# STATE OF WYOMING

# Department of Health

## Rules and Regulations for
## "Wyoming Emergency Medical Services Act of 1977"
## W.S. 33-36-101
## (2020 Revision)

**Chapters 1 through 17**

**January 2020**

# State of Wyoming
# Department of Health

Rules and Regulations for
Wyoming Emergency Medical Services
Chapters 1 through 17

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Table of Contents


CHAPTER 1 GENERAL PROVISIONS ..... 1-1
Section 1. Authority ..... 1-1
Section 2. Applicability ..... 1-1
Section 3. Purpose ..... 1-1
Section 4. Definitions ..... 1-1
Section 5. Notice ..... 1-6
Section 6. Violations: Penalties ..... 1-7
Section 7. Reporting to the Board ..... 1-7
Section 8. Enjoining or Restraining Unlawful Acts ..... 1-7
Section 9. Interpretation ..... 1-7
Section 10. Effective Date ..... 1-7

CHAPTER 2 AMBULANCE SERVICE BUSINESS LICENSE ..... 2-1
Section 1. License Required ..... 2-1
Section 2. Exceptions ..... 2-1
Section 3. Application ..... 2-1
Section 4. Decision and Appeal ..... 2-3
Section 5. Expiration ..... 2-3
Section 6. Renewal of License ..... 2-4
Section 7. Non-transferability of License ..... 2-4
Section 8. Change in Ownership or Termination ..... 2-4
Section 9. Change in Information ..... 2-4
Section 10. Insurance Coverage ..... 2-4
Section 11. Operation Requirements ..... 2-4
Section 12. Disciplinary Action ..... 2-5

CHAPTER 3 AMBULANCE SERVICE PERMIT REQUIREMENTS ..... 3-1
Section 1. Permit Required ..... 3-1
Section 2. Application ..... 3-1
Section 3. Ambulance Specification Criteria ..... 3-1
Section 4. Types of Aircraft Meeting the Criteria ..... 3-1
Section 5. Equipment Criteria ..... 3-1
Section 6. Equipment Criteria for Air Ambulances ..... 3-1
Section 7. Safety Equipment Criteria ..... 3-2
Section 8. Communications Equipment Criteria ..... 3-2
Section 9. Maintenance Criteria ..... 3-2
Section 10. Inspection and Decision ..... 3-3
Section 11. Term of Permit; Non-transferable ..... 3-3
Section 12. Permit Display ..... 3-3
Section 13. Ambulance Inspection ..... 3-3

CHAPTER 4 RESPONSE AND REPORTING REQUIREMENTS ..... 4-1
Section 1. Authority ..... 4-1
Section 2. Ambulance Personnel Criteria ..... 4-1
Section 3. Running Criteria ..... 4-1
Section 4. Patient Care Reporting ..... 4-2
Section 5. Patient Classifications ..... 4-3
Section 6. Other Mandatory Reporting Requirements ..... 4-4

CHAPTER 5 PERSONNEL LICENSING REQUIREMENTS REPEALED AUGUST 2018

CHAPTER 6 ADVANCED TRAINING PROGRAMS ..... 6-1
Section 1. Required ..... 6-1

Section 2. Review by Agencies ..... 6-1
Section 3. Program Committee ..... 6-1
Section 4. Application ..... 6-1
Section 5. Decision ..... 6-2
Section 6. Supervision ..... 6-2
Section 7. Admission Requirements ..... 6-2
Section 8. Instructors ..... 6-3
Section 9. Curriculum ..... 6-4
Section 10. Educational Records ..... 6-4
Section 11. Task Force on Prehospital Care ..... 6-4

CHAPTER 7 ADVANCED LIFE SUPPORT (ALS) SYSTEMS ..... 7-1
Section 1. Operational Approval ..... 7-1
Section 2. Application ..... 7-1
Section 3. Sponsor Hospital ..... 7-1
Section 4. Physician Medical Director ..... 7-2
Section 5. Communication Systems ..... 7-3
Section 6. Decision ..... 7-3

CHAPTER 8 CONTINUING MEDICAL EDUCATION RECERTIFICATION REQUIREMENTS ..... 8-1
Section 1. General Requirements and Criteria ..... 8-1
Section 2. Certified First Responder (FR) Continuing Medical Recertification Criteria ..... 8-1
Section 3. Certified EMT Basic Continuing Medical Education Recertification Criteria ..... 8-2
Section 4. Certified EMT Intermediate, Continuing Medical Education Recertification Criteria ..... 8-3
Section 5. Certified Paramedic Continuing Medical Education Recertification Criteria. 8-5
Section 6. Responsibilities ..... 8-6
Section 7. Criminal Background Checks ..... 8-7

CHAPTER 9 HEARINGS ..... 9-1
Section 1. Purpose ..... 9-1
Section 2. Definitions ..... 9-1
Section 3. Emergency Suspension ..... 9-1
Section 4. Appeal Following Denial, Suspension, Revocation, or Restriction ..... 9-2
Section 5. Initiation of Contested Case Hearing ..... 9-3
Section 6. Answer ..... 9-3
Section 7. Informal Disposition ..... 9-3
Section 8. Hearing Officer ..... 9-4
Section 9. Discovery ..... 9-5
Section 10. Pre-Hearing Conference ..... 9-5
Section 11. Evidence and Testimony ..... 9-5
Section 12. Representation ..... 9-6
Section 13. Location of Hearing ..... 9-6
Section 14. Consolidation of Hearings ..... 9-6
Section 15. Procedural Rights of Contestant ..... 9-6
Section 16. Failure to Appear ..... 9-7
Section 17. Order of Procedure ..... 9-7
Section 18. Decisions ..... 9-7
Section 19. Appeals ..... 9-8
Section 20. Transcripts and Record ..... 9-8
Section 21. Ex Parte Matters. ..... 9-9

CHAPTER 10 NON-AMBULANCE EMS PERSONNEL REPEALED APRIL 2015..... 10-1

CHAPTER 11 MEDICAL DIRECTORS STIPENDS REPEALED NOVEMBER 2015. 11.1

CHAPTER 12 NEED ASSESSMENT MASTER PLAN IMPLEMENTATION GRANTS..... 12-1
Section 1. Authority..... 12-1
Section 2. Purpose and Applicability..... 12-1
Section 3. Severability..... 12-1
Section 4. Definitions..... 12-1
Section 5. Needs Assessment Grant Application Requirements..... 12-2
Section 6. Needs Assessment Grant Application Calendar and Award..... 12-2
Section 7. Emergency Medical Services Needs Assessment..... 12-3
Section 8. Master Plan Implementation Grant Applications and Awards..... 12-5

CHAPTER 13 DESIGNATION OF HEART ATTACK AND STROKE CENTERS..... 13-1
Section 1. Authority..... 13-1
Section 2. Definitions..... 13-1
Section 3. Severability..... 13-2
Section 4. Categories of Recognition and Accrediting Agencies..... 13-2
Section 5. Application, Recognition and Renewal Process..... 13-2
Section 6. Withdrawal of designation..... 13-4
Section 7. Coordination among designated hospitals..... 13-4

CHAPTER 14 COMMUNITY EMS PRACTITIONERS, AGENCIES AND EDUCATION PROGRAMS..... 14-1
Section 1. Authority..... 14-1
Section 2. Definitions..... 14-1
Section 3. Endorsement..... 14-1
Section 4. Approved Educational Programs..... 14-2
Section 5. Community EMS Technician and Community EMS Clinician Scope of Practice and Authority..... 14-5
Section 6. Agency Approval Requirements..... 14-5
Section 7. Documentation and Reporting..... 14-8

CHAPTER 15 ASSESSMENT, TRIAGE, TREATMENT AND TRANSPORT OF TIME SENSITIVE EMERGENCIES..... 15-1
Section 1. Authority..... 15-1
Section 2. Definitions..... 15-1
Section 3. General Operation Requirements for EMS Agencies..... 15-3
Section 4. Assessment, Triage, Treatment and Transport of the Trauma Patient by EMS Providers..... 15-6
Section 5. Assessment, Triage, Treatment and Transport of the Heart Attack Patient by EMS Providers..... 15-8
Section 6. Assessment, Triage, Treatment and Transport of the Stroke Patient by EMS Providers..... 15-10

CHAPTER 16 LICENSING OF PERSONNEL..... 16-1
Section 1. Definitions..... 16-1
Section 2. License Required..... 16-2
Section 3. Eligibility for Licensure..... 16-3
Section 4. Application for Licensure..... 16-4
Section 5. Education Requirements..... 16-4
Section 6. Examination Requirements..... 16-5
Section 7. Decision on Application..... 16-6
Section 8. License Terms..... 16-7

Section 9. Application to Upgrade or Downgrade a License ..... 16-7
Section 10. Application to Renew a License ..... 16-8
Section 11. Criteria to Recover a License and Recovered License Terms ..... 16-8
Section 12. Disciplinary Action ..... 16-8
Section 13. Displaying of Licensure ..... 16-10
Section 14. Emergency Licensing ..... 16-10
Section 15. Conditional Licensing ..... 16-11

CHAPTER 17 SCOPES OF PRACTICE ..... 17-1
Section 1. Authorized Acts or Scope of Practice, Generally ..... 17-1
Section 2. Duties of a Physician Medical Director ..... 17-1
Section 3. Authorized Acts or Scope of Practice for an EMR ..... 17-2
Section 4. Authorized Acts or Scope of Practice for an EMT ..... 17-2
Section 5. Authorized Acts or Scope of Practice for an AEMT ..... 17-3
Section 6. Authorized Acts or Scope of Practice for an IEMT ..... 17-3
Section 7. Authorized Acts or Scope of Practice for a Paramedic ..... 17-5

APPENDIX A EXECUTIVE ORDER No. 76-4 ..... A-1
APPENDIX B EXECUTIVE ORDER No. 1998-7 ..... B-1
APPENDIX C EQUIPMENT REQUIREMENT FOR AMBULANCES ..... C-1
APPENDIX D AMBULANCE SAFETY INSPECTION REPORT ..... D-1
APPENDIX E ARTICLE 2. CARDIOPULMONARY RESUSCITATION DIRECTIVES ..... E-1

# RULES AND REGULATIONS FOR EMERGENCY MEDICAL SERVICES

## CHAPTER 1

## GENERAL PROVISIONS

Section 1. **Authority.** The statutory authority for these rules is W.S. § 33-36-103 and W.S. § 16-3-102(a).

Section 2. **Applicability.**

(a) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the copy contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

(b) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is on the effective date of this Chapter.

Section 3. **Purpose.** These rules and regulations promote the health and safety of the people of Wyoming by establishing minimum standards and procedures relating to ambulances, a system for the licensing of ambulance businesses, the training and certification criteria for prehospital emergency medical personnel, land ambulance attendants, emergency medical fire protection service personnel, and by providing for penalties.

Section 4. **Definitions.** The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably except where the context dictates otherwise. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender shall include individuals of the other gender.

(a) "Act" means the Wyoming Emergency Medical Services Act, W.S. §§ 33-36-101 through 33-36-113.

(b) "Advanced Life Support" or "(ALS)" means treatment rendered by highly skilled certified personnel, including procedures such as cardiac monitoring, advanced airway management, intravenous therapy, and the administration of certain medications.

(c) "Affidavit" means written notarized statement of facts made voluntarily under oath.

(d) "Ambulance" means:

(i) Any land motor vehicle maintained, operated or advertised for the medical care and transportation of patients upon any street, highway, or public way;

(ii) Any land motor vehicle owned and operated on a regular basis by the State of Wyoming or any agency, municipality, city, town, county or political subdivision of Wyoming for medical care and transportation of patients upon any street, highway or public way; or

(iii) Any aircraft which is maintained, operated or advertised for the medical care and transportation of patients in this state.

(iv) This definition does not include any land motor vehicle or aircraft owned and operated by the United States.

(e) "Ambulance Administrator" means any person who has responsibility for quality assurance and control of an ambulance service.

(f) "Ambulance Service" means any organizational entity utilizing ambulances and providing authorized care to patients by attendants at the scene of an emergency or transportation.

(g) "Attendant" means a trained and qualified individual responsible for the care of patients in an ambulance but not involved in search and rescue operations.

(h) "Authorization" means discretionary consent given to permit the actions of others.

(i) "Authorized acts" or "scope of practice" means those skills, procedures, and medications that have been approved for use by EMTs by the Division, the Physician Task Force on Prehospital Care, and the Board of Medicine.

(j) "Automated external defibrillator" or "AED" means a device used in cardiac arrest to perform a computer analysis of the patient's cardiac rhythm and deliver defibrillatory shocks when indicated.

(k) "First Responder" or "FR" means an individual who has successfully completed a training program that is current with the Department of Transportation's First Responder program or an approved First Responder training program sponsored by the Division. A First Responder shall not practice alone as an ambulance attendant in Wyoming.

(l) "Basic Life Support" or "BLS" means treatment rendered by personnel certified at the FR or basic EMT level, including procedures such as bandaging, splinting, basic first aid, performing defibrillation utilizing an AED, basic airway management, oxygen administration, and performing CPR.

(m) "Board" means the Board of Medicine of the State of Wyoming, established by W.S. 33-28-102. The Board serves as the final authorizing agency for the Division on prehospital training programs and requests for medications and skills used by EMS personnel.

(n) "Committee on Accreditation of Allied Health Education Programs (CAAHEP)," means the nonprofit membership organization that provides programmatic postsecondary accreditation for over twenty health science discipline training programs.

(o) "Certificate" means a certificate granted by the Division authorizing an individual to practice at a First Responder FR, EMT, EMT Intermediate, or Paramedic level in this state.

(p) "Consent" means the granting of permission to treat, by a patient to a healthcare provider.

(q) "Contestant" means the person against whom the Division is proceeding in a disciplinary matter or a person whose request for a contested case has been granted.

(r) "Contested Case" means a proceeding involving the denial, revocation, restriction or suspension of a license or certificate, during legal rights, duties or privileges of a contestant are required by law to be determined by the Division after an opportunity for hearing. The hearing shall be conducted in accordance with the Wyoming Administrative Procedure Act, Wyoming Administrative Procedure Act, Wyoming Statues Section 16-3-101, et seq. (t) "Continuing medical education recertification requirements" means Division-approved training criteria, the completion of which must be verified to the Division as a condition of having a certificate remain current or renewable.

(s) "Criminal Background Checks" means completion of a Federal Bureau of Investigation (FBI) criminal background check and a State of Wyoming Division of Criminal Investigation (DCI) criminal background check to include fingerprinting as per W.S. § 7-19-106.

(t) "Days" means calendar days.

(u) "Division" means the Department of Health, Office of Emergency Medical Services (OEMS).

(v) "Emergency" means a situation where an illness or injury could expose a patient to risk of death or permanent disability and immediate transport and treatment, using the appropriate sirens and warning lights, are deemed necessary.

(w) "Emergency Medical Services" or "EMS" means the agencies personnel, and institutions involved in planning for, providing response to, treatment of, and monitoring emergency medical care for those suffering illness or injury.

(x) "Emergency Medical Services for Children" or "EMS-C" means that portion of the emergency medical services system relating to the training of personnel and the provision of patient care to children suffering illness or injury.

(y) "Emergency Medical Technician" means a person who has graduated from a Division approved training program for Emergency Medical Technicians. EMTs at all levels may be referred to as Medics. The levels of the Emergency Medical Technicians include the following:

(i) "Emergency Medical Technician Basic" or "EMT Basic" means an individual who has successfully completed a training program that meets or exceeds the National EMS Education Standards program or Division approved training program for EMTs and who continues to meet all the applicable continuing medical education recertification requirements.

(ii) "Emergency Medical Technician Intermediate or "EMT Intermediate" hereinafter referred to as an "EMT Intermediate", means an individual who has successfully completed a training program that meets or exceeds the a Division approved training program for EMT Intermediate, and who continues to meet all the applicable continuing medical education recertification requirements.

(iii) "Paramedic" means an individual who has successfully completed a training program that meets or exceeds the minimum requirements of the National EMS Education Standards program or an in-state Division approved training program for Paramedics and who continues to meet all the applicable continuing medical education recertification requirements.

(z) "Fraud" means an intentional act of deception or misrepresentation, including any act that constitutes fraud under applicable Federal or state statutes, rules or regulations.

(zz) "Fire protection service" means a paid or volunteer fire department, fire company or other fire suppression entity organized under the laws of this state, any party state or an agency of the government of the United States.

(bb) "Health care professional" means a physician, nurse, certified prehospital provider, or any person who, in accordance with law or a license granted by a state agency, provides health care.

(cc) "Industrial ambulance" means any motor vehicle maintained and operated by an industrial company for the purpose of medical care and transportation of employees or guests who are injured or taken ill on the company premises, or when providing care at the request of or with the authorization of the public or local community emergency medical service.

(dd) "License" means an ambulance business license, issued under W.S. § 33-36-104, which has not expired or been revoked or suspended.

(ee) "Monitored Bed Unit" or "MBU" refers to those areas of a facility that focus on those patients who are acutely ill and require skilled nursing care, close observation, monitoring and management. All patients who in the opinion of the attending physician are critically ill, unstable or require intensive monitoring can be admitted to the MBU.

(ff) "Non-emergency ambulance service" means an ambulance service that does not respond to or advertise that it responds to public medical emergencies, and is limited to transportation from scheduled events or convalescent transfers. Convalescent transfer, for the purpose of this definition, shall mean the transportation of patients initially classified on the request for service as non-emergent between medical facilities, physician offices, homes or transportation depots.

(gg) "Notice" or "Notify" means a written statement, delivered by hand or sent by certified mail, return receipt requested, to the latest known address of the concerned person or entity which appears in the records of the Division, in which the Division communicates any action taken by the Division to deny, revoke, restrict, or suspend a license or certification. Such statement shall include the reasons for and the evidence supporting the action, the right to be represented by a lawyer or other interested person.

(hh) "Patient" means an individual who is sick, injured, or otherwise incapacitated or helpless.

(ii) "Permit" means an ambulance permit issued by the Division authorizing the use of a specified land motor vehicle or aircraft as an ambulance. See Chapter 3 of these rules and regulations.

(jj) "Person" means an individual, firm, partnership, association, corporation or a group of individuals acting together for a common purpose, including the State of Wyoming or any agency, municipality, city, town, county or political subdivision of the State of Wyoming.

(kk) "Physician Assistant" or "PA" means any person who: graduates from a physician assistant education program approved by the commission on accreditation of allied health education programs or its predecessor or successor agency; satisfactorily completes a certification examination administered by the National Commission on the Certification of Physician Assistants or other national physician assistant certifying agency established for such purposes which has been reviewed and approved by the Board, and is currently certified; or who has been approved by the Board to assist in the practice of medicine under the supervision of a physician or group of physicians approved by the board to supervise such assistant.

(ll) "Medical Director" means a Medical Doctor (MD) or Doctor of Osteopathy (DO) licensed in Wyoming who is responsible for the medical supervision of ambulance services, fire protection services, organized first responder units, attendants, and/or non-ambulance EMTs.

(mm) "Prehospital Providers" means personnel who are certified or who are licensed and function at any level in actually delivering prehospital medical care.

(nn) "Program Director" means a physician licensed in this state who supervises basic and/or advanced level EMT/Paramedic training programs.

(oo) "Request for Service" means any response by a licensed ambulance service or Division authorized fire protection service to respond to any request for medical assistance.

(pp) "Search and Rescue" means activities carried out by persons recognized by the county sheriff who are organized, trained, and equipped to provide assistance to patient(s) as part of a rescue operation. Search and rescue activities are primarily limited to locating, providing initial treatment, and removing individuals from imminent danger. Search and rescue activities may, if no ambulance is readily available, include the transportation of an individual to a hospital other than in an ambulance if such transport is in the best medical interest of the patient.

(qq) "Service of process" means the exhibition or delivery of a writ, summons and complaint, criminal summons, notice, order, or other legal document, by an authorized person, to a person or an entity who is thereby officially notified of some legal action or proceeding in which he is involved.

(rr) "Sponsor hospital" means a Wyoming hospital or licensed medical facility that has formally agreed to work with any EMT Basic, EMT Intermediate or Paramedic program or system.

(ss) "State EMS Advisory Committee" means the eight (8) member, Governor appointed committee established through Executive Order 78-4; reaffirmed through Executive Order 1998-7. [See attached Appendix A and B.]

(tt) "Tactical EMS providers" means state certified Medics who provide medical support to law enforcement or military tactical operations.

(uu) "Task Force on Prehospital Care" or "Task Force" means a subcommittee of the State EMS Advisory Committee consisting of Wyoming licensed physicians who act as medical advisors to the Division and the Board on matters relating to EMS training, skill and medication utilization, proficiency requirements, actions on EMT Intermediate and Paramedic personnel, and EMS agencies.

(vv) "Volunteer ambulance service" means an ambulance service operated and staffed by individuals who donate their time and service without any express or implied promise of remuneration or compensation.

Section 5. **Notice.**

(a) Any notice which the Division is required by these rules to provide, shall be provided in writing and delivered by hand or sent by certified mail, return receipt requested, to

the latest known address of the concerned person or entity which appears in the records of the Division. It shall be the responsibility of each person and entity certified or licensed under these rules to keep the Division informed of its current mailing address.

(b) Any notice which a person or entity is required by these rules to provide to the Division shall be provided in writing and sent by certified mail, return receipt requested, or delivered by hand to the Division at the following address:

Wyoming Department of Health
Office of Emergency Medical Services
6101 Yellowstone Rd., Suite 400
Cheyenne, Wyoming 82002

Should the issue arise of whether such notice was received, the return receipt from the U.S. Post Office or a receipt signed and dated by an employee of the Wyoming Department of Health's Office of Emergency Medical Services shall be presumptive evidence that notice was provided.

