Ambulance Supplemental Questionnaire

ZURICH

Today's Date: _____

BASIC INFORMATION:

1. Named Insured: _____
2. DBA: _____
3. Is this a new venture? ☐ Yes ☐ No If yes, provide resume and business plan.
4. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? ☐ Yes ☐ No
   If Yes, please explain on separate sheet.
5. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No
   If Yes, please explain: _____
6. Has your business been involved in consolidations of separate entities? ☐ Yes ☐ No
   If Yes, please explain: _____
7. Is your service involved in activities or operations other than EMS? ☐ Yes ☐ No
   If Yes, please explain: _____

OPERATIONAL INFORMATION:

1. List the major metropolitan area(s) served:
   a. _____ **b.** _____
2. The number of ambulance calls in the past 12 months? Emergency _____ Non Emergency _____
   The estimated ambulance calls in the next 12 months? Emergency _____ Non Emergency _____
3. The number of paratransit/wheelchair calls in the past 12 months? _____
   The estimate of paratransit/wheelchair calls in the next 12 months? _____
4. Does your service perform the following?

☐ Advanced Life Support	☐ Basic Life Support	☐ Capnography or Capnometry
☐ Conscious Sedation	☐ Endotracheal Intubation	☐ IV Therapy or Monitoring
☐ Manual Defibrillation	☐ Mechanical Ventilation	☐ Pulse Oximetry
☐ Telemetry	☐ Thrombolytic Therapy	☐ 12-Lead EKG Monitoring

5. Number of full and part time employees/volunteers that drive or provide patient care:

Paramedics	_____	Critical Care Paramedics	_____
Registered Nurses	_____	Emergency Medical Tech (EMT-B)	_____
Advanced EMT (EMT-A or EMT-I)	_____	Emergency Medical Responder	
Advanced EMT (EMT-A or EMT-I)	_____	(First Responder, EMR)	_____
Non-Emergency Medical Tech	_____	Other	_____

TOTAL _____

6. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago	Renewal Date 2 years ago
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			
Wheelchair Vans			
Stretcher Vans			
Ambulatory Vehicles			

7. Number of Ambulance by type: Type I _____ Type II _____ Type III _____

8. Does your service have a Medical Director? ☐ Yes ☐ No Duties: _____

9. Do your medical protocols meet all local, state and federal requirements? ☐ Yes ☐ No

10. Patient Handling: Stretcher

a. Select all Stretcher types used at your service and give the brand and number of each type:

Type of Stretcher	Brand	Number
X-Frame		
Fold Away Undercarriage		
Power Cot		
Bariatric Cot		
Other		

b. Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? ☐ Yes ☐ No

c. Does your service have a mandatory lift assist policy? ☐ Yes ☐ No

d. Select the engineering controls used at your service and give the brand and number of each type:

Engineering Control	Brand	Number
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

11. Patient Handling: Wheelchair

a. Name the wheelchair tie-down occupant restraint system (WTORS) you use:

_____

b. Provide product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.

c. If you do not use a commercially developed WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its occupant.

d. Please provide the section of your SOP that addresses the transportation of a scooter and its user.

12. Do you transport prisoners or others whose pick up site is determined by their legal status? ☐ Yes ☐ No

If Yes, please list the contracts responsible for these transports and provide a copy of your restraint policy including obligations regarding client escape: _____

_____

13. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)

a. Brand name of systems(s): _____

b. Date the system was installed: _____

c. Number of vehicles currently installed with the system: _____

d. Employee responsible for the management of the OBM: Name: _____

14. What are your hours of operation? _____

15. Number of hours per shift for employees? _____

16. Dispatch

a. Is your dispatch center a Public Safety Answering Point (PSAP)? ☐ Yes ☐ No

If No, please check the following if it applies:

☐ PSAP directly dispatches your units.

☐ PSAP refers calls to your service for internal dispatch.

☐ You do not interact with a PSAP.

b. Check the functions performed by your internal dispatchers:

☐ Dispatch emergency requests for your service. ☐ Dispatch non-emergency requests for your service.

☐ Schedule routine ambulance transfers. ☐ Schedule wheelchair/paratransit transfers.

