

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

EMERGENCY MEDICAL SERVICES

6 CCR 1015-3

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

CHAPTER ONE – RULES PERTAINING TO EMS AND EMR EDUCATION, EMS CERTIFICATION OR LICENSURE, AND EMR REGISTRATION

Chapter 1 Adopted by the Board of Health on October 22, 2020. Effective January 1, 2021.

Section 1 – Purpose and Authority For Rules

- 1.1 These rules address the recognition process for emergency medical services (EMS) and Emergency Medical Responder (EMR) education programs; the certification or licensure process for all levels of EMS Providers; the registration process for emergency medical responders; and the procedures for denial, revocation, suspension, limitation, or modification of a certificate, license, or registration.
- 1.2 The authority for the promulgation of these rules is set forth in Section 25-3.5-101 *et seq.*, C.R.S.

Section 2 – Definitions

- 2.1 All definitions that appear in Section 25-3.5-103, C.R.S., shall apply to these rules.
- 2.2 “Accredited College or University” - For purposes of EMS provider licensing, a four-year college or university that is accredited by an educational accrediting body recognized by the Council for Higher Education Accreditation (CHEA) or the United States Department of Education, or is an international program that is recognized to be the equivalent of a four-year accredited college or university.
- 2.3 “Advanced Cardiac Life Support (ACLS)” - A course of instruction designed to prepare students in the practice of advanced emergency cardiac care.
- 2.4 “Advanced Emergency Medical Technician (AEMT)” - An individual who has a current and valid AEMT certificate or license issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight.
- 2.5 “Basic Cardiac Life Support (CPR)” - A course of instruction designed to prepare students in cardiopulmonary resuscitation techniques.
- 2.6 “Board for Critical Care Transport Paramedic Certification (BCCTPC)” - a non-profit organization that develops and administers the Critical Care Paramedic Certification and Flight Paramedic Certification exam.
- 2.7 “Certificate” - Designation as having met the requirements of Section 5 of these rules, issued to an individual by the Department. Certification is equivalent to licensure for purposes of the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

- 2.8 “Certificate Holder” - An individual who has been issued a certificate as defined in Section 2.7.
- 2.9 “Continuing Education” - Education required for the renewal of a certificate, license, or registration.
- 2.10 “Department” - Colorado Department of Public Health and Environment.
- 2.11 “Emergency Medical Practice Advisory Council (EMPAC)” - The council established pursuant to Section 25-3.5-206, C.R.S., that is responsible for advising the Department regarding the appropriate scope of practice for EMS providers and for the criteria for physicians to serve as EMS medical directors.
- 2.12 “Emergency Medical Responder (EMR)” - An individual who has successfully completed the training and examination requirements for emergency medical responders and who provides assistance to the injured or ill until more highly trained and qualified personnel arrive.
- 2.13 “Emergency Medical Technician (EMT)” - An individual who has a current and valid EMT certificate or license issued by the Department and who is authorized to provide basic emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight.
- 2.14 “Emergency Medical Technician Intermediate (EMT-I)” - An individual who has a current and valid EMT-I certificate or license issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight.
- 2.15 “Emergency Medical Technician with IV Authorization (EMT-IV)” - An individual who has a current and valid EMT certificate or license issued by the Department and who has met the conditions defined in the Rules Pertaining to EMS Practice and Medical Director Oversight relating to IV authorization.
- 2.16 “EMR Education Center” - A state-recognized provider of initial courses, EMR continuing education topics and/or refresher courses that qualify graduates for the National Registry of Emergency Medical Technician’s EMR certification and for state registration renewal.
- 2.17 “EMR Education Group” - A state-recognized provider of EMR continuing education topics and/or refresher courses that qualify individuals for renewal of a national registry EMR certification and for state registration renewal.
- 2.18 “EMS Education Center” - A state-recognized provider of initial courses, EMS continuing education topics and/or refresher courses that qualify graduates for state and/or National Registry EMS provider certification or licensure.
- 2.19 “EMS Education Group” - A state-recognized provider of EMS continuing education topics and/or refresher courses that qualify individuals for renewal of a state and/or National Registry EMS provider certification or licensure.
- 2.20 “Education Program” - A state-recognized provider of EMS and/or EMR education including a recognized education group or center.
- 2.21 “Education Program Standards” – Department-approved minimum standards for EMS or EMR education that shall be met by state-recognized EMS or EMR education programs.

- 2.22 “EMS Provider” - Means an individual who holds a valid emergency medical service provider certificate or license issued by the Department and includes Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician Intermediate and Paramedic.
- 2.23 “Equivalent Field” - For purposes of EMS provider licensing, a four-year bachelor’s degree program that includes a minimum of 40 completed semester credit hours in courses that the Department determines, pursuant to Section 5.4.2, to be comparable to health sciences fields and disciplines.
- 2.24 “Field Related to the Health Sciences” - For purposes of EMS provider licensing, a four-year bachelor’s degree program in emergency medical services or in health professions and related programs as identified by the United States Department of Education, Institute of Education Sciences, National Center For Education Statistics, Classification of Instructional Programs (CIP-2020).
- 2.25 “Graduate Advanced Emergency Medical Technician” - An EMT certificate holder or licensee who has successfully completed a Department-recognized AEMT education course but has not yet successfully completed the AEMT certification requirements set forth in these rules.
- 2.26 “Graduate Paramedic” - An EMT, AEMT or EMT-I certificate holder or licensee who has successfully completed a Department-recognized Paramedic education course but has not yet successfully completed the Paramedic certification or licensure requirements set forth in these rules.
- 2.27 “Initial Course” - A course of study based on the Department-approved curriculum that meets the education requirements for issuance of a certificate, license, or registration for the first time.
- 2.28 “Initial Certification or Licensure” - First time application for and issuance by the Department of a certificate or license at any level as an EMS provider. This shall include applications received from persons holding any level of EMS certification or license issued by the Department who are applying for either a higher or lower level certificate or license.
- 2.29 “Initial Registration” - First time application for and issuance by the Department of a registration as an EMR. This shall include applications received from persons holding any level of EMS certification or license issued by the Department who are applying for registration.
- 2.30 “International Board of Specialty Certification (IBSC)” - A non-profit organization that develops and administers a national Community Paramedic certification exam.
- 2.31 “Letter of Admonition” - A form of disciplinary sanction that is placed in an EMS provider’s or EMR’s file and represents an adverse action against the certificate holder, registration holder, or licensee.
- 2.32 “License” - Designation as having met the requirements of Section 25-3.5-203(1)(b) and (b.5), C.R.S., and Section 5.4 issued to an individual by the Department.
- 2.33 “Licensee” - An individual who has been issued a license as defined in Section 2.32.
- 2.34 “Medical Director” - For the purposes of these rules, a physician licensed in good standing who authorizes and directs, through protocols and standing orders, the performance of students-in-training enrolled in Department-recognized EMS or EMR education programs and/or EMS certificate holders or licensees who perform medical acts, and who is specifically identified as being responsible to assure the performance competency of those EMS providers as described in the physician’s medical continuous quality improvement program.

- 2.35 “National Registry of Emergency Medical Technicians (NREMT)” - A national non-governmental organization that certifies entry-level and ongoing competency of EMS providers and EMRs.
- 2.36 “Paramedic” - An individual who has a current and valid Paramedic certificate or license issued by the Department and who is authorized to provide acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight.
- 2.37 “Paramedic with Community Paramedic Endorsement (P-CP)” - An individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Community Paramedic endorsement from the Department and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to Community Integrated Health Care Services, as set forth in Sections 25-3.5-206, C.R.S and 25-3.5-1301, et seq. C.R.S.
- 2.38 “Paramedic with Critical Care Endorsement (P-CC)” - An individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Critical Care endorsement from the Department and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to Critical Care, as set forth in Section 25-3.5-206, C.R.S.
- 2.39 “Practical Skills Examination” - A skills test conducted at the end of an initial course and prior to application for national or state certification or licensure.
- 2.40 “Provisional Certification or Licensure” - A certification or license, valid for not more than 90 days, that may be issued by the Department to an EMS provider applicant seeking certification or licensure.
- 2.41 “Provisional Registration” - A registration, valid for not more than 90 days, that may be issued by the Department to an EMR applicant seeking registration.
- 2.42 “Refresher Course” - A course of study based on the Department-approved curriculum that contributes in part to the education requirements for renewal of a certificate, license or registration.
- 2.43 “Registered Emergency Medical Responder (EMR)” - An individual who has successfully completed the training and examination requirements for EMRs, who provides assistance to the injured or ill until more highly trained and qualified personnel arrive, and who is registered with the Department pursuant to Section 6 of these rules.
- 2.44 “Rules Pertaining to EMS Practice and Medical Director Oversight” - Rules adopted by the Executive Director or Chief Medical Officer of the Department upon the advice of the EMPAC that establish the responsibilities of medical directors and all authorized acts of EMS certificate holders or licensees, located at 6 CCR 1015-3, Chapter Two.
- 2.45 “State Emergency Medical and Trauma Services Advisory Council (SEMTAC)” - A council created in the Department pursuant to Section 25-3.5-104, C.R.S., that advises the Department on all matters relating to emergency medical and trauma services.

Section 3 – State Recognition of Education Programs

- 3.1 Application for State Recognition as an Education Program
 - 3.1.1 The Department may grant recognition for any of the following types of education programs:

- A) EMR education center
 - B) EMR education group
 - C) EMT education center
 - D) EMT education group
 - E) EMT-IV education group
 - F) AEMT education center
 - G) AEMT education group
 - H) EMT-I education center
 - I) EMT-I education group
 - J) Paramedic education center
 - K) Paramedic education group
- 3.1.2 An education program recognized as an education center at any level shall also be authorized to serve as an education group at the same level(s).
- 3.1.3 Any education provider seeking to prepare graduates for EMS certification or licensure or EMR registration shall apply for state recognition as described in Section 3.1.9.
- 3.1.4 Initial education program recognition shall be valid for a period of three (3) years from the date of the Department's written notice of recognition.
- 3.1.5 Education programs shall utilize personnel who meet the qualification requirements in the Department's EMS or EMR education program standards.
- 3.1.6 State-recognized EMS education programs are required to present the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two, including the current Colorado EMS scope of practice content as established in those rules, within every initial and refresher course.
- 3.1.7 EMS education centers that provide initial education at the Paramedic level shall obtain accreditation from the Commission on Accreditation of Allied Health Education Programs (CAAHEP). The EMS education center shall provide the Department with verification that an application for accreditation has been submitted to CAAHEP prior to the EMS education center initiating a second course.
- 3.1.8 EMS education centers that provide initial education at the Paramedic level shall maintain accreditation from CAAHEP.
- 3.1.9 Applicants for education program recognition shall submit the following documentation to the Department:
- A) Completed application form provided by the Department;
 - B) Personnel roster, to include a current resume for the program director and medical director;

- C) Description of the facilities to be used for course didactic, lab, and clinical instruction and a listing of all education aids and medical equipment available to the program;
 - D) Policies and procedures, which at a minimum shall address:
 - 1) Admission requirements;
 - 2) Attendance requirements;
 - 3) Course schedule that lists as separate elements the didactic, lab, clinical, skills and written testing criteria of the education program;
 - 4) Discipline/counseling of students;
 - 5) Grievance procedures;
 - 6) Successful course completion requirements;
 - 7) Testing policies;
 - 8) Tuition policy statement;
 - 9) Infection control plan;
 - 10) Description of insurance coverage for students, both health and liability;
 - 11) Practical skills testing policies and procedures;
 - 12) A continuous quality improvement plan; and
 - 13) Recognition of continuing medical education provided by outside parties including, but not limited to, continuing medical education completed by members of the armed forces or reserves of the United States or the National Guard, military reserves or naval militia of any state.
- 3.1.10 After receipt of the application and other documentation required by these rules, the Department shall notify the applicant of recognition or denial as an education program, or shall specify a site review or modification of the materials submitted by the applicant.
- 3.1.11 If the Department requires a site visit, the applicant shall introduce staff, faculty, and medical director, and show all documentation, equipment, supplies and facilities.
- 3.1.12 Applications determined to be incomplete shall be returned to the applicant.
- 3.1.13 The Department shall provide written notice of education program recognition or denial of recognition to the applicant. The Department's determination shall include, but not be limited to, consideration of the following factors:
- A) Fulfillment of all application requirements;
 - B) Demonstration of ability to conduct education, at the requested level, in compliance with the Department's education program standards; and

- C) Demonstration of necessary professional staff, equipment and supplies to provide the education.

3.1.14 Denial of recognition shall be in accordance with Section 4 of these rules.

3.2 Education Program Recognition Renewal

3.2.1 Renewal of recognition shall be valid for a period of five (5) years from the date of the Department's notice of recognition renewal and shall be based upon satisfactory past performance and submission of an updated application form.

3.2.2 Additional information as specified in Section 3.1.9 may be required by the Department.

3.2.3 The Department may require a site review in conjunction with the renewal application.

Section 4 – Disciplinary Sanctions and Appeal Procedures for Education Program Recognition

4.1 The Department, in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S., may initiate proceedings to deny, revoke, suspend, limit or modify education program recognition for, but not limited to, the following reasons:

4.1.1 The applicant fails to meet the application requirements specified in Section 3.1 of these rules.

4.1.2 The applicant does not possess the necessary qualifications to conduct an education program in compliance with the Department's education program standards.

4.1.3 The applicant fails to demonstrate access to adequate clinical or internship services as required by the Department's education program standards.

4.1.4 Fraud, misrepresentation, or deception in applying for or securing education program recognition.

4.1.5 Failing to conduct the education program in compliance with the Department's education program standards.

4.1.6 Failing to notify the Department of changes in the program director or medical director.

4.1.7 Providing false information to the Department with regard to successful completion of education or practical skill examination.

4.1.8 Failing to comply with the provisions in Section 3 of these rules.

4.1.9 Losing CAAHEP accreditation by an EMS education center.

4.2 If the Department initiates proceedings to deny, revoke, suspend, limit or modify an education program recognition, the Department shall provide notice of the action to the education program (or program applicant) and shall inform the program (or program applicant) of its right to appeal and the procedure for appealing. Appeals of Departmental actions shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

Section 5 – Emergency Medical Services Provider Certification or Licensure

5.1 General Requirements

- 5.1.1 The Department may issue the following EMS provider certifications or licenses:
 - A) EMT
 - B) AEMT
 - C) EMT-I
 - D) Paramedic
 - E) Provisional ninety (90)-day certification or license at the EMT, AEMT, EMT-I or Paramedic level.
- 5.1.2 An EMS provider may apply for certification or licensure. Application for dual certification and licensure shall not be permitted.
- 5.1.3 No person shall hold himself or herself out as a certificate holder or licensee or offer, whether or not for compensation, any services included in these rules, or authorized acts permitted by the Rules Pertaining to EMS Practice and Medical Director Oversight, unless that person holds a valid certificate or license.
- 5.1.4 Certificates or licenses shall be effective for a period of three (3) years after the date of issuance. The date of issuance shall be determined by the date the Department approves the application.
- 5.1.5 Multiple certificates or licenses within the levels of EMS provider shall not be permitted. Certification or licensure at a higher level indicates that the certificate holder or licensee may also provide medical care allowed at all lower levels of certification or licensure.
- 5.1.6 If a certificate holder or licensee seeks a higher or lower level of certification or licensure, he or she shall satisfy the requirements for initial certification or licensure at the new level, except as described below.
 - A) If the higher level certificate or license is valid and in good standing or within six months of the expiration date, the applicant for a lower level certificate or license shall not be required to submit current and valid certification from the NREMT at the lower level.

5.2 Initial Certification or licensure

- 5.2.1 Applicants for initial certification or licensure shall be no less than eighteen (18) years of age at the time of application.
- 5.2.2 Applicants for initial certification or licensure shall submit to the Department a completed application provided by the Department, including the applicant's signature in a form and manner as determined by the Department, that contains the following:
 - A) Evidence of compliance with criminal history record check requirements:

- 1) The applicant must submit to a Federal Bureau of Investigation (FBI) fingerprint-based national criminal history record check from the Colorado Bureau of Investigations (CBI).
 - 2) If the results of an applicant's fingerprint-based national criminal history record check reveal a record of arrest without a disposition, the applicant must submit to a name-based criminal history record check as defined in Section 22-2-119.3(6)(d), C.R.S.
 - 3) If an applicant has twice submitted to a fingerprint-based criminal history record check and the FBI or CBI has been unable to classify the fingerprints, then the Department may accept a CBI and/or FBI name-based criminal history report generated through the CBI.
- B) Evidence of current and valid certification from the NREMT at or above the EMS Provider level being applied for.
- C) Evidence of current and valid professional level Basic Cardiac Life Support (CPR) course completion from a national or local organization approved by the Department, except as provided for in Paragraph H) below.
- D) In addition to Paragraph C), above, Paramedic applicants shall submit evidence of current and valid Advanced Cardiac Life Support (ACLS) course completion from a national or local organization approved by the Department, except as provided in Paragraph H) below.
- E) In addition to Paragraphs C) and D) above, a P-CC applicant shall submit evidence of current and valid Critical Care Paramedic or Flight Paramedic certification issued by the BCCTPC.
- F) In additional to Paragraphs C) and D) above, a P-CP applicant shall submit the following additional information:
- 1) Current and valid Community Paramedic certification issued by the IBSC.
 - 2) Proof of completion of a course in community paramedicine from one of the following institutions:
 - a) An accredited paramedic training program,
 - b) A college accredited by an educational accrediting body, or
 - c) A university accredited by an educational accrediting body.
- G) Evidence of lawful presence in the United States pursuant to Section 24-76.5-101, C.R.S.
- H) While stationed or residing within Colorado, all veterans, active military service members, and members of the National Guard and reserves that are separating from an active duty tour, or the spouse of a veteran or a member, may apply for certification or licensure to practice in Colorado. The veteran, member, or spouse is exempt from the requirements of Paragraphs C) and D).