Section 6. **Violations: Penalties.**

(a) No person shall aid or abet in the violation of these rules.

(b) Any person who violates these rules is guilty of a misdemeanor, as provided by W.S. § 33-36-113. If the Division receives allegations that any individual has violated these rules, it may certify the facts to the Attorney General, who shall take appropriate action.

Section 7. **Reporting to the Board.** The Division shall notify the Board and the Attorney General's office if it has reason to believe that a person certified by the Division has engaged in the unauthorized practice of medicine.

Section 8. **Enjoining or Restraining Unlawful Acts.** Whenever any person has engaged or is about to engage in any acts or practices constituting a violation of these regulations, the Division may take appropriate action, as provided by W.S. § 33-36-112, through the Attorney General's Office. This may include, but is not necessarily limited to, making an application for injunctive or other relief to the appropriate court.

Section 9. **Interpretation.** Where the context in which words are used in these rules and regulations indicates that such is the intent, words in the singular number shall include the plural and vice versa. Words in the masculine gender include feminine and neuter genders.

Section 10. **Effective Date.** These rules and regulations are effective when duly approved by the Governor and filed by the Secretary of State.

RULES AND REGULATIONS
FOR EMERGENCY MEDICAL SERVICES

# CHAPTER 2

## AMBULANCE SERVICE BUSINESS LICENSE

Section 1. License Required. No person shall maintain, conduct, operate, or advertise that they operate an ambulance service in this state without a license.

Ambulance services desiring to have their personnel participate in the State Volunteer EMT Pension Fund program must maintain a current business license.

Section 2. Exceptions. An ambulance service business license shall not be required for:

(a) The United States or an agency or political subdivision of the State of Wyoming;

(b) An industrial ambulance, except for annual reporting requirements;

(c) An individual operating a search and rescue vehicle;

(d) A person operating a volunteer ambulance service in an ambulance area in which no other ambulance services meeting the requirements of the Act are located;

(e) A person using a vehicle rendering service as an ambulance in the case of a major catastrophe or emergency when licensed ambulances based in the locality of the catastrophe or emergency are incapable of rendering the services required;

(f) A person using a privately owned vehicle or aircraft not designated as an ambulance and not ordinarily used in transporting patients, while operating under the provisions of W.S. 33-28-103 in the performance of a life-saving act; or

(g) A person operating an ambulance service based outside of Wyoming, except that any ambulance service receiving a patient within this state shall be required to obtain an ambulance business license. The Division shall grant a license to an ambulance service based in another state whose licensing requirements insure that the purpose of W.S. 33-38-101, *et seq* and these rules are met.

Section 3. Application.

(a) Unless the service operated is a type listed in Section 2 above, no person shall commence operation of an ambulance service in this state prior to receiving an ambulance service business license.

(b) A person planning to establish an ambulance service shall apply for an ambulance service business license at least thirty (30) says prior to the date when she anticipates

commencing operations. The applicant shall complete an application form provided by the Division and shall submit the completed application form and a twenty dollar ($20.00) application fee to the Division by certified mail, return receipt requested.

(c) The application form shall contain the following information:

(i) The applicant's name, physical address, and mailing address;

(ii) The type of business organization (for example, sole proprietorship, partnership or corporation) and a statement of whether the business organization is for profit or nonprofit;

(iii) If the business organization is a partnership, the names, business addresses and mailing addresses of each partner, including silent partners and limited partners;

(iv) If the business organization is a corporation or a limited liability company, the names, business addresses and mailing addresses of all corporate officers and the name, business address and mailing address of each shareholder who owns ten percent (10%) or more of the corporation's stock. If a parent corporation owns ten percent (10%) or more of the corporation's stock, the application shall list the names, business addresses and mailing addresses of all corporate officers of the parent corporation and of each shareholder in the parent corporation who owns ten percent (10%) or more of the parent corporation's stock;

(v) The trade name or business name of the applicant;

(vi) For each attendant whom the applicant anticipates using, the name, training history, and current certification status of the individual;

(vii) The name of the individual responsible for ensuring that each attendant working for the ambulance service meets all continuing medical education. If this individual is designated as an ambulance administrator, that title should be included on the application form;

(viii) A completed application for a permit for each ambulance to be used in the ambulance service business. Each such application shall comply with Chapter 3 of these rules;

(ix) The location from which the ambulance service shall operate, and the boundaries of its normal area of operation;

(x) A copy of a certificate of insurance, issued by an insurance carrier licensed to do business in Wyoming, which certificate shows that each ambulance owned or operated by the ambulance service company is covered by insurance providing for the payment of benefits and damages in at least the following amounts:

(A) Liability coverage in the amount of one million dollars ($1,000,000.00) for each individual claim and two million dollars ($2,000,000.00) for personal injury or death claims arising out of any one (1) motor vehicle accident, or the limits allowed to participants of the state's Local Government Liability Pool;

(B) Liability coverage in the amount of one hundred thousand dollars ($100,000.00) for property damage claims arising out of any one (1) transaction or occurrence, or the limits allowed to participants of the state's Local Government Liability Pool; and

(C) Liability coverage in the amount of two million dollars ($2,000,000.00) for personal injury, death or other claims arising out of any one (1) transaction or occurrence, or the limits allowed to participants of the state's Local Government Liability Pool.

(xi) A statement of affirmation that the ambulance service shall be operated in full compliance with all applicable federal and state requirements, including such rules as the Division may from time to time promulgate or amend;

(xi) The name of the physician medical director and, if an individual is so designated, of the ambulance administrator, with signatures indicating that those individuals have agreed to serve in their respective capacities; and

(xii) Such other information as the Division may require in order to accomplish full implementation of applicable federal and state requirements and of the Division's rules.

(d) Inspection of records. The Division, at its sole discretion, may at any time inspect the records of any person holding an ambulance service business license to verify information contained in the ambulance business license application.

Section 4. Decision and Appeal.

(a) Within thirty (30) days after receipt of an application for an ambulance service business license, the Division shall issue the license or deny the application for a license. The Division's decision shall be based upon whether the application for an ambulance service business license is in compliance with all applicable federal and state requirements and with the Division's rules.

(b) If the Division issues an ambulance service business license to the applicant, it shall mail the license to the applicant.

(c) If the Division denies the applicant's application for an ambulance service business license, it shall send a written notice of denial to the applicant. The notice of denial shall explain the reasons for the denial.

(d) An applicant for an ambulance service business license whose application is denied, may appeal the denial by sending its request for an administrative hearing on the denial to the Division, by certified mail, return receipt requested, so that it is received by the Division within thirty (30) days of the date when the Division mailed the notice of denial to the applicant. All aspects of the administrative hearing on the denial shall be governed by the provisions of Chapter 9 of these rules.

Section 5. Expiration. A license shall expire on December 31st of each year.

Section 6. Renewal of License. The Division may renew a license if the license holder has complied with the requirements of these regulations. Applicants for a license renewal must complete a license renewal form and pay a twenty dollar ($20.00) license fee. The license holder must convey the license renewal form and fee to the Division at the following address:

Wyoming Department of Health
Office of Emergency Medical Services
Hathaway Building
Cheyenne, Wyoming 82002

The Division must receive the license renewal form and the license renewal fee before December 1st of each year for renewal to be processed by the expiration date.

Section 7. Non-transferability of License. A license is not transferable. Any change in ownership, including sale, transfer or assignment, shall terminate the license.

Section 8. Change in Ownership or Termination. The license holder shall notify the Division at least thirty (30) days before terminating the business or transferring the ownership of the business to another entity or location.

Section 9. Change in Information. A license holder shall notify the Division by certified mail within ten (10) days after any information contained in the application changes or becomes inaccurate.

Section 10. Insurance coverage. A license holder shall immediately notify the Division and cease operations if the coverage required by Section 3 (c)(x) is no longer in force and effect.

Section 11. Operation Requirements.

(a) An ambulance service business license holder shall:

(i) Obtain an ambulance permit, as required by Chapter 3 of these rules, for each ambulance used in the ambulance service business;

(ii) Insure that all attendants are certified as required by these rules. An ambulance service business license holder shall not, at any time, allow a person not appropriately certified as an attendant (including individuals who at one time were appropriately certified but whose certification is no longer current) to function as an attendant on any ambulance operated by the ambulance service business license holder;

(iii) Display a copy of the ambulance service business license in a prominent location on the premises of the ambulance service business at all times; and

(iv) Be operational and en route within ten (10) minutes or as soon thereafter within a reasonable and prudent amount of time of each request for service, unless other arrangements regarding dispatch time have been made and agreed to by the individual requesting service.

(b) An ambulance service business license holder, other than a non-emergency ambulance service or an air ambulance, shall provide ambulance service twenty-four (24) hours per day, seven (7) days per week.

Section 12. Disciplinary Action.

(a) The Division may, at its sole discretion, deny, refuse to renew, restrict, suspend, or revoke an ambulance service business license at any time when the Division has received a credible allegation that an applicant for or a holder of an ambulance service business license has:

(i) Renewed, obtained, or attempted to renew or obtain a license by fraud, bribery, or misrepresentation;

(ii) Advertised the ambulance service in a false or misleading manner;

(iii) Obtained a fee by fraud or submitted a fraudulent billing, including billing for a service not rendered or billing for a service not medically necessary;

(iv) Failed to establish and abide by a set of procedures and precautions, as published by the Centers for Disease Control, to assist health care personnel in protecting themselves from infectious disease;

(v) Violated any federal or state law or regulations, or violated any of these rules; or

(vi) Received a termination notice from the physician medical director of the ambulance service. [See the requirements for summary suspension in Chapter 9 of these rules.]

(b) Before notice of suspension is sent pursuant to Chapter 9, Section 3, the Division may at its sole discretion, send a written warning to the license holder.

(c) A holder of an ambulance service business license may appeal any adverse action which the Division takes under this section by:

(i) Filing a request for an administrative hearing within thirty (30) days of the time the Division has mailed the notice of action to the license holder. Such request shall be sent by certified mail, return receipt requested, to the Division; and

(ii) Complying with all requirements of Chapter 9 of these rules.

RULES AND REGULATIONS
EMERGENCY MEDICAL SERVICES

# CHAPTER 3

## AMBULANCE PERMIT REQUIREMENTS

Section 1. Permit Required. All ambulance services covered by these Rules shall be required to obtain a permit for each ambulance used in his ambulance service.

Section 2. Application. An ambulance service shall apply for a permit by completing an application provided by the Division. The application shall contain at a minimum:

(a) A description of each ambulance including type, make, model, year of manufacture, and motor or chassis number;

(b) An inventory verification of the recommended supplies and equipment carried aboard the ambulance;

(c) Motor vehicle license number or aircraft registration number; and

(d) The name and address of the person(s) owning and operating the ambulance.

Section 3. Ambulance Specification Criteria. All ground ambulances purchased or leased, per Manufacturers Statement of Origin, shall not exceed the Federal certified Gross vehicle Weight Rating for the chassis when fully configured and assuming payload of one hundred fifty (150) pounds per passenger space.

Section 4. Types of Aircraft Meeting the Criteria. Aircraft, when used for ambulance service, shall comply with the current Federal Aviation Regulations and 14 CFR 135, or these rules and regulations, whichever are more restrictive.

Section 5. Equipment Criteria. Recommended minimum equipment for ground ambulances shall be established by the Division. Recommended equipment lists shall be available from the Division. [See attached Appendix C]

Section 6. Equipment Criteria for Air Ambulances.

(a) Required equipment for an air ambulance service may be kept separate from the aircraft in modular prepackaged form to facilitate rapid loading and easy access aboard the aircraft when responding to a call.

(b) All equipment and materials used in an air ambulance shall be secured to prevent any hazard during flight.

(c) Each air ambulance shall provide stretcher security and patient restraint in the vertical and horizontal plane.

(d) The equipment required to be on board an air ambulance when the aircraft is used to provide ambulance service shall be as indicated in the Federal Aviation Regulations 14 CFR 135, and the above Section 5.

Section 7. Safety Equipment Criteria.

(a) A ground ambulance shall be equipped with approved safety belts for the driver and for the front seat passenger(s), if any, and for all seating places in the rear compartment.

(b) An air ambulance shall have a Federal Aviation Administration (FAA) certificate of airworthiness maintained current by compliance with all required FAA inspections, as defined by the Federal Aviation Regulation.

(c) Every ambulance shall carry:

(i) A minimum 1A10BC rated fire extinguisher;

(ii) A portable battery operated light; and

(iii) Maps covering areas in which the ambulance provides services.

Section 8. Communications Equipment Criteria.

(a) Each ambulance shall be equipped with a two-way radio or telephone or other wireless communication device capable of direct communication with Wyoming hospitals for the purpose of patient evaluation and medical procedure authorization.

(b) Any ambulance-to-hospital communication shall be conducted on a Federal Communications Commission (FCC), State Communications Office or Division-approved frequency.

(c) Each air ambulance shall comply with communication requirements as specified by Federal Aviation Regulations.

(d) Each ground ambulance shall be identified with an MS # for communication purposes with hospitals and other agencies. Ambulances MS# are assigned by the Wyoming Hospital Association on behalf of the OEMS.

Section 9. Maintenance Criteria.

(a) The ambulance shall contain compartments so that medical supplies may be kept in a clean and sanitary condition.

(b) Equipment shall be securely stored so that the patient is not injured during a sudden stop or movement.

(c) The ambulance interior and exterior shall be kept clean. The interior shall be cleaned, as necessary, after each use. When a patient with a communicable disease, other than the common cold, has been transported in an ambulance, the ambulance interior and all equipment coming in contact with the patient shall be thoroughly disinfected. The infection control guidelines of the Centers for Disease Control shall be adhered to.

(d) All linens, airway and oxygen masks, nasal cannulas or any other supplies or equipment coming into direct patient contact shall either be of a single use, disposable type or cleaned, laundered or disinfected prior to reuse, as appropriate.

(e) All equipment shall be kept clean and in proper working order.

(f) The ambulance shall be maintained in accordance with manufacturer's specifications and be in good safe operating condition at all times.

(g) Emergency vehicle warning lights and audible warning devices shall be maintained to function in the manner in which they were designed to function.

(h) The ground ambulance shall meet the safety inspection criteria, as established by the Division. [See attached Appendix D]

Section 10. Inspection and Decision. After receiving an application, the Division may inspect the ambulance or have its designee inspect the ambulance. The Division shall grant the permit if the ambulance meets the requirements of this Chapter. If the Division denies the permit, it shall specify the reasons for denial, the corrective action required by the Division, and a date by which the corrective action must be taken. The Division may at any time inspect an ambulance requiring a permit under this Chapter.

Section 11. Term of Permit; Non-transferable. Permits shall remain effective as long as the ambulance meets the requirements of this Chapter. The permit is not transferable.

Section 12. Permit Display. Permit decals shall be prominently affixed to the rear door or rear window of the ambulance.

Section 13. Ambulance Inspection. The Division may, at its sole discretion, inspect each ambulance subject to the requirements of this Chapter. The Division may inspect an ambulance or its maintenance records at any time or place to determine if the ambulance is being operated safely and in compliance with these regulations. [See attached Appendix D]

RULES AND REGULATIONS

FOR EMERGENCY MEDICAL SERVICES

CHAPTER 4

RESPONSE AND REPORTING REQUIREMENTS

Section 1. **Authority.** In addition to the authority delegated under W.S. 33-36-101, these rules are promulgated under the authority of W.S. 35-1-801 to enable the Division in developing and reporting on the comprehensive EMS and Trauma system by establishing uniform criteria for EMS agency reporting and response. For the purposes of this chapter, "EMS agency" means any ambulance, authorized fire protective service or other entity dispatched with the intent to provide medical care in response to an emergency request for medical care.

Section 2. **Ambulance Personnel Criteria.** An ambulance shall comply with the following:

(a) Ground ambulances, when transporting a patient, shall be staffed with a driver and at least one (1) licensed EMT as provided in Chapter 5;

(b) All air ambulance service flights shall require at least one (1) licensed EMT and a flight crew in conformity with current Federal Aviation Regulations and 14 CFR Parts 91, 120, and 135; and

(c) Any physician, registered nurse, physician assistant, or nurse practitioner currently licensed in this state may provide care in an ambulance in accordance with their scope of practice when approved by the ambulance service.

Section 3. **Running Criteria.**

(a) The driver of a ground ambulance shall comply with all Wyoming traffic laws and regulations, including W.S. 31-5-928 and 31-5-952;

(b) In the absence of decisive factors to the contrary, ambulances shall transport "emergent" or "urgent" patients to the closest accessible medical facility equipped, staffed and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patient; and

(c) Siren and approved warning light restrictions. Ground ambulance drivers shall not activate warning lights or use the siren except when responding to an emergency call, providing for safety at the scene of a response or other hazard, or transporting

emergency patients who are classified as "emergent" or "urgent" as defined in Section 5 of this Chapter.

Section 4. **Patient Care Reporting.**

(a) To promote the uniform provision and accountability of the comprehensive emergency medical services and trauma system, all EMS agencies and their personnel shall utilize the Division's electronic patient care reporting system to document the provision of emergency medical services or related trauma care.

(b) EMS personnel providing care to a patient shall provide patient care reports to any EMS agency or healthcare facility receiving the transfer of care of a patient to ensure the continuity of patient care and patient safety.

(c) At a minimum, EMS personnel shall ensure that appropriate personnel receiving the transfer of care of a patient are aware of the patient's presence, that systems and equipment necessary for the monitoring and safety of the patient are in place, and that a verbal report of the care provided by the ambulance service has been provided to the appropriate person.

(d) EMS personnel providing care to and transport of a patient shall leave a copy of the patient care report with the receiving medical facility or EMS agency at the time of the transfer of care of the patient whenever practicable. EMS personnel that provide care to a patient shall submit complete and accurate patient care reports for every request for service in the electronic system maintained by the Division no later than two (2) hours after the ambulance or agency is returned to service and available for response with the following exceptions:

(i) If a patient is transported to a receiving facility outside of the agency's primary response area, and the distance and return time factors prohibit the upload of the patient care report into the system, then the patient care report shall be submitted to the Division's electronic system no later than twelve (12) hours after the return to service;

(ii) If an equipment or system failure occurs that prohibits the upload of the patient care report into the system, then the patient care report shall be submitted to the Division's electronic system no later than twenty-four (24) hours after the system is restored. In these circumstances, the EMS agency or reporting party shall notify the Division. Password expiration or system access actions that are the responsibility of the EMS agency or person shall not be considered equipment or system failures;

(iii) The submission of an amendment or addendum to a previously submitted patient care report, which is submitted to ensure that the previous report is complete and accurate.

(e) Cardiac rhythm strips, 12 lead electrocardiograph (ECG) tracings, and any other reports generated by patient monitoring equipment, shall be considered to be part of the patient care report. Copies of these reports shall be provided to the receiving facility and uploaded into the Division's electronic system.

(f) The Division may inspect the patient care reports of any EMS agency covered by these rules.

(g) No person shall release a patient care report without the patient's consent, except as provided in subpart (h) of this section.

(h) A person may release a patient care report:

(i) to a health care facility;

(ii) to the Department of Health, including its individual divisions and programs;

(iii) to a law enforcement officer;

(iv) to the Wyoming Attorney General's office;

(v) pursuant to a lawful court order; or

(vi) as otherwise required or permitted by law.

Section 5. **Patient Classifications.** For the purpose of these Rules and Regulations the following patient classification definitions shall be used:

(a) "Emergent" means the patient requires immediate transport and treatment to prevent death or permanent disability.

(b) "Urgent" means there is a serious illness or injury to the patient which could expose the patient to risk of death or permanent disability unless treatment is initiated at a medical facility within a reasonable length of time.

(c) “Non-emergent” means a patient who has an injury or illness that is presently stable, which poses no present threat to life or risk of permanent disability, and does not require the use of emergency vehicle warning devices.

(d) For patients who are classified as emergent or urgent, the use of emergency vehicle warning devices is appropriate.

Section 6. **Other Mandatory Reporting Requirements.**

(a) All EMS agencies that come under the provisions of these rules shall submit to the Division a copy of any requests for information filed with them. Any such requests shall be sent to the Division by certified mail, return receipt requested, within thirty (30) days of receipt of such request.

(b) All EMS agencies shall report any service of process, as defined in Chapter 1, Section 4(qq) of these rules to the Division within one (1) working day of receipt of service.

(c) Any EMS agency or person licensed or authorized under these rules that has cause to believe or information indicating that any person or EMS agency is, or may be in violation of these rules, shall report that information to the Division. Failure to report such information shall be considered aiding and abetting in the violation of these rules.

(d) EMS agencies authorized to perform needle or surgical cricothyrotomy or rapid sequence intubation (RSI) shall notify the Division via e-mail within two hours of the performance of these procedures. The Division shall review all cases.

(e) Ambulance services shall notify the Division within two (2) hours of any incident or accident requiring reporting to the Federal Aviation Administration (FAA) or the National Transportation Safety Board, or that inhibits or prohibits the ability of the ambulance to transport a patient.

RULES AND REGULATIONS FOR EMERGENCY MEDICAL SERVICES

CHAPTER 5

PERSONNEL LICENSURE REQUIREMENTS

REPEALED 8/13/2018

RULES AND REGULATIONS FOR
EMERGENCY MEDICAL SERVICES

# CHAPTER 6

## ADVANCED TRAINING PROGRAMS

Section 1. Required. All ambulance services and fire protection services desiring to utilize advanced level prehospital personnel must establish training and continuing education programs. Training programs for emergency medical personnel shall address not only adults but shall include emergency medical services for children (EMS-C).