☐ Screen calls to determine whether or not an ambulance will be sent.

c. How many years experience are dispatchers required to have prior to hiring? _____

d. Are your dispatchers Emergency Medical Dispatch Certified? ☐ Yes ☐ No

e. Describe your in-house training for dispatchers, including length of training: _____

_____

f. The name of the dispatch software used: _____

17. Mark all your business is involved in and complete the total annual percentage for each operation.

☐ Air Ambulance % ☐ Water Rescue % ☐ Tactical Medic Services %

☐ Aerial Rescue % ☐ Off-shore EMS % ☐ Confined Space Rescue %

Special Events: ☐ Car/Motocross Races ☐ Horse Races ☐ Concerts

☐ High School Sports ☐ Professional Sports ☐ Night Clubs ☐ Rave Events

18. If air or water rescue performed is coverage for the watercraft and aircraft provided elsewhere? ☐ Yes ☐ No

VEHICLE MAINTENANCE

1. Is a condition report completed on each transport vehicle and its equipment on each shift? ☐ Yes ☐ No

If No, please explain: _____

2. Who performs the maintenance on your fleet? ☐ In-house Mechanic ☐ Outside Service

Are they certified by the manufacturer? ☐ Yes ☐ No

3. Do you keep maintenance repair records on file for each vehicle? ☐ Yes ☐ No

If No, please explain: _____

4. Do you perform any after-market vehicle modifications? ☐ Yes ☐ No

If No, please explain: _____

5. Do you have a Medical Equipment Maintenance Program? (i.e. AEDs, gurneys, etc.) ☐ Yes ☐ No

HUMAN RESOURCE

1. Please provide the following information for the person who is responsible for new employee hiring and orientation:

Name: _____ Title: _____

2. Check all that apply to your employee selection process:

☐ Written Application ☐ Job Specific Physical Examination

☐ Psychological Testing ☐ Criminal Background Check ☐ MVR Check

☐ Obtain evidence of Pertinent Certification Licensure ☐ Post Employment Drug Screening

. Is previous ambulance driving experience required on new hires? ☐ Yes ☐ No If Yes, how many years? _____

. Please provide the name of the driver training program(s) that you provide or participate in: _____

_____

Number of Classroom Hours: _____ Number of Behind the Wheel Hours: _____

5. What is your employee turnover rate? _____

6. Explain training done for patient securement. _____

7. Minimum & maximum ages for drivers? _____ Minimum _____ Maximum

8. Do your guidelines state a minimum hiring age? ☐ Yes ☐ No Do you hire outside your guidelines? ☐ Yes ☐ No

9. Process in place to ensure all employees are properly trained and certified for their designation? ☐ Yes ☐ No

SAFETY/RISK MANAGEMENT

1. Is a record kept of each request for service? ☐ Yes ☐ No

2. Is a trip ticket for billing purposes completed for each transport? ☐ Yes ☐ No

3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? ☐ Yes ☐ No ☐ N/A

4. What percent of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____ %

   How frequently are they reviewed? ☐ Daily ☐ Weekly ☐ Other _____

   Who is responsible for the reviews? Name _____ Title _____

5. At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated? _____

6. Do you have protocols stating when EWS is to be activated? ☐ Yes ☐ No

7. Are your vehicles always locked when unattended? ☐ Yes ☐ No

8. Do you require third party riders (non patient/non EMS personnel) to sit in the front passenger seat unless the patient's well being requires the rider to be in the back of the ambulance? ☐ Yes ☐ No

9. Does your service maintain accident files? ☐ Yes ☐ No If yes, how long do you keep the files? _____

10. Are safety violations (i.e. auto crashes) part of your progressive discipline process? ☐ Yes ☐ No

11. Does your service have a Medical Equipment Failure policy? ☐ Yes ☐ No

    If Yes, does it address checking, charging and replacing batteries for medical equipment? ☐ Yes ☐ No

12. Do you have a violent patient restraint policy? ☐ Yes ☐ No

13. Do you allow EMT students to ride along on calls? ☐ Yes ☐ No

    If Yes, how many annually? _____

    Are you looking for coverage under this policy? ☐ Yes ☐ No

    What duties are they allowed to perform? _____

14. Safety review process in place? ☐ Yes ☐ No Details: _____

15. Securement and audit controls in place for all medications? ☐ Yes ☐ No

WORKERS' COMPENSATION

Name of Carrier: _____

Policy #: _____ Eff. Dates: _____ to _____

Employers Liability Limit: $_____

Bodily Injury by Accident: $_____ Each Accident

Bodily Injury by Disease: $_____ Policy Limit

Bodily Injury by Disease: $_____ Each Employee

Does your Workers Compensation policy include volunteers as insured's by endorsement? _____