- 1) The Department may require evidence of military status and appropriate orders in order to determine eligibility for this exemption.

5.3 Renewal of Certification or Licensure

5.3.1 General Requirements

- A) Upon the expiration date of a Department-issued certificate or license, the certificate or license is no longer valid and the individual shall not hold himself or herself out as a certificate or license holder, except under the circumstances specified below in Paragraph F).
- B) Persons who have permitted their certification or license to expire:
 - 1) Shall not, until such time as the Department has issued a new or renewed certification or license:
 - a) Hold themselves out as a certificate holder or licensee after the certification or licensure has expired, except as provided in Section 5.3.1.F,
 - b) Offer or perform, whether or not for compensation, any services included in these rules, or
 - c) Offer or perform, whether or not for compensation, any authorized acts permitted by the Rules Pertaining to EMS Practice and Medical Director Oversight; and
 - 2) May renew their certification or license by complying with the provisions of Section 5.3 of these rules (Renewal of Certification or License) for a period not to exceed six (6) months from the expiration date; or
 - 3) Must, if certification or licensure has expired for a period of greater than six (6) months from the expiration date, comply with the provisions of Section 5.2 of these rules (Initial Certification or Licensure), unless exempted pursuant to Section 5.3.1.F below.
- C) All certificates or licenses renewed by the Department shall be valid for three (3) years from the date of issuance.
- D) Date of issuance is the date of application approval by the Department, except, for applicants successfully completing the renewal of certification or licensure requirements during the last six (6) months prior to their certificate or license expiration date, the date of issuance shall be the expiration date of the current valid certificate or license being renewed.
- E) If a certificate holder or licensee has made timely and sufficient application for certification or license renewal and the Department fails to take action on the application prior to the certificate's or license's expiration date, the existing certification or license shall not expire until the Department acts upon the application. The Department, in its sole discretion, shall determine whether the application was timely and sufficient.

- F) Certificate holders or licensees who have been called to federally funded active duty for more than 120 days to serve in a war, emergency or contingency, shall be exempt from the requirements of Sections 5.3.2.B.2 and 5.3.2.B.3 and 5.3.2.C below, provided the holder's certificate or license expired:

- 1) During the service, or
- 2) During the six months after the completion of service.

The Department may require appropriate documentation of service to determine eligibility for this exemption.

5.3.2 Application for Renewal of Certification or Licensure

An applicant for renewal of a certification or license shall:

- A) Submit to the Department a completed application form provided by the Department, including the applicant's signature in a form and manner as determined by the Department;
- B) Submit to the Department with a completed application form all of the following:
 - 1) Evidence of compliance with criminal history record check requirements:
 - a) The applicant is not required to submit to a subsequent fingerprint-based criminal history record check if the applicant has lived in Colorado for more than three (3) years at the time of renewal application and the applicant has submitted to a Federal Bureau of Investigation (FBI) fingerprint-based national criminal history record check at the time of initial certification or licensure or at the time of a previous renewal of certification or licensure.
 - b) If the applicant has lived in Colorado for three (3) years or less at the time of renewal application and submitted to an FBI fingerprint-based criminal history record check at the time of initial certification or licensure or a previous renewal of certification or licensure, the applicant shall submit to another FBI fingerprint-based national criminal history record check from the Colorado Bureau of Investigation (CBI).
 - c) If, in accordance with Subparagraph b) above, an applicant has twice submitted to a fingerprint-based criminal history record check and the FBI or CBI has been unable to classify the fingerprints, then the Department may accept a CBI and/or FBI name-based criminal history report generated through the CBI.
 - d) If the results of the applicant's fingerprint-based national criminal history record check reveal a record of arrest without a disposition, the applicant must submit to a name-based criminal history record check as defined in Section 22-2-119.3(6)(d), C.R.S.
 - 2) Evidence of current and valid professional level Basic Cardiac Life Support (CPR) course completion from a national or local organization approved by the Department.

- 3) In addition to Paragraph 2) above, EMT-I and Paramedic applicants shall submit evidence of current and valid Advanced Cardiac Life Support (ACLS) course completion from a national or local organization approved by the Department.
 - 4) In addition to Paragraphs 2) and 3) above, an applicant for P-CC shall submit evidence of current and valid Critical Care Paramedic or Flight Paramedic Certification issued by the BCCTPC.
 - 5) In addition to Paragraphs 2) and 3) above, applicants for P-CP shall submit evidence of current and valid Community Paramedic Certification issued by the IBSC.
 - 6) Evidence of lawful presence in the United States pursuant to Section 24-76.5-101, C.R.S.
- C) Complete one of the following:
- 1) Except for an EMT-I, current and valid NREMT certification at or above the EMS provider level being renewed. The Department will continue to accept education hours consistent with Section 5.3.3 for renewal of EMT-I providers in the State of Colorado notwithstanding the discontinuance of the EMT-I exam by the NREMT.
 - 2) Appropriate level refresher course as described in Section 5.3.3 conducted or approved through signature of a Department-recognized EMS education program representative and skill competency as attested to by signature of medical director or Department-recognized EMS education program representative.
 - 3) The minimum number of education hours as described in Section 5.3.3 completed or approved through signature of a Department-recognized EMS education program representative and skill competency as attested to by signature of medical director or Department-recognized EMS education program representative.

5.3.3 Education Requirements to Renew a Certificate or License Without the Use of a Current and Valid NREMT Certification

- A) For renewal of a certificate or license without the use of a current and valid NREMT certification, the following education is required:
- 1) Education required for the renewal of an EMT or AEMT certificate or license shall be no less than thirty-six (36) hours and shall be completed through one of the following:
 - a) A refresher course at the EMT or AEMT level conducted or approved by a Department-recognized EMS education program plus additional continuing education topics such that the total education hours is no less than thirty-six (36) hours; or

- b) Continuing education topics consisting of no less than thirty-six (36) hours of education that is conducted or approved through a Department-recognized EMS education program consisting of the following minimum content requirements on the EMT or AEMT level:
 - i) One (1) hour of preparatory content that may include scene safety, quality improvement, health and safety of EMS providers, or medical legal concepts.
 - ii) Two (2) hours of obstetric patient assessment and treatment.
 - iii) Two (2) hours of pediatric patient assessment and treatment.
 - iv) Six (6) hours of trauma patient assessment and treatment.
 - v) Five (5) hours of patient assessment.
 - vi) Three (3) hours of airway assessment and management.
 - vii) Six (6) hours of medical/behavioral emergency patient assessment and management.
 - viii) Eleven (11) hours of elective content that is relevant to the practice of emergency medicine.
- 2) Education required for the renewal of an EMT-I or Paramedic certificate or license shall be no less than fifty (50) hours and shall be completed through one of the following methods:
 - a) A refresher course at the EMT-I or Paramedic level conducted or approved by a Department-recognized EMS education program plus additional continuing education topics such that the total education hours is no less than fifty (50) hours.
 - b) Continuing education topics consisting of no less than fifty (50) hours of education that is conducted or approved through a Department-recognized EMS education program consisting of the following minimum content requirements at the EMT-I or Paramedic level:

No less than twenty-five (25) hours as described below:

- i) Eight (8) hours of airway, breathing, and cardiology assessment and treatment.
- ii) Four (4) hours of medical patient assessment and treatment.
- iii) Three (3) hours of trauma patient assessment and treatment.

- iv) Four (4) hours of obstetric patient assessment and treatment.
 - v) Four (4) hours of pediatric patient assessment and treatment.
 - vi) Two (2) hours of operational tasks and no less than twenty-five (25) hours of elective content that is relevant to the practice of emergency medicine.
 - 3) Education cannot be used in lieu of a valid and current BCCTPC Critical Care or Flight Paramedic Certification to maintain the Critical Care endorsement.
 - 4) Education cannot be used in lieu of current and valid Community Paramedic certification issued by the IBSC.
- 5.3.4 In satisfaction of the requirements of Section 5.3.3 above, the Department may accept continuing medical education, training, or service completed by a member of the armed forces or reserves of the United States or the National Guard, military reserves or naval militia of any state, upon presentation of satisfactory evidence by the applicant for renewal of certification or licensure.
- A) Satisfactory evidence may include but is not limited to the content of the education, method of delivery, length of program, qualifications of the instructor and method(s) used to evaluate the education provided.
- 5.4 Licensure
- 5.4.1 On or after January 1, 2021, an individual applying for an initial license or an individual who currently holds a valid Colorado Emergency Medical Service provider certificate who wishes to convert the certificate to a license shall:
- A) Submit one transcript establishing that the applicant has:
 - 1) Completed a four-year bachelor's degree program from an accredited college or university in a field related to the health sciences; or
 - 2) Completed a four-year bachelor's degree program from an accredited college or university in an equivalent field as set forth in Section 5.4.2.
 - B) An applicant seeking initial licensure from the department as an EMS provider must also satisfy all requirements set forth in Section 5.2 of these rules.
 - C) An applicant seeking to convert certification to licensure, or who subsequently seeks renewal of licensure from the Department as an EMS provider, shall satisfy all requirements set forth in Section 5.3 of these rules.
- 5.4.2 A licensure applicant who seeks to establish that a four-year bachelor's degree program is in a field equivalent to the health sciences, as defined in Section 2.23, shall demonstrate the following:
- A) The successful completion of a four-year bachelor's degree from an accredited college or university; and

- B) Successful completion of a minimum of forty (40) semester credit hours from one or more of the following content areas, as contained in a single transcript:
 - 1) Chemistry;
 - 2) Biology;
 - 3) Physics;
 - 4) Mathematics;
 - 5) Sociology;
 - 6) Psychology;
 - 7) Public health;
 - 8) Anthropology;
 - 9) Exercise science;
 - 10) Philosophy;
 - 11) Education;
 - 12) Emergency medical services;
 - 13) Fire science;
 - 14) Public safety;
 - 15) Business/finance; or
 - 16) Communications.

5.5 Provisional Certification or Licensure

5.5.1 General Requirements

- A) The Department may issue a provisional certification or license to an applicant whose fingerprint-based criminal history record check has not been received by the Department at the time of application for certification or licensure.
- B) To be eligible for a provisional certification or license, the applicant shall, at the time of application, have satisfied all requirements in these rules for initial or renewal certification or licensure.
- C) A provisional certification or license shall be valid for not more than ninety (90) days.
- D) The Department may impose disciplinary sanctions pursuant to these rules if the Department finds that a certificate or license holder who has received a provisional certification or license has violated any of the certification or license requirements or any of these rules.

- E) Once a provisional certification or license becomes invalid, an applicant may not practice or act as a certificate or license holder unless an initial or renewal certification or license has been issued by the Department to the applicant.

5.5.2 Application for Provisional Certification or Licensure

An applicant for a provisional certification or license shall:

- A) Submit to the Department a completed provisional certification or licensure application.
- B) Submit to a fingerprint-based criminal history record check as provided in Sections 5.2.2 and 5.3.2 of these rules. At the time of application, the applicant shall have already submitted the required materials to the CBI to initiate the fingerprint-based criminal history record check.
- C) Submit to the Department with a completed application form all of the following:
 - 1) A fee in the amount of \$23.00.
 - 2) A name-based criminal history record check.
 - a) If the applicant has lived in Colorado for more than three (3) years at the time of application, a name-based criminal history report conducted by the CBI, including any internet-based system on CBI's website, or other name-based report as determined by the Department.
 - b) If the applicant has lived in Colorado for three (3) years or less at the time of application, a name-based criminal history report for each state in which the applicant has lived for the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency, or other name-based report as determined by the Department.
 - c) Any name-based criminal history report provided to the Department for purposes of this Paragraph c) shall have been obtained by the applicant not more than ninety (90) days prior to the Department's receipt of a completed application.

Section 6 – Emergency Medical Responder Registration

6.1 General Requirements

- 6.1.1** An EMR may register with the Department on a voluntary basis by meeting registration requirements included in this Section.

- A) Registration is not required to perform as an EMR.
- B) Registration provides recognition that an EMR has successfully completed the training from a recognized education program, passed the NREMT EMR examination, and undergone a fingerprint-based criminal history record check by the Department.

- 6.1.2 No person shall hold himself or herself out as a registered EMR unless that person has registered with the Department in accordance with this Section.
- 6.1.3 Registrations shall be effective for a period of three (3) years after the registration date. The registration date is the date the Department approves the application.

6.2 Initial Registration

- 6.2.1 Applicants for initial registration shall be no less than sixteen (16) years of age at the time of application.
- 6.2.2 Applicants for initial registration shall submit to the Department a completed application provided by the Department, including the applicant's signature in a form and manner as determined by the Department, which contains the following:

- A) Evidence of compliance with criminal history record check requirements:
 - 1) If the applicant has lived in Colorado for more than three (3) years at the time of application, the applicant is required to submit to a fingerprint-based criminal history record check generated by the CBI.
 - 2) If the applicant has lived in Colorado for three (3) years or less at the time of application, the applicant shall submit to a fingerprint-based criminal history record check generated by the FBI and processed through the CBI.
 - 3) If, in accordance with Subparagraphs 1) or 2) above, an applicant has twice submitted to a fingerprint-based criminal history record check and the FBI or CBI has been unable to classify the fingerprints, then the Department may accept a CBI and/or FBI name-based criminal history report generated through the CBI.
 - 4) If the results of the applicant's fingerprint-based national criminal history record check reveal a record of arrest without a disposition, the applicant must submit to a name-based criminal history record check as defined in Section 22-2-119.3(6)(d), C.R.S.
- B) Proof of adequate training and education with a current and valid certification from the NREMT at the EMR level.
- C) Evidence of current and valid professional level basic CPR course completion from a national or local organization approved by the Department.
- D) Evidence of lawful presence in the United States pursuant to Section 24-76.5-101, C.R.S.

6.3 Renewal of Registration

6.3.1 General Requirements

- A) Upon the expiration of an EMR registration, the registration is no longer valid and the individual shall not hold him or herself out as a registered EMR.
- B) Persons who have permitted their registration to expire:

- 1) May renew their registration by complying with the provisions of Section 6.3 of these rules (renewal of registration) for a period not to exceed six (6) months from the expiration date; or
 - 2) Must, if the registration has expired for a period of greater than six (6) months from the expiration date, comply with the provisions of Section 6.2 of these rules (Initial Registration).
- C) All registrations renewed by the Department shall be valid for three (3) years from the date of registration.
- D) Registration date is the date of renewal application approval by the Department, except, for applicants successfully completing the renewal of registration requirements during the last six (6) months prior to their registration expiration date, the registration date shall be the expiration date of the current valid registration being renewed.
- E) If a registered EMR has made timely and sufficient application for registration renewal and the Department fails to take action on the application prior to the registration's expiration date, the existing registration shall not expire until the Department acts upon the application. The Department, in its sole discretion, shall determine whether the application was timely and sufficient.

6.3.2 Application for Renewal of Registration

An Applicant For Registration Renewal Shall:

- A) Submit to the Department a completed application form provided by the Department, including the applicant's signature in a form and manner as determined by the Department;
- B) Submit to the Department with a completed application form all of the following:
- 1) Evidence of compliance with criminal history record check requirements:
 - a) The applicant is not required to submit to a fingerprint-based criminal history record check if the applicant has lived in Colorado for more than three (3) years at the time of application and the applicant has submitted to a fingerprint-based criminal history record check through the CBI for a previous Colorado EMR registration application.
 - b) If the applicant has lived in Colorado for more than three (3) years at the time of application and has not submitted to a fingerprint-based criminal history record check as described in Subparagraph a) above, the applicant shall submit to a fingerprint-based criminal history record check generated by the CBI.
 - c) If the applicant has lived in Colorado for three (3) years or less at the time of application, the applicant shall submit to a fingerprint-based criminal history record check generated by the FBI through the CBI.

- d) If, in accordance with Subparagraphs b) or c) above, an applicant has twice submitted to a fingerprint-based criminal history record check and the FBI or CBI has been unable to classify the fingerprints, then the Department may accept a CBI and/or FBI name-based criminal history report generated through the CBI.
 - e) If the results of the applicant's fingerprint-based national criminal history record check reveal a record of arrest without a disposition, the applicant must submit to a name-based criminal history record check as defined in Section 22-2-119.3(6)(d), C.R.S.
- 2) Evidence of current and valid professional level basic CPR course completion from a national or local organization approved by the Department.
- 3) Evidence of lawful presence in the United States pursuant to Section 24-76.5-101, C.R.S.
- C) Complete one of the following training requirements:
 - 1) Current and valid NREMT certification at the EMR level.
 - 2) Appropriate level refresher course as described in Section 6.3.3 conducted or approved through signature of a Department-recognized EMR education program representative and skill competency as attested to by signature of medical director or Department-recognized EMR education program representative.
 - 3) The minimum number of education hours as described in Section 6.3.3 completed or approved through signature of a Department-recognized EMR education program representative and skill competency as attested to by signature of medical director or Department-recognized EMR education program representative.