Section 2. Review by Agencies. All advanced training programs shall be reviewed and approved by the Division, the Task Force on Prehospital Care, and the Board.

Section 3. Program Committee. Any person desiring to establish a training program for EMT Intermediate or Paramedic personnel shall form a Program Committee:

(a) Program Committees for EMT Intermediate personnel shall consist of:

(i) Ambulance service and/or fire protection service representatives in the geographic area who shall employ or utilize the personnel.

(ii) A physician licensed to practice medicine in this state as a Medical Doctor or Doctor of Osteopathy who agrees to act as program director;

(iii) A representative from the sponsoring hospital; and

(iv) An identified course coordinator. The coordinator must be certified at or above the EMT Intermediate level, and have completed a Division approved Instructor/Coordinator program.

(b) Program Committees for Paramedic personnel shall include:

(i) Ambulance service and or fire protection service representatives in the geographic area who shall employ or utilize the personnel;

(ii) A physician licensed to practice medicine in this state as, a Medical Doctor or Doctor of Osteopathy, who agrees to act as program director;

(iii) Personnel from the sponsoring hospital who represent nursing, administration, the emergency department, and the intensive care unit; and

(iv) An identified course coordinator. The Coordinator shall be certified at the Paramedic level or licensed as a nurse, Medical Doctor or Doctor of Osteopathy, and have completed a Division approved Instructor/Coordinator program.

Section 4. Application. The Program Committee shall submit an application for an

advanced training program to the Division. The application must include:

(a) A summary, with appropriate documentation, explaining the medical need for the program;

(b) A description of the proposed training program consisting of:

(i) Content;

(ii) Time Schedule;

(iii) Instructors by name and subject;

(iv) Materials and physical facilities;

(v) Number of students;

(vi) Clinical and field internship requirements, and

(vii) Record keeping methods;

(c) The local criteria for students acceptance and graduation, if more restrictive than Division criteria; and

(d) Provisions for commitment of sponsor hospital as required by Chapter 7 of these rules. (See Chapter 7, Section 3.)

Section 5. Decision. The Division shall notify the Program Committee of its decision concerning the applicant's application for an advanced training program within ten (10) days of its decision. If the Division denies an applicant's application, the applicant may reapply.

Section 6. Supervision. Following approval, the program shall be supervised by the program director, who shall be a Wyoming licensed physician (Medical Doctor) or (Doctor of Osteopathy). The program director shall ensure that each instructor is thoroughly knowledgeable in his subject and understands his responsibility and shall maintain the standards of quality instruction as provided in the curriculum.

Section 7. Admission Requirements.

(a) Students shall be admitted to an EMT Intermediate training program who:

(i) Are currently certified by the Division as an EMT Basic;

(A) Show evidence of having completed twelve (12) months of active affiliation with a Wyoming licensed ambulance service attendant. The Division, at its sole discretion, may waive this after review by the Division on a case-by-case basis; or

(B) Show evidence of having completed twelve (12) months of active affiliation with the Division recognized fire protection service providing basic patient care.

The Division, at its sole discretion, may waive this after review by the Division on a case-by-case basis;

(ii) Are recommended by at least one (1) licensed physician;

(iii) Are approved by the agency's physician medical director and the ambulance administrator and/or the fire protection service's chief.

(iv)Are free of any physical or mental disabilities which would, in the judgment of the student's physician medical director, render them incapable of performing as an EMT Intermediate.

(v) Complete the practical performance review with the physician medical director using the state proficiency checklist; and

(vi) Successfully complete the precourse written exam no more than thirty (30) days prior to the program's starting date.

(b) Students shall be admitted to a Division approved Paramedic training program only if they:

(i) Are currently certified by the Division as an EMT Basic or EMT Intermediate.

(ii) Have at least one (1) year of regular patient care while serving as an EMT Basic attendant or EMT Intermediate.

(iii) Are recommended by one (1) licensed physician;

(iv) Are accepted by the Program Committee; and

(v) Are free from any physical or mental disabilities which would, in the judgment of the student's physician medical director, render them incapable of performing as a Paramedic.

Section 8. Instructors. Instructors for an EMT Intermediate program shall be:

(a) Physicians;

(i) Physicians shall be current in the American College of Surgeon's Advanced Trauma Life Support (ATLS) program or the American College of Emergency Physicians (ACEP) equivalent program, and

(ii) Be current in Advanced Life Support (ACLS) as developed by the American Heart Association, in accordance with current national standards, shall serve as the instructor for the advanced life support/emergency cardiac care sections of the training program.

(b) Registered nurses licensed in this state;

(c) Paramedics; or

(d) Individuals acceptable to the Division.

Section 9. Curriculum. Curriculum requirements shall be established by the Division. Programs must include completion of a Division approved field preceptorship program.

Section 10. Educational Records. The program coordinator shall maintain accurate records of each student's involvement in the training curriculum. These records must be submitted to the OEMS at the time of course completion. Such records shall include, but not necessarily be limited to, attendance at lectures, demonstrations, subject matters covered, completion of the prescribed clinical requirements, time spent at each clinical area, special experience containing a clinical training component, and verification of practical skill competency.

Section 11. Task Force on Prehospital Care.

(a) Composition of the Task Force. The Division shall appoint a Task Force on Prehospital Care selected from currently practicing Wyoming licensed physicians. The Task Force shall consist of seven (7) members selected from the following specialties:

(i) Anesthesiology;

(ii) Cardiology;

(iii) Emergency room medicine;

(iv) Family/general practice;

(v) General Surgery and/or other surgical specialty;

(vi) Internal medicine; or

(vii) Pediatrics.

(b) Operation of the Task Force. The Task Force may meet quarterly, or as needed, for the purpose of advising the Division and Board by:

(i) Reviewing applications and making recommendations on EMT Intermediate or Paramedic training program requests;

(ii) Reviewing the appointment of hospitals as sponsor hospitals for the EMT Intermediate or Paramedic program;

(iii) Reviewing EMT Intermediate and Paramedic training curriculum;

(iv) Recommending the EMT Intermediate and Paramedic certification policy;

(v) Making Recommendations concerning other technical medical areas as requested by the Division or the Board; and

(vi) Reviewing requests from physician medical directors and make recommendations to the Board on requests for new/additional First Responder, EMT Basic, EMT Intermediate, or Paramedic medication and/or skill authorizations.

RULES AND REGULATIONS FOR
EMERGENCY MEDICAL SERVICES

# CHAPTER 7

## ADVANCED LIFE SUPPORT (ALS) SYSTEMS

Section 1. Operation Approval. Before engaging or employing EMT Intermediate or Paramedic personnel, all ALS services shall establish a system in accordance with this Chapter and obtain operational approval from the Division. An ALS system shall consist of one (1) or more (ALS) services, a physician medical director, and a sponsor hospital.

(a) "EMT Intermediate system" means an ALS service that has been authorized by the Board and the Division to utilize EMT Intermediate personnel in accordance with the guidelines established by the Board and the Division.

(b) "Paramedic System" means an ALS service that has been authorized by the Board and the Division to utilize Paramedic personnel in accordance with the guidelines established by the Board and the Division.

Section 2. Application.

(a) The physician medical director shall submit an application to the Division. The application for an ALS system shall contain:

(i) A description of the medical need for the proposed system, including any supporting documentation; and

(ii) A proposed operations manual.

(b) The application shall be reviewed by the Division and the Task Force on Prehospital Care. The Task Force shall provide a recommendation to the Board for final review.

Section 3. Sponsor Hospital.

(a) An ALS service shall obtain the commitment of a sponsor hospital.

(b) The system shall be approved by the hospital administrator and chief of the medical staff of the sponsor hospital.

(c) Eligibility requirements. The sponsor hospital:

(i) For an EMT Intermediate system, shall have a registered nurse on duty for the emergency room twenty-four (24) hours a day and capable of constant voice communication coverage with a physician.

(ii) For a Paramedic system, shall have a registered nurse, on duty in the

emergency room twenty-four (24) hours a day and capable of constant voice communication coverage with a physician.

(A) The registered nurse shall:

(I) (Be) current in Advanced Cardiac Life Support (ACLS) with the standards of the American Heart Association;

(II) Have audited the Advanced Trauma Life Support (ATLS) course of the American College of Surgeons or an equivalent nursing trauma course;

(III) Function in accordance with the Wyoming Nursing Act; W.S. 33-21-119, *et seq.*; and

(IV) Be immediately available at all times to communicate with EMT Intermediate, or Paramedic personnel in the field.

(B) The Physician shall:

(I) Be current in Advanced Trauma Life Support (ATLS) with the standards of the American College of Surgeons or its equivalent from the American College of Emergency Physicians;

(II) Be current in Advanced Cardiac Life Support (ACLS) with the standards of the American Heart Association;

(III) Be available to communicate with the EMT Intermediate or Paramedic personnel in the field;

(IV) Explain the medical role of EMT Intermediate and Paramedic personnel to appropriate hospital staff;

(V) Cooperate with the Division in the collection of statistical data;

(VI) Maintain direct communications capability between the sponsor hospital and the ALS service(s);

(VII) Provide clinical experience with supervision for trainees during the training program and for continuing medical education;

(VIII) Provide for audit in review of EMT Intermediate cases and Paramedic advanced life support cases as outlined in Chapter 8. All concerned EMT Intermediate or Paramedic personnel shall attend the meetings; and

(IX) Practice in a hospital which has an intensive care unit or a monitored bed unit (MBU).

Section 4. Physician Medical Director. Both EMT Intermediate and Paramedic

systems shall be supervised by a physician medical director. The physician medical director shall be a physician licensed to practice medicine in this state. The physician medical director's duties shall include at a minimum:

(a) Filing with the Division copies of current protocols and authorizations, that have been reviewed and approved by the Division and the Task Force, for EMT Intermediate or Paramedic systems;

(b) Monitoring PCRs where EMT Intermediate activities were carried out. The trip reports shall be monitored quarterly;

(c) Monitoring Paramedic PCR forms where advanced life support activities were carried out. The trip reports shall be monitored quarterly; and

(d) Reviewing reports of EMT Intermediate and Paramedic advanced skills usage with all concerned personnel, then submitting reports to the Division no later than December 31st of each year or as requested by the Division.

Section 5. Communication Systems. All ALS service systems shall maintain a communication system capable of:

(a) Voice communication between the ALS service and the sponsor hospital and physicians;

(b) Voice and/or EKG recording units for services utilizing manual, automatic or semiautomatic defibrillation certified personnel.

(c) Telemetry is not mandatory except for the EMT Intermediate ambulance services approved for the optional cardiac level skills and medications. Advanced life support data shall be reviewed for the purpose of medical audit by the Physician Medical Director, the Division and the Physician's Task Force, as deemed necessary.

Section 6. Decision. Upon receipt of all required information, the Division shall notify the Program Committee within ten (10) working days following its decision. The Division shall approve the system if it meets the requirements of this Chapter. If the proposed system does not meet the requirements of this Chapter, the Division shall not approve the system. If the Division does not approve the application for the system it shall provide recommendations for future compliance and applicant may reapply.

RULES AND REGUALTIONS FOR
EMERGENCY MEDICAL SERIVICES

# CHAPTER 8

## CONTINUING MEDICAL EDUCATION RECERTIFICATION REQUIREMENTS

Section 1. General Requirements and Criteria. To assure the maintenance of skill levels attained by First Responders, and all levels of Medics which are the basis for the conduct of authorized acts, as provided in Chapter 5, the Division, the Task Force, and the Board hereby establish criteria for continuing medical education.

(a) Criteria for recertification. First Responders, and all levels of Medics may be recertified by complying with the following requirements:

(i) Making application to the Division, as described in Chapter 5; and

(ii) Submitting documentation of satisfactory completion of the continuing medical education program for the First Responders, and all levels of Medics, as appropriate, no more than ninety (90) and no less than thirty (30) days prior to the expiration date.

(b) Accurate records of the person's involvement in the continuing medical education program must be maintained. Educational records may be reviewed by the Division at any time. Information in such records shall include, but need not be limited to, attendance at lectures or demonstrations, subject matter, name of instructor, time spent in each clinical area and special clinical experiences.

(c) Criteria for testing. Recertification examinations for all levels of attendant shall be scheduled on a regional basis during the one hundred fifty (150) days prior to the expiration of the certification period. A maximum of two (2) attempts to pass the test are allowed. Any retest must be completed within sixty (60) days after receipt of notice of failure. Individuals failing two (2) attempts shall be required to repeat the entire training course specific to their category in order to be eligible for further testing or certification.

Section 2. Certified First Responder (FR) Continuing Medical Recertification Criteria. To be eligible for recertification within the certification period, the FR shall have completed:

(a) CPR certification. Regardless of the teaching agency, all CPR training must adhere to the Healthcare Provider standards of the American Heart Association or its equivalent;

(b) Twenty-six (26) hours of continuing medical education, including:

(i) Eighteen hours structured by specific topic:

2 hrs- Preparatory

2 hrs- Patient assessment, diagnostic signs and triage;

2 hrs- Airway Management;

4 hrs - Trauma;

4 hrs -Medical Emergencies;

2 hrs- pediatrics and childbirth; and

2 hrs- EMS operations

(ii) Four (4) unstructured hours of any subject covered in the FR ~~BEC~~ course. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars or other approved in service training. Those topics not listed within the FR curriculum shall require prior written approval by the Division.

(iii) Four (4) hours in the use of an automated external defibrillator (AED).

(c) One (1) hour in service every six (6) months in which the equipment, precautions and skills of defibrillation are reviewed. This shall include a practice session with the particular (AED) used by the service.

Section 3. Certified EMT Basic Continuing Medical Education Recertification Criteria. To be eligible for recertification within the certification period, the EMT Basic shall complete:

(a) CPR certification. Regardless of the teaching agency, all CPR training must adhere to the Healthcare Provider standards of the American Heart Association or its equivalent;

(b) Fifty-five (55) hours of continuing medical education, including:

(i) Forty-nine (49) hours structured by specific topics:

3 hrs- Preparatory;

4 hrs- Airway Management;

5 hrs- Patient assessment;

10 hrs- Medical Emergencies;

10 hrs- Trauma;

6 hrs - Infants/children;

3 hrs – Ambulance operations;

4 hrs- Self assisted medications; to include practical sessions; and

4 hrs- Automatic External Defibrillation; to include practical sessions

(ii) Six (6) unstructured hours: Any subject covered in the EMT course shall be accepted for continuing medical education credit. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars or other approved in service training. Those topics not listed within the EMT curriculum shall require prior written approval by the Division.

(c) It is recommended that EMT personnel audit an American College of Surgeon's Advanced Trauma Life Support (ATLS) program or Rural Trauma Team Development Course (RTTDC). Attach copy of certificate;

(d) Recertification exam. Successfully complete the EMT written recertification exam administered by the Division during the final one hundred fifty (150) days of recertification period;

(e)~~(i)~~ Practical skills verification. Verification of practical skills shall be provided by the physician medical director unless this was accomplished during a formal Division approved EMT-Refresher course; and

(f)~~(j)~~ Successful completion of a Division approved Paramedic course during the certification period shall fulfill all continuing medical education requirements for EMT recertification.

Section 4. Certified EMT Intermediate, Continuing Medical Education Recertification Criteria. Within the certification period, the EMT Intermediate must:

(a) Complete all continuing medical education requirements listed in Section 3 of this Chapter;

(b) Submit to the Division documentary verification of a favorable recommendation from the physician medical director for EMT Intermediate continuing medical education. The Division has established the following as appropriate criteria in meeting continual medical education specific to the EMT Intermediate's skill authorization. The physician medical director shall verify the EMT Intermediate's practical performance competency in the following areas:

(i) Intravenous therapy. Successfully perform six (6) venipunctures in each six (6) month period. (Blood draws do not satisfy this requirement);

(ii) Authorized medications. Participate in a one (1) hour in service each six (6) month period on the preparation and administration of the Division approved list of drugs, to include dosages, indications, contraindications, available preparations and concentrations, and techniques of administration. This should include a practice session. Drawing blood samples, glucose determination, saline locks, and Heparin locks, must be included in such in service training; and

(iii) Defibrillation. Participate in a one (1) hour in service every six (6) months, in which the equipment, indications, precautions, and skills of defibrillations are

reviewed. This must include a practice session with the device used by the service for which the EMT Intermediate is affiliated;

(iv) Chest Decompression. Participate in a one (1) hour in service, presented t least every six (6) months, in which related anatomy, indications, precautions, equipment, protocol, and techniques of needle decompression of the chest are reviewed;

(v) Electrocardiogram monitoring. Participate in a one (1) hour in service, presented at least every six (6) months, in which the electro physiology, equipment and protocols for EKG monitoring are reviewed; and

(vi) If authorized, for the optional level, EMT Intermediate shall have completed an Advanced Cardiac Life Support (ACLS) course equivalent to American Heart Association guidelines and submit a legible copy of a current certificate to the Division.

(c) If authorized, complete the following required advanced airway management continuing medical education, in advanced airway management:

(i) In multi-lumen lower airway adjuncts:

(A) Successfully insert six (6) multi-lumen lower airways during six (6) month period; and

(B) Participate in a one (1) hour in service of the utilized airway every six (6) months, including indications for use, contraindications, precautions, insertion and removal techniques;

(ii) Endotracheal intubations:

(A) Successfully insert six (6) endotracheal tubes during each six (6) month period. Intubations performed during each six (6) month period shall be in humans, however if necessary, may be performed on an intubation manikin under supervision; and

(B) Participate in a one (1) hour in service on endotracheal intubation every six (6) months. The review must include indications for use, contraindications, precautions, insertion and removal techniques;

(d) It is recommended that EMT Intermediate personnel audit an American College of Surgeon's Advanced Trauma Life Support (ATLS) program or Rural Trauma Team Development Course (RRTDC). Attach copy of certificate;

(e) Participate in EMT Intermediate case reviews, for a minimum of one (1) hour quarterly. EMT Intermediate cases shall be reviewed by the physician medical director to provide medical audit and control; and

(f) Successfully completed the EMT Intermediate written recertification exam administered by the Division, during the final one hundred fifty (150) days of the recertification period.

Section 5. Certified Paramedic Continuing Medical Education Recertification Criteria. Within the certification period, the Paramedic must have:

(a) Completed all continuing education requirements listed in Section 3 of this Chapter;

(b) It is recommended that Paramedic personnel audit an American College of Surgeon's, Advanced Trauma Life Support (ATLS) program or a Rural Trauma Team Development Course (RTTDC). Attach copy of certificate;

(c) Completed an Advanced Cardiac Life Support (ACLS) program that is equal to or equivalent to that presented by the American Heart Association and submit a legible copy of a current certificate to the Division;

(d) Submitted to the Division documentary verification of a favorable recommendation from the physician medical director for Paramedic continuing medical education. The Division has established the following as appropriate criteria in meeting continuing medical education specific to the Paramedic's skill authorization. The physician medical director shall verify the attendant's practical performance competency in the areas listed below:

(i) Complete twelve (12) hours of advanced continuing medical education: [Note that these hours are above and beyond those as shown in Section 4.]

6 hrs- Cardiology and Arrhythmia recognition

6 hrs- Advanced Patient assessment

(ii) Intravenous therapy: Successfully perform six (6) venipunctures during each six (6) month period;

(iii) Authorized medications: Participate in a one (1) hour in service every six (6) months on the preparation and administration of the Division approved drugs, to include dosages, indications, contraindications, available preparations and concentrations, and techniques of administration. This should include a practice session. Drawing blood samples, glucose reagent strips, saline locks, and Heparin locks, must be included in such in service training;

(iv) Defibrillation and Cardioversion: Participate in a one (1) hour in service every six (6) months in which the equipment, indications, precautions and skills of defibrillation and cardioversion are reviewed. This must include a practice session on the particular monitor/defibrillator used;

(v) Electrocardiogram monitoring: Participate in a one (1) hour in service, presented at least every six (6) months, in which the electro physiology, equipment and protocols for EKG monitoring are reviewed;

(vi) If an authorized skill, orogastric/nasogastric intubations: Participate in a one (1) hour in service, presented at least every six (6) months, in which related anatomy, indications, precautions, equipment and techniques of orogastric/nasogastric intubations are

reviewed;

(vii) Cricothyroidotomy: Participate in a one (1) hour in service, presented at least every six (6) months, in which related anatomy, indications, precautions, equipment and the Division and Board approved technique of cricothyroidotomy are reviewed; and

(viii) Chest Decompression: Participate in a one (1) hour in service, presented at least every six (6) months, in which related anatomy, indications, precautions, equipment, protocol, and techniques of needle decompression of the chest are reviewed.

(e) Complete the following advanced airway management continuing medical education, if the attendant has skill authorization in advanced airway management, completes the following:

(i) In Multi-lumen lower airway adjuncts:

(A) Successfully insert six (6) multi-lumen lower airways during each six (6) month period; and

(B) Participate in a one (1) hour in service of the utilized airway every six (6) months, to include indications for use, contraindications, precautions, insertion and removal techniques.

(f) Participate in paramedic case reviews, for a minimum of one (1) hour each quarter. Paramedic cases shall be reviewed by the physician medical director to provide medical director to provide medical audit and control; and

(g) Successfully complete the paramedic written recertification exam, as administered the Division or its representative, during the final one hundred fifty (150) days of the certification period.

Section 6. Responsibilities.

