUCTION DEVICE, UNIT W/RIGID TIP OR SOFT TIP SUCTION CATHETER
- \_\_\_\_\_ 6 AIRWAYS 55MM TO 115MM
- \_\_\_\_\_ 1 O2 CYLINDER W/FLOW & CONTENT GAUGE
- \_\_\_\_\_ 2 O2 MASKS & NASAL CANNALS W/DELIVERY TUBES, ADULT & CHILD
- \_\_\_\_\_ 2 SETS OF RIGID SPLINTS (2 FULL ARM & 2 FULL LEGS)
- \_\_\_\_\_ 1 AED
- \_\_\_\_\_ 1 RADIO WITH CAPABILITIES TO COMMUNICATE WITH LOCAL AHJ
- \_\_\_\_\_ 1 SET OF INCIDENT COMMAND FORMS PER AHJ Download these forms at the following link which: <http://www.ncarems.org/standards.php>