6.3.3 Education Requirement to Renew a Registration without the Use of a Current and Valid NREMT Certification

- A) For renewal of a registration without the use of a current and valid NREMT EMR certification, the following education is required:
 - 1) Education required for the renewal of an EMR registration shall be no less than twelve (12) hours and shall be completed through one of the following:
 - a) A refresher course at the EMR level conducted or approved by a Department-recognized EMR education program plus additional continuing education topics such that the total education hours is no less than twelve (12) hours.
 - b) Continuing education topics consisting of no less than twelve (12) hours of education that is conducted or approved through a Department-recognized EMR education program consisting of the following minimum content requirements:

- i) One (1) hour of preparatory content that may include scene safety, quality improvement, health and safety of EMRs, or medical legal concepts
- ii) Two (2) hours of airway assessment and management
- iii) Two (2) hours of patient assessment
- iv) Three (3) hours of circulation topics
- v) Three (3) hours of illness and injury topics
- vi) One (1) hour of childbirth and pediatric topics

6.4 Provisional Registration

6.4.1 General Requirements

- A) The Department may issue a provisional registration to an applicant whose fingerprint-based criminal history record check has not been received by the Department at the time of application for registration.
- B) To be eligible for a provisional registration, the applicant shall, at the time of application, have satisfied all requirements in these rules for initial or renewal registration.
- C) A provisional registration shall be valid for not more than ninety (90) days.
- D) The Department may impose disciplinary sanctions pursuant to these rules if the Department finds that an EMR who has received a provisional registration has violated any requirements for registration or any of these rules.
- E) Once a provisional registration becomes invalid, an applicant may not hold him or herself out as a registered EMR unless an initial or renewal registration has been issued by the Department to the applicant.

6.4.2 Application for Provisional Registration

An applicant for a provisional registration shall:

- A) Submit to the Department a completed provisional registration application.
- B) Submit to a fingerprint-based criminal history record check as provided in Sections 6.2.2 and 6.3.2 of these rules. At the time of application, the applicant shall have already submitted the required materials to the CBI to initiate the fingerprint-based criminal history record check.
- C) Submit to the Department with a completed application form, a fee in the amount of \$23.00 and either:
 - 1) A name-based criminal history report conducted by the CBI, including a criminal history report from an internet-based system on CBI's website, or other name-based report as determined by the Department if the applicant has lived in Colorado for more than three (3) years at the time of application; or

- 2) A name-based criminal history report for each state in which the applicant has lived for the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency, or other name-based report as determined by the Department if the applicant has lived in Colorado for three (3) years or less at the time of application.
- D) Ensure the name-based criminal history report provided to the Department shall have been obtained by the applicant not more than ninety (90) days prior to the Department's receipt of a completed application.

Section 7 – Disciplinary Sanctions and Appeal Procedures for EMS Provider Certification, EMS Provider Licensure, or EMR Registration

- 7.1 For good cause, the Department may deny, revoke, suspend, limit, modify, or refuse to renew an EMS provider certificate or license or EMR registration, may impose probation on an EMS provider certificate holder, licensee, or registration holder, or may issue a letter of admonition in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- 7.2 Good cause for disciplinary sanctions listed above shall include, but not be limited to:
 - 7.2.1 Failing to meet the requirements of these rules pertaining to issuance and renewal of certification, licensure, or registration.
 - 7.2.2 Engaging in fraud, misrepresentation, or deception when applying for or securing certification, licensure, or registration.
 - 7.2.3 Aiding and abetting in the procurement of certification, licensure, or registration for any person not eligible for certification, licensure, or registration.
 - 7.2.4 Utilizing NREMT certification that has been illegally obtained, suspended or revoked, to obtain a state certification, licensure, or registration.
 - 7.2.5 Unlawfully using, possessing, dispensing, administering, or distributing controlled substances.
 - 7.2.6 Driving an emergency vehicle in a reckless manner, or while under the influence of alcohol or other performance altering substances.
 - 7.2.7 Responding to or providing patient care while under the influence of alcohol or other performance altering substances.
 - 7.2.8 Demonstrating a pattern of alcohol or other substance abuse.
 - 7.2.9 Materially altering any Department certificate, license, or registration, or using and/or possessing any such altered certificate, license, or registration.
 - 7.2.10 Having any certificate, license, or registration related to patient care suspended or revoked in Colorado or in another state or country.
 - 7.2.11 Unlawfully discriminating in the provision of services.
 - 7.2.12 Representing qualifications at any level other than the person's current EMS provider certification or licensure level.

- 7.2.13 Representing oneself to others as a certificate or license holder or providing medical care without possessing a current and valid certificate or license issued by the Department.
- 7.2.14 Representing oneself to others as a registered EMR without being currently registered with the Department.
- 7.2.15 Failing to follow accepted standards of care in the management of a patient, or in response to a medical emergency.
- 7.2.16 Failing to administer medications or treatment in a responsible manner in accordance with the medical director's orders or protocols.
- 7.2.17 Failing to maintain confidentiality of patient information.
- 7.2.18 Failing to provide the Department with the current place of residence or failing to promptly notify the Department of a change in current place of residence or change of name.
- 7.2.19 Engaging in a pattern of behavior that demonstrates routine response to medical emergencies without being under the policies and procedures of a designated emergency medical response agency and/or providing patient care without medical direction when required.
- 7.2.20 Performing medical acts not authorized by the Rules Pertaining to EMS Practice and Medical Director Oversight and in the absence of other lawful authorization to perform such medical acts.
- 7.2.21 Performing medical acts requiring an EMS provider certification or license while holding only a valid EMR registration.
- 7.2.22 Failing to provide care or discontinuing care when a duty to provide care has been established.
- 7.2.23 Appropriating or possessing without authorization medications, supplies, equipment, or personal items of a patient or employer.
- 7.2.24 Falsifying entries or failing to make essential entries in a patient care report, EMS or EMR education document, or medical record.
- 7.2.25 Falsifying or failing to comply with any collection or reporting required by the state.
- 7.2.26 Failing to comply with the terms of any agreement or stipulation regarding certification, licensure, or registration entered into with the Department.
- 7.2.27 Violating any state or federal statute or regulation, the violation of which would jeopardize the health or safety of a patient or the public.
- 7.2.28 Engaging in unprofessional conduct at the scene of an emergency that hinders, delays, eliminates, or deters the provision of medical care to the patient or endangers the safety of the public.
- 7.2.29 Failure by a certificate or license holder or registered EMR to report to the Department any violation by another certificate or license holder or registered EMR of the good cause provisions of this Section when the certificate or license holder knows or reasonably believes a violation has occurred.

- 7.2.30 Committing or permitting, aiding or abetting the commission of an unlawful act that substantially relates to performance of a certificate or license holder or registered EMR's duties and responsibilities as determined by the Department.
- 7.2.31 Committing patient abuse including the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish, or patient neglect, including the failure to provide goods and services necessary to attain and maintain physical and mental well-being.
- 7.2.32 With respect to EMS certificate holders and licensees, failing to attend or complete a peer health assistance program as provided in Section 25-3.5-208(9), C.R.S.
- 7.2.33 Holding oneself out as a certificate holder or licensee after certification or licensure has expired, except as provided in Section 5.3.1.A, including offering or performing, whether or not for compensation, either any services included in these rules or any authorized acts permitted by the Rules Pertaining to EMS Practice and Medical Director Oversight.
- 7.3 Good cause for disciplinary sanctions also includes conviction of, or a plea of guilty, or of no contest, to a felony or misdemeanor that relates to the duties and responsibilities of a certificate, license or registration holder, including patient care and public safety. For purposes of this Paragraph, "conviction" includes the imposition of a deferred sentence.
 - 7.3.1 The following crimes set forth in the Colorado Criminal Code (Title 18, C.R.S.) are considered to relate to the duties and responsibilities of a certificate or license holder:
 - A) Offenses under Article 3 - offenses against a person.
 - B) Offenses under Article 4 - offenses against property.
 - C) Offenses under Article 5 - offenses involving fraud.
 - D) Offenses under Article 6 - offenses involving the family relations.
 - E) Offenses under Article 6.5 - wrongs to at-risk adults.
 - F) Offenses under Article 7 - offenses related to morals.
 - G) Offenses under Article 8 - offenses - governmental operations.
 - H) Offenses under Article 9 - offenses against public peace, order and decency.
 - I) Offenses under Article 17 - Colorado Organized Crime Control Act.
 - J) Offenses under Article 18 - Uniform Controlled Substances Act of 2013.
 - 7.3.2 The offenses listed above are not exclusive. The Department may consider other pleas or criminal convictions, including those from other state, federal, foreign or military jurisdictions.
 - 7.3.3 In determining whether to impose disciplinary sanctions based on a plea or on a felony or misdemeanor conviction, the Department may consider, but is not limited to, the following information:

- A) The nature and seriousness of the crime including but not limited to whether the crime involved violence to or abuse of another person and whether the crime involved a minor or a person of diminished capacity;
- B) The relationship of the crime to the purposes of requiring a certificate, license, or registration;
- C) The relationship of the crime to the ability, capacity or fitness required to perform the duties and discharge the responsibilities of a certified or licensed EMS provider or registered EMR; and
- D) The time frame in which the crime was committed.

7.4 Appeals

7.4.1 If the Department denies certification, licensure, or registration, the Department shall provide the applicant with notice of the grounds for denial and shall inform the applicant of the applicant's right to request a hearing.

- A) A request for a hearing shall be submitted to the Department in writing within sixty (60) calendar days from the date of the notice.
- B) If a request for a hearing is made, the hearing shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- C) If the applicant does not request a hearing in writing within sixty (60) calendar days from the date of the notice, the applicant is deemed to have waived the opportunity for a hearing.

7.4.2 If the Department proposes disciplinary sanctions as provided in this Section, the Department shall notify the certificate, license, or registration holder by first class mail to the last address furnished to the Department by the certificate, license, or registration holder. The notice shall state the alleged facts and/or conduct warranting the proposed action and state that the certificate, license, or registration holder may request a hearing.

- A) The certificate, license, or registration holder shall file a written answer within thirty (30) calendar days of the date of mailing of the notice.
- B) A request for a hearing shall be submitted to the Department in writing within thirty (30) calendar days from the date of mailing of the notice.
- C) If a request for a hearing is made, the hearing shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- D) If the certificate, license, or registration holder does not request a hearing in writing within thirty (30) calendar days of the date of mailing of the notice, the certificate, license, or registration holder is deemed to have waived the opportunity for a hearing.

- 7.4.3 If the Department summarily suspends a certificate, license, or registration, the Department shall provide the certificate, license, or registration holder notice of such in writing, which shall be sent by first class mail to the last address furnished to the Department by the certificate, license, or registration holder. The notice shall state that the certificate, license, or registration holder is entitled to a prompt hearing on the matter. The hearing shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- 7.4.4 If the Department summarily suspends the certification or license of any EMS provider pursuant to Section 25-3.5-208(9), C.R.S., and Section 7.2.32 of these rules, the EMS provider may submit a written request to the Department for a formal hearing. The written request must be submitted within two (2) days after receiving notice of the suspension. The certificate or license holder shall have the burden of proving that the certificate or license holder's certification or licensure should not be suspended. The hearing shall be conducted in accordance with Section 24-4-105, C.R.S.

Section 8 – Incorporation by Reference

- 8.1 These rules incorporate by reference:
- 8.1.1 The Commission on Accreditation of Allied Health Education Programs (CAAHEP) Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions as revised in 2015; and
- 8.1.2 United States Department of Education, Institute of Education Sciences, National Center For Education Statistics, Classification of Instructional Programs (CIP-2020).
- 8.2 Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the Department maintains copies of the incorporated material for public inspection during regular business hours, and shall provide certified copies of any non-copyrighted material to the public at cost upon request. Information regarding how the incorporated material may be obtained or examined is available from the Division by contacting:
- EMTS Branch Chief
Health Facilities and EMS Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530
- 8.3 The incorporated material may be obtained at no cost from the websites of:
- 8.3.1 The Committee on Accreditation of Education Programs for the Emergency Medical Services Professions at <https://coaemsp.org/caahep-standards-and-guidelines#1>; and
- 8.3.2 United States Department of Education, Institute of Education Sciences, National Center for Education Statistics, Classification of Instructional Programs (CIP-2020) at <https://nces.ed.gov/ipeds/cipcode/cipdetail.aspx?y=55&cipid=88742>

CHAPTER TWO – RULES PERTAINING TO EMS PRACTICE AND MEDICAL DIRECTOR OVERSIGHT

Adopted by the Chief Medical Officer on October 29, 2021. Effective December 30, 2021.

SECTION 1 – Purpose and Authority for Establishing Rules

- 1.1 These rules define the authorized medical acts of Emergency Medical Service (EMS) providers in the settings in which they may practice: prehospital, as defined by Sections 25-3.5-206(5)(b) and 25-3.5-209, C.R.S. and these rules; out-of-hospital, as defined by 6 CCR 1011-3 and these rules; and clinical, as defined by Section 25-3.5-207(1)(a), C.R.S and these rules.
- 1.2 These rules also define medical director qualifications and duties within EMS agencies, Community Integrated Health Care Service (CIHCS) agencies, and clinical settings. These rules apply to any physician functioning as a medical director in these settings.
- 1.3 These rules also define the duties of medical supervisors of EMS providers in the clinical setting.
- 1.4 The general authority for the promulgation of these rules by the executive director or chief medical officer of the Department is set forth in Sections 25-3.5-203, 206, and 207, C.R.S.

SECTION 2 – Definitions

- 2.1 All definitions that appear in Sections 25-3.5-103, 25-3.5-205 – 207, C.R.S., and 6 CCR 1015-3, Chapter One shall apply to these rules. Unless otherwise stated, the definitions in this section shall apply to:
 - 2.1.1 Prehospital and Interfacility Transport settings,
 - 2.1.2 CIHCS (Out- of- Hospital) settings, and
 - 2.1.3 Clinical settings.
- 2.2 “Advanced Cardiac Life Support (ACLS)” - a course of instruction designed to prepare students in the practice of advanced emergency cardiac care.
- 2.3 “Advanced Emergency Medical Technician (AEMT)” - an individual who has a current and valid AEMT certificate or license issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.
- 2.4 “Care Coordination” - the deliberate organization of patient care activities between two or more participants, including the patient, involved in the patient’s care to facilitate the appropriate delivery of medical care services.
- 2.5 “Certificate” - designation as having met the requirements of Section 5 of Chapter One, 6 CCR 1015-3, issued to an individual by the Department. Certification is equivalent to licensure for purposes of the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- 2.6 “Clinical Medical Director” - for purposes of these rules, a physician licensed in Colorado and in good standing who determines, authorizes, and directs, through protocols, standing orders, and operational policies or procedures developed by the facility’s medical staff, the medical acts performed by EMS providers in a clinical setting. The clinical medical director is also responsible for assuring the competency of the performance of those acts by EMS providers as described in the Facility’s Medical Continuous Quality Improvement Program.

- 2.7 “Clinical Setting” - a health care facility licensed or certified by the Department pursuant to Section 25-1.5-103(1)(a), C.R.S.
- 2.8 “Colorado Medical Board” - the Colorado Medical Board established in Title 12, Article 240, C.R.S.
- 2.9 “Community Integrated Health Care Service (CIHCS)” - the provision of certain out-of-hospital medical services that a Community Paramedic may provide and may include:
 - 2.9.1 Services authorized pursuant to Section 25-3.5-1203(3), C.R.S.
 - 2.9.2 Services authorized pursuant to 6 CCR 1011-3, Standards for Community Integrated Health Care Service Agencies.
 - 2.9.3 Services authorized under the scope of practice as set forth in this chapter.
 - 2.9.4 Services authorized pursuant to Section 25-3.5-206(4)(a.5)(II), C.R.S.
- 2.10 “Community Integrated Health Care Service Agency (CIHCS Agency)” - a sole proprietorship, partnership, corporation, nonprofit entity, special district, governmental unit or agency, or licensed or certified health care facility that is subject to regulation under Article 1.5 or 3 of Title 25, C.R.S., that manages and offers, directly or by contract, community integrated health care services.
- 2.11 “CIHCS Agency Medical Director” - as used in these rules, means a Colorado licensed physician in good standing who is identified as being responsible for supervising, directing, and assuring the competency of those individuals who are employed by or contracted with the CIHCS Agency to perform community integrated health care services on behalf of the agency.
- 2.12 “Consumer” - an individual receiving community integrated health care services.
- 2.13 “Consumer Service Plan” - the approved written plan specific to each consumer receiving CIHCS in a series of visits that: identifies the consumer's physical, medical, social, mental health, and/or environmental needs, as necessary; sets forth the out-of-hospital medical services the CIHCS Agency agrees to provide to the consumer; and is overseen by the CIHCS Agency medical director.
- 2.14 “Department” - the Colorado Department of Public Health and Environment.
- 2.15 “Direct Verbal Order” - verbal authorization given by a physician to an EMS provider for the performance of specific medical acts through a Medical Base Station or in person; or in a clinical setting, given by a physician contemporaneous to when a patient is receiving treatment or by a medical supervisor as an instruction based on a physician order.
- 2.16 “Emergency Medical Practice Advisory Council (EMPAC)” - the council established pursuant to Section 25-3.5-206, C.R.S. that is responsible for advising the Department regarding the appropriate scope of practice for EMS providers and for the criteria for physicians to serve as EMS agency medical directors, CIHCS Agency medical directors or clinical medical directors.
- 2.17 “Emergency Medical Technician (EMT)” - an individual who has a current and valid EMT certificate or license issued by the Department and who is authorized to provide basic emergency medical care in accordance with these rules.
- 2.18 “Emergency Medical Technician with Intravenous Authorization (EMT-IV)” - an individual who has a current and valid EMT certificate or license issued by the Department and who has met the conditions defined in Section 6.6 of these rules.