(a) It is the responsibility of the individual certified to keep one's continuing medical education and testing and to renew one's certification in a timely fashion. Because the physician medical director is ultimately responsible for the EMT Basic, EMT Intermediate or Paramedic's competency during the certification period, a physician medical director has the right to request that the Division test the EMT Basic, EMT Intermediate, or Paramedic for competency, or the physician medical director may conduct competency testing independent of the Division. The Physician medical director may withdraw the EMT Basic, EMT Intermediate, or Paramedic sponsorship at any time for any reason. It is also the physician medical director's, or his designee's responsibility to notify the Division at any time when an EMT Basic, EMT Intermediate, or Paramedic is deficient or lacking annual or semiannual continuing medical education requirements.

(b) It is the responsibility of the Division to see that the continuing medical education requirements are consistent with current medical education trends. The Division may, at its sole discretion, initiate pilot continuing medical education programs in order to keep abreast of current national trends.

Section 7. Criminal Background Checks.

(a) Beginning August 1, 2009 any Medic applying for recertification who holds a current Wyoming certification shall complete and submit a Federal Bureau of Investigation (FBI) Criminal Background check and a State of Wyoming Division of Criminal Investigation (DCI) Background Check to include fingerprinting if one has not previously been submitted to the OEMS.

(b) Criminal Background check forms shall be provided by the Division. Costs of the background check and fingerprinting are the sole responsibility of the Medic.

(c) Individuals who have been certified continuously for four (4) years as a Wyoming Medic shall only be required to have a Wyoming Division of Criminal Investigation (DCI) background check completed.

(d) The Medic shall attach the criminal history check form to the Wyoming EMT recertification form.

(e) Failure to comply with the request for the criminal background check and fingerprints will result in denial of certification.

RULES AND REGULATIONS
EMERGENCY MEDICAL SERVICES

# CHAPTER 9

# HEARINGS

Section 1. Purpose. This Chapter has been adopted to provide uniform procedures for the conduct of contested cases involving the denial, revocation, restriction or suspension of a license or certificate.

Section 2. Definitions. The definitions set forth in the Wyoming Administrative Procedures Act W.S. 16-3-101, *et seq.*, are incorporated by reference and, for the purposes of a contested case hearing the following definitions apply.

(a) "Contested Case" means a proceeding involving the denial, revocation, restriction or suspension of a license or certification during which legal rights, duties or privileges of a Contestant are required by law to be determined by the Department after an opportunity for hearing. The hearing shall be conducted in accordance with the Wyoming Administrative Procedures Act, W.S. 16-3-101, *et seq.;*

(b) "Contestant" means the person who requests the hearing;

(c) "Department" means the Wyoming Department of Health, its agent, designee or successor;

(d) "Discovery" means pre-hearing procedures used to obtain information from the adverse party;

(e) "Hearing" means a contested case hearing before a hearing officer;

(f) "Hearing Officer" means the individual or individuals designated by the Department to serve as the presiding officer(s) at a hearing held under this Chapter of these rules;

(g) "Respondent" means the Department;

(h) "Wyoming Administrative Procedures Act" or "WAPA" means W.S. 16-3-101, *et seq.;* and

(i) "Wyoming Rules of Civil Procedure" or "WRCP" means the rules governing procedure in all courts of record in the State of Wyoming, in all actions, suits or proceedings of a civil nature, Rule 1 of the Wyoming Rules of Civil Procedure.

Section 3. Emergency Suspension.

(a) Pursuant to W.S. 16-3-113, the Department shall order summary suspension of a certificate or license if the Department finds, and incorporates such finding in the order, that

public health, safety or welfare imperatively requires emergency action of suspension of the certificate or license.

(b) The Department shall accept written notice from the physician medical director that the physician has terminated his position as physician medical director for an EMT, attendant or ambulance service as constituting sufficient evidence supporting a finding that public health, safety or welfare imperatively requires emergency action of suspension, if the physician also provides reason to believe that:

(i) The EMT, attendant or ambulance service has failed or refused to demonstrate the practical performance competency required of an EMT, attendant, or ambulance service;

(ii) The EMT, attendant or ambulance service intentionally misstated or failed to provide any fact that would have resulted in the denial of a certificate or license; or

(iii) Some fact, reason or condition exists that would have resulted in the denial of a certificate or license, whether or not such fact, reason or condition existed at the time of the approval.

(c) The notice of summary suspension shall be issued immediately upon receipt by the Department of the notice described in paragraph (b) of this section. This notice shall be sent by certified mail and/or delivered personally to the ambulance service, attendant or EMT's last known address. Any summary suspension shall become effective immediately upon receipt by the EMT, attendant or ambulance service of notice from the Department.

(d) Proceedings consistent with this Chapter shall be promptly instituted to determine whether the summary suspension shall be affirmed as a revocation or suspension, modified as a restriction, vacated or terminated.

Section 4. <u>Appeal Following Denial, Suspension, Revocation, or Restriction.</u>

(a) A person or an entity whose license or certificate was denied, suspended, revoked, or restricted on the grounds of engaging in conduct constituting a ground for disciplinary action set forth in Chapter 2, Section 12, or Chapter 5, Section 9 or as otherwise provided by law, may request an appeal of the decision within thirty (30) days following the Division's decision.

(b) The request for appeal of the decision shall be in writing and shall contain:

(i) The name of the person or entity (Contestant), address and telephone number;

(ii) A statement in ordinary and concise language setting forth the grounds for the appeal including all statues or rules upon which the Contestant relies;

(iii) The action for which the appeal is sought; and

(iv) The remedy requested by the Contestant.

(c) Within thirty (30) days after receiving the request, the Department shall make its decision and notify the Contestant. The Department may:

(i) Decide in favor of the Contestant;

(ii) Notify the Contestant that a contested case hearing shall be held; or,

(iii) Notify the Contestant a contested case hearing is denied. Following such notification, the Department shall issue findings and an order. The order shall be the Department's final decision and may be appealed to the district court pursuant to the WAPA.

Section 5. Initiation of Contested Case Hearing.

(a) The Department shall notify the Contestant at least twenty (20) days before holding a contested case hearing. The Department and Contestant may waive this requirement by written agreement.

(b) The Notice of the complaint shall be served as required by Chapter 1, Section 4(qq) of these rules.

(c) The Notice shall, at minimum, contain the following information:

(i) The potential Contestant's name;

(ii) The time and place of the hearing;

(iii) The docket number assigned to the case;

(iv) The legal authority and jurisdiction under which the hearing is to be held;

(v) The particular sections of the statues and rules involved; and

(vi) A statement in ordinary and concise language setting forth the grounds for the Department's intended action.

Section 6. Answer. If she wishes to contest the Department's intended action, the potential Contestant must file a response within twenty (20) days after receiving the notice. Failure to file a response within twenty (20) days shall be deemed a waiver of any right to respond.

Section 7. Informal Disposition.

(a) Unless contrary to law or rule, a disciplinary proceeding may be settled by informal means at any time.

(b) Settlement conference. Any party may request that the matter be set for a settlement conference. Upon such request, the Hearing Officer shall schedule a conference and direct that a representative of each party attend, such representative to have authority to settle the

matter. The Hearing Officer shall neither attend the conference nor be advised of the proposals of either party. The Hearing Officer may designate another individual, not previously involved in the matter, to attend the conference and assist the parties in attempting to reach a settlement.

Section 8. Hearing Officer.

(a) The Department shall appoint a Hearing Officer to preside over each contested case hearings on a case-by-case basis, or for schedules period of time, as she sees fit.

(b) The Hearing Officer shall be an individual or individuals determined by the Department to be qualified to serve in such a capacity, who has not taken part in the investigation, preparation, or earlier disposition of the case to be heard.

(i) The Hearing Officer shall withdraw himself from consideration of a case at any time he deems himself disqualified. Withdrawal shall be made in writing to the Department.

(ii) Any party may request in writing that the Department remove and replace the Hearing Officer in a contested case. This request must be accompanied by a statement and affidavits, setting forth the alleged grounds for disqualification. The Department may deny a party's request for removal and shall issue a written statement explaining grounds for his denial which shall be made part of the record. If the request is granted, the Department shall appoint a new Hearing Officer as soon as is practicable.

(iii) The Contestant may object to the appointment of the Hearing Officer in the record at the hearing. The objection shall set forth the alleged grounds for disqualification.

(c) The Hearing Officer shall have all powers necessary to conduct a fair and impartial hearing, including but not limited to the following authority:

(i) To administer oaths and affirmations;

(ii) To subpoena witnesses and require the production of any books, papers or other documents relevant or material to the inquiry;

(iii) To rule upon offers of proof and relevant evidence;

(iv) To provide for discovery and determine its scope;

(v) To regulate the course of the hearing;

(vi) To schedule conferences for the settlement and to hold conferences for simplifications of the issues;

(vii) To dispose of procedural requests or similar matters; and

(viii) To take any other action authorized by the Department's rules.

(d) Failure or refusal to appear or obey orders of the Hearing Officer may result in

the sanctions provided in W.S. 16-3-107(c) and (f).

Section 9. Discovery. Discovery in a Department disciplinary proceeding shall be governed by W.S. 16-3-107 and Wyoming Rules of Civil Procedure (WRCP).

Section 10. Pre-hearing Conference.

(a) At a time on or before the day of the hearing, the Hearing Officer, on his own or either party's motion, may meet with the parties for a conference to consider simplification of the issues, stipulations and admissions of fact, clarifications or limitation of evidence, and any other matters that may expedite the proceeding and assure a just conclusion of the case. The meeting may be held by the telephone conference.

(b) Any stipulations, limitations or agreements made at a pre-hearing conference shall be recited in the record and shall control the course of the proceedings, unless modified during the hearing to prevent manifest injustice.

Section 11. Evidence and Testimony.

(a) Burden of Proof. The Department shall have the burden of proof for all disciplinary proceedings.

(b) Admissibility of Evidence. Admissibility is governed by W.S. 16-3-108 and WRCP.

(i) The parties shall be entitled to present oral or documentary evidence, submit rebuttal evidence and conduct cross-examinations, as maybe required for a full disclosure of the facts. All documentary or physical evidence submitted for consideration shall be marked as exhibits. The Department's exhibits shall be marked by letters of the alphabet beginning with "A." Contestant's exhibits shall be marked by numbers beginning with "1."

(ii) The Hearing Officer shall allow oral or documentary evidence which is not relevant, immaterial or unduly repetitions evidence.

(c) Objections.

(i) The grounds for objections to any evidentiary rulings by the Hearing Officer shall be briefly stated. Rulings on all objections shall appear in the records. Only those objections made before the Hearing Officer, or specifically stipulated to by both parties, may be relied on in a subsequent proceeding.

(ii) Formal exception to an adverse ruling is not required.

(d) Privileged and Confidential Information.

(i) Any privilege at law shall be recognized by the Hearing Officer in considering evidence.

(ii) No employee of the Department shall be compelled to testify, or to

divulge information which is confidential or privileged at law and which is contained within the records of the Department or acquired within the scope of his employment except as provided in W.S. 16-3-107.

(e) The Hearing Officer may take official notice of any material fact not appearing in evidence in the record that is of the nature of traditional matters of judicial notice or within the special technical knowledge or files of the Department. Parties shall be given an opportunity to contest matters officially noticed prior to a final decision by the Department in accordance with W.S. 16-3-108.

(f) Each witness who is present to give testimony must identify himself or herself by stating his or her name and address, indicate on whose behalf he or she shall testify, and be administered the following oath by the Hearing Officer: "Do you swear or affirm to tell the whole truth, and nothing but the truth?"

Section 12. Representation.

(a) All parties have a right to represent themselves, to be represented by an attorney authorized to practice pursuant to the rules of the Supreme Court of Wyoming, or be represented by any other person chosen by the Contestant to appear on his behalf. If the Contestant is represented by an attorney, the Contestant shall pay his attorney's fees and costs. During such hearings:

(i) A party, his attorney, or his representative may examine or cross-examine witnesses;

(ii) The Hearing Officer may examine witnesses; but

(iii) Other than as delineated in (i) or (ii) above, no other person may examine or cross-examine witnesses.

(b) The Respondent may request the Attorney General to assist in contested case hearings to the extent required by W.S. 16-3-112(c).

Section 13. Location of Hearing.

(a) Hearings involving certification of a Contestant and licensing of an ambulance service shall be held in Cheyenne, Wyoming unless the Department consents, in writing to a different location.

Section 14. Consolidation of Hearings. Upon motion of on of the parties, the Hearing Officer may consolidate two or more hearings if the hearings involve the same parties with similar related issues.

Section 15. Procedural Rights of Contestant. The Contestant, or his representative may, in keeping within the Wyoming Rules of Civil Procedure:

(a) Engage in discovery; and

(b) Bring witnesses, establish all pertinent facts and circumstances, present an argument, and question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses, in compliance with the WRCP.

Section 16. Failure to Appear. If a Contestant fails to appear at the place, date, and time specified in a notice, the Hearing Officer may:

(a) Continue the hearing until a later date and provide proper notice as prescribed in these rules;

(b) Proceed to conduct the hearing without the Contestant and dispose of the contested case; or

(c) Enter a finding adverse to the Contestant.

Section 17. Order of Procedure.

(a) As nearly as practicable, the following order shall be followed:

(i) Opening statements may be made, Respondent first, then Contestant.

(ii) The Respondent shall have the burden of proof and shall offer evidence first, and then the Contestant may offer evidence.

(iii) No testimony shall be received by the Hearing Officer unless given under oath/affirmation administered by the Hearing Officer.

(iv) Closing statements may be made, Respondent first, then Contestant, then the Respondent in rebuttal.

(v) The Hearing Officer may limit the time for opening and closing statements.

(vi) After all parties have had an opportunity to be heard, the Hearing Officer shall excuse all witnesses and close the evidence.

(vii) Evidence may be reopened only upon written motion by a party to the proceeding and a showing of good cause.

(b) Upon their own motion, all parties or other interested parties may submit legal briefs after the close of the hearing. The Hearing Officer shall allow reasonable time, not less than ten (10) days from the date of the hearing, for preparation of briefs. The time may be extended upon agreement between the parties with the approval of the Hearing Officer.

Section18. Decisions.

(a) The Hearing Officer shall make proposed findings of fact and conclusions of law within twenty (20) working days of the close of the hearings (the time permitted for parties or other interested persons to submit briefs shall be included within twenty {20} working days) and

forward them to the Department for final determination. This time may be extended but not by more than ten (10) working days, unless the parties stipulate in writing or on the record at the hearing, to a later date.

(i) Within ten (10) working days of the close of the hearing, or at such later time as the Hearing Officer may allow, each party shall be allowed to file with the Hearing Officer any proposed findings of fact and conclusions of law, together with a supporting brief. Such proposals and briefs shall be served on all other parties.

(ii) Within ten (10) working days after the issuance of the Hearing Officer's proposed findings of fact and conclusions of law, any of the parties may submit exceptions. Such exceptions shall be filed with the Department and served on all other parties.

(b) Within ten (10) working days after the period for submitting exceptions pursuant to (a)(ii), the Department shall make and enter into the record the final decision. The final decision shall be served on all parties to the proceedings. The final decision shall include:

(i) A statement of the findings of fact and conclusions of law; and

(ii) The appropriate rule, order, relief or denial thereof. The Decision shall be based upon the contested case record or any portion stipulated to by the parties. The decision shall include facts officially noticed and relief upon as provided by W.S. 16-3-108(d). It shall be made on the basis of a preponderance of evidence contained in the record.

(c) Final decision of the Department shall be in accordance with W.S. 16-3-114 and Rule 12 of the Wyoming Rules of Appellate Procedure, except as otherwise agreed by the parties.

Section 19. Appeals

Appeals from a final decision of the Department shall be in accordance with W.S. 16-3-114 and Rule 12 of the Wyoming Rules of Appellate Procedure, except as otherwise agreed by the parties.

Section 20. Transcripts and Record.

(a) When a contested case is set for hearing, the Department shall assign a docket number and date of filing on a docket. The Department shall maintain a separate file for each docketed case in which all pleadings, transcriptions, correspondence, appears, and exhibits for that case shall be maintained. All such items shall have noted thereon the assigned docket number and the date of filing.

(b) The Department shall record all contested case proceedings:

(i) Electronically;

(ii) Through the use of a qualified court reporter; or

(iii) Any other appropriate means determined by the Department. Transcription of oral proceedings or written transcripts of a witness' testimony may be obtained

by Contestant from the Department upon payment of the cost of copying the transcripts.

(c) The record of the hearing shall contain:

(i) All formal and informal notices, pleadings, motions and intermediate rulings;

(ii) Evidence received or considered, including matters officially noticed;

(iii) Questions and offers of proof, objections and rulings;

(iv) Proposed findings of fact and conclusions of law, submitted by any party;

(v) The proposed findings of fact and conclusions of law of the Hearing Officer; and

(vi) Any exceptions to the Hearing Officer's proposed findings of fact and conclusions of law.

(d) The Department's final decision or a stipulation resolving the matter shall be part of the record unless otherwise agreed by the parties.

Section 21. Ex Parte Matters. Unless required for the disposition of ex parte matters authorized by law, the Hearing Officer shall not consult with an individual or party on any matter at issue as allowed in W.S. 16-3-111.

RULES AND REGULATIONS FOR
EMERGENCY MEDICAL SERVICES

CHAPTER 10

NON-AMBULANCE EMS PERSONNEL

**REPEALED 04/06/2015**

RULES AND REGULATIONS FOR
EMERGENCY MEDICAL SERVICES

# CHAPTER 11

# MEDICAL DIRECTOR STIPENDS

**REPEALED 11/05/2015**

# EMERGENCY MEDICAL SERVICES
# NEED ASSESSMENT MASTER PLAN IMPLEMENTATION GRANTS

## CHAPTER 12

Section 1. Authority.

These rules are promulgated by the Department of Health, Office of Emergency Medical Services pursuant to W.S. § 33-36-115, and the Wyoming Administrative Procedures Act at W.S. § 16-3-1101, *et. seq.*

Section 2. Purpose and Applicability.

These rules establish eligibility, implement an application procedure, and create a process for facilitating the award of grant funds from the Emergency Medical Services Sustainability Trust Income Account for Emergency Medical Services Needs Assessment and Master Plan Implementation Grants.

Section 3. Severability.

If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.

Section 4. Definitions.

The following definitions shall apply in the interpretation and enforcement of this chapter only. All other terms apply as defined in Chapter 1 of these rules.

(a) "Authorized Representatives" means those individuals designated by appointment or election to act on behalf of an applicant, grantee, and/or a political subdivision within a proposed service area including, but not limited to, a county, joint powers board, or emergency medical services special district.

(b) "Department" means the Wyoming Department of Health.

(c) "Division" means the Office of Emergency Medical Services (OEMS).

(d) "Political Subdivision" means any area defined or recognized as a political subdivision under state law.

(e) "Service Area" means any area typically and reasonably served by an emergency medical service regardless of existing geopolitical boundaries and which corresponds to a rural urban commuting area as defined by the U.S. Department of Agriculture (USDA).

Section 5. Needs Assessment Grant Application Requirements.

(a) Any person, entity, or group that is interested in improving emergency medical services in a proposed service area may submit an application to the Division for an Emergency Medical Services Needs Assessment Grant.

(b) Needs assessment Grant applications must include:

(i) A narrative request for an assessment of emergency medical services in the proposed service area and an analysis of the current emergency medical services system. The narrative must include information on the following:

(A) The proposed service area and population served within the proposed service area;

(B) The need for the assessment including any concerns with the current level of volunteerism and certification, call volume, and response times, and any additional concerns that form the basis for the request;

(C) Current budget sustainability including each applicant's funding sources and billing practices; and

(D) The level of commitment of all entities involved to implement changes proposed as a result of an Emergency Medical Services Needs Assessment.

(ii) A signed letter of commitment for local matching funds in an amount not less than Five Thousand Dollars ($5,000.00).

(iii) Signatures of authorized representatives of all involved political subdivisions within the proposed service area.

Section 6. Needs Assessment Grant Application Calendar and Award Procedure.

(a) Applications for Emergency Medical Services Needs Assessment Grants may be submitted to the Division from April 1st through June 30th of each year.

(b) The Division may consult with applicants during the review process to determine whether a further detailed assessment of emergency medical services in the proposed service area is appropriate.

(c) No later than sixty (60) days after the close of the application period, the Division shall make a final determination to either:

(i) Award an Emergency Medical Services Needs Assessment Grant to the applicant(s); and

(ii) Engage a contractor to further assess the current capabilities, strengths, weaknesses, coverage gaps, and workforce shortfalls of the entire emergency medical services system within the proposed service area; or

(iii) Deny the request for an Emergency Medical Services Needs Assessment Grant.

(d) Within sixty (60) days of notification of award, grantee must submit local matching funds to the Division in an amount not less than Five Thousand Dollars ($5,000.00).

(i) The Division shall apply all matching funds to the Emergency Medical Services Needs Assessment contract.

(ii) The Emergency Medical Services Needs Assessment shall not commence until matching funds are received from the grantee.

(iii) Failure to submit local matching funds to the Division within sixty (60) days shall void the Emergency Medical Services Needs Assessment Grant Award.

Section 7. Emergency Medical Services Needs Assessment.

The Department shall contract with a third-party to conduct the Emergency Medical Services Needs Assessment for awarded applicants. The contractor shall be chosen through the Request for Proposal (RFP) process.

(a) Contractor shall consult with the grantee and affected entities within the proposed service area including representatives of public, private, and volunteer ambulance services, county and local government agencies, hospitals providing emergency medical services, and other appropriate stakeholders.