- 2.19 “Emergency Medical Technician-Intermediate (EMT-I)” - an individual who has a current and valid EMT-Intermediate certificate or license issued by the Department and who is authorized to provide limited acts of advanced emergency medical care in accordance with these rules.
- 2.20 “EMS Agency Medical Director” - for purposes of these rules, means a physician licensed in Colorado and in good standing who authorizes and directs, through protocols and standing orders, the performance of students-in-training enrolled in Department-recognized EMS education programs, Graduate AEMTs, EMT-IIs, or Paramedics, or EMS providers of a prehospital EMS service agency and who is specifically identified as being responsible to assure the competency of the performance of those acts by such EMS providers as described in the physician’s medical CQI program.
- 2.21 “EMS Provider” - means an individual who holds a valid emergency medical service provider certificate or license issued by the Department and includes Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate, and Paramedic.
- 2.22 “EMS Service Agency or EMS Agency” - any organized agency including but not limited to a “rescue unit” as defined in Section 25-3.5-103(11), C.R.S., using EMS providers to render initial emergency medical care to a patient prior to or during transport. This definition does not include criminal law enforcement agencies, unless the criminal law enforcement personnel are EMS providers who function with a “rescue unit” as defined in Section 25-3.5-103(11), C.R.S. or are performing any medical act described in these rules.
- 2.23 “Graduate Advanced EMT” - an individual who has a current and valid Colorado EMT certification or license issued by the Department and who has successfully completed a Department-recognized AEMT initial course but has not yet successfully completed the certification or licensing requirements set forth in the Rules Pertaining to EMS and EMR Education, EMS Certification or Licensure, and EMR Registration, 6 CCR 1015-3, Chapter One, for the AEMT level.
- 2.24 “Graduate Paramedic” - an individual who has a current and valid Colorado EMT certificate or license, AEMT certificate or license, or EMT-I certificate or license issued by the Department and who has successfully completed a Department-recognized Paramedic initial course but has not yet successfully completed the certification or licensing requirements set forth in the Rules Pertaining to EMS and EMR Education, EMS Certification and Licensure, and EMR Registration, 6 CCR 1015-3, Chapter One for the Paramedic level.
- 2.25 “In-Scope Tasks and Procedures” - tasks and procedures performed by an EMS provider within the EMS provider’s scope of practice in a clinical setting as set forth in these rules.
- 2.26 “Interfacility Transport” - any transport of a patient from one licensed healthcare facility to another licensed healthcare facility, after a higher level medical care provider (i.e., a physician, physician assistant, or an individual of similar/equivalent training, certification, licensing, and patient interaction) has initiated treatment.
- 2.27 “International Board of Specialty Certification (IBSC)” - a non-profit organization that develops and administers a national Community Paramedic certification exam.
- 2.28 “Licensed in Good Standing” - as used in these rules, means that a physician functioning as a medical director, or a physician, physician assistant, advanced practice nurse, or registered nurse functioning as a medical supervisor, holds a current and valid Colorado license to practice the applicable profession.

- 2.29 “Maintenance” - to observe the patient while continuing, assessing, adjusting, and/or discontinuing care of a previously established medical procedure or medication via standing order, written physician order, or the direct verbal order of a physician.
- 2.30 “Medical Acts”- as used in these rules, means the tasks, medications, or procedures that an EMS provider is authorized to perform or administer within the EMS provider’s applicable scope of practice including in-scope tasks and procedures in a clinical setting.
- 2.31 “Medical Base Station” - the source of direct medical communications with EMS providers.
- 2.32 “Medical Direction” - may include, but is not limited to, the following duties:
 - 2.32.1 Approval of the medical components of treatment protocols and appropriate prearrival instructions;
 - 2.32.2 Routine review of program performance and maintenance of active involvement in quality improvement activities, including access to prehospital recordings as necessary for the evaluation of care;
 - 2.32.3 Authority to recommend appropriate changes to protocols for the improvement of patient care;
 - 2.32.4 Provision of oversight for the ongoing education, training, and quality assurance of EMS providers as appropriate for the medical acts being performed in the prehospital, out-of-hospital, or clinical setting in which the EMS provider is practicing; and
 - 2.32.5 Reporting of any misconduct by certified or licensed EMS providers that the medical director knows or reasonably believes has occurred.
- 2.33 “Medical Supervision” - the oversight, guidance, and instructions that a medical supervisor provides to an EMS provider in a clinical setting, as defined in Section 25-3.5-207(1)(d), C.R.S. and these rules.
- 2.34 “Medical Supervisor” - in a clinical setting, means a Colorado licensed physician, physician assistant, advanced practice nurse, or registered nurse.
- 2.35 “Monitoring” - to observe and detect changes, or the absence of changes, in the clinical status of the patient for the purpose of documentation.
- 2.36 “Out-of-hospital Medical Services” - services performed by a Paramedic with a Community Paramedic endorsement, including the initial assessment of the patient and any subsequent assessments, as needed; the furnishing of medical treatment and interventions; care coordination; resource navigation; patient education; medication inventory, compliance and administration; gathering of laboratory and diagnostic data; nursing services; rehabilitative services; complementary health services; as well as the furnishing of other necessary services and goods for the purpose of preventing, alleviating, curing, or healing human illness, physical disability, physical injury; alcohol, drug, or controlled substance abuse; behavioral health services that may be provided in an out-of-hospital setting; and the medical acts identified in Appendix G of these rules. Out-of-hospital medical services cannot be provided or performed in the prehospital setting.
- 2.37 “Paramedic” - for purposes of this Chapter Two, an individual who has a current and valid Paramedic certificate or license issued by the Department and who is authorized to provide advanced emergency medical care in a prehospital or clinical setting in accordance with these rules.

- 2.38 "Paramedic with Community Paramedic Endorsement (P-CP)" - an individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Community Paramedic endorsement from the Department and is authorized to provide acts in accordance with these rules relating to community integrated health care services, and as set forth in Sections 25-3.5-206, C.R.S., and 25-3.5-1301, *et seq.*, C.R.S.
- 2.39 "Paramedic with Critical Care Endorsement (P-CC)" - an individual who has a current and valid Paramedic certificate or license issued by the Department and who has met the requirements in these rules to obtain a Critical Care endorsement from the Department and is authorized to provide acts in accordance with conditions defined in these rules relating to critical care and as set forth in Section 25-3.5-206, C.R.S.
- 2.40 "Point of Care Testing (POCT)" - medical diagnostic testing performed outside the clinical laboratory in close proximity to where the patient is receiving care, the results of which are used for clinical decision-making.
- 2.41 "Prehospital Care" - any medical acts performed prior to a patient receiving care at a licensed healthcare facility.
- 2.42 "Prehospital Setting" - means one of the following settings in which an EMS provider performs patient care, which care is subject to medical direction by an EMS agency medical director at the site of an emergency, during emergency transport, or during interfacility transport.
- 2.43 "Protocol" - written standards for patient medical assessment and management approved by a medical director.
- 2.44 "Scope of Practice" - refers to the tasks, medications, and procedures (medical acts) that an EMS provider is authorized to perform or administer in accordance with Sections 25-3.5-203 and 25-3.5-206, C.R.S., and rules promulgated pursuant to those sections.
- 2.45 "State Emergency Medical and Trauma Services Advisory Council (SEMTAC)" - a council created in the Department pursuant to Section 25-3.5-104, C.R.S., that advises the Department on all matters relating to emergency medical and trauma services.
- 2.46 "Standing Order" - written authorization provided in advance by a medical director for the performance of specific medical acts by EMS.
- 2.47 "Supervision" - as applicable to physician medical direction, means the oversight, direction, or medical management that the medical director provides to an EMS provider in any setting. Supervision may be through direct observation or by indirect oversight as defined in the medical director's CQI program.
- 2.48 "Waiver" - a Department-approved exception to these rules granted to an EMS agency medical director.
- 2.49 "Written Order" - written authorization that a physician issues to an EMS provider for the performance of specific medical acts.

SECTION 3 – Emergency Medical Practice Advisory Council

- 3.1 The Emergency Medical Practice Advisory Council (EMPAC), under the direction of the executive director of the Department, shall advise the Department in the areas set forth below in Section 3.8.

- 3.2 The EMPAC shall consist of the following thirteen members:
 - 3.2.1 Ten voting members appointed by the governor as follows:
 - A) Two physicians licensed in good standing in Colorado who are actively serving as EMS agency medical directors and are practicing in rural or frontier counties;
 - B) Two physicians licensed in good standing in Colorado who are actively serving as EMS agency medical directors and are practicing in urban counties;
 - C) One physician licensed in good standing in Colorado who is actively serving as an EMS agency medical director in any area of the state;
 - D) One EMS provider certified or licensed at an advanced life support level who is actively involved in the provision of emergency medical services;
 - E) One EMS provider certified or licensed at a basic life support level who is actively involved in the provision of emergency medical services; and
 - F) One EMS provider certified or licensed at any level who is actively involved in the provision of emergency medical services;
 - G) One clinical psychiatrist licensed in good standing in Colorado who is recommended by a statewide association of psychiatrists;
 - H) One anesthesiologist licensed in good standing in Colorado who is recommended by a statewide association of anesthesiologists;
 - 3.2.2 One voting member who is a member of the SEMTAC, appointed by the executive director of the Department; and
 - 3.2.3 Two nonvoting ex officio members appointed by the executive director of the Department.
- 3.3 EMPAC members shall serve four-year terms.
- 3.4 A vacancy on the EMPAC shall be filled by appointment by the appointing authority for that vacant position for the remainder of the unexpired term.
- 3.5 EMPAC members serve at the pleasure of the appointing authority and continue in office until the member's successor is appointed.
- 3.6 The EMPAC shall meet at least quarterly and more frequently as necessary to fulfill its obligations.
- 3.7 The EMPAC shall elect a chair and vice-chair from its members.
- 3.8 The duties of the EMPAC include:
 - 3.8.1 Provide general technical expertise on matters related to the provision of patient care by EMS providers.
 - 3.8.2 Advise or make recommendations to the Department on:
 - A) The acts and medications that EMS providers are authorized to perform or administer under the direction of all medical directors.

- B) Requests by medical directors for waivers to the scope of practice of EMS providers as established in these rules.
- C) Modifications to EMS provider certification or licensing levels and capabilities.
- D) Criteria for physicians to serve as EMS agency medical directors.

SECTION 4 – Medical Director Qualifications and Duties

- 4.1 All medical directors subject to these rules shall be a physician currently licensed in good standing to practice medicine in the State of Colorado.
- 4.2 In addition to 4.1 above, the expectations and requirements of a physician acting as a medical director are located in the following sections:
 - 4.2.1 For EMS agency medical director, see Section 5 of these rules,
 - 4.2.2. For CIHCS agency (out-of-hospital) medical director, see Section 18, and
 - 4.2.3 For clinical medical director, see Section 19.
- 4.3 Physicians acting as medical directors for Department-recognized EMS education programs must possess authority under their licensure to perform any and all medical acts to which they extend their authority to EMS providers, including any and all curricula presented by EMS education programs.
- 4.4 Departmental review of all medical directors
 - 4.4.1 The Department may review the records of any medical director subject to these rules to determine compliance with the requirements and standards in these rules and with accepted standards of medical oversight and practice.
 - 4.4.2 Complaints in writing against medical directors for violations of these rules may be initiated by any person, the Colorado Medical Board, or the Department.
 - 4.4.3 Complaints in writing against medical directors may be referred to the Colorado Medical Board for review as deemed appropriate by the Department.

SECTION 5 - EMS Agency Medical Directors

- 5.1 EMS agency medical directors are responsible for the medical direction of EMS providers in the prehospital setting. Their duties shall include:
 - 5.1.1 Be actively involved in the provision of emergency medical services in the community served by the EMS service agency being supervised. Involvement does not require that a physician have such experience prior to becoming a medical director but does require such involvement during the time that he or she acts as a medical director. Active involvement in the community could include, by way of example and not limitation, those inherent, reasonable, and appropriate responsibilities of a medical director to interact with patients, the public served by the EMS service agency, the hospital community, the public safety agencies, and the medical community and should include other aspects of liaison, oversight, and communication normally expected in the supervision of EMS providers.

- 5.1.2 Be actively involved on a regular basis with the EMS service agency being supervised. Involvement does not require that a physician have such experience prior to becoming a medical director but does require such involvement during the time that he or she acts as a medical director. Involvement could include, by way of example and not limitation, involvement in continuing education, audits, and protocol development. Passive or negligible involvement with the EMS service agency and supervised EMS providers does not meet this requirement.
- 5.1.3 Notify the Department on an annual basis and upon any change of medical direction of the EMS service agencies for which medical direction is being provided in a manner and form as determined by the Department.
- 5.1.4 Establish a medical continuous quality improvement (CQI) program for each EMS service agency being supervised. The medical CQI program shall assure the continuing competency of the performance of that agency's EMS providers. This medical CQI program shall include, but not be limited to: appropriate protocols and standing orders and provision for medical care audits, observation, critiques, continuing medical education, and direct supervisory communications.
- 5.1.5 Submit to the Department an affidavit that attests to the development and use of a medical CQI program for all EMS service agencies supervised by the medical director. As set forth in Section 4.4, the Department may review the records of a medical director to determine compliance with the CQI requirements in these rules.
- 5.1.6 Provide monitoring and supervision of the medical field performance of EMS providers. This includes ensuring that EMS providers have adequate clinical knowledge of, and are competent in performing, medical acts within the EMS provider's scope of practice authorized by the medical director. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the medical director. However, the medical director shall retain ultimate authority and responsibility for the monitoring and supervision, for establishing protocols and standing orders, and for the competency of the performance of authorized medical acts.
- 5.1.7 Ensure that all protocols issued by the medical director are appropriate for the certification or license and skill level of each EMS provider to whom the performance of medical acts is authorized and compliant with accepted standards of medical practice. Ensure that a system is in place for timely access to communication of direct verbal orders.
- 5.1.8 Be familiar with the training, knowledge, and competence of EMS providers under his or her supervision and ensure that EMS providers are appropriately trained and demonstrate ongoing competency in all medical acts authorized in accordance with Section 15.1 and, as applicable, Appendices A-G.
- 5.1.9 Be aware that certain medical acts authorized in accordance with Section 15.1 and, as applicable, Appendices A-G (and as identified by the Department) may not be included in the National EMS Education Standards and ensure that appropriate additional training is provided to supervised EMS providers.
- 5.1.10 Ensure that any data and/or documentation required by the rules are submitted to the Department.
- 5.1.11 Notify the Department within fourteen business days excluding state holidays prior to his or her cessation of duties as medical director.

- 5.1.12 Notify the Department within fourteen business days excluding state holidays of his or her termination of the supervision of an EMS provider for reasons that may constitute good cause for disciplinary sanctions pursuant to the Rules Pertaining to EMS and EMR Education, EMS Certification or Licensure, and EMR Registration 6 CCR 1015-3, Chapter One. Such notification shall be in writing and shall include a statement of the actions or omissions resulting in termination of supervision and copies of all pertinent records.
 - 5.1.13 Physicians acting as medical directors for EMS education programs recognized by the Department that require clinical and field internship performance by students shall be permitted to delegate authority to a student-in-training during their performance of program-required medical acts and only while under the control of the education program.
 - 5.1.14 Physicians acting as medical directors responsible for the supervision and authorization of a P-CC shall have training and experience in the medical acts for which they are providing supervision and authorization. Additional duties related to medical directors responsible for the supervision and authorization of a P-CC are set forth in Section 17 of these rules.
- 5.2 EMS agency medical directors shall be trained in Advanced Cardiac Life Support.

SECTION 6 – Medical Acts Allowed for the EMT

- 6.1 An EMT may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT.
- 6.2 An EMT may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT.
- 6.3 Any EMT who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have authorization and be supervised by an EMS agency medical director to perform the medical acts.
- 6.4 Any EMT who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.
- 6.5 An EMT may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.
- 6.6 An EMT who has successfully completed a Department-recognized Intravenous Therapy and Medication Administration Course may be referred to as an Emergency Medical Technician with Intravenous Authorization (EMT-IV). Any provisions of these rules that are applicable to an EMT shall also be applicable to an EMT-IV. In addition to the acts an EMT is allowed to perform, an EMT-IV may, under authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-IV. In addition to the medications and classes of medications an EMT is allowed to administer and monitor pursuant to these rules, an EMT-IV may, under authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an EMT-IV.

- 6.7 An EMT-IV may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-IV under the direct visual supervision of an AEMT, EMT-I, or Paramedic when in the prehospital setting, or the medical supervisor in a clinical setting, when the following conditions have been established:
- 6.7.1 The patient must be in cardiac arrest or in extremis.
 - 6.7.2 Drugs administered must be limited to those authorized by these rules for an AEMT, EMT-I, or Paramedic as stated in Appendices B and D.
 - 6.7.3 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and the protocols of the EMT-IV and the AEMT, EMT-I, or Paramedic shall all be in agreement.
- 6.8 In the event of a governor-declared disaster or public health emergency, the Chief Medical Officer for the Department or designee may temporarily authorize the performance of additional medical acts, such as the administration of other immunizations, vaccines, biologicals, or tests not listed in these rules.

SECTION 7 – Medical Acts Allowed for the Advanced EMT

- 7.1 An AEMT may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an AEMT.
- 7.2 An AEMT may, under authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications consistent with and not to exceed those listed in Appendices B and D of these rules for an AEMT.
- 7.3 Any AEMT who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have authorization and be supervised by an EMS agency medical director to perform medical acts.
- 7.4 Any AEMT who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.
- 7.5 An AEMT may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.
- 7.6 An AEMT may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an AEMT under the direct visual supervision of an EMT-I or Paramedic when in the prehospital setting, or a medical supervisor in a clinical setting, and the following conditions have been established:
- 7.6.1 The patient must be in cardiac arrest or in extremis.
 - 7.6.2 Drugs administered must be limited to those authorized by these rules for EMT-I or Paramedic as stated in Appendices B and D.

- 7.6.3 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and the protocols of the AEMT and the EMT-I or Paramedic shall all be in agreement.
- 7.7 In the event of a governor-declared disaster or public health emergency, the Chief Medical Officer for the Department or designee may temporarily authorize the performance of additional medical acts, such as the administration of other immunizations, vaccines, biologicals or tests not listed in these rules.

SECTION 8 – Medical Acts Allowed for the EMT-Intermediate

- 8.1 In addition to the acts an EMT, an EMT-IV, and an AEMT are allowed to perform pursuant to these rules, an EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, perform medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for an EMT-I.
- 8.2 In addition to the medications and classes of medications an EMT, an EMT-IV, and an AEMT are allowed to administer and monitor pursuant to these rules, an EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications defined in Appendices B and D of these rules for an EMT-I.
- 8.3 Any EMT-I who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have the authorization of and be supervised by an EMS agency medical director.
- 8.4 Any EMT-I who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor.
- 8.5 An EMT-I may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.
- 8.6 An EMT-I may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications which exceed those listed in Appendices B and D of these rules for an EMT-I under the direct visual supervision of a Paramedic in a prehospital setting, or a medical supervisor in a clinical setting, when the following conditions have been established:
- 8.6.1 Drugs administered must be limited to those authorized by these rules for Paramedics as stated in Appendices B and D.
- 8.6.2 The EMS agency medical director or clinical medical director shall amend the appropriate protocols and medical CQI program used to supervise the EMS providers to reflect this change in patient care. The applicable medical director and protocols of the EMT-I and Paramedic shall all be in agreement.
- 8.7 In the event of a governor-declared disaster or public health emergency, the Chief Medical Officer for the Department or designee may temporarily authorize the performance of additional medical acts, such as the administration of other immunizations, vaccines, biologicals, or tests not listed in these rules.

SECTION 9 – Medical Acts Allowed for the Paramedic

- 9.1 In addition to the acts all other EMS providers are allowed to perform pursuant to these rules, a Paramedic may, under the authorization of an EMS agency medical director or under the authorization of a clinical medical director and supervision of a medical supervisor, perform advanced medical acts consistent with and not to exceed those listed in Appendices A and C of these rules for a Paramedic.
- 9.2 In addition to the medications and classes of medications all other EMS providers are allowed to administer and monitor pursuant to these rules, a Paramedic may, under the authorization of an EMS agency medical director or clinical medical director, administer and monitor medications and classes of medications defined in Appendices B and D for a Paramedic.
- 9.3 Paramedics may carry out a physician order for a mental health hold as set forth in Section 27-65-105(1), C.R.S. Such physician order may be a direct verbal order or by electronic communications.
- 9.4 Any Paramedic who is a member or employee of an EMS service agency and who performs medical acts in a prehospital setting must have the authorization of and be supervised by an EMS agency medical director to perform medical acts.
- 9.5 Any Paramedic who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor to perform medical acts.
- 9.6 In addition to the acts of a Paramedic, a P-CC may, under the supervision and authorization of an EMS agency medical director or under the authorization of a clinical medical director and supervision of a medical supervisor perform advanced medical acts consistent with and not to exceed those authorized in Appendix E of these rules for Critical Care.
- 9.7 In addition to the medications a Paramedic is allowed to administer and monitor, a P-CC may, under the authorization of an EMS or clinical medical director, administer and monitor medications defined in Appendix F of these rules for Critical Care.
- 9.8 In addition to the acts of a Paramedic, a P-CP may, under the supervision and authorization of a CIHCS Agency medical director or under the authorization of a clinical medical director and supervision of a medical supervisor perform out-of-hospital medical services and medical acts consistent with and not to exceed those authorized in Appendix G of these rules for Community Paramedics.
- 9.9 In addition to the medications a Paramedic is allowed to administer and monitor, a P-CP may, under the supervision and authorization of a CIHCS Agency medical director or under the authorization of a clinical medical director, administer and monitor medications defined in Appendix G of these rules for Community Paramedics.
- 9.10 Any P-CP who is a member or employee of an CIHCS Agency and who performs medical acts in an out-of-hospital setting must have authorization and be supervised by a CIHCS Agency medical director to perform medical acts.
- 9.11 Any P-CP who performs medical acts in a clinical setting must have the authorization of a clinical medical director and be supervised by a medical supervisor to perform medical acts.
- 9.12 In the event of a governor-declared disaster or public health emergency, the Chief Medical Officer for the Department or designee may temporarily authorize the performance of additional medical acts, such as the administration of other immunizations, vaccines, biologicals, or tests not listed in these rules.

SECTION 10 – Graduate Advanced EMTs and Graduate Paramedics

Medical directors may supervise Graduate AEMTs and Paramedics acting as AEMTs or Paramedics for a period of no more than six months following successful completion of an appropriate Department-recognized initial course. Upon expiration of this six month period, such Graduate AEMTs and Graduate Paramedics must successfully complete certification or licensing requirements, as specified in Rules Pertaining to EMS and EMR Education, EMS Certification or Licensure, and EMR Registration 6 CCR 1015-3, Chapter One, to continue to function under the provisions of these rules.

SECTION 11 – General Acts Allowed

- 11.1 Any EMS provider working for an EMS service agency shall be supervised by an EMS agency medical director who complies with the requirements in these rules.
- 11.2 EMS providers who are providing medical care in a clinical setting must function under the authority of a clinical medical director and under the medical supervision of a medical supervisor.
- 11.3 An EMS agency medical director, CIHCS agency medical director, or clinical medical director may limit the scope of practice of any EMS provider over whom they provide medical direction.
- 11.4 In a prehospital setting, the gathering of laboratory and/or other diagnostic data for the sole purpose of providing information to another health care provider does not require a waiver provided:
 - 11.4.1 The method by which the data is gathered is within the scope of practice of the EMS provider as contained in these rules;
 - 11.4.2 The collection method and analysis of the information collected is done in accordance with applicable regulations including, but not limited to, the Clinical Laboratory Improvement Amendments (CLIA) and FDA requirements; and,
 - 11.4.3 Unless otherwise allowed in Table A.6, the information obtained will not be used to alter the prehospital treatment or destination of the patient without a direct verbal order.
 - 11.4.4 A medical director shall obtain a waiver as set forth in Section 12 of these rules for any other data gathering activities that do not meet the provisions listed above.
- 11.5 EMS providers who are providing out-of-hospital medical services, as specifically defined in Section 2.36 of these rules, for a CIHCS agency or in a clinical setting must obtain a Community Paramedic endorsement.
 - 11.5.1 An endorsed Community Paramedic may provide out-of-hospital medical services as defined in these rules while employed by or contracting with a CIHCS agency.
 - 11.5.2 Paramedics with a Community Paramedic endorsement working in a CIHCS agency can perform and interpret POCT, excluding imaging procedures that are not performed by the P-CP in real time, as defined in Appendix G.
 - A) A P-CP may interpret POCT for clinical decision making based on the protocols and procedures of the CIHCS agency medical director.
 - B) A P-CP may interpret laboratory studies outside of POCT if part of a prescribed service plan approved by the CIHCS agency medical director.

- 11.5.3 An endorsed Community Paramedic may provide out-of-hospital medical services in the clinical setting pursuant to the provisions set forth in Section 9 of these rules.
- 11.6 EMS providers may not practice in camps in a nursing capacity including the dispensing of medications.

SECTION 12 – Waivers to Scope of Practice for EMS Providers in Prehospital Settings

- 12.1 Any EMS agency medical director may apply to the Department for a waiver to the scope of practice set forth in these rules for EMS providers under his or her supervision in specific circumstances, based on established need, provided that on-going quality assurance of each EMS provider's competency is maintained by the medical director. Waivers to scope of practice are limited to prehospital settings.
- 12.2 A waiver is not necessary for the allowed medical acts listed in Appendices A, B, C, or D of this rule.
 - 12.2.1 In addition to the medical acts allowed in Section 12.2, a P-CC does not require a waiver for the allowed medical acts listed in Appendices E and F.
 - 12.2.2 In addition to the medical acts allowed in Section 12.2, a P-CP does not require a waiver for the allowed out-of-hospital medical services listed in Appendix G when providing medical services in a CIHCS agency setting.
- 12.3 All levels of EMS provider may, under the supervision and authorization of an EMS agency medical director, perform specific skills or administer specific medications not listed in Appendices A, B, C, D, E, or F of this rule, only if the EMS agency medical director has been granted a waiver from the Department for that specific skill or medication.
 - 12.3.1 Waivered skills or medication administration may be authorized by the EMS agency medical director under standing orders or direct verbal orders of a physician, including by electronic communications.
 - 12.3.2 No EMS provider shall function beyond the scope of practice identified in these rules for their level until their EMS agency medical director has received official written confirmation of the waiver being granted by the Department.
- 12.4 EMS agency medical directors seeking a waiver shall submit a completed application to the Department in a form and manner determined by the Department.
 - 12.4.1 The application shall include, but not be limited to, a description of the act or medication to be waived, information regarding the justification for the waiver, the proposed education, training, and quality assurance process, literature review, and copies of the applicable protocols. The forms and affidavit required by Section 5 of these rules shall also be included.
 - 12.4.2 The Department may require the applicant to provide additional information if the initial application is determined to be insufficient.
 - 12.4.3 An application shall not be considered complete until the required information is submitted.
 - 12.4.4 The completed waiver application shall be submitted to the Department in a timely fashion as specified by the Department.

- 12.4.5 The application shall be a matter of public record and is subject to disclosure requirements under the Colorado Open Records Act (Section 24-72-200.1 *et seq.*, C.R.S.).
- 12.5 The EMPAC shall review waiver requests and make recommendations to the Department. The EMPAC may make recommendations, including but not limited to: deny, approve, table, request more information from the EMS agency medical director, or impose special conditions on the waiver.
- 12.6 After receiving recommendations from the EMPAC, the Department shall make a decision on the waiver request and send notice of that decision to the EMS agency medical director within thirty (30) calendar days of the recommendation. If granted, the notice shall include the effective date and expiration date of the waiver.
- 12.6.1 If the waiver is granted, the Department may:
- A) Specify the terms and conditions of the waiver.
 - B) Specify the duration of the waiver.
 - C) Specify any reporting requirements.
- 12.6.2 The Department may require the submission of data or other information regarding waivers.
- A) Unless otherwise specified by the Department, any data or information submitted to the Department shall not contain patient-identifying information.
 - B) If the Department requires submission of data or reports containing patient-identifying information for purposes of overseeing a statewide continuing quality improvement system, that information shall be kept confidential pursuant to Section 25-3.5-704(2)(h)(I)(E), C.R.S.
 - C) If the Department requires submission of data, information, records, or reports related to the identification of individual patient's, provider's, or facility's care outcomes for purposes of overseeing a statewide continuing quality improvement system, that information shall be kept confidential pursuant to Section 25-3.5-704(2)(h)(II), C.R.S.
- 12.6.3 The Department may deny, revoke, or suspend a waiver if it determines:
- A) That its approval or continuation jeopardizes the health, safety, and/or welfare of patients.
 - B) The EMS agency medical director has provided false or misleading information in the waiver application.
 - C) The EMS agency medical director has failed to comply with conditions or reporting on an approved waiver.
 - D) That a change in federal or state law prohibits continuation of the waiver.

- 12.7 If the Department denies a waiver application or revokes or suspends a waiver, it shall provide the EMS agency medical director with a notice explaining the basis for the action. The notice shall also inform the EMS agency medical director of his or her right to appeal and the procedure for appealing the action.
- 12.8 Appeals of Departmental actions shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.
- 12.9 If the rule pertaining to a waived medical act is amended or repealed obviating the need for the waiver, the waiver shall expire on the effective date of the rule change.
- 12.10 If an EMS agency medical director has made timely and sufficient application for renewal of a waiver and the Department fails to take action on the application prior to the waiver's expiration date, the existing waiver shall not expire until the Department acts upon the application. The Department, in its sole discretion, shall determine whether the application was timely and sufficient.
- 12.11 In the case of exigent circumstances, including but not limited to the death or incapacitation of an EMS agency medical director or the termination of the relationship between a EMS agency medical director and an EMS service agency, the Department may transfer waivers upon request by a replacement EMS agency medical director for a period not to exceed six (6) months. The EMS agency medical director shall then apply for new waiver(s) for consideration and Department action within sixty (60) days of the transfer.

SECTION 13 – Technology and Pharmacology Dependent Patients in Prehospital Settings

The transport of patients with continuously administered medications, continuous technology support, and nutritional support, previously prescribed by licensed health care workers and typically managed day-to-day at their residence by either the patient or caretakers, shall be allowed. The EMS provider is not authorized to discontinue, interfere with, alter, or otherwise manage these patient medication/nutrition systems except by direct verbal order or where cessation and/or continuation of medication pose a threat to the safety of the patient.

SECTION 14 – Combination Benzodiazepine and Opiate Therapy

- 14.1 The administration of a combination of benzodiazepines and opiates, for the purpose of pain management, anxiolysis, and/or muscle relaxation is permitted. Safeguards shall be taken to maximize patient safety including but not limited to the patient's ability to:
 - 14.1.1 Independently maintain an open airway and normal breathing pattern,
 - 14.1.2 Maintain normal hemodynamics, and
 - 14.1.3 Respond appropriately to physical stimulation and verbal commands.
- 14.2 The administration of combination therapy requires appropriate monitoring and care including, but not limited to: IV or IO access, continuous waveform capnography, pulse oximetry, ECG monitoring, blood pressure monitoring, and administration of supplemental oxygen.

SECTION 15 – Scope of Practice

- 15.1 All of the following appendices define the maximum medical acts an EMT, EMT-IV, AEMT, EMT-I, and Paramedic may be authorized to perform under appropriate medical direction by the applicable medical director for each setting.

- 15.2 A medical director may establish the methods by which an EMS provider obtains authorization in the prehospital or clinical setting to perform any medical acts contained in these rules including, but not limited to: advanced standing orders that are written or electronically conveyed, contemporaneous orders that are direct verbal orders, or written orders that are conveyed in real-time.
- 15.3 As used in all of the Appendices, the following terms are defined to mean:
- 15.3.1 “Y” = YES: May be performed or administered by EMS providers with supervision as described in these rules.
- 15.3.2 “VO” = Verbal Order: Indicates a category of medical acts or medications that EMS providers may only perform or administer within their scopes of practice after receiving authorization from a physician. Such authorization shall be communicated by direct verbal or written order received from a physician contemporaneous to when patient is receiving treatment, unless specific exception criteria are established by the applicable medical director.
- A) In a clinical setting, a medical supervisor may instruct EMS providers to perform a medical act or administer a medication that requires a physician’s authorization only if the physician has contemporaneously communicated the direct verbal or written order to the medical supervisor.
- B) Exception criteria may include, but are not limited to cardiac arrest, behavioral management, or communications failure.
- C) Medical Directors shall not develop exception criteria that merely waive all direct verbal order requirements.
- 15.3.3 “N” = NO: May not be performed or administered by EMS providers except with an approved waiver as described in Section 12 of these rules.
- 15.3.4 “EMT” = Medical acts that may be performed or administered by an EMT with appropriate medical director authorization and training recognized by the Department.
- 15.3.5 “EMT-IV” = Medical acts that may be performed or administered by an EMT-IV with appropriate medical director authorization and training recognized by the Department.
- 15.3.6 “AEMT” = Medical acts that may be performed or administered by an AEMT with appropriate medical director authorization and training recognized by the Department.
- 15.3.7 “EMT-I” = Medical acts that may be performed or administered by an EMT-I with appropriate medical director authorization and training recognized by the Department.
- 15.3.8 “P” = Medical acts that may be performed or administered by a Paramedic with appropriate medical director authorization and training recognized by the Department.