(b) Contractor shall assess the current capabilities, strengths, weaknesses, coverage gaps, and workforce shortfalls of the entire emergency medical services system within the proposed service area.

(i) The assessment shall include the collection of data using common quality and performance improvement benchmarks, indicators, and scoring formats.

(A) Benchmarks, indicators, and scoring formats to be utilized by the contractor for the needs assessment shall be determined by the Division prior to engaging the contractor to conduct the assessment.

(ii) The assessment may build upon but not duplicate the findings in the Rural Policy Research Institute's "Status and Future of Health Care Delivery in Rural Wyoming, June 2007" report to the Wyoming Healthcare Commission.

(iii) The assessment shall address the following components and relevant sub-components within the current emergency medical services delivery system:

(A) System design and delivery model to include:

(I) Local authority structure, ordinances and integration with and support from other local healthcare and emergency response entities;

(II) Human resources including EMS leadership and administration and management practices;

(III) The level of volunteerism and the potential for sustainment;

(B) Response time reliability to include:

(I) The total demand for service upon the system by type, including historical demand and projected trends;

(II) A fractile measurement of the systems response times;

(III) The system's ability or inability to respond to every request for service and the causative factors;

(C) Fiscal structure and stability in accordance with standard business practice benchmarks to include:

(I) Current system finances;

(II) Billing practices;

(III) Funding sources within the service area, including the third-party payor mix within the service area and the relative need for subsidy;

(D) The delivery and quality of clinical care and the use of quality improvement processes to include:

(I) The current level of care authorized and provided based on the scopes of practice established within the Wyoming EMS system;

(II) Medical direction including the level of involvement and expertise of the local Medical Director;

(III) Education and training status;

(E) Public education and outreach efforts to include the support and perception of the local community.

(F) Public access to the emergency response system.

(G) Communication systems to include the EMS agency's ability to communicate with hospitals, local and state emergency management, air medical ambulances, emergency response agencies and the support and involvement of the local dispatch entity or public safety answering point (PSAP).

(H) Integration and involvement with other components and activities of the comprehensive, statewide, emergency medical system, such as the trauma plan and program, or the cardiac or stroke patient programs.

(I) The level of emergency preparedness of the system and its ability to respond to a disaster or public health emergency.

(J) The Division, at its discretion, may choose alternate components to be addressed in the assessment on a case-by-case basis.

(c) Contractor shall prepare a written report of the findings and recommendations of the Emergency Medical Needs Assessment, including a master plan for a coordinated, efficient emergency medical service delivery system within the service area.

Section 8. Master Plan Implementation Grant Applications and Awards.

Subsequent to the completion of an Emergency Medical Services Needs Assessment under Section 7 of this Chapter, service areas may apply for funding to assist in the implementation of the master plan developed as a result of the needs assessment, subject to the following:

(a) Applications for a Master Plan Implementation Grant may be submitted by a county, joint powers board, or an emergency medical services special district.

(b) Applications must be submitted to the Division no later than ninety (90) days after the completion of the Emergency Medical Services Needs Assessment.

(c) Applications for a Master Plan Implementation Grant must include the following:

(i) A narrative specifying how Master Plan Implementation Grant funds will be used to address findings and recommendations identified in the Emergency Medical Services Needs Assessment, including, but not limited to:

(A) the intended use of the funds; and

(B) how those funds will allow the applicant to improve emergency medical service delivery for the service area; and

(ii) A working budget which demonstrates how the grant will be used to address revenue gaps on a temporary basis, not to exceed two (2) years, while transitioning to a defined time when revenue is expected to be sufficient to sustain services in the master plan service area.

(d) Award of Master Plan Implementation Grants shall be based upon demonstrable need. Those service areas demonstrating the greatest need for assistance, at the discretion of the Division, shall be given the highest priority in receiving Master Plan Implementation Grants.

(e) Grants shall be documented in writing through an executed grant award agreement, signed by the Department and an authorized representative of the grantee, and shall specify the terms and conditions of the award, payments terms, and grantee deliverables.

# CHAPTER 13

## DESIGNATION OF HEART ATTACK AND STROKE CENTERS

Section 1. **Authority.**

(a) This Chapter is promulgated by the Department of Health pursuant to W.S. §§ 35-2-1001 and the Wyoming Administrative Procedure Act at W.S. §§ 16-3-101 through 16-3-115.

(b) The Department may issue manuals, bulletins, or both to interpret the provisions of this rule. Such manuals and bulletins shall be consistent with and reflect the policies contained in this rule and regulation. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this rule and regulation.

Section 2. **Definitions.** The following definitions shall apply in the interpretation and enforcement of this chapter. Except as otherwise specified, the terminology used in this chapter is intended to have the standard meaning used in healthcare.

(a) "Accreditation" means the recognition or certification made by an independent agency establishing that a hospital has met the criteria specified by that agency for recognition as outlined in this chapter.

(b) "Accrediting agency" means the American Heart Association, the Society for Cardiovascular Patient Care or the Joint Commission.

(c) "Heart Attack Receiving Center" means a hospital that has applied for and received designation as a Heart Attack Receiving Center under the provisions of this chapter. Heart Attack Receiving Centers shall be considered a higher level of care than Heart Attack Referring Centers.

(d) "Heart Attack Referring Center" means a hospital that has applied for and received designation as a Heart Attack Referring Center under the provisions of this chapter.

(e) "Higher level of care" means a hospital capable of providing diagnostic, interventional or tertiary care beyond the capacity of the hospital from which a patient originates.

(f) "Comprehensive Stroke Center" means a hospital that has applied for and received designation as a Comprehensive Stroke Center under the provisions of this chapter. Comprehensive Stroke Centers shall be considered a higher level of care than Primary Stroke Centers.

(g) "Department" means the Wyoming Department of Health.

(h) "Designated hospital" means a hospital designated under the provisions of this chapter.

(i) "OEMS" means the Wyoming Office of Emergency Medical Services.

(j) "Primary Stroke Center" means a hospital that has applied for and received designation as a Primary Stroke Center under the provisions of this chapter. Primary Stroke Centers shall be considered a higher level of care than Acute Stroke Ready Centers.

(k) "The Joint Commission" means the not-for-profit organization known until January 1, 2007 as the "Joint Commission on Accreditation of Healthcare Organizations" (JCAHO).

(l) "Acute Stroke Ready Center" means a hospital that has applied for and received designation as an Acute Stroke Ready Center under the provisions of this chapter.

Section 3. **Severability.** If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

Section 4. **Categories of Recognition and Accrediting Agencies.**

(a) Hospitals may apply for and receive designation under this chapter as one or more of the following:

(i) Heart Attack Receiving Center

(ii) Heart Attack Referring Center

(iii) Comprehensive Stroke Center

(iv) Primary Stroke Center

(v) Acute Stroke Ready Center

(b) Designation of hospitals under the provisions of this chapter shall be contingent on the accreditation of the facility by an accrediting agency as specified by this chapter.

Section 5. **Application, Recognition and Renewal Process.** Any hospital desiring recognition under the provisions of this chapter shall complete the following application process:

(a) Prior to the initiation of an accreditation process with an independent agency, hospitals will submit a Letter of Intent to the OEMS declaring the following:

(i) The category of accreditation and recognition being sought;

(ii) The anticipated accrediting agency;

(iii) The expected timeframe of completion;

(iv) Contact information for the designated person with oversight of the hospital's accreditation process.

(b) Upon receiving recognition by an accrediting agency the hospital will provide to the OEMS:

(i) A Letter of Completion of the Accreditation Process from the facility to the Department;

(ii) A completed Facility Designation Application;

(iii) Copies of documentation establishing the successful completion of the accreditation process and recognition by the accrediting agency, to include but not limited to, certificates, letters or other means provided by the accrediting agency;

(iv) Copies of agreements required under Section 7 of this chapter;

(v) Other documentation as may be required by the OEMS.

(c) Within thirty (30) days of receipt of the materials specified under paragraph (b) of this section, the OEMS will provide a letter of recognition stating that the hospital is duly recognized under the requirements of this chapter or a request for further documentation in support of the application.

(d) Hospitals already accredited or certified according to the provisions of this chapter prior to the effective date of these rules may submit documentation as specified in paragraph (b) of this section and request recognition under this chapter.

(e) No less than ninety (90) days prior to the expiration of an accreditation as outlined in Section 6 of this chapter, a hospital designated under the provisions of this chapter will submit the following to the OEMS:

(i) A Letter of Intent to Renew Accreditation; or

(ii) A Notice of Voluntary Withdrawal pursuant to Section 6(a) of this chapter.

Section 6. **Withdrawal of designation.** Hospitals designated under the provisions of this chapter may have the designation withdrawn under the following provisions:

(a) Voluntary Withdrawal. If a hospital designated under the provisions of this chapter chooses to withdraw designation under this chapter, the hospital shall provide a letter stating its intent to withdraw from these provisions, and the reason(s) for withdrawal.

(b) Involuntary Withdrawal. The OEMS shall provide a written Notice of Involuntary Withdrawal when it determines that any of the following conditions exist:

(i) The receipt of notice by the OEMS from the accrediting agency that the hospital is no longer compliant with the agency's criteria.

(ii) The suspension, revocation or denial of accreditation or renewal of accreditation by the accrediting agency.

(iii) Failure to comply with the provisions of this chapter.

(c) Declaration of action. Hospitals designated under the provisions of this chapter shall provide written notice of suspension, revocation, denial of accreditation or any other disciplinary, corrective, or administrative action taken by the accrediting agency to the OEMS within ten (10) days of receipt of such action.

Section 7. **Coordination among designated hospitals.** Hospitals designated under the provisions of this chapter will provide for the coordination of the referral and transfer of acute heart attack and stroke patients by ensuring the following:

(a) The establishment of written agreement(s) with a facility or facilities determined to be the next higher level of care whether such facility exists within the state or outside of the state.

(b) The establishment of written agreement(s) with Wyoming licensed ambulance services, both ground and air ambulance, to provide for the timely transfer of patients to the next higher level of care.

# CHAPTER 14

## COMMUNITY EMS PRACTITIONERS, AGENCIES AND EDUCATION PROGRAMS

Section 1. **Authority.** The Department adopts these rules under W.S. § 33-36-103 and W.S. § 35-1-804 to enhance the comprehensive Emergency Medical Services (EMS) and trauma system by establishing criteria for the establishment and operation of Community EMS Programs.

Section 2. **Definitions.** As used in this chapter, "Division" means the Department of Health, Office of Emergency Medical Services (OEMS). The terminology used in this chapter is intended to have the standard meaning used in healthcare, except as otherwise specified.

Section 3. **Endorsement**.

(a) A currently licensed EMT, AEMT, IEMT or Paramedic, may apply for endorsement as a Community EMS Technician or Community EMS Clinician.

(b) Applications for endorsement must contain a verifiable copy of a transcript showing the successful completion of the appropriate Division-approved Community EMS Education Program as described in section 3 of this chapter.

(c) The Division may deny endorsement to any person who submits incomplete or inaccurate information on an application. Fraudulent information shall also be cause for denial, revocation or suspension of the person's EMT, AEMT, IEMT, or Paramedic license.

(d) A person may not hold himself out to be or provide the services of a Community EMS Technician or Community EMS Clinician without endorsement as such by the Division.

(e) An endorsement as a Community EMS Technician or Community EMS Clinician shall expire concurrently with the expiration of the person's EMT, AEMT, IEMT, or Paramedic license.

(f) An endorsement as a Community EMS Technician or Community EMS Clinician may be renewed concurrent with the renewal of the person's EMT, AEMT, IEMT or Paramedic license upon submission of documentation of ten (10) hours of continuing medical education in any subject covered in the Community EMS Technician or Community EMS Clinician curriculum described in section 3 of this chapter. These hours are in addition to the continuing education requirements for renewal of the EMT, AEMT, IEMT, or Paramedic license.

(g) The Division may endorse Paramedics who receive the standardized Certified Community Paramedic (CP-C) credential from the Board for Critical Care Transport Paramedic Certification as a Community EMS Clinician as long as the Paramedic's CP-C credential is maintained.

(h) The Division may revoke an endorsement of a Community EMS Technician or Community EMS Clinician for failure to maintain compliance with this section or for any reason established under chapter 5 of these rules.

Section 4. **Approved Educational Programs.**

(a) The Division may approve a Community EMS Education Program that:

(i) Submits an application for approval to the Division;

(ii) Is conducted by:

(A) A college or university;

(B) An educational institution that has an articulation agreement with a college or university; or

(C) An educational program accredited by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in which case approval shall only be for Community EMS Technician courses;

(iii) Tests student proficiency and periodically measures student learning;

(iv) Maintains records of student attendance at didactic sessions, practical laboratory requirements, and performance of clinical requirements;

(v) Provides, by policy, for the removal of a student from the course for unsatisfactory performance; and

(vi) Demonstrates that the program has adequate training space, equipment and other resources required to conduct the particular level of instruction.

(b) Community EMS Technician education programs must provide:

(i) A minimum of forty (40) hours of didactic training in the following subjects:

(A) The Community EMS Technician role in the health care system;

(B) The social determinants of health model;

(C) The role of the Community EMS Technician in public health and primary care;

(D) Developing cultural competency;

(E) Personal Safety and Wellness of the Community EMS Technician; and

(ii) A minimum of forty (40) hours of practical lab skills training and clinical experience in a primary or public health setting.

(c) Community EMS Clinician education programs must provide:

(i) A minimum of one hundred fourteen (114) hours of didactic training and practical and lab skills covering the following subjects:

(A) The Community EMS Clinician's role in the health care system;

(B) The social determinants of health model;

(C) The role of the Community EMS Clinician in public health and primary care;

(D) Developing cultural competency;

(E) Personal safety and wellness of the Community EMS Clinician; and

(ii) A minimum of two hundred (200) hours of clinical experience, appropriate to the individual's established scope of practice, in a primary or public health care setting which provides instruction in:

(A) The compiling of the medical history of sub-acute, semi-chronic patients;

(B) The performance of physical examinations and documentation;

(C) The utilization of specialized equipment in performing physical examinations;

(D) The recognition of the clinical differences between populations;

(E) Obtaining specimens and samples for laboratory testing;

(F) Interpreting test and report results;

(G) The use and maintenance of home health equipment and devices; and

(H) Proper accessing, care, and maintenance of implanted ports, central lines, catheters, and ostomies.

(d) An application for approval under this section must contain:

(i) A description of the structure of the program within the college, university or educational program showing reporting relationships and academic oversight of the Community EMS Education Program;

(ii) The name, contact information, and curriculum vitae of the individual supervising the conduct of the Community EMS Education Program. The curriculum vitae of supervising individuals must demonstrate by experience and education that the individual is qualified to provide the required supervision and instruction. Examples of acceptable qualifications include, but are not limited to:

(A) Experience or academic qualifications in teaching Community EMS Education Programs;

(B) Experience and familiarity with the provision of Emergency Medical Services;

(C) Experience in the provision of Community EMS services;

(D) Academic credentials demonstrating the ability to teach at the baccalaureate level; or

(E) Experience in the provision of primary and public health services; and

(iii) The curriculum vitae of any adjunct or assistant faculty or instructors demonstrating the knowledge and experience to teach within the Community EMS Education Program. Examples of acceptable qualifications include, but are not limited to:

(A) Significant experience and education as a Community EMS Technician or Community EMS Clinician or a comparable license, certification or endorsement in another state;

(B) Professors of medicine, nursing or related disciplines;

(C) Clinicians with experience in providing or supervising Community EMS services;

(D) Clinicians with experience in the provision of primary or public health; and

(iv) A description of the proposed curricula addressing the requirements in subsection (a).

(e) The Division may periodically review the program to determine compliance with the requirements of these rules.

(f) The Division may revoke the approval of a Community EMS Education Program for failure to maintain compliance with the requirements of this section.

Section 5. **Community EMS Technician and Community EMS Clinician Scope of Practice and Authority.**

(a) The authorized acts and scope of practice for a Community EMS Technician or Community EMS Clinician are limited to those skills listed for the individual's EMS license level as described in chapter 5 of these rules, and may only be exercised in accordance with protocols or standing orders approved by the Physician Medical Director of the Community EMS Agency.

Section 6. **Agency Approval Requirements.**

(a) EMS Agencies may apply for approval to provide services at one of the following levels:

(i) Community EMS Technician (CET) Agency. The activities of these agencies are directed towards reducing the burden of patients accessing the larger health care system through the emergency medical system. Community EMS Technician Agencies may utilize either Community EMS Technicians or Community EMS Clinicians to perform the following activities:

(A) Appropriately treating and releasing patients, rather than providing transport to a hospital or emergency department;

(B) Treating and transporting patients to appropriate destinations other than a hospital or an emergency department if the Community EMS Technician Agency is operated under a valid Ambulance Business License;

(C) Treatment and referral to a primary care or urgent care facility;

(D) Assessment of the patient and reporting to a primary care provider to determine an appropriate course of action.

(ii) Community EMS Clinician (CEC) Agency. The activities of these programs are directed toward the integration of EMS personnel in addressing specific gaps in a community's primary and public health care systems, and may incorporate the activities of a Community EMS Technician program. Community EMS Clinician Agencies may utilize Community EMS Clinicians for the purpose of integrating EMS personnel in addressing specific gaps in a community's primary and public health care systems. Community EMS Clinician Agencies may also utilize either Community EMS Technicians or Clinicians for activities listed in section 5(a)(i).

(b) Prior to initiation of operations as a Community EMS Agency, proposals for programs shall be submitted to the Division for approval. Proposals shall contain and describe:

(i) The area and population to be served;

(ii) The conclusions or recommendations of a healthcare gap assessment in the area and population;

(iii) The healthcare goals and objectives;

(iv) The benchmarks and performance measures that will be utilized to measure the efficacy of the program;

(v) The treatment protocols intended to meet the healthcare goals and objectives;

(vi) The name and contact information of the Physician Medical Director providing clinical oversight to the program;

(vii) The name and contact information of the person serving as the administrator of the program; and

(viii) A Memorandum of Agreement with the local ambulance service or services operating in the same area if the Community EMS Agency is not the ambulance service typically providing transport. Memoranda of Agreement must address:

(A) An acknowledgement by the local ambulance service or services that a Community EMS Agency is operating in the same service area;

(B) Coordination for the transport of a patient seen by the Community EMS Agency in the event of a real or perceived emergency;

(C) Coordination for the continuance of care in the event that a patient of the Community EMS Agency requires transport. If the Community EMS Technician or Clinician is licensed at the same level or lower than the EMT of the ambulance service, the ambulance service Agency shall assume control of the patient for transport. If the Community EMS Technician or Clinician is licensed at a level higher than that of the attending EMT of the ambulance service, the Community EMS Technician or Clinician may continue as the primary caregiver, assuming that the ambulance service has agreed to relinquish care in the Memorandum of Agreement; and

(D) Memoranda of Agreement must contain the signatures of the Ambulance Service Administrator, the Community EMS Agency Director or administrator, and the Physician Medical Directors of both the ambulance service and the Community EMS Agency.

(c) If a patient has a care plan, then the Community EMS Technician or Clinician may provide services of the care plan only if the plan has been developed by the patient's primary care provider and there is no duplication of services to the patient from another provider.

(d) The Community EMS Technician or Clinician shall provide only those services listed in a care plan that are within the scope of services and practice of the Community EMS Agency, and that are approved in protocols or standing orders by the medical director of the Community EMS Agency.

(e) The Division may approve the Community EMS Agency proposal when the Division is satisfied that the proposal adequately addresses the requirements of this section. The Division may request supplemental information or clarification of any information contained in the proposal prior to approval.

(f) Approval as a Community EMS Agency shall remain valid for a period of five (5) years from the date of approval.

(g) No later than one hundred and twenty (120) days prior to the expiration of the current approval, the Community EMS Agency must submit a request for continuation as a Community EMS Agency utilizing the requirements specified under paragraph (b) of this section. Requests for continued approval must include an evaluation of the efficacy of the Community EMS Agency in meeting its stated goals and objectives, supported by valid clinical and financial data.

(h) An approved Community EMS Agency may request an amendment to its proposal and functions at any time by a submitting the requested amendment in writing to the Division.

(i) The Division may revoke a Community EMS Agency's approval for:

(i) Failure to operate the Community EMS Agency in accordance with the approved proposal;

(ii) Failure to utilize EMTs endorsed at the appropriate level for the Community EMS Agency; or

(iii) Failure to maintain compliance with any of these rules or the Wyoming Emergency Medical Services Act of 1977.

Section 7. **Documentation and Reporting.**

(a) Community EMS Technician programs shall utilize the electronic patient care reporting system provided by the Division for the documentation of clinical care. It is the responsibility of the individual Community EMS Technician to ensure completion of the patient care report.

(b) Community EMS Clinician programs may utilize locally developed and approved forms or electronic reporting systems for documenting the provision of clinical care. Emergency requests for service must be documented in accordance with the requirements of chapter 4 of these rules.

(c) Community EMS Technician and Clinician programs shall provide reports of patient care activities as periodically required by the Division, in a format approved by the Division.

# CHAPTER 15

## ASSESSMENT, TRIAGE, TREATMENT AND TRANSPORT OF TIME SENSITIVE EMERGENCIES

**Section 1. Authority.** The authority for this chapter is Wyo. Stat. Ann. §§ 35-1-801 and 35-2-1001.

**Section 2. Definitions.**

(a) For the purposes of this chapter and enforcement of other rules in relation to this chapter, the following definitions shall apply:

(i) "Advanced Life Support personnel" or "ALS personnel" means EMS providers licensed to function with a scope of practice that exceeds that of an Advanced Emergency Medical Technician as defined in chapter 5 of these rules and functioning as a crew member assigned to an EMS agency that maintains the equipment and medications allowable to these scopes of practice.