Note: Section 16 – INTERFACILITY TRANSPORT begins following APPENDIX B.

Note: Section 17 – CRITICAL CARE begins following APPENDIX D.

Note: Section 18 – COMMUNITY PARAMEDIC begins following APPENDIX F.

Note: Section 19 – CLINICAL SETTING begins following APPENDIX G.

APPENDIX A

MEDICAL ACTS ALLOWED

- A.1.1 In the prehospital setting, additions to these medical acts are not allowed unless a waiver has been granted as described in Section 12 of these rules. A waiver may not be granted for medical acts in the out-of-hospital or clinical settings.
- A.1.2 Not all medical acts allowed are included in initial education for various EMS provider levels. All medical directors subject to these rules shall ensure providers are appropriately trained as noted in Sections 5.1.8 and 5.1.9, Sections 18 (CIHCS) and 19 (Clinical Settings).
- A.1.3 In addition to the medical acts allowed in Appendix A, EMS providers may provide services allowable under the Community Assistance Referral and Education Services (CARES) Program, as set forth in Section 25-3.5-1203(3), C.R.S.

TABLE A.1 – AIRWAY/VENTILATION/OXYGEN

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Airway – Supraglottic	Y	Y	Y	Y	Y
Airway – Nasal	Y	Y	Y	Y	Y
Airway – Oral	Y	Y	Y	Y	Y
Bag – Valve – Mask (BVM)	Y	Y	Y	Y	Y
Carbon Monoxide Monitoring	Y	Y	Y	Y	Y
Chest Decompression – Needle	N	N	N	Y	Y
Chest Tube Insertion	N	N	N	N	N
CPAP	Y	Y	Y	Y	Y
PEEP	Y	Y	Y	Y	Y
Cricoid Pressure – Sellick's Maneuver	Y	Y	Y	Y	Y
Cricothyroidotomy – Needle	N	N	N	N	Y
Cricothyroidotomy – Surgical	N	N	N	N	Y
End Tidal CO2 Monitoring/Capnometry/ Capnography	Y	Y	Y	Y	Y
Flow Restrictive Oxygen Powered Ventilatory Device	Y	Y	Y	Y	Y
Gastric Decompression – NG/OG Tube Insertion	N	N	N	N	Y
Inspiratory Impedance Threshold Device	Y	Y	Y	Y	Y
Intubation – Digital	N	N	N	N	Y
Intubation – Bougie Style Introducer	N	N	N	Y	Y
Intubation – Lighted Stylet	N	N	N	Y	Y
Intubation – Medication Assisted (non-paralytic)	N	N	N	N	N
Intubation – Medication Assisted (paralytics) (RSI)	N	N	N	N	N
Intubation – Maintenance with paralytics	N	N	N	N	N
Intubation – Nasotracheal	N	N	N	N	Y
Intubation – Orotracheal	N	N	N	Y	Y
Intubation – Retrograde	N	N	N	N	N
Extubation	N	N	N	Y	Y
Obstruction – Direct Laryngoscopy	N	N	N	Y	Y
Oxygen Therapy – Humidifiers	Y	Y	Y	Y	Y
Oxygen Therapy – Nasal Cannula	Y	Y	Y	Y	Y
Oxygen Therapy – Non-rebreather Mask	Y	Y	Y	Y	Y
Oxygen Therapy – Simple Face Mask	Y	Y	Y	Y	Y
Oxygen Therapy – Venturi Mask	Y	Y	Y	Y	Y
Peak Expiratory Flow Testing	N	N	N	Y	Y
Pulse Oximetry	Y	Y	Y	Y	Y
Suctioning – Tracheobronchial	N	N	Y	Y	Y
Suctioning – Upper Airway	Y	Y	Y	Y	Y

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Tracheostomy Maintenance – Airway management only	Y	Y	Y	Y	Y
Tracheostomy Maintenance – Includes replacement	N	N	N	N	Y
Ventilators – Automated Transport (ATV) ¹	N	N	N	N	Y

¹ Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR), fraction of inspired oxygen (FIO₂), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of mechanical ventilation devices by EMS providers requires a waiver to these rules.

TABLE A.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Cardiac Monitoring – Application of electrodes and data transmission	Y	Y	Y	Y	Y
Cardiac Monitoring – Rhythm and diagnostic EKG interpretation	N	N	N	Y	Y
Cardiopulmonary Resuscitation (CPR)	Y	Y	Y	Y	Y
Cardioversion – Electrical	N	N	N	N	Y
Carotid Massage	N	N	N	N	Y
Defibrillation – Automated/Semi-Automated (AED)	Y	Y	Y	Y	Y
Defibrillation – Manual	N	N	N	Y	Y
External Pelvic Compression	Y	Y	Y	Y	Y
Hemorrhage Control – Direct Pressure	Y	Y	Y	Y	Y
Hemorrhage Control – Pressure Point	Y	Y	Y	Y	Y
Hemorrhage Control – Tourniquet	Y	Y	Y	Y	Y
Implantable cardioverter/defibrillator magnet use	N	N	N	N	N
Mechanical CPR Device	Y	Y	Y	Y	Y
Transcutaneous Pacing	N	N	N	Y	Y
Transvenous Pacing – Maintenance	N	N	N	N	N
Targeted Temperature Management ²	N	N	N	VO	Y
Arterial Blood Pressure Indwelling Catheter – Maintenance	N	N	N	N	N
Invasive Intracardiac Catheters – Maintenance	N	N	N	N	N
Central Venous Catheter Insertion	N	N	N	N	N
Central Venous Catheter Maintenance/Patency/Use	N	N	N	Y	Y
Percutaneous Pericardiocentesis	N	N	N	N	N

² Targeted Temperature Management (TTM)

1. Approved methods of cooling include:
 - a. Surface cooling methods including ice packs, evaporative cooling, and surface cooling blankets or surface heat-exchange devices.
 - b. Internal cooling with the intravenous administration of cold crystalloids (4°C / 39°F)
2. Esophageal temperature probe allowed for monitoring core temperatures in patients undergoing TTM.
3. The medical director should work with the hospital systems to which their agencies transport in setting up a "systems" approach to the institution of TTM. Medical directors should not institute TTM without having receiving facilities that also have TTM programs to which to transport these patients.

TABLE A.3 – IMMOBILIZATION

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Spinal Immobilization – Cervical Collar	Y	Y	Y	Y	Y
Spinal Immobilization – Long Board	Y	Y	Y	Y	Y
Spinal Immobilization – Manual Stabilization	Y	Y	Y	Y	Y
Spinal Immobilization – Seated Patient	Y	Y	Y	Y	Y
Splinting – Manual	Y	Y	Y	Y	Y
Splinting – Rigid	Y	Y	Y	Y	Y
Splinting – Soft	Y	Y	Y	Y	Y
Splinting – Traction	Y	Y	Y	Y	Y
Splinting – Vacuum	Y	Y	Y	Y	Y

TABLE A.4 – INTRAVENOUS CANNULATION / FLUID ADMINISTRATION / FLUID MAINTENANCE

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Blood/Blood By-Products Initiation (out of facility initiation)	N	N	N	N	N
Colloids – (Albumin, Dextran) – Initiation	N	N	N	N	N
Crystalloids (D5W, LR, NS) – Initiation/Maintenance	N	Y	Y	Y	Y
Intraosseous – Initiation	N	N	Y	Y	Y
Intraosseous Initiation – In Extremis	N	Y	Y	Y	Y
Medicated IV Fluids Maintenance – As Authorized in Appendix B	N	N	N	Y	Y
Peripheral – Excluding External Jugular – Initiation	N	Y	Y	Y	Y
Peripheral – Including External Jugular – Initiation	N	N	Y	Y	Y
Use of Peripheral indwelling Catheter for IV medications (Does not include PICC)	N	Y	Y	Y	Y

TABLE A.5 – MEDICATION ADMINISTRATION ROUTES

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aerosolized	Y	Y	Y	Y	Y
Atomized	Y	Y	Y	Y	Y
Auto-Injector	Y	Y	Y	Y	Y
Buccal	Y	Y	Y	Y	Y
Endotracheal Tube (ET)	N	N	N	Y	Y
Extra-abdominal umbilical vein	N	N	N	Y	Y
Intradermal	N	N	N	Y	Y
Intramuscular (IM)	Y	Y	Y	Y	Y
Intranasal (IN)	Y	Y	Y	Y	Y
Intraosseous	N	Y	Y	Y	Y
Intravenous (IV) Piggyback	N	N	N	Y	Y
Intravenous (IV) Push	N	Y	Y	Y	Y
Nasogastric	N	N	N	N	Y
Nebulized	Y	Y	Y	Y	Y
Ophthalmic	N	N	N	Y	Y
Oral	Y	Y	Y	Y	Y
Rectal	N	N	N ³	Y	Y
Subcutaneous	N	N	Y	Y	Y
Sublingual	Y	Y	Y	Y	Y
Sublingual (nitroglycerin)	Y	Y	Y	Y	Y
Topical	Y	Y	Y	Y	Y
Use of Mechanical Infusion Pumps	N	N	N	Y	Y

³AEMTs may not employ the rectal administration route in any situation except for the one exception set out in Table B.10, "Benzodiazepine –Diazepam rectal administration."

TABLE A.6 – MISCELLANEOUS

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aortic Balloon Pump Monitoring	N	N	N	N	N
Assisted Delivery	Y	Y	Y	Y	Y
Capillary Blood Sampling	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Glucose ⁴	Y	Y	Y	Y	Y
Diagnostic Interpretation – Blood Lactate ⁴	N	N	Y	Y	Y
Dressing/Bandaging	Y	Y	Y	Y	Y
Esophageal Temperature Probe for TTM	N	N	N	VO	Y
Eye Irrigation Noninvasive	Y	Y	Y	Y	Y
Eye Irrigation Morgan Lens	N	N	N	Y	Y
Maintenance of Intracranial Monitoring Lines	N	N	N	N	N
Physical examination	Y	Y	Y	Y	Y
Public Health Related-Oral/Nasal Swab Sample Collection	Y	Y	Y	Y	Y
Restraints – Verbal	Y	Y	Y	Y	Y
Restraints – Physical	Y	Y	Y	Y	Y
Restraints – Chemical	N	N	N	Y	Y
Urinary Catheterization – Initiation	N	N	N	N	Y
Urinary Catheterization – Maintenance	Y	Y	Y	Y	Y
Venous Blood Sampling – Obtaining	N	Y	Y	Y	Y

⁴ See also Section 11.4

APPENDIX B

FORMULARY OF MEDICATIONS ALLOWED

- B.1.1 In prehospital settings, additions to this medication formulary are not allowed unless a waiver has been granted as described in Section 12 of these rules.
- B.1.2 Not all medical acts allowed are included in initial education for various EMS provider levels. All medical directors subject to these rules shall ensure providers are appropriately trained as noted in Sections 5.1.8 and 5.1.9 (Prehospital), 18.3.6 (CIHCS), 19.3.7, 19.3.8, and 19.3.9 (Clinical Setting).

TABLE B.1 – GENERAL

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Over-the-counter-medications	Y	Y	Y	Y	Y
Oxygen	Y	Y	Y	Y	Y
Specialized prescription medications to address acute crisis ¹	VO	VO	VO	VO	VO

¹ EMS providers may assist with the administration of, or may directly administer, specialized medications prescribed to the patient for the purposes of alleviating an acute medical crisis event provided the route of administration is within the provider's scope as listed in Appendix A.

TABLE B.2 – ANTIDOTES

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Atropine	N	N	N	VO	Y
Calcium salt – Calcium chloride	N	N	N	N	Y
Calcium salt – Calcium gluconate	N	N	N	N	Y
Cyanide antidote	N	N	N	Y	Y
Glucagon	N	N	VO	VO	Y
Naloxone	Y	Y	Y	Y	Y
Nerve agent antidote	Y	Y	Y	Y	Y
Pralidoxime	N	N	N	N	Y
Sodium bicarbonate	N	N	N	N	Y

TABLE B.3 – BEHAVIORAL MANAGEMENT

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-Psychotic – Droperidol	N	N	N	VO	Y
Anti-Psychotic – Haloperidol	N	N	N	VO	Y
Anti-Psychotic – Olanzapine	N	N	N	VO	Y
Anti-Psychotic – Ziprasidone	N	N	N	VO	Y
Benzodiazepine – Diazepam	N	N	N	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
Diphenhydramine	N	N	N	VO	Y
Ketamine (Ketalar)	N	N	N	N	N

TABLE B.4 – CARDIOVASCULAR

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Adenosine	N	N	N	VO	Y
Amiodarone	N	N	N	VO	Y
Aspirin	Y	Y	Y	Y	Y
Atropine	N	N	N	VO	Y
Calcium salt – Calcium chloride	N	N	N	N	Y
Calcium salt – Calcium gluconate	N	N	N	N	Y
Diltiazem – bolus infusion only	N	N	N	N	Y
Dopamine	N	N	N	N	Y
Epinephrine	N	N	N	VO	Y
Lidocaine	N	N	N	VO	Y
Magnesium sulfate – bolus infusion only	N	N	N	N	Y
Nitroglycerin – sublingual (patient assisted)	VO	VO	Y	Y	Y
Nitroglycerin – sublingual (tablet or spray)	N	N	Y	Y	Y
Nitroglycerin – topical paste	N	N	VO	VO	Y
Norepinephrine	N	N	N	N	Y
Sodium bicarbonate	N	N	N	VO	Y
Vasopressin	N	N	N	VO	Y
Verapamil – bolus infusion only	N	N	N	N	Y

TABLE B.5 – DIURETICS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Bumetanide	N	N	N	N	Y
Furosemide	N	N	N	VO	Y
Mannitol (trauma use only)	N	N	N	N	Y

TABLE B.6 – ENDOCRINE AND METABOLISM

Medications	EMT	EMT-IV	AEMT	EMT-I	P
IV Dextrose	N	Y	Y	Y	Y
Glucagon	N	N	Y	Y	Y
Oral glucose	Y	Y	Y	Y	Y
Thiamine	N	N	N	N	Y
Corticosteroid	N	N	N	Y	Y

TABLE B.7 – GASTROINTESTINAL MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-nausea – Droperidol	N	N	N	VO	Y
Anti-nausea – Metoclopramide	N	N	N	VO	Y
Anti-nausea – Ondansetron ODT	Y	Y	Y	Y	Y
Anti-nausea – Ondansetron IM/IVP	N	Y	Y	Y	Y
Anti-nausea – Prochlorperazine	N	N	N	N	Y
Anti-nausea – Promethazine	N	N	N	VO	Y
Decontaminant – Activated charcoal	Y	Y	Y	Y	Y
Decontaminant – Sorbitol	Y	Y	Y	Y	Y

TABLE B.8 – PAIN MANAGEMENT

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Acetaminophen (Tylenol) IV	N	N	Y	Y	Y
Anesthetic – Lidocaine (for intraosseous needle insertion)	N	N	Y	Y	Y
Benzodiazepine – Diazepam	N	N	N	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
General – Nitrous oxide	N	N	Y	Y	Y
Ketorolac (Toradol)	N	N	N	N	Y
Narcotic Analgesic – Fentanyl	N	N	VO	Y	Y
Narcotic Analgesic – Hydromorphone	N	N	N	N	Y
Narcotic Analgesic – Morphine sulfate	N	N	VO	Y	Y
Ophthalmic anesthetic-Ophthaine	N	N	N	Y	Y
Ophthalmic anesthetic-Tetracaine	N	N	N	Y	Y
Topical Anesthetic – Benzocaine spray	N	N	N	N	Y
Topical Anesthetic – Lidocaine jelly	N	N	N	N	Y

TABLE B.9 – RESPIRATORY AND ALLERGIC REACTION MEDICATIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Antihistamine – Diphenhydramine	N	N	Y	Y	Y
Bronchodilator – Anticholinergic – Atropine (aerosol/nebulized)	N	N	N	VO	Y
Bronchodilator – Anticholinergic – Ipratropium	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – L-Albuterol	Y	Y	Y	Y	Y
Bronchodilator – Beta agonist – Metaproterenol	N	N	N	VO	Y
Bronchodilator – Beta agonist – Terbutaline	N	N	N	N	Y
Corticosteroid – Dexamethasone	N	N	N	Y	Y
Corticosteroid – Hydrocortisone	N	N	N	Y	Y
Corticosteroid – Methylprednisolone	N	N	N	Y	Y
Corticosteroid – Prednisone	N	N	N	Y	Y
Epinephrine 1:1,000 IM or SQ Only	Y	Y	Y	Y	Y
Epinephrine IV Only	N	N	N	VO	Y
Epinephrine Auto-Injector	Y	Y	Y	Y	Y
Magnesium Sulfate – bolus infusion only	N	N	N	N	Y

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Racemic Epinephrine	N	N	N	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI) (Patient assisted)	VO	VO	VO	Y	Y
Short Acting Bronchodilator meter dose inhalers (MDI)	Y	Y	Y	Y	Y

TABLE B.10 – SEIZURE MANAGEMENT

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Benzodiazepine – Diazepam	N	N	N	Y	Y
Benzodiazepine – Diazepam – rectal administration	N	N	Y	Y	Y
Benzodiazepine – Lorazepam	N	N	N	Y	Y
Benzodiazepine – Midazolam	N	N	N	Y	Y
Benzodiazepine – Midazolam – intranasal administration	N	N	Y	Y	Y
OB – associated – Magnesium sulfate – bolus infusion only	N	N	N	Y	Y

TABLE B.11 – VACCINES

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Post-exposure, employment, or pre-employment related – Hepatitis A	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Hepatitis B	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Tetanus	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – Influenza	N	N	N	N	Y
Post-exposure, employment, or pre-employment related – PPD placement & interpretation	N	N	N	N	Y
Public Health Related – Vaccine administration in conjunction with county public health departments and local EMS medical direction, after demonstration of proper training, will be authorized for public health vaccination efforts and pandemic planning exercises.	N	N	Y	Y	Y

TABLE B.12 – MISCELLANEOUS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Analgesic Sedative – Etomidate	N	N	N	N	N
Benzodiazepine – Midazolam for TIH	N	N	N	VO	Y
Topical hemostatic agents	Y	Y	Y	Y	Y

SECTION 16 – Interfacility Transport

- 16.1 The EMS agency medical director shall have protocols in place to ensure the appropriate level of care is available during interfacility transport.
- 16.2 The transporting EMS provider may decline to transport any patient he or she believes requires a level of care beyond his or her capabilities.
- 16.3 The interfacility transport typically involves three types of patients:
 - 16.3.1 Those patients whose safe transport can be accomplished by ambulance, under the care of an EMT, EMT-IV, AEMT, EMT-I, or Paramedic, within the medical acts allowed under these rules.

- 16.3.2 Those patients whose safe transport can be accomplished by ambulance, under the care of a Paramedic, but may require medical acts that are outside the medical acts allowed under these rules, but which acts have been approved through waiver granted by the Department.
- 16.3.3 Those patients whose safe transport requires the skills and expertise of a Critical Care transport team under the care of an experienced Critical Care practitioner.
- 16.4 The hemodynamically unstable patient or patient who may require Intensive Care Unit level of treatment, regardless if coming from an Intensive Care Unit, who requires special monitoring (e.g. central venous pressure, intracranial pressure), multiple cardioactive/vasoactive medications, or specialized critical care equipment (i.e. intra-aortic balloon pump) should remain under the care of an experienced Critical Care practitioner, and every attempt should be made to transport that patient while maintaining the appropriate level of care. The capabilities of the institution, the capabilities of the transporting agency and, most importantly, the safety of the patient should be considered when making transport decisions.
- 16.5 Unless otherwise noted, the following Appendices C and D indicate hospital/facility initiated interventions and/or medications.
 - 16.5.1 Additions to these medical acts are not allowed unless a waiver has been granted as described in Section 12 of these rules.
 - 16.5.2 The following medical acts are approved for interfacility transport of patients, with the requirements that the medical acts allowed must have been initiated in a medical facility under the direct order and supervision of licensed medical providers and are not authorized for field initiation. EMS continuation and monitoring of these interventions is to be allowed with any alterations in the therapy requiring direct verbal order. The EMS provider should continue the same medical standards of care with regard to patient monitoring that were initiated in the facility.
 - 16.5.3 It is understood that these medical acts may not be addressed in the National EMS Education Standards for EMT, AEMT, EMT-I, or Paramedic. As such, it is the joint responsibility of the EMS agency medical director and individuals performing these medical acts to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the interfacility transport environment.
- 16.6 Any of the medical acts and medications allowed in interfacility transport in Appendices C and D may be performed in the clinical setting under the medical direction of a clinical medical director and under medical supervision.

APPENDIX C

INTERFACILITY TRANSPORT

MEDICAL ACTS ALLOWED

TABLE C.1 – AIRWAY/VENTILATION/OXYGEN

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Ventilators – Automated Transport (ATV) ¹	N	N	N	N	Y

¹ Use of automated transport ventilators (ATVs) is restricted to the manipulation of tidal volume (TV or VT), respiratory rate (RR), fraction of inspired oxygen (FIO₂), and positive end expiratory pressure (PEEP). Manipulation of any other parameters of mechanical ventilation devices by EMS providers requires a waiver to these rules.

TABLE C.2 – CARDIOVASCULAR/CIRCULATORY SUPPORT

Skill	EMT	EMT-IV	AEMT	EMT-I	P
Aortic Balloon Pump Monitoring	N	N	N	N	N
Chest Tube Monitoring	N	N	N	N	Y
Central Venous Pressure Monitor Interpretation	N	N	N	N	N

APPENDIX D

FORMULARY OF MEDICATIONS ALLOWED – INTERFACILITY TRANSPORT

TABLE D.1 – CARDIOVASCULAR

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Anti-arrhythmic – Amiodarone – continuous infusion	N	N	N	Y	Y
Anti-arrhythmic – Lidocaine – continuous infusion	N	N	N	Y	Y
Anticoagulant – Glycoprotein inhibitors	N	N	N	N	Y
Anticoagulant – Heparin (unfractionated)	N	N	N	N	Y
Anticoagulant – Low Molecular Weight Heparin (LMWH)	N	N	N	N	Y
Diltiazem	N	N	N	N	Y
Dobutamine	N	N	N	N	N
Dopamine – Monitoring and Maintenance	N	N	N	N	Y
Epinephrine – infusion	N	N	N	N	Y
Nicardipine	N	N	N	N	Y
Nitroglycerin, intravenous	N	N	N	N	Y
Norepinephrine	N	N	N	N	Y
Thrombolytics – Monitoring and Maintenance	N	N	N	N	Y

TABLE D.2 – HIGH RISK OBSTETRICAL PATIENTS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Magnesium sulfate	N	N	N	N	Y
Oxytocin – infusion	N	N	N	N	Y

TABLE D.3 – INTRAVENOUS SOLUTIONS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Monitoring and maintenance of hospital/medical facility initiated crystalloids	N	Y	Y	Y	Y
Monitoring and maintenance of hospital/medical facility initiated colloids (non-blood component) infusions	N	N	N	Y	Y
Monitoring and maintenance of hospital/medical facility initiated blood component infusion	N	N	N	N	Y

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Initiate hospital/medical facility supplied blood component infusions	N	N	N	N	Y
Total parenteral nutrition (TPN) and/or vitamins	N	N	N	Y	Y

TABLE D.4 – MISCELLANEOUS

Medications	EMT	EMT-IV	AEMT	EMT-I	P
Antibiotic infusions	N	N	N	Y	Y
Antidote infusion – Sodium bicarbonate infusion	N	N	N	N	Y
Antiviral infusion	N	N	N	Y	Y
Electrolyte infusion – Magnesium sulfate	N	N	N	N	Y
Electrolyte infusion – Potassium chloride	N	N	N	N	Y
Insulin	N	N	N	N	Y
Mannitol	N	N	N	N	Y
Methylprednisolone – infusion	N	N	N	N	Y
Octreotide	N	N	N	N	Y
Pantoprazole	N	N	N	N	Y

SECTION 17 – Critical Care

17.1 In addition to the medical acts within the scope of practice of a Paramedic contained within Appendices A, B, C, and D, a P-CC may perform the medical acts contained within this section, Appendices E and F, under the authorization of an EMS agency medical director or clinical medical director.

17.1.1 Additions to these medical acts in a prehospital setting are not allowed unless a waiver has been granted as described in Section 12 of these rules.

17.1.2 It is understood that these medical acts may not be addressed in the National EMS Education Standards for Paramedics. As such, it is the joint responsibility of the applicable medical director and individuals performing these medical acts to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the critical care environment.

17.2 A P-CC may decline transport of any patient that requires a level of care outside of their defined scope of practice or that the P-CC believes is beyond their capabilities.

17.3 In addition to the duties of an EMS agency medical director or clinical medical director outlined in Sections 5 and 19 of these rules, the duties of such a medical director responsible for authorization of a P-CC shall include:

17.3.1 Be qualified, by education, training, and experience in the medical acts for which the applicable medical director is authorizing the P-CC to practice.

17.3.2 Have protocols in place clearly defining which medical acts, from Appendices E and F, the applicable medical director is authorizing the P-CC to perform.

17.3.3 Have protocols in place to ensure the appropriate level of care is available during critical care transport. The capabilities of the transporting agency and the safety of the patient should be considered when making transport decisions.

Appendix E – MEDICAL ACTS ALLOWED

TABLE E.1

Skill	P-CC
Manual Transport Ventilators	Y
Blood Chemistry Interpretation	Y
Rapid Sequence Intubation – Adult (age 13 & over)	Y
Transvenous Pacing – Monitoring and Maintenance	Y

Appendix F – FORMULARY OF MEDICATIONS ALLOWED

TABLE F.1 – CRITICAL CARE FORMULARY

Medications	P-CC
Acetylcysteine (Mucomyst)	Y
Antibiotics	Y
Bilvalirudin (Angiomax)	Y
Blood Products	Y
Dobutamine (Dobutamine)	Y
Esmolol (Brevibloc)	Y
Etomidate (Amidate)	Y
Fosphenytoin (Cerebyx)	Y
Ketamine (Ketalar)	Y (may only be used for analgesia, rapid sequence induction (RSI), and post-intubation management)
Labetalol (Normodyne)	Y
Levetiracetam (Keppra)	Y
Metoprolol (Lopressor)	Y
Phenytoin (Dilantin)	Y
Propofol (Diprivan)	Y
Rocuronium (Zemuron)	Y
Succinylcholine (Anectine)	Y
tPA infusion	Y
Tranexamic acid (TXA)	Y
Vecuronium (Norcuron)	Y

SECTION 18 – Community Paramedic

18.1 In addition to the medical acts within the scope of practice of a Paramedic contained within Appendices A, B, C, and D, a P-CP may perform the out-of-hospital medical services contained within this section and Appendix G, under the authorization of a CIHCS Agency medical director while providing community integrated health care services. A P-CP may also provide those medical acts that are out-of-hospital medical services contained in this Section, Appendix G, and Section 19 under the authorization of a clinical medical director and under the medical supervision of a medical supervisor.

18.1.1 A waiver cannot be granted to expand the out-of-hospital medical services that a P-CP may perform in a CIHCS setting.

18.1.2 It is understood that these out-of-hospital medical services may not be addressed in the National EMS Education Standards for Paramedics. As such, it is the joint responsibility of the applicable medical director and P-CPs performing these services to obtain appropriate additional training needed to safely and effectively utilize and monitor these interventions in the out-of-hospital and clinical setting environments.

- 18.2 A CIHCS Agency or clinical medical director may limit the scope of a P-CP. A P-CP may decline to provide out-of-hospital medical services to any individual that requires a level of care outside of their defined scope of practice or that the P-CP believes is beyond their capabilities.
- 18.3 The duties of a CIHCS Agency medical director responsible for supervision and authorization of a P-CP, in addition to those located at 6 CCR 1011-3, Section 5.2, shall include:
- 18.3.1 Be actively involved in the provision of community integrated health care services in the community served by the CIHCS Agency. Involvement does not require that a physician have such experience prior to becoming a medical director but does require such involvement during the time that he or she acts as a CIHCS medical director. Active involvement in the community could include, by way of example and not limitation, those inherent, reasonable, and appropriate responsibilities of a medical director to interact and as needed collaborate with the community served by the CIHCS Agency, the hospital community, the public safety agencies, home care, hospice, and the medical community. Active involvement should include other aspects of liaison oversight and communication normally expected in the supervision of CIHCS providers.
 - 18.3.2 Be actively involved on a regular basis with the P-CP being supervised. Involvement does not require that a physician have such experience prior to becoming a medical director, but it does require such involvement during the time that he or she acts as a medical director. Involvement could include, by way of example and not limitation, involvement in continuing education, audits, and protocol development. Passive or negligible involvement with the CIHCS Agency and supervised P-CP does not meet this requirement.
 - 18.3.3 In conjunction with the CIHCS Agency administrator, develop and implement a quality management policy for the CIHCS Agency and P-CP that includes consumer chart reviews in order to determine that appropriate assessments, referrals, documentation, and communication are occurring between the consumer's care providers, P-CPs, and the consumer.
 - 18.3.4 Ensure that all issued protocols are appropriate for the skill level of each authorized P-CP to whom the performance of medical acts is delegated and are compliant with accepted standards of medical practice.
 - 18.3.5 Develop, implement, and annually review protocols, guidelines, and standing orders regarding medical supervision, consultation requirements, and follow up care by other medical professionals. CIHCS Agency medical directors will ensure that P-CPs have adequate clinical knowledge of, and are competent in, out-of-hospital medical services performed on behalf of the CIHCS Agency. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the medical director. However, the CIHCS Agency medical director shall retain ultimate authority and responsibility for the monitoring and supervision, for establishing protocols and standing orders and for the competency of the performance of authorized medical acts of P-CP providers.
 - 18.3.6 Oversee the ongoing training and education programs for P-CP personnel for the provision of out-of-hospital medical services. Ensure the competence of the P-CP under his or her supervision in all skills, procedures, and medications authorized.
 - 18.3.7 Notify the Department within fourteen business days of the cessation of duties as the CIHCS Agency's medical director;

- 18.3.8 In collaboration with the CIHCS Agency administrator, designate through policy when the CIHCS Agency medical director is unavailable, a backup for medical direction in accordance with the requirements of 6 CCR 1011-3, Section 5.2.
- 18.3.9 Ensure that medical direction is available at all appropriate times as determined by the CIHCS Agency policy.
- 18.3.10 Provide evaluation, treatment, and transportation guidelines and protocols for non-urgent CIHCS Agency consumers.
- 18.3.11 In conjunction with the CIHCS consumer's care provider, if applicable, develop, monitor, and evaluate consumer service plans.
- 18.3.12 In conjunction with the CIHCS consumer's care provider(s), if applicable, and the P-CP, develop and implement a discharge summary as part of each consumer's service plan.
- 18.3.13 Physicians acting as medical directors for a Community Integrated Health Care Service agency pursuant to Section 25-3.5-1303(1)(a), C.R.S. that are responsible for the supervision and authorization of a P-CP shall have training and experience in the acts and skills for which they are providing supervision and authorization.
- 18.4 A clinical medical director's responsibilities for authorizing a P-CP in a clinical setting shall include those located in Section 19.3 of these rules.

Appendix G – OUT-OF-HOSPITAL MEDICAL SERVICES ALLOWED

- G.1 An initial assessment of the patient and any subsequent assessments, care coordination, resource navigation, as needed, in an out-of-hospital setting over one or more visits.
- G.2 Patient education that may include, but is not limited to, a patient's family or caregiver.
- G.3 Provide allowable services as an employee or contractor of a Community Assistance Referral and Education Services (CARES) Program, as set forth in Section 25-3.5-1203(3), C.R.S.
- G.4 Medical interventions, as set forth in a patient service plan:

Table G.1

Intervention	P-CP
Access central lines, indwelling venous ports, peritoneal dialysis catheters, or percutaneous tubes	Y
Assist with home mechanical ventilators	Y
Complex wound closure (suturing, steri-strips, adhesive glue, staples)	N
Ostomy care	Y
Simple wound closure (limited to dressings, bandages, butterfly closures)	Y
Simple wound care (monitor progress, simple dressing change, wet-to-dry dressing change, suture removal)	Y
Ultrasound - assist procedures	Y
Ultrasound – diagnosis	N

G.5 Assist with the inventory, compliance, and administration of, or may directly administer, specialized medications prescribed to the individual by a prescribing physician under a care plan. The route of administration must be within the provider's scope as listed in Appendix A and this Appendix G.

G.6 Gather laboratory and diagnostic data for POCT

Table G.2

Sites	P-CP
Indwelling ports or drains	Y
Nasal	Y
Oral	Y
Skin	Y
Urine	Y
Stool	Y

G.7 Vaccinations as part of a consumer service plan.

SECTION 19 - Clinical Setting

19.1 Any licensed or certified EMT, AEMT, EMT-I, or Paramedic may perform the medical acts within their applicable scope, as set forth in Appendices A, B, C, D, E, F, and G in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.2 An EMT-IV may perform the medical acts within the EMT-IV scope of practice in a clinical setting if authorized by a clinical medical director consistent with Section 6.6 and pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.3 A Paramedic with a Critical Care endorsement may perform the medical acts within the P-CC scope, as set forth in Appendices E and F, in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.4 A Paramedic with a Community Paramedic endorsement may perform the medical acts within the P-CP scope, as set forth in Appendix G, in a clinical setting pursuant to orders or instructions from, and under the medical supervision of, a medical supervisor.

19.1.5 Nothing in these rules alters the authority of a physician or registered nurse to delegate acts to an EMS provider that are outside of the EMS provider's applicable scope of practice in the clinical setting, pursuant to Sections 12-240-107 and 12-255-131, C.R.S.. Such delegation shall be in conformance with the applicable rules of the Colorado Medical Board and the Colorado Nursing Board.

19.2 A licensed or certified health care facility that employs EMS providers to perform in-scope tasks and procedures in a clinical setting shall:

19.2.1 Collaborate with its clinical medical director, medical supervisors, and EMS providers to establish policies and procedures ensuring that EMS providers are limited to performing medical acts within their scopes of practice.