(ii) "Acute stroke patient" means a patient who has been exhibiting the signs and symptoms of stroke for less than six (6) hours and is not hypoglycemic.

(iii) "Decisional boundary" means a geographical point at which the clinical benefits to the patient of transport to one facility outweigh the benefits of transport to another facility.

(iv) "Effective treatment window" means that period of time in which a patient may experience a better clinical outcome if they receive appropriate treatment. Effective treatment windows vary by treatment and pathophysiology.

(v) "Evidence-based prehospital care protocols" means those treatment modalities that reflect the most current and recommended standards of medical practice based on significant clinical evidence.

(vi) "EMS agency" means an EMS agency as defined in chapter 4 of these rules.

(vii) "Emergency medical service providers" or "EMS providers" means an employee of an EMS agency or a person acting as an agent or otherwise on behalf of an EMS agency.

(viii) "FAST" means the acronym developed by the American Stroke Association (ASA) for the rapid identification of an acute stroke patient and activation of the 911 system. FAST stands for: Facial droop; Arm droop; Slurred speech; and Time to call for help.

(ix) "High index of suspicion" means the provider has sufficient or significant cause to believe that the patient is or may soon be acutely ill or injured.

(x) "Index of suspicion" means the degree to which a healthcare provider suspects that a patient may be suffering from a particular illness or injury based on the provider's training and experience, the patient's clinical presentation of signs and symptoms, and the mechanism of injury if applicable.

(xi) "Local system design" means the interrelation of the structure, hierarchy, and relationship of all of the components of the comprehensive EMS and trauma system within a specific community. In well-designed local systems of care, hospitals, TSE facilities, EMS agencies, dispatch organizations, and other healthcare and public health providers work cooperatively to ensure that patients are receiving care that is based on current clinical evidence and recommended practice, and are transported to a facility best suited for providing optimal care in the shortest time possible.

(xii) "Operational procedures" means those policies and procedures adopted by an EMS agency under these rules that direct the administrative and operational practices affecting the decision making process of the individual.

(xiii) "Scene time" means that portion of time between when an ambulance arrives at the location of the patient and when the ambulance departs the scene.

(xiv) "Stroke Alert" means a notification given by EMS providers to a Stroke Center that will be receiving a patient that has a positive FAST assessment.

(xv) "System design" means the structure, hierarchy, and relationship of all of the components of the comprehensive EMS and trauma system.

(xvi) "Time sensitive emergency" or "TSE" means a condition for which there is substantial clinical evidence demonstrating that minimal time delays in the provision of correct treatment and transport to the most appropriate facility results in improved clinical outcomes. For the purposes of these rules time sensitive emergencies are limited to traumatic injuries, heart attacks, and strokes.

(xvii) "Trauma Center" means a hospital designated as a "Regional Trauma Center" under *Rules Wyoming Department of Health, Trauma Program*, Chapter 4 or a hospital verified by the American College of Surgeons as a Level I or Level II Trauma Center.

(xviii) "Triage" means the process of assessing a patient or patients to determine the priority of patient treatment or transport based on the severity of injury or illness. In the case of a single patient, triage is utilized to determine the need for transport to a TSE facility. In the case of multiple patients, triage is used to determine the need for transport to a TSE facility, as well as the priority of needs of all of the patients.

(xix) "TSE facility" means:

(A) A Wyoming hospital that has been designated in one of the categories specified in Chapter 13, Section 4(a) of these rules;

(B) A hospital outside of the state that is accredited by the American Heart Association (AHA), the Society for Cardiovascular Patient Care or the Joint Commission as a hospital equivalent to one of the categories in Chapter 13, Section 4(a) of these rules;

(C) A Trauma Center or a facility designated in one of the categories specified in *Rules Wyoming Department of Health, Trauma Program*, Chapter 4.

**Section 3. General Operation Requirements for EMS Agencies.**

(a) The Division adopts the standards listed in this subsection. These standards shall control except as otherwise provided in this chapter. The adoption of these standards does not include later amendments or editions of the incorporated matters and shall not be interpreted as adding to or subtracting from the scope of practice for EMS providers. EMS agencies and EMS providers shall incorporate these standards into their local system design to the extent possible.

(i) The triage decision scheme for trauma patients shall be U.S. Dep't of Health and Human Servs., Ctrs. for Disease Control and Prevention, *Guidelines for Field Triage of Injured Patients* (2012). Copies are available from the Division upon request, and may be obtained through the CDC at: http://www.cdc.gov/mmwr/pdf/rr/rr6101.pdf.

(ii) The basis for the development of local systems of cardiac care shall be Am. Heart Ass'n, *2015 Guidelines for CPR and ECC* (2015). Copies are available from the Division upon request, and may be obtained through the AHA at: https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/.

(iii) The basis for the development of local systems of stroke care and evidence based prehospital care protocols shall be:

(A) Am. Heart Ass'n & Am. Stroke Ass'n, *Guidelines for the Early Management of Patients with Acute Ischemic Stroke* (2013); copies are available from the Division upon request, and may be obtained through the AHA at: http://stroke.ahajournals.org/content/44/3/870.full.pdf+htmland; and

(B) Am. Heart Ass'n & Am. Stroke Ass'n, *2015 AHA/ASA Focused Update of the 2013 Guidelines for the Early Management of Patients with Acute Ischemic Stroke Regarding Endovascular Treatment* (2015); copies are available from the Division upon request, and may be obtained through the AHA at: http://stroke.ahajournals.org/content/early/2015/06/26/STR.0000000000000074.full.pdf+html.

(b) EMS agency operations shall be conducted in accordance with the standards adopted in subsection (a) of this section and in accordance with the following principles:

(i) Ambulances shall transport patients to the facility best suited to care for the patient suffering a TSE, based on achieving the following principles:

(A) Transport of the trauma patient to a Trauma Center within one (1) hour of the time of injury;

(B) Transport of the patient suffering an acute heart attack to a facility with the capability to perform cardiac percutaneous coronary intervention (PCI) that minimizes the time between the onset of symptoms and the PCI procedure. Current evidence shows improved clinical outcomes when the PCI is performed less than 90 minutes from the onset of symptoms;

(C) Transport of the patient suffering an acute stroke to a primary or comprehensive stroke center as soon as possible. Current evidence indicates that the effective treatment window for the acute stroke patient is up to six hours.

(ii) The times listed in subsection (b)(i)(A)-(C) reflect benchmarks for ideal care. Patients may still benefit from transport to or treatment by a higher level TSE facility when these times are exceeded.

(iii) The bypass of a facility in favor of a facility with a higher capability shall be considered even if the required transport time exceeds that of the transport time to a closer facility. Factors influencing the decision to bypass include, but are not limited to:

(A) The additional time required to reach the facility with higher capability;

(B) The stability of the patient's condition;

(C) The scope of practice of the EMS providers and their capabilities for management of the TSE;

(D) The time that will be expended at the initial facility prior to the transfer of the patient.

(c) EMS agencies shall adopt in writing:

(i) Evidence-based prehospital care protocols using the standards adopted in subsection (a) of this section;

(ii) Operational procedures that address the requirements of this chapter and incorporate the principles of section 3(b) within the specific resources of the local community and region. The operational procedures shall include, but are not limited to:

(A) Procedures for limiting the scene time for each TSE;

(B) Procedures for assessing the incident scene to determine:

(I) Hazards to EMS providers, the patient, and bystanders;

(II) The number of patients and the mechanism of injury;

(III) The need for additional resources and the benefits and risks of waiting for additional resources rather than providing rapid transport to definitive care;

(IV) The need to declare a mass casualty incident;

(C) The proximity of hospitals and TSE facilities relative to the EMS response area and their specific capability to treat a TSE;

(D) Decisional boundaries where the transport of a patient to a TSE specific facility may prove to be beneficial to a patient experiencing a TSE;

(E) Procedures for the intercept of an ambulance service by another ambulance service capable of providing a higher level of care;

(F) The optimal course of action for the treatment and transport of a TSE during normal, day-to-day operations;

(G) Alternative courses of action that address circumstances under which the optimal course of action is prohibited or would not prove of benefit to the patient including, but not limited to:

(I) Adverse weather conditions;

(II) Permanent or temporary factors that increase the time required to transport a patient to the ideal TSE facility such as road closures;

(III) Closure of or non-availability of the optimal TSE facility due to compromised infrastructure or loss of specialized equipment, personnel, or resources;

(IV) Transport to alternative destinations in the event of mass-casualty incidents or public health emergencies.

(H) The means and circumstances for requesting additional resources;

(I) Standardized methods of notifying receiving facilities of the arrival of a possible TSE as soon as practicable;

(J) The means and circumstances for requesting the dispatch of air medical resources to the scene to facilitate rapid transport.

(d) An EMS agency shall not prohibit EMS providers from requesting an air ambulance transport from the field.

**Section 4. Assessment, Triage, Treatment and Transport of the Trauma Patient by EMS Providers.**

(a) Assessment of the Trauma Patient.

(i) An initial assessment shall be performed to identify patients with major hemorrhage, hemodynamic instability, penetrating torso trauma, or signs of traumatic brain injury who may require immediate management of life-threatening injuries or rapid surgical intervention.

(ii) After the initial assessment is complete and immediately identifiable life threatening injuries or conditions have been addressed, a secondary assessment to identify other injuries shall be performed unless a patient's condition and the requirement to continue treating an injury or condition prohibits the completion of an entire secondary assessment.

(iii) Continuous monitoring for deterioration over time, including serial vital signs and repeated neurologic status assessment, shall be performed.

(b) Treatment of the Trauma Patient.

(i) All treatment provided to the trauma patient shall be done in conjunction with the preparation of the patient for rapid transport to a trauma facility.

(ii) Hemorrhage control shall include appropriate dressing and bandaging and the early application of tourniquets in extremity trauma.

(iii) Airway management shall be done with an appropriate level of cervical spine precautions.

(iv) Spinal immobilization is not warranted in every trauma patient, and EMS protocols may be developed to allow discretion in determining which patients should receive this treatment.

(v) The management of the patient may incorporate the concepts of permissive hypotension.

(vi) EMS providers may withhold or terminate resuscitative efforts in the presence of:

(A) Decapitation;

(B) Hemicorpectomy;

(C) Signs of rigor mortis or dependent lividity;

(D) A mechanism of blunt trauma, and the patient is apneic, pulseless, and has no organized electrical activity on a cardiac monitor;

(E) Cardiac arrest after a mechanism of trauma and who have no return to spontaneous circulation after 15-30 minutes of resuscitative efforts, including minimally interrupted cardiopulmonary resuscitation.

(c) Transport of the Trauma Patient.

(i) Patients who are assessed to have injuries consistent with Step One or Step Two as specified under Section 3(c)(i) of this chapter should be considered priority for transport to the facility with the highest level of capability.

(ii) Any patient who does not qualify for immediate transport to a Trauma Center, but is determined to have injuries consistent with Step Three and Step Four as specified in Section 3(c)(i) of this chapter may be transported to the most appropriate facility in accordance with regional or local system guidelines.

(iii) A transport may be refused, or an alternate destination requested, if the patient is determined to be of legal age, has the mental capacity to make an informed decision related to healthcare, and is not otherwise legally constrained from making such a decision. Under these circumstances, non-transport of the patient or transport of the patient to an alternate destination shall not violate this rule and shall not constitute refusal of care.

(iv) When the required transport time is equal to or less than the required transport time to a facility with a lower level of capability, the ambulance shall transport to the higher level of capability as listed below in descending order of capability:

(A) Trauma centers as defined in this chapter.

(B) Area Trauma Hospital

(C) Community Trauma Hospital

(D) Trauma Receiving Facility

(v) The following exceptions apply to this subpart:

(A) Ambulances will not transport chemical or radiation contaminated patients prior to decontamination;

(B) If the Trauma Center chosen as the patient's destination is overloaded and cannot treat the patient, then the patient's destination shall be determined pursuant to regional or local system guidelines;

(C) A transport may be diverted from the original destination if a patient's condition becomes unmanageable or exceeds the capabilities of the transporting ambulance.

(vi) Situations giving rise to any exceptions listed in subpart (v) of this subsection should prompt review of that transport by the quality improvement process of the entire system.

**Section 5. Assessment, Triage, Treatment and Transport of the Heart Attack Patient by EMS Providers.**

(a) Assessment of the Heart Attack Patient.

(i) EMS providers shall maintain a high index of suspicion that a patient may be suffering a myocardial infarction or acute coronary syndrome when the patient presents with signs or symptoms that include, but are not limited to:

(A) A prior history of myocardial infarction, acute coronary syndrome, or other cardiac related health problems;

(B) Chest pain;

(C) Pain or discomfort in other areas of the body (e.g. arm, jaw or epigastrium) of suspected cardiac origin;

(D) Shortness of breath;

(E) Sweating;

(F) Nausea or vomiting;

(G) Dizziness;

(H) Atypical or unusual symptoms, particularly in women, the elderly, and diabetic patients;

(I) Congestive heart failure (CHF);

(J) Syncope or shock.

(ii) The 12-lead ECG is the primary diagnostic tool that identifies an ST segment elevation myocardial infarction (STEMI). EMS providers shall acquire a 12-lead ECG, and transmit the recording as soon as possible for all patients.

(b) Triage of the Heart Attack Patient. Heart attack patients shall be triaged to the most appropriate facility based on the index of suspicion formed by the cumulative assessed findings.

(c) Treatment of the Heart Attack Patient. The care provided by EMS providers shall be directed toward reducing the following time factors:

(i) The time between the first indication of a myocardial infarction or acute coronary syndrome and the administration of aspirin;

(ii) The time between the arrival on scene to the time of 12-lead ECG acquisition;

(iii) The time between 12-lead ECG acquisition and transmission of the recording;

(iv) The time between 12-lead ECG acquisition and the identification of a STEMI;

(v) The time between the identification of a STEMI and notification of the findings to the receiving facility;

(vi) The time between the onset of a STEMI patient's symptoms and their ultimate arrival at a PCI center;

(vii) The time between EMS agency notification and the time of activation of a cardiac catheterization laboratory;

(viii) The time between arrival at the PCI center and the time of cardiac catheterization (door-to-balloon time);

(ix) The time between prehospital 12-lead ECG acquisition and the time of cardiac catheterization (ECG-to-balloon time).

(d) ALS personnel shall assess the patient's cardiac rhythm utilizing a cardiac monitor and 12-lead ECG and treat in accordance with the appropriate local protocols and standing orders.

(e) If the patient is dyspneic, hypoxemic, or has obvious signs of heart failure and there are no other contraindications, EMS providers shall perform the following to the extent allowed by the individual's scope of practice:

(i) Titrate oxygen therapy to achieve an oxygen saturation of greater than or equal to 94%;

(ii) Administer aspirin - chewable, non-enteric-coated, 160 to 325 mg is preferred;

(iii) Establish intravenous access;

(iv) Transmit a 12-lead ECG at the earliest opportunity for remote interpretation or confirmation by a physician;

(v) Provide advance notification as soon as possible to the receiving hospital for patients identified as having STEMI;

(vi) Perform serial ECGs and make copies of all ECGs available to treating personnel at the receiving hospital, whether they are presented in hard copy or transmitted from the field;

(vii) Administer nitroglycerin (tablets or spray) every three to five minutes as long as the patient's systolic blood pressure remains greater than 100mmHg.

(A) Nitrates in all forms are contraindicated in patients with a systolic blood pressure less than 90 mmHg, in patients with suspected right ventricular infarction, or when patients have taken an erectile dysfunction medication within 24 hours, or within 48 hours of the use of tadalafil (Adcirca, Cialis);

(viii) Analgesia is indicated in STEMI when chest discomfort is unresponsive to nitrates. Morphine should be used with caution in unstable angina due to an association with increased mortality.

(f) Transport of the Heart Attack Patient. Ambulance destination decisions shall be preferential based on the following descending order of preference and capability:

(i) Heart Attack Receiving Center or a hospital with a PCI facility;

(ii) Heart Attack Referring Center;

(iii) A hospital with an emergency department.

**Section 6. Assessment, Triage, Treatment and Transport of the Stroke Patient by EMS Providers.**

(a) Assessment of the Stroke Patient.

(i) Adult patients exhibiting signs and symptoms of a stroke or transient ischemic attack (TIA) shall be assessed with a validated stroke screening scale such as the Miami Emergency Neurologic Deficit (MEND) checklist or the Cincinnati Stroke Scale.

(ii) EMS providers shall maintain a high index of suspicion that the patient is experiencing a stroke or TIA when the patient is exhibiting signs and symptoms that include, but are not limited to:

(A) Neurologic deficits, such as facial droop, localized weakness, gait disturbance, slurred speech or altered mentation;

(B) Hemiparesis or hemiplegia;

(C) A dysconjugate, forced, or crossed gaze accompanied by a low level of consciousness (LOC), including an inability to follow commands, complete tasks, or make a discernible effort to respond;

(D) Severe headache, neck pain or stiffness, or difficulty seeing.

(iii) In assessing a patient exhibiting signs and symptoms of a stroke EMS providers shall:

(A) Utilize the FAST exam to rapidly evaluate patients;

(B) Perform a blood glucose analysis;

(C) Attempt to determine the time of onset of symptoms.

(b) Triage of the stroke patient.

(i) Acute stroke patients shall be triaged to the most appropriate facility based on the index of suspicion formed by the cumulative assessed findings.

(ii) Notification of a Stroke Alert shall be made as soon as possible to enable the receiving facility to take necessary steps to ensure the facility is prepared to receive the patient.

(c) Treatment of the stroke patient.

(i) For the adult patient exhibiting the signs and symptoms of stroke or TIA, EMS providers shall:

(A) Provide oxygen only if the patient's oxygen saturation is determined to be less than 94% and titrated to achieve a saturation of 94%;

(B) Manage seizures according to local protocol;

(C) Provide glucose only if the patient's blood glucose level is determined to be less than 60 milligrams per deciliter (60mg/dcl);

(D) Acquire and transmit a 12-lead electrocardiogram (ECG);

(E) Provide continuous cardiac monitoring.

(ii) Generally, hypertension should not be treated with pharmacological agents. Management of the blood pressure may include:

(A) Positioning the patient in the supine position if the systolic blood pressure is less than 120 mmHg;

(B) Positioning the patient with the head and torso at approximately a 30 degree angle if the systolic blood is greater than 120 mmHg;

(C) If the patient's systolic blood pressure is greater than 220 mm Hg, and if the heart rate is at least forty-five beats per minute, administer labetalol, ten (10) milligrams every ten (10) minutes, if authorized by scope of practice.

(iii) Patients exhibiting signs and symptoms of acute stroke shall be considered "nothing passed orally" (NPO), unless the patient is in need of glucose and intravenous glucose cannot be given, and the patient has been cleared for swallowing.

(d) Transport.

(i) Ambulance destination decisions shall be preferential based on the following descending order of preference and capability:

(A) Comprehensive Stroke Center;

(B) Primary Stroke Center;

(C) Acute Stroke Ready Hospital;

(D) A hospital with an emergency department.

(ii) Transport to a more distant, designated facility, with a higher level of designation, shall be considered if the additional transport time is less than sixty (60) minutes more than the transport time to the nearest designated facility.

## Chapter 16
## Licensing of Personnel

**Section 1. Definitions.**

(a) As used in these Rules, the following definitions apply:

(i) "Abuse" means inappropriate or offensive physical, sexual or verbal contact or interaction with another person. Abuse includes, but is not limited to, the following:

(A) Physical abuse, which includes conduct by a licensee which causes, by physical contact, physical injury, or serious or protracted impairment of the physical, mental, or emotional condition of a patient, or which causes the likelihood of such injury or impairment. Such conduct includes, but is not limited to, slapping, hitting, kicking, biting, chocking, smothering, shoving, dragging, pinching, punching, shaking, sitting upon, burning, cutting, strangling, striking, using corporal punishment, or throwing objects at a patient. Physical abuse does not include reasonable emergency interventions necessary to protect the safety of any person.

(B) Psychological abuse, which includes verbal or non-verbal conduct by a licensee, directed to a patient, which insults, denigrates, humiliates, shocks, mocks, threatens, harasses, or alarms the patient. Psychological abuse does not include verbal or non-verbal conduct which has medical or therapeutic purpose or justification; and

(C) Offensive sexual contact or interaction, which may include, but is not limited to, engaging in, or facilitating sexual contact, exposure, performances, photography or any other form of sexual image collection or dissemination, irrespective of the patient's consent or receptiveness to the conduct.

(ii) "Deceive the Division" means to withhold information in any form or provide false, inaccurate, or misleading information to the Division.

(iii) "Emergency," in the context of an emergency license, means an event or circumstance exists that requires the presence of ambulance services, EMRs, EMTs, AEMTs, IEMTs, or Paramedics beyond the number of resources normally available to the area and beyond the control of the local area, such as a disaster, wildland fire, or public health emergency. The need for ambulance services on a routine basis does not constitute an emergency.

(iv) "Emergency Medical Services" or "EMS" means those organizations, people, and vehicles involved in the provision of medical care in a field environment. Generally, these services provide response to emergency calls for assistance for medical care and may provide medical care at the scene of the response, transport by ambulance to a hospital or other medical facility, and medical care during the transport. EMS primarily relies on the care provided by an EMR, EMT, AEMT, IEMT or Paramedic, but may involve care provided by other professions. This definition shall not be construed as limiting the EMR, EMT, AEMT,

IEMT or Paramedic from providing care within their scope of practice in any setting or place of employment.

(v) "Incompetence" means a lack of, or loss of, skill or knowledge to practice the profession or practicing with negligence, as negligence is defined in this part, on one or more occasions while treating a patient.

(vi) "Negligence" means a failure to perform, as an ordinary, reasonable, similarly situated license holder licensed at the same level would, as delineated in controlling protocols, curricula, and policies and as demonstrated by an ordinary, reasonable license holder's prevailing standards of practice.

(vii) "Non-criminal offense" means a finding of inappropriate conduct or misconduct not constituting a criminal offense in any jurisdiction, including, but not limited to, a finding by either a designated governmental authority or a court of law of patient abuse, neglect, mistreatment, or misappropriation of patient property; spousal or intimate partner violence; unpermitted sexual contact; child abuse, neglect or abandonment; abuse, neglect or abandonment of the elderly or other vulnerable persons; vehicle and traffic findings involving reckless or aggressive driving; findings by any governmental entity of diversion of controlled substances from any health care facility, health care provider, or pharmacy; findings involving dishonesty or other unethical conduct; and other abusive acts which compromise the public trust in the profession, regardless of the circumstances, including whether the licensee is acting in the capacity of an EMS provider or "on-duty."

(viii) "Patient abandonment" means the termination of patient care prior to delivering the patient for medical evaluation or treatment or securing a proper refusal of medical attention in accordance with applicable protocol. Patient abandonment may be effected through means including, but not limited to, leaving a patient unattended after establishing patient contact or leaving a patient to the care of a person licensed at a lower level when the licensee knew or should have known that the patient required a higher level of care.

(ix) "Prevailing standards of practice" means those clinical or operational standards usually applied in the emergency medical services.

(x) "Public trust in the profession" means the reasonable trust and confidence held by the public that persons licensed by the Division are competent in the provision of medical care and do not present a threat to the public's person or property.

(xi) "Reasonable request by the Division" means any request for information or action from the Division to a person or entity in the course of the Division performing its duties.

**Section 2. License Required.**

(a) Unless appropriately licensed by the Division or as otherwise provided by law, a person may not:

(i) Profess or represent himself to be an Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Intermediate Emergency Medical Technician (IEMT), or Paramedic; or

(ii) Practice as or assume the duties incident to an EMR, EMT, AEMT, IEMT, or Paramedic.

(iii) Act in the capacity of an attendant or represent that they are licensed to do so without obtaining a license as specified under Subsection (a) of this Section and affiliating with an ambulance service licensed under Chapter 2, of these Rules. As used in this section, "attendant" means a person licensed under this Chapter who is employed by or a member of a licensed ambulance service, and is responsible for the provision of care to a patient.

**Section 3. Eligibility for Licensure.**

(a) An applicant is eligible to be licensed as an EMR, EMT, AEMT, IEMT, or Paramedic if the applicant:

(i) Is at least sixteen (16) years of age when applying to be licensed as an EMR or is at least eighteen (18) years of age when applying to be licensed as an EMT, AEMT, IEMT, or Paramedic;

(ii) Has completed the appropriate course of education under Section 5 of this Chapter;

(iii) Has passed the appropriate examination under Section 6 of this Chapter;

(iv) Has not been convicted of a felony nor has a pending felony charge;

(v) Has not been convicted of, nor has a pending charge involving a misdemeanor that impacts the public trust in the profession or the ability to practice as a licensee;

(vi) Has not had the applicant's right to practice in a health care profession limited, suspended, terminated, or voluntarily surrendered in any jurisdiction.

(b) An applicant may request the Division to waive the eligibility requirements under Sections 3(a)(iv) and (v) of this Chapter by submitting to the Division a request for waiver in the format prescribed by the Division.

(i) A request for waiver must be submitted concurrent with the applicant's application for licensure.

(ii) A request for waiver must address the following factors:

(A) The nature and seriousness of the convicted crime;

(B) The length of time since the crime was committed;

(C) Additional arrests, charges, or convictions since the crime was committed;

(D) Compliance with court orders related to the conviction; and

(E) Other information the Division may determine is necessary to establish the applicant's character and fitness to provide emergency medical services.

(iii) A request for waiver may not address whether the applicant was duly convicted.

(c) The Division may grant a request for waiver submitted under Section 2(b) of this Chapter if:

(i) The applicant submitted a timely and complete request for waiver; and

(ii) The Division finds that the applicant does not present a potential danger to the health, safety, and welfare of the citizens of Wyoming nor threaten the public trust in the profession if the applicant is licensed as an EMR, EMT, AEMT, IEMT, or Paramedic.

**Section 4. Application for Licensure.**

(a) To be licensed as an EMR, EMT, AEMT, IEMT, or Paramedic, an applicant shall submit to the Division an application for licensure in the format prescribed by the Division.

(b) If an applicant desires to be licensed as an EMT, AEMT, IEMT, or Paramedic, the applicant shall complete and submit to a criminal check as part of the application process.

(i) The criminal background check must:

(A) Be in the format prescribed by the Division; and

(B) Contain federal and state criminal information.

(ii) The applicant shall pay all costs for the criminal background check.

**Section 5. Education Requirements.**

(a) Except as otherwise provided in these rules, the standards for the course of education for an EMR, EMT, AEMT, Paramedic, and, to the extent that is practicable, IEMT, are those described in the United States Department of Transportation, National Highway Traffic and Safety Administration (NHTSA), DOT HS 811 077A, National Emergency Medical Services Education Standards (Jan. 2009), available at https://www.ems.gov/pdf/education/EMS-

Education-for-the-Future-A-Systems-Approach/National_EMS_Education_Standards.pdf ("NHTSA National EMS Education Standards").

(i) The Division incorporates the NHTSA National EMS Education Standards into these rules by this reference.

(ii) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of these rules.

(iii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date noted in subsection (a) of this section.

(iv) The incorporated standard is maintained at https://health.wyo.gov/public health/ems/ and is available for public inspection and copying at cost from the Division.

(b) To be eligible for licensure by the Division, an applicant shall complete the appropriate course of education for the level of licensure desired.

(i) For the EMR, EMT and AEMT levels, an appropriate course of education is based on the NHTSA National EMS Education Standards.

(ii) For the IEMT level, an appropriate course of education is based on the NHTSA National EMS Education Standards for the AEMT, and includes additional curricula developed by the Division.

(iii) For the Paramedic level, an appropriate course of instruction is based on the NHTSA National EMS Education Standards and is accredited by the Commission on Accreditation of Allied Health Programs (CAAHEP).

**Section 6. Examination Requirements.**

(a) To be eligible for licensure by the Division, an applicant shall pass the appropriate examination for the level of licensure desired.

(i) If applying for licensure as an EMR, the applicant shall pass the appropriate Division Licensure Exam. Applicants for licensure as an EMR may take the National Registry of Emergency Medical Technicians (NREMT) exam as an alternative to the Division Licensure Exam.

(ii) If applying for licensure as an IEMT, the applicant shall pass the appropriate Division Licensure Exam.

(iii) If applying for licensure as an EMT, AEMT, or Paramedic, the applicant shall pass the appropriate NREMT exam.

(b) The Division Licensure Exam is comprised of a practical skills demonstration and a written examination appropriate for the level of licensure desired. An applicant that fails only one of these two components will only be required to reattempt the failed component.

(i) An applicant may attempt to pass the appropriate Division Licensure Exam six times. A successive attempt must occur more than seven (7) days and less than thirty (30) days after the previous attempt, unless the applicant is required to complete a remedial course of instruction.

(ii) If an applicant has not passed the appropriate Division Licensure Exam after three attempts, the applicant must complete a remedial course of instruction prior to a fourth attempt. The remedial course of instruction must be equivalent to the National Continued Competency Program requirements as outlined by the NREMT and appropriate to the level of licensure. The applicant has 180 days from the date of the third attempt to complete the remedial instruction and make the fourth attempt.

(iii) If an applicant has not passed the appropriate Division Licensure Exam after six attempts, the applicant may not retake the exam until the applicant again completes an appropriate course of education for the level of licensure desired under Section 5 of this Chapter.

(iv) If an applicant has not passed the appropriate Division Licensure Exam, and fails to make a successive attempt within the required time frame, the applicant may not retake the exam until the applicant again completes an appropriate course of education for the level of licensure desired under Section 5 of this Chapter.

(c) An applicant is exempt from the examination requirements of this section if the applicant:

(i) Is licensed or certified in another state or through the NREMT; and

(ii) Satisfies all other requirements for licensure under this Chapter.

**Section 7. Decision on Application.**

(a) Upon the receipt of a complete application for licensure, the Division may take up to forty-five (45) days to issue or deny a license. An application is complete when the Division has received all required documentation, any requested supplemental information, and the results of a criminal background check indicating that there is no conviction or pending charge related to Section 3(a) of this chapter or a resolution has been reached with regard to any issues identified in the criminal background check.

(b) If the Division denies a license, the Division shall send written notice to the applicant. The written notice must state the reason for denial.

(c) The Division shall issue a license to an applicant if the Division finds the applicant:

(i) Is eligible for licensure; and

(ii) Has submitted a complete application for licensure.

(d) The Division may deny an applicant a license if the Division finds:

(i) The applicant is ineligible for licensure;

(ii) The applicant has failed to submit a complete application for licensure;

(iii) Grounds for denial under Section 12 of this Chapter.

**Section 8. License Terms.**

(a) If the Division issues an initial license under Section 7 of this Chapter, the license is valid until a date determined by the Division, not to exceed three years and not to be less than two years from the date of issuance.

(b) If the Division upgrades or downgrades a license under Section 9 of this Chapter, the upgraded or downgraded license is valid until the expiration date of the previous license.

(c) If the Division renews a license under Section 10 or issues a recovered license under Section 11 of this Chapter, the renewed or recovered license is valid until a date determined by the Division, not to exceed two years and not to be less than one year from the date of issuance.

(d) If the Division reinstates a license revoked under Section 12 of this Chapter, the reinstated license retains the original expiration date. A reinstated licensee shall renew the license under Section 10 of this Chapter if the original expiration date occurs before the date of reinstatement.

**Section 9. Application to Upgrade or Downgrade a License.**

(a) A licensee is eligible for an upgraded or downgraded license if the licensee:

(i) Is eligible to be licensed at the level of licensure desired; and

(ii) Is not the subject of an ongoing investigation or other administrative action by the Division.

(b) To be issued an upgraded or downgraded license, a licensee shall submit to the Division a complete application to upgrade or downgrade a license in the format prescribed by the Division.

**Section 10. Application to Renew a License.**

(a) A licensee is eligible for the renewal of a license if the licensee has completed the appropriate continuing medical education requirements under Chapter 8 of these Rules.

(b) To be issued a renewed license, a licensee shall submit to the Division a renewal application in the format prescribed by the Division. The renewal application must be submitted to the Division not less than thirty (30) days but not more than ninety (90) days before the licensee's license expires.

**Section 11. Criteria to Recover a License and Recovered License Terms.**

(a) A former licensee is eligible to recover a license under the following conditions.

(i) If a license has been expired for less than or equal to one (1) year, the former licensee must be otherwise eligible for renewal under Section 10 of this Chapter.

(ii) If a license has been expired for more than one (1) year and less than or equal to four (4) years, the former licensee must:

(A) Complete a refresher course approved by the Division for the appropriate level of licensure; and

(B) Be otherwise eligible for renewal under Section 10 of this Chapter.

(iii) If a license has been expired for more than four (4) years, the former licensee must:

(A) Have a comparable license in another state or certification through the NREMT; and

(B) Be otherwise eligible for renewal under Section 10 of this Chapter.

(b) To recover a license, the former licensee shall submit to the Division an application in the format prescribed by the Division.

**Section 12. Disciplinary Action.**

(a) The Division may take disciplinary action against a licensee or refuse to issue a license for one (1) or more of the following acts or conduct:

(i) Inability to function with reasonable skill and safety as a licensee including, but not limited to, the following reasons:

(A) Physical or mental disability;

(B) Negligence or incompetence;

(C) Substance abuse or dependency;

(D) Patient abandonment or abuse;

(E) Fraud or deceit;

(F) Violation of patient privacy or confidentiality; or

(G) Exceeding the authorized scope of practice or representing oneself to be licensed at a higher level of licensure;

(ii) Misappropriation of money or property from any source while acting as a licensee;

(iii) Felony conviction;

(iv) Misdemeanor conviction that impacts the public trust in the profession or the ability to practice as a licensee;

(v) Drug diversion for self or others;

(vi) Distribution, sale, unauthorized use, illegal possession, or manufacturing of controlled or illicit drugs;

(vii) Failure to comply with a reasonable request from the Division including, but not limited to, the failure to:

(A) Respond to an administrative complaint or notice;

(B) Respond to a request for explanation or clarification;

(C) Cooperate in an investigation; or

(D) Comply with a term, condition, or obligation imposed by the Division;

(viii) Failure to conform to the standards of acceptable and prevailing emergency medical services practice, in which case actual injury need not be established;

(ix) Failure to comply with the requirements of these rules or the Act;

(x) Knowingly aiding or abetting another in the violation of these rules or the Act;

(xi) Deceiving or attempting to deceive the Division; and

(xii) Disciplinary action in any jurisdiction related to the right to practice in a health care profession;

(xiii) Commission of a non-criminal offense as defined under Section 1 of this Chapter.

(b) Disciplinary action may include a reprimand, conditions, restrictions, non-renewal, suspension, revocation, other appropriate action, or a combination thereof.

(c) The Division may initiate investigations or proceedings under this section on its own motion or on the written or oral complaint of any person. The identity of a complainant is confidential. The Division shall make reasonable efforts to protect the identity of a complainant. The Division shall not disclose identifying information related to a complainant except upon waiver by the complainant, court order, request of law enforcement, or request of the Attorney General's Office.

**Section 13. Displaying of Licensure.**

While on duty, a licensee shall display the licensee's level of licensure on the licensee's outer clothing by means of the Division-approved insignia or other means approved by the Division.

**Section 14. Emergency Licensing.**

(a) Pursuant to Wyoming Statute § 35-4-114(b), the Division may issue a license to an ambulance service or an individual in order to manage a declared public health emergency within the state in accordance with the following conditions:

(i) The Division may grant an emergency license to an ambulance service not licensed in this state, based on written or electronic confirmation that the ambulance service is licensed within another state; and

(ii) An emergency license for an ambulance service or an individual terminates upon the Governor's declaration that the public health emergency has ended.

(b) Pursuant to Wyoming Statute § 33-36-110(h), the Division may grant an Emergency License to an individual as an EMR, EMT, AEMT, IEMT or Paramedic based on written or electronic confirmation that the individual is currently licensed or was previously licensed at a comparable level in another state.

(i) An Emergency License expires upon whichever arise first of the following:

(A) Notification to the Division that the emergency no longer exists;

(B) Notification to the Division that the licensee's services are no longer required; or

(C) Ninety (90) days from the date of issuance.

(ii) An applicant for an Emergency License shall comply with one of the following:

(A) Submission via electronic means of a completed application for an Emergency License found at https://health.wyo.gov/publichealth/ems/ems-forms/;

(B) Submission via electronic means of a National Wildfire Coordinating Group Limited Request for Recognition found at https://www.nwcg.gov/sites/default/files/request_recognition.pdf or on the Division website: https://health.wyo.gov/publichealth/ems/ems-forms/.

(iii) The Division may deny approval of an application for an Emergency License if the Division determines:

(A) An emergency does not exist or that issuing the license is otherwise not warranted; or

(B) An applicant has submitted an incomplete or fraudulent application.

(c) The Division may issue an Emergency License equivalent to the level requested. The Division may also restrict or limit an Emergency License issued under this Section.

(d) An individual issued an Emergency License shall comply with the relevant scope of practice established under these rules.

(e) An individual issued an Emergency License is exempt from any other licensing requirements of this Chapter.

**Section 15. Conditional Licensing.**

(a) Pursuant to Wyoming Statute § 33-36-103(d), an applicant for licensure may request that the Division issue a conditional license while the results of a criminal background check are pending. To qualify for a conditional license, the applicant shall:

(i) Satisfy all eligibility requirements for the relevant level of licensure, except for those related to the criminal background check; and

(ii) Submit an attestation by notarized signature that the applicant has no prior criminal convictions nor pending criminal charges.

(b) If the Division grants a conditional license, the conditional licensee may provide care consistent with the scope of practice established for the relevant level of licensure. An entity that utilizes or employs a conditional licensee retains the right to limit the practice of the conditional licensee as a condition of employment.

(c) A conditional license expires ninety (90) days after the date of issuance. The Division may, at its sole discretion, grant a single ninety (90) day extension of a conditional license if the Division determines that circumstances beyond the conditional licensee's control prohibited the processing of the criminal background check.

(d) The Division shall immediately revoke a conditional license if the Division discovers any fact that would disqualify the conditional licensee from licensure. The Division may use the immediate revocation of a conditional license as grounds for the permanent denial of licensure.

## Chapter 17
## Scopes of Practice

### Section 1. Authorized Acts or Scope of Practice, Generally.

(a) Except as otherwise provided in these rules, the authorized acts or scope of practice for an EMR, EMT, AEMT, IEMT, or Paramedic in this state are those described in United States Department of Transportation, National Highway Traffic and Safety Administration (NHTSA), DOT HS 812 471, National EMS Scope of Practice Model (Dec. 2017), available at https://www.ems.gov/pdf/812471_2007-National-EMS-Scope-Practice-Mode_Change-Notices-1-and-2.pdf ("NHTSA National EMS Scope of Practice Model").

(i) The Division incorporates the NHTSA National EMS Scope of Practice Model into these rules by this reference.

(ii) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of these rules.

(iii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date noted in subsection (a) of this section.

(iv) The incorporated standard is maintained at https://health.wyo.gov/public health/ems/ and is available for public inspection and copying at cost from the Division.

(b) An EMR, EMT, AEMT, IEMT, or Paramedic may not practice beyond the scope of practice outlined in this Chapter unless licensed or certified to do so by another professional board or agency under Wyoming Statutes.

(c) The acts an EMR, EMT, AEMT, IEMT, or Paramedic may perform within the licensee's scope of practice are limited to the written or verbal orders of a physician. A written order from a physician must be through one of the following means:

(i) A standing order authorizing a licensee at any level to perform a skill or administer a medication;

(ii) A protocol that addresses unforeseen or unusual circumstances and authorizes the licensee to perform a skill or administer a medication not previously addressed in a standing order; or

(iii) A written order on the appropriate patient care form utilized by a medical facility.

### Section 2. Duties of a Physician Medical Director.

(a) A physician medical director shall:

(i) Promulgate written protocols and standing orders as contemplated by this section; and

(ii) Indicate by signature on each written protocol and standing order that:

(A) The written protocol or standing order has been reviewed and approved at least once every two years;

(B) Any amendment to the written protocol or standing order was approved at the time of adoption; and

(C) Any pre-existing written protocol or standing order at the time a new physician medical director or supervising physician assumes responsibility has been approved by the new physician medical director.

**Section 3. Authorized Acts or Scope of Practice for an EMR.**

(a) An EMR may:

(i) Administer up to 324 milligrams of aspirin orally to patients complaining of chest pain;

(ii) Insert a nasopharyngeal airway;

(iii) Utilize a mechanical device approved by the Division for the provision of CPR;

(iv) Utilize an electronic device for the measurement of vital signs;

(v) Provide immobilization of the spinal column through manual means and the use of appropriate equipment;

(vi) Provide splinting of an extremity, including the use of traction splints for the femur;

(vii) Administer epinephrine intramuscularly via an auto-injection device in the treatment of an allergic reaction or anaphylaxis; and

(viii) Utilize a person's prescribed medication to treat or prevent an Addisonian Crisis.

**Section 4. Authorized Acts or Scope of Practice for an EMT.**

(a) An EMT may not utilize automatic transport ventilators.

(b) An EMT may:

(i) Perform the authorized acts of an EMR;

(ii) Utilize a syringe and needle to administer epinephrine in the treatment of anaphylaxis;

(iii) Perform capillary blood glucose testing; and

(iv) Utilize twelve (12) lead electrocardiograph (ECG) machines to capture and transmit a patient's ECG to a receiving facility.

**Section 5. Authorized Acts or Scope of Practice for an AEMT.**

(a) An AEMT may:

(i) Perform the authorized acts of an EMT;

(ii) Provide nebulized ipratropium (Atrovent) or combinations of albuterol and ipratropium;

(iii) Utilize a continuous positive airway pressure (CPAP) device; and

(iv) Perform intra-osseous access, with the administration of lidocaine as a local anesthetic, on adult and pediatric patients.

**Section 6. Authorized Acts or Scope of Practice for an IEMT.**

(a) An IEMT may:

(i) Perform the authorized acts of an AEMT;

(ii) Administer the following additional medications in accordance with written standing orders and protocols and the prevailing standards of practice:

(A) Amiodarone bolus and maintenance drip infusion;

(B) Ativan;

(C) Atropine;

(D) Benadryl;

(E) Diazepam;

(F) Epinephrine, 1:10,000;

(G) Fentanyl;

(H) Furosemide;

(I) Glucagon;

(J) Heparin, monitoring and discontinuation of infusion drips initiated by a hospital or healthcare facility;

(K) Lidocaine, bolus and maintenance drip infusion;

(L) Morphine sulfate;

(M) Naloxone via any appropriate route;

(N) Nitroglycerin administered:

(I) Sublingual as a tablet or spray; or

(II) Through the monitoring, titrating, and discontinuing of infusion drips initiated by a hospital or healthcare facility;

(O) Ondansetron;

(P) Sodium bicarbonate;

(Q) Thiamine;

(R) Vasopressin;

(S) Xopenex.

(iii) Perform manual defibrillation;

(iv) Apply non-invasive patient monitoring devices, including the application of cardiac monitoring devices;

(v) Perform needle thoracotomy;

(vi) Perform endotracheal intubation if specifically authorized by the Division; and

(vii) Monitor antibiotic infusions.

(b) An individual that was certified or licensed at an Intermediate level that exceeds the scope of practice for that of the EMT level in this section prior to the adoption of this Chapter, shall be considered to be "grandfathered" and shall retain the authorization to perform those specific skills unless one of the following occurs:

(i) The license is revoked subsequent to a disciplinary action.

(ii) The license is upgraded as specified in Chapter 16, Section 9 of these Rules.

(iii) The licensee completes a Transition Course approved by the Division. Transition Courses shall not be considered to meet the entirety of the Continuing Education Requirements for license renewal under Chapter 8 of these Rules.

(iv) The licensee is granted a voluntary downgrade under Chapter 16, Section 9 of these Rules.

(v) The license has been expired more than one (1) year. In these circumstances, the applicant may only recover an EMT or AEMT level license as specified in Section 11(a)(i) of Chapter 16.

**Section 7. Authorized Acts or Scope of Practice for a Paramedic.**

(a) A Paramedic may:

(i) Perform the authorized acts of an IEMT;

(ii) Perform urethral catheterization;

(iii) Perform rapid sequence intubation (RSI) with the administration of paralyzing agents if the EMS agency with which the Paramedic is affiliated has received prior written approval to implement an RSI protocol from the Division. To receive approval RSI protocols must:

(A) Emphasize that less invasive airway and ventilation support as preferable to RSI;

(B) Comport with generally accepted standards of practice in the performance of RSI;

(C) Specify which pharmaceutical agents are to be used;

(D) Mandate the continuous use of end tidal carbon dioxide monitoring for intubated patients; and

(E) Address circumstances for the performance of surgical airways or percutaneous devices that allow for adequate respiration.

APPENDIX A

EXECUTIVE ORDER No. 76-4

Pursuant to the authority vested in the office of the Governor of the State of Wyoming under W. S. Sections 9-32.4 and 9-160.7, I Ed Herschler, Governor of the State of Wyoming, hereby order:

Section 1: The Wyoming Advisory Committee on Emergency Medical Services

is created under the sponsorship of the Wyoming Department of Health and Social Services, Division of Health and Medical Services for the purpose of assisting the efforts of various Federal, State and local agencies, private industry, and interested citizens toward the development and implementation of an integrated, statewide program for emergency medical services. The said Committee shall stimulate the interest, planning, and development of activities which result in the highest possible standard of medical care to victims of trauma and critical illness in Wyoming.

Section 2: The said Committee shall perform the following

(a) Act in an advisory capacity to the Division of Health and Medical Services and through the said Division to the Governor on all matters related to emergency medical care programs.

(b) Make recommendations concerning the development and implementation of statewide emergency medical care programs.

(c) Determine statewide emergency Medical care needs and provide a broad basis for responsibility and policy decisions.

(d) Make recommendations concerning guidelines and standards for the delivering of emergency medical care which recognizes the concepts of the National Highway Safety Act of 1966 and the Emergency Medical Services Act of 1973.

(e) Foster and encourage action in the interest of improved care and treatment to victims of trauma and critical illness in Wyoming.

(f) Coordinate the State's participation in federally supported programs related to emergency medical care and make recommendations as to the use of funds received under such programs.

Section3: The members of the said Committee shall be appointed by the Governor and serve at his pleasure. Persons appointed to serve on the Committee shall have demonstrated an interest or involvement in emergency medical care activities. A Chairman and Vice-Chairman shall be elected from the membership of the Committee in accordance with by-laws approved by the Governor. The composition of the Committee shall be one member representing each of the following:

(1) Wyoming Chapter of the American Academy of Orthopaedic Surgeons.
(2) The Wyoming Trauma Committee, American College of Surgeons.
(3) Wyoming Ambulance and Emergency Medical Services Association.
(4) Wyoming Highway Patrol.
(5) Wyoming Disaster and Civil Defense Agency.
(6) Wyoming Hospital Association.
(7) Wyoming Governor's Office of Highway Safety.
(8) Wyoming Nurses Association.

(9) Wyoming Office of Emergency Medical Services.
(10) Wyoming State Health Planning and Development Agency.
(11) Wyoming Registered Emergency Medical Technician.
(12) Private Physician
(13) Private Physician
(14) Consumer from Wyoming Health Safety System Agency
(15) Consumer from Wyoming Health Safety System Agency
(16) Wyoming Hospital Administrator
(17) Wyoming Ambulance Operator

Section 4: The Wyoming Department of Health and Social Services, Division of Health and Medical Services, and its responsible office, is hereby designated as the official administrative and operational agency for coordination, planning, implementation, and evaluation of the Wyoming Emergency Medical Services System.

GIVEN under my hand and the Executive Seal of the State of Wyoming this 7th day of December 1976.

APPENDIX B

EXECUTIVE ORDER No. 1998-7

Pursuant to the authority vested in the Office of Governor of the State of Wyoming under W. S. Sections 9-23.4 and 9-160.7, I, Jim Geringer, Governor of the State of Wyoming, hereby order:

Section 1: The Wyoming Advisory committee on Emergency Medical Services is reaffirmed under the sponsorship of the Wyoming Department of Health Division of Public Health, Office of Emergency Medical Services for the purpose of assisting the efforts of various federal, state, and local agencies, private industry, and interested citizens toward the continued development and implementation of an integrated, statewide program for emergency medical services and trauma system. The Committee shall promote the planning and development of activities which will result in the delivery of the highest possible standard of medical care to victims of trauma and critical illness in Wyoming.

Section 2: The Committee shall perform the following duties:

(a) Act in an advisory capacity to the Department of Health's Office of Emergency Medical Services on all matters related to emergency medical services programs and trauma system development.

(b) Make recommendations concerning the development and implementation of statewide emergency medical services programs.

(c) Determine statewide emergency medical services' needs and provide a broad basis for responsibility and policy decisions.

(d) Make recommendations concerning guidelines and standards for the delivery of emergency medical care, which recognizes the concepts of the National Highway Safety Act of 1966 and the Emergency Medical Services Act of 1973, *et seq*.

(e) Make recommendations concerning the development and implementation of the statewide trauma system.

(f) Coordinate the State's participation in federally supported programs related to emergency medical care and trauma systems and make recommendations as to the use of funds received under such programs.

Section 3: The members of the Committee shall be appointed by the Governor and serve at his pleasure. Individuals appointed to serve on the Committee shall have demonstrated an interest or involvement in emergency medical care or trauma system activities. A chairman and vice-chairman shall be elected from the membership of the Committee in accordance with by-laws approved by the Department of Health. The composition of the Committee shall be one member representing each of the following:

(1) A physician form the Wyoming Chapter of the American Academy of Family Physicians.
(2) A physician from the Wyoming Chapter of the American College of Emergency Physicians.

(3) A physician from the Wyoming Trauma Committee of the American College of Surgeons.

(4) A member of the Wyoming Nurses Association.
(5) A representative from the Wyoming Hospital Association.
(6) A representative from the Wyoming Medical Society.
(7) A Wyoming certified Emergency Medical Technician.
(8) A Wyoming licensed ambulance operator.

Terms are indefinite. A member who ceases to represent the organization he/she was appointed to represent shall be replaced at the recommendation of the Department of Health.

Section 4: The Wyoming Department of Health, Division of Public Health, Office of Emergency Medical Services is hereby designated as the official administrative and operational agency for coordination, planning, implementation, and evaluation of the Wyoming Emergency Medical Services System and Trauma System.

GIVEN under my hand and the executive seal of the Governor's office this 16th day of November, 1998.

# APPENDIX C

## EQUIPMENT REQUIREMENTS FOR AMBULANCES

The Department of Health's Office of Emergency Medical Services has established the following equipment list as the recommended minimum necessary for ground ambulances involved in the transportation or treatment of ill or injured patients in the prehospital setting.

### Basic Life Support

Airway Management and Ventilation:

- Oxygen tank - fixed (minimum capacity of 3,000 liters with reduction gauge and flow meter) and portable with regulator.
- Oxygen masks in infant, child and adult sizes.
- Nasal cannulas in child and adult sizes.
- Oral airways; infant, child and adult sizes.
- Nasopharyngeal airways with lubricant; infant, child and adult sizes.
- Self-inflating resuscitation bags; with oxygen reservoir. Infant, child and adult sizes.
- Masks for use with resuscitation bags; neonate, infant, child and adult sizes.
- Oxygen connecting tubing.
- Portable suction unit with various tonsillar and flexible suction catheters.
- Bite sticks.

Patient Assessment:

- Blood pressure cuff, infant, child and adult sizes.
- Stethoscope; infant and adult.
- Flashlight/penlight (with extra batteries and bulbs).
- Thermometer with hypothermia capacity

Obstetrics:

- Sterile pre-packaged OB delivery kit.
- Thermal absorbent blanket and head cover.

Immobilization:

- Traction splint - child and adult.
- Firm upper and lower extremity splints to include joint above and below injury, rigid with padding.
- Backboard with appropriate securing straps; pediatric and adult sizes.
- Spinal immobilization device; such as KED.
- Rigid cervical collars; pediatric and adult sizes.
- Triangular bandages - minimum of six (6).
- Scoop type stretcher

Personal Protection:

- Infectious disease prevention materials - gloves, goggles or face shields, masks, gowns, boots or shoe covers, appropriate disinfectants.
- Sharp object disposable containers which can be permanently be sealed when full.
- Antiseptic hand wipes.
- Hearing protection.
- HEPA mask.
- Appropriate mask with one-way valve & appropriate filter.
- Minimum of a Level C protective suit.
- Traffic safety vest.

Bandaging:

- Burn package - includes sterile sheets or towels for children.
- Sterile trauma dressings of various sizes - 5 x 9; 8 x 10.
- Sterile gauze bandages of various sizes.
- Adhesive tape in various sizes.
- Elastic bandages in various sizes.

Communications:

- Two-way communication equipment between dispatcher, ambulance and medical facity.

Other:

- Sterile saline irrigation fluid.
- Bandage/trauma shears.
- Disposable basins or emesis bags.
- Disposable bedpan and urinal.
- Stretcher, main; shall be four-wheeled elevating cot for primary patient with appropriate patient restraining device.
- Activated charcoal as directed by physician medical director.
- Patient restraints as directed by physician medical director.
- Sugar cubes or hypertonic sugar solution.
- Cold Packs
- Blankets.
- Disaster/triage tags.
- Warning flares and /or signal devices.
- Fire extinguisher.

Optional:

- Automatic external defibrillator (AED) - strongly recommended for systems that lack immediate response from an advanced life support service.

- Length-based tape or chart for pediatric equipment sizing such as Broselow type tape.
- Pulse oximetry.
- Protective helmets.
- Protective coat with reflective materials.
- Scissors capable of cutting heavy metal.
- Pediatric transport chair.
- Ring cutter.
- Tweezers (splinter).
- Portable trauma kits for treating patients away from the ambulance.
- Eye wash.
- Self-assisted medications as outlined in the basic EMT curriculum - ambulance service's physician medical director must authorize ambulance service to stock.
- Pedi-wheel.
- Small stuffed toy.

**It is highly recommended that pediatric equipment be maintained in a separate jump kit from the adult equipment.**

Advanced Life Support
(In addition to Basic Life Support)

Airway Management and Ventilation:

- Laryngoscope handle with extra batteries and bulbs; pediatric and adult.
- Laryngoscope blades - sizes 0, 1 and 2 straight - sizes 3 and 4 straight or curved.
- Endotracheal tubes (minimum of 2 each size) - sizes 2.5 to 5.0 mm uncuffed - 5.5 to 8.0 mm cuffed.
- Combitube or similar Division approved multi-lumen lower airway adjunct.
- Stylettes for endotracheal tubes; pediatric and adult.
- Magill forceps - pediatric and adult.
- Lubricating jelly (water soluble).
- Nasogastric tubes - pediatric sizes 5F and 8F - adult sizes 14F, 16F, and 18F.
- End-tidal CO2 detectors or esophageal detector devices.

Monitor/Defibrillator:

- Portable, battery-operated, cardiac monitoring defibrillator with recorder, quick- look paddles or hands-free patches, pediatric and adult electrodes and paddles, with capability to provide electrical discharge below 25 watt-seconds.

Vascular access:

- Intravenous catheters, 14g - 22 g.
- Intraosseous needles or devices.
- Tourniquets - constricting bands.
- Syringes of various sizes
- Needles; sizes 14g - 24g.
- Blood sample tubes; adult and pediatric.
- Intravenous administration sets - micro/macro/adjustable flow rate sets
- Intravenous securing devices.

Medications: The Office of Emergency Medical Services shall maintain separate lists of approved medication for the EMT-Intermediate and Paramedic ambulance services.

**It is recommended that pediatric medications/equipment be maintained in a separate jump kit from the adult medications/equipment.**

APPENDIX D

**OFFICE OF EMERGENCY MEDICAL SERVICES**
**WYOMING DEPARTMENT OF HEALTH**

AMBULANCE SAFETY INSPECTION REPORT

State License No. _____ Ambulance Service Name _____ Manufacturer of Body _____ Year _____
Odometer Reading _____ Ambulance Permit # _____ Date _____ VIN #_____

This is to certify that I have this day made a safety inspection of the ambulance described above and made a report as follows: (Items checked are to be corrected)

OUTSIDE INSPECTION: Instruct the driver to start engine and to remain behind the wheel with engine running, then start from the right door and proceed counter-clockwise around the ambulance checking essentially in the following order:

____ 1. Ambulance Identification Painting & Lettering
____ 2. Mirrors
____ 3. Headlights Hi/Lo Beams
____ 4. Turn Signals - R/L & Front/Rear
____ 5. Warning system lights
____ 6. Clearance Lamps - Front/Rear (if necessary)
____ 7. Hazard Warning Lights (4-Way Flashers)
____8. Steering, Front Brakes, Tubing, Hoses, Suspension and Wheels
____ 9. Front Tires - R/L
____ 10. Siren
____ 11. Ambulance Permit Attached
____ 12. Rear Tires - R/L
____ 13. Rear Brakes, Tubing, Hoses, Suspension & Wheels
____ 14. Stop Lamps - R/L
____ 15. Tail Lamps - R/L
____ 16. Exhaust System
____ 17. Brake Fluid
____ 18. Power Steering Unit

INSIDE INSPECTION: Check the following items:

____19. Windows
____20. Windshield Wipers
____21. Horn
____22. Heater & Defrosting Device, Air Conditioning
____23. Interior Lights
____24. Rear-Vision Mirrors
____25. Pt. Compartment/Heat, AC, Lights
____ 26. Parking Brake
____ 27. Two-way Radio
____ 28. Battery Operated Light
____ 29. Cleanliness
____ 30. Fire Extinguisher – 1A10BC
____ 31. Seat Belt - All Occupant Spaces

Inspected By: _____

Location: _____

**********REPAIRS REQUIRED NOTICE**********

**No person shall operate this ambulance until necessary repairs have been completed and restored to safe operating condition. Repairs to be completed:** _____
_____
_____

**********CERTIFICATION OF REPAIRS**********

I certify that the required repairs listed in the "REQUIRED REPAIRS NOTICE" immediately above this certification have been satisfactorily completed.

_____ _____ _____
Signature of Repairman Name of Garage Date Repair Work Completed

**********AMBULANCE OPERATOR CERTIFICATION OF ACTION TAKEN**********

I certify that all defects upon this report have been corrected and action taken to assure compliance with the State Law and Regulations insofar as they are applicable to ambulance vehicles.

_____ _____ _____
Signature of Responsible Party Title Date

This form should be utilized for the required ambulance inspection. Forms are available upon request from the Office of Emergency Medical Services, Hathaway Building, Cheyenne, WY 82002. Distribute copies as follows upon completion of inspection; WHITE for ambulance service's return to Office of Emergency Medical Services upon completion of REQUIRED REPAIRS; CANARY for Office of Emergency Medical Services to be sent immediately upon completion of inspection by the inspector; PINK for ambulance operator's files.

Ambulance Inspection Report 7/08

APPENDIX E

ARTICLE 2. CARDIOPULMONARY RESUSCITATION DIRECTIVES

Effective dates. - Laws 1993, ch. 108, § 2, makes the act effective immediately upon completion of all acts necessary for a bill to become law as provided by art. 4, § 8, Wyo Const. Approved February 25, 1993.

§ 35-22-201. Definitions

(a) As used in this article, unless the context otherwise requires:

(i) "Cardiopulmonary resuscitation" means measures to restore cardiac function or to support breathing in the event of respiratory or cardiac arrest or malfunction. "Cardiopulmonary resuscitation" includes, but is not limited to, chest compression, delivering electric shock to the chest, or manual or mechanical methods to assist breathing;

(ii) "Cardiopulmonary resuscitation directive" means as advance

medical directive pertaining to the administration of cardiopulmonary resuscitation;

(iii) "Emergency medical service personnel" means any emergency medical technician at any level who is certified by the Department of Health. "Emergency medical service personnel" includes a first responder certified by the Department of Health. (Laws 1993, ch. 108, § 1.)

Editor's notes. - There is no subsection (b) in this section as it appears in the 1993 printed act.

§ 35-22-202. Cardiopulmonary resuscitation directives; who may execute.

Any adult who has the decisional capacity to provide informed consent to or refusal of medical treatment or any other person who is, pursuant to the laws of this state or any other state, authorized to make medical treatment decisions on behalf of a person who has such decisional capacity, may execute a cardiopulmonary resuscitation directive. (Laws 1993, Ch. 108, §1.)

§ 35-22-203. Cardiopulmonary resuscitation directive forms; duties of Department of Health.

(a) On or before January 1, 1994, the state Department of Health shall

promulgate rules and protocols for the implementation of cardiopulmonary resuscitation directives by emergency medical personnel. The protocols adopted shall include uniform methods of identifying persons who have executed a cardiopulmonary resuscitation directive. Protocols adopted by the Department of Health shall include methods for rapid identification of persons who have executed a cardiopulmonary resuscitation directive, controlled distribution of methods of identifying persons who have executed a cardiopulmonary resuscitation directive, and the information described in subsection (b) of this section. Nothing in this subsection shall be construed to restrict any other manner in which a person may make a cardiopulmonary resuscitation directive.

(b) Cardiopulmonary resuscitation directive protocols to be adopted by the

state Department of Health shall, at a minimum, require the following information concerning the person who is the subject of the cardiopulmonary resuscitation directive;

(i) The person's name, date of birth and sex:

(ii) The person's eye and hair color;

(iii) The person's race or ethnic background;

(iv) If applicable, the name of the hospice program in which the person is enrolled;

(v) The name, address and telephone number of the person's attending physician;

(vi) The person's signature or mark or, if applicable, the signature of a person authorized by this article to execute a cardiopulmonary resuscitation directive;

(vii) The date on which the cardiopulmonary resuscitation directive was signed;

(viii) the person's directive concerning the administration of cardiopulmonary resuscitation , countersigned by the person's attending physician. (Laws 1993, Ch. 108, § 1.)

§ 35-22-204. Duty to comply with cardiopulmonary resuscitation directive immunity; effect on criminal charges against another person.

(a) Emergency medical service personnel, health care providers and health care facilities shall comply with a person's cardiopulmonary resuscitation directive that is apparent and immediately available. Any emergency medical service personnel, health care provider, healthcare facility or any other person who, in good faith, complies with a cardiopulmonary resuscitation directive which is perceived to be valid shall not be subject to civil or criminal liability or regulatory sanction for such compliance.

(b) Compliance by emergency medical service personnel, healthcare providers or healthcare facilities with a cardiopulmonary resuscitation directive shall not affect the criminal prosecution of any person otherwise charged with the commission of a criminal act.

(c) In the absence of a cardiopulmonary resuscitation directive, a person's consent to cardiopulmonary resuscitation shall be presumed. (Laws 1993, Ch. 108, § 1.)

§ 35-22-205. Effect of declaration after inpatient admission.

A cardiopulmonary resuscitation directive for any person who is admitted to a health care facility shall be implemented as a physician's order concerning resuscitation as directed by the person in the cardiopulmonary resuscitation directive, pending further physicians' orders. (Laws 1993, ch. 108, § 1.)

§ 35-22-206. Effect of cardiopulmonary resuscitation directive; absence; on life; or health insurance.

Neither a cardiopulmonary resuscitation directive nor the failure of a person to execute one shall affect, impair or modify any contract of life or health insurance or annuity or be the basis for any delay in issuing or refusing to issue an annuity or policy of life or health insurance or any increase of a premium therefor. (Laws 1993, ch. 108, § 1.)

§ 35-22-207. Revocation of cardiopulmonary resuscitation directive.

A cardiopulmonary resuscitation directive may be revoked at any time by the person who is the subject of the directive or by any other person who is, pursuant to the laws of this state or any other state authorized to make medical treatment decisions on behalf of the person who is the subject of the directive. (Laws 1993, ch. 108, § 1.)

§ 35-22-208. Effect of article on euthanasia; mercy killing; construction of statute.

Nothing in this article shall be construed as condoning, authorizing or approving euthanasia or mercy killing. In addition, the legislature does not intend that this article be construed as permitting any affirmative or deliberate act to end a person's lief, except to permit natural death as provided by this article. (Laws 1993, ch. 108, § 1.)