19.2.2 Require its clinical medical director to:

- (i) Determine and document each EMS provider's scope of practice in the clinical setting; and

- (ii) Communicate the authorized medical acts that each individual EMS provider may perform under medical supervision to the facility's medical supervisors.
- 19.3 Clinical medical directors are responsible for the medical direction of EMS providers in the clinical setting. Their duties shall include:
 - 19.3.1 Being aware of and familiar with the medical acts that all EMS provider types may be authorized to perform in a clinical setting pursuant to the scope of practice put forth in these rules in Appendices A, B, C, D, E, F, and G, as applicable.
 - 19.3.2 Collaborating with the medical supervisor(s) and EMS providers to establish policies and procedures ensuring that EMS providers only perform medical acts that are within the applicable EMS provider's scope of practice.
 - 19.3.3 Ensuring that each EMS provider working in the clinical setting is limited to performing medical acts that are within the applicable scope of practice and are performed competently under medical supervision. This shall include, but not be limited to, determining those medical acts that each EMS provider may perform under medical supervision and communicating to the medical supervisor(s) the authorized medical acts that each individual EMS provider may perform.
 - 19.3.4 Ensuring that all clinical protocols issued by the clinical medical director are appropriate for the certification or license and skill level of each EMS provider to whom the performance of medical acts is authorized and compliant with accepted standards of medical practice. Ensure that a system is in place for timely access to communication of verbal orders.
 - 19.3.5 Being actively and routinely involved with the EMS providers providing care in the clinical setting. Involvement does not require that a physician have such experience prior to becoming a clinical medical director, but it does require such involvement during the time that the physician acts as a medical director. Involvement could include, by way of example and not limitation, involvement in continuing education, audits, and protocol development. Passive or negligible involvement with the EMS providers does not meet this requirement.
 - 19.3.6 Being actively involved in the facility's medical continuous quality improvement (CQI) program for EMS providers. The medical CQI program shall assure the continuing competency of the performance of the EMS providers. This medical CQI program shall include, but not be limited to: appropriate protocols and standing orders applicable to the EMS providers' scopes of practice, provision for medical care audits, observation, critiques, continuing medical education, and supervisory communications.
 - 19.3.7 Providing oversight, direction, and medical management of the medical performance of EMS providers in the clinical setting. This includes ensuring that EMS providers have adequate clinical knowledge of and are competent in performing medical acts within the EMS provider's scope of practice authorized by the clinical medical director. These duties and operations may be delegated to other physicians or other qualified health care professionals designated by the clinical medical director. However, the clinical medical director shall retain ultimate authority and responsibility for the oversight, direction, and medical management of the medical performance of EMS providers in the clinical setting, for establishing protocols and standing orders, and for the competency of the performance of authorized medical acts.

- 19.3.8 Being familiar with the training, knowledge, and competence of EMS providers subject to their oversight and ensuring that EMS providers are appropriately trained and demonstrate ongoing competency in all medical acts authorized to be performed under medical supervision.
- 19.3.9 Being aware that certain skills, procedures, and medications contained within Appendices A, B, C, D, E, F, and G may not be included in the National EMS Education Standards and ensuring that appropriate additional training is provided to EMS providers, if necessary, for the performance of an authorized skill or act.
- 19.3.10 Physicians acting as clinical medical directors responsible for the oversight and authorization of a P-CC shall have training and experience in the acts and skills for which they are providing oversight and authorization. Additional duties related to clinical medical directors responsible for the oversight and authorization of a P-CC are set forth in Section 17 of these rules.
- 19.3.11 Physicians acting as clinical medical directors responsible for the oversight and authorization of a P-CP shall have training and experience in the acts and skills for which they are providing oversight and authorization. Additional duties related to clinical medical directors responsible for the oversight and authorization of a P-CP are set forth in Section 18 of these rules.
- 19.4 Medical supervision of the EMS provider in a clinical setting must be provided by a medical supervisor who is:
 - 19.4.1 A Colorado licensed physician, physician assistant, advanced practice nurse, or registered nurse licensed in good standing,
 - 19.4.2 Trained and experienced in the acts and skills for which supervision is being provided,
 - 19.4.3 Knowledgeable about the maximum skills, acts, or medications that an EMT, EMT-IV, AEMT, EMT-I, Paramedic, P-CC, and P-CP are authorized to perform pursuant to these rules, and
 - 19.4.4 Immediately available and physically present at the clinical setting where the care is being delivered to provide oversight, guidance, or instruction to the EMS provider during the performance of medical acts.

CHAPTER THREE – RULES PERTAINING TO EMERGENCY MEDICAL SERVICES DATA AND INFORMATION COLLECTION AND RECORD KEEPING

Adopted by the Board of Health on April 20, 2022; effective June 14, 2022

Section 1 – Purpose and Authority for Rules

- 1.1 The authority and requirement for data collection is provided in § 25-3.5-501(1), C.R.S., which states, "Each ambulance service shall prepare and transmit copies of uniform and standardized records, as specified by regulation adopted by the Department, concerning the transportation and treatment of patients in order to evaluate the performance of the emergency medical services system and to plan systematically for improvements in said system at all levels."

Additional authority for data collection and analysis is provided in § 25-3.5-307, C.R.S., requiring data collection and reporting by air ambulance agencies, § 25-3.5-308(1)(e), C.R.S., requiring data collection and reporting by a ground ambulance service, and § 25-3.5-704(2)(h), C.R.S., requiring the establishment of a continuous quality improvement system to evaluate the statewide emergency medical and trauma services system.

- 1.2 This section consists of rules for the collection and reporting of essential data related to the performance, needs, and quality assessment of the statewide emergency medical and trauma services system. These rules focus primarily on the data that ambulance agencies are required to collect and provide to the Department. Rules regarding the collection of data by designated trauma facilities can be found in 6 CCR 1015-4, Chapter 1.

Section 2 – Definitions

- 2.1 "Agency" or "agencies" - Ambulance service(s) and/or air ambulance service(s).
- 2.2 "Air Ambulance" - A fixed-wing or rotor-wing aircraft that is equipped to provide air transportation and is specifically designed to accommodate the medical needs of individuals who are ill, injured, or otherwise mentally or physically incapacitated and who require in-flight medical supervision.
- 2.3 "Air Ambulance Service"- Any public or private entity that uses an air ambulance to transport patients to a medical facility.
- 2.4 "Ambulance"- Any privately or publicly owned vehicle that meets the requirements of § 25-3.5-103(1.5), C.R.S.
- 2.5 "Ambulance Service"- The furnishing, operating, conducting, maintaining, advertising, or otherwise engaging in or professing to be engaged in the transportation of patients by ambulance. Taken in context, it also means the person so engaged or professing to be so engaged. The person so engaged and the vehicles used for the emergency transportation of persons injured at a mine are excluded from this definition when the personnel utilized in the operation of said vehicles are subject to the mandatory safety standards of the federal mine safety and health administration, or its successor agency.
- 2.6 "Care Outcomes" – For the purposes of this Chapter 3, information related to patient care, combined with the result(s) of that care.
- 2.7 "Department" - The Colorado Department of Public Health and Environment.
- 2.8 "NEMSIS" - National Emergency Medical Services Information System

2.9 "Patient"- Any individual who is sick, injured, or otherwise incapacitated or helpless.

Section 3 – Reporting Requirements

3.1 All agencies licensed in Colorado shall provide the Department with the required data and information as specified in Sections 3.2 and 3.3 below in a form and manner determined by the Department.

3.2 Agencies shall provide organizational profile data in a manner determined by the Department.

3.2.1 Organizational profile data shall include but not be limited to information about licensing, service types and level, agency contact information, agency director and medical director contact information, demographics of the service area, number and types of responding personnel, number of calls by response type, counties served, organizational type, and number and type of vehicles.

3.2.2 Agencies shall update organizational profile data whenever changes occur and at least annually.

3.3 The required data and information on patient care shall be based on the NEMSIS EMS Data Standard published on November 30, 2019, referenced below.

3.3.1 The National Highway Traffic Safety Administration (NHTSA) Office of Emergency Medical Services, NEMSIS Data Dictionary NHTSA Version 3.5.0, EMS Data Standard, published on November 30, 2019 (NEMSIS 3.5.0) is hereby incorporated by reference into this rule. Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the Department maintains a copy of the complete text of required data elements for public inspection at https://drive.google.com/file/d/1yjkW192TyL7w_RLRhVE_0PTUYtcgLzPz/view. Certified copies of the incorporated materials may be obtained from the Division by contacting:

EMTS Branch Chief
Health Facilities and EMS Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

3.3.2 No later than January 1, 2023, agencies shall submit patient care data to the Department as defined by NEMSIS 3.5.0.

A) All elements that are identified as National Mandatory, National Required, State Recommended, and State Optional by NEMSIS 3.5.0 shall be reported to the Department.

3.3.3 Submission of NEMSIS 3.5.0 data as stated above in Section 3.3.2 is required. However, ambulance services may provide additional data as outlined in the complete NEMSIS 3.5.0 Data Dictionary or as suggested by the Department.

3.3.4 All agencies licensed in Colorado shall report the required data elements, as stated in Section 3.3.2, on all responses that resulted in patient contact. Although not required, agencies may also report the required data elements on responses that did not result in patient contact or transport.

- 3.3.5 Agencies unable to transmit or submit data in a form and manner determined by the Department shall obtain written approval from the Department prior to submitting patient care data and information in any other format.
- 3.3.6 Agencies shall provide the data to the Department within 48 hours from the time the unit went back in service.
- 3.4 The Department will monitor and enforce compliance regarding submission of organizational profile information as described in Section 3.2, and regular submission of patient care information as described in Sections 3.3.2 and 3.3.6, including, but not limited to, the below.
 - 3.4.1 In order to be eligible to apply for funding through the EMTS grants program, agencies shall provide organizational profile information as described in Section 3.2 and regularly submit patient care information as described in Sections 3.3.2 and 3.3.6.
 - 3.4.2 In order to be eligible to apply for scope of practice waivers, pursuant to 6 CCR 1015-3, Chapter Two, agencies shall provide organizational profile information as described in Section 3.2 and regularly submit patient care information as described in Sections 3.3.2 and 3.3.6.
 - 3.4.3 If an agency fails to comply with these rules, the Department may report this lack of compliance to any counties in which the agency is licensed.
 - 3.4.4 The Department may establish policies and procedures to implement parts 3.4.1 through 3.4.3, above.

Section 4 – Confidentiality of Data and Information on Patient Care

- 4.1 The data and information provided to the Department in accordance with Section 3.3 of these rules shall be used to conduct continuing quality improvement of the Emergency Medical and Trauma System, pursuant to § 25-3.5-704 (2)(h)(I), C.R.S. Any data provided to the Department that identifies an individual or an individual patient's, provider's, or facility's care outcomes shall be strictly confidential, whether such data are recorded on paper or electronically. The confidentiality protections provided in § 25-3.5-704 (2)(h)(II), C.R.S. apply to these data.
- 4.2 The Department may establish procedures to allow agencies, institutions, or individuals to obtain information from the EMS data system.
 - A) The Department shall not release patient care data from the EMS data system that could be reasonably expected to identify individual patients, or care outcomes that, when combined with other data, identifies an individual, provider, agency, or facility, except as provided in Section 4.3.
 - B) The Department procedures shall address circumstances under which the Department may deny a request for data.
- 4.3 An agency may retrieve the patient care data that the agency has transmitted to the Department or submitted via the Department's web-based data entry utility.

CHAPTER FOUR – RULES PERTAINING TO LICENSURE OF GROUND AMBULANCE SERVICES

Adopted by the Board of Health on November 21, 2018. Effective January 14, 2019.

Section 1 – Purpose and Scope

- 1.1 These rules are promulgated pursuant to § 25-3.5-308, C.R.S. They are consistent with §§ 25-3.5-301, 302, and 304 -306, C.R.S. Each county may adopt rules that exceed these rules adopted herein.

Section 2 – Definitions

- 2.1 Ambulance: any public or privately owned licensed ground vehicle especially constructed or modified and equipped, intended to be used and maintained or operated by, ambulance services for the transportation, upon the streets and highways of this state, of individuals who are sick, injured, or otherwise incapacitated or helpless.
- 2.2 Ambulance-advanced life support: a type of permit issued by a county to an ambulance equipped in accordance with Section 9 of these rules and operated by an ambulance service authorizing the vehicle to be used to provide ambulance service limited to the scope of practice of the Advanced Emergency Medical Technician, Emergency Medical Technician-Intermediate or Paramedic as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3, Chapter Two.
- 2.3 Ambulance-basic life support: a type of permit issued by a county to an ambulance equipped in accordance with Section 9 of these rules and authorized to be used to provide ambulance service limited to the scope of practice of the Emergency Medical Technician as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3, Chapter Two.
- 2.4 Ambulance service: the furnishing, operating, conducting, maintaining, advertising, or otherwise engaging in or professing to be engaged in the transportation of patients by ambulance. Taken in context, it also means the person so engaged or professing to be so engaged. The vehicles used for the emergency transportation of persons injured at a mine are excluded from this definition when the personnel utilized in the operation of said vehicles are subject to the mandatory safety standards of the federal Mine Safety and Health Administration, or its successor agency.
- 2.5 Ambulance service license: a legal document issued to an ambulance service by a county in which the ambulance is based as evidence that the applicant meets the requirements for licensure to operate an ambulance service as defined by county resolution or regulations.
- 2.6 Based: an ambulance service headquartered, having a substation, office, ambulance post, service area or other permanent location in a county.
- 2.7 County: county or city and county government within Colorado.
- 2.8 Department: the Colorado Department of Public Health and Environment.
- 2.9 EMS Provider: refers to all levels of emergency medical service provider certification issued by the department, including Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician Intermediate and Paramedic.

- 2.10 Medical Continuous Quality Management (CQM) Program: a process consistent with the EMS Practice and Medical Director Oversight rules at 6 CCR 1015-3, Chapter Two, used to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of care provided by the medical care providers operating on an ambulance service.
- 2.11 Medical Director: a Colorado licensed physician who establishes protocols and standing orders for medical acts performed by EMS providers of an ambulance service agency and who is specifically identified as being responsible to assure the competency of the performance of those acts by such EMS providers as described in the physician's medical CQM program.
- 2.12 Patient Care Report: a medical record of an encounter between any patient and a provider of medical care.
- 2.13 Permit: the authorization issued by the governing body of a local government with respect to an ambulance used or to be used to provide ambulance service in this state.

Section 3 – County Issuance of Licenses and Permit

3.1 License Required

- 3.1.1 Except as provided in Section 3.2 of these rules, no ambulance service, public or private, shall transport a sick or injured person from any point within Colorado to any point within or outside Colorado unless that ambulance service holds a valid license and permits issued by the county or counties in which the ambulance service is based.
- 3.1.2 Counties may enter into reciprocal licensing and permitting agreements with other counties and neighboring states.

3.2 County Exemptions from Licensure or Permit Requirements:

- 3.2.1 Vehicles used for the transportation of persons injured at a mine when the personnel used on the vehicles are subject to the mandatory safety standards of the federal Mine Safety and Health Administration, or its successor agency.
- 3.2.2 Vehicles used to evacuate patients from areas inaccessible to a permitted ambulance. Vehicles used in this capacity may only transport patients to the closest practical point of access to a permitted ambulance or medical facility.
- 3.2.3 Vehicles, including ambulances from another state, used during major catastrophe or multicasualty (disaster) events, rendering services when permitted ambulances are insufficient.
- 3.2.4 An ambulance service that does not transport patients from points originating in Colorado, or transporting a patient originating outside the borders of Colorado.
- 3.2.5 Vehicles used or designed for the scheduled transportation of convalescent patients, individuals with disabilities, or persons who would not be expected to require skilled treatment or care while in the vehicle.
- 3.2.6 Vehicles used solely for the transportation of intoxicated persons or persons incapacitated by alcohol as defined in § 27-81-102(11), C.R.S. but who are not otherwise disabled or seriously injured and who would not be expected to require skilled treatment or care while in the vehicle.

- 3.2.7 Ambulances operated by a department or an agency of the federal government, originating from a federal reservation for the purpose of responding to, or transporting patients under federal responsibility.
- 3.3 General Requirements for County Licensure Of Ambulance Services And Permitting Of Ambulance Vehicles
 - 3.3.1 Counties shall adopt by resolution or regulations, and periodically review, a process for licensure of ambulance services. The process shall include, but not be limited to:
 - A) Compliance with all applicable laws and regulations to operate an ambulance service in Colorado.
 - B) An application form adopted by the county.
 - C) An application fee, as defined in county resolution or regulations.
 - D) Submission to the county, upon request, of copies of the ambulance service's written policy and procedure manual, operational or medical protocols, or other documentation the county may deem necessary.
 - E) Demonstration by the applicant of minimum vehicle insurance coverage as defined by § 10-4-609, C.R.S. and § 42-7-103 (2), C.R.S. with the county(s) identified as the certificate holder.
 - F) Demonstration by the applicant of proof of any additional insurance as identified in county resolution or regulations. In making a decision about additional insurance requirements at any time it deems necessary to promote the public health, safety and welfare, the county shall require a minimum level of worker's compensation consistent with the Colorado Worker's Compensation Act of Colorado Revised Statutes title 8, articles 40-47.
 - G) Prior to beginning operations and upon change of ownership of an ambulance service, the new owner or operator must file for and obtain an ambulance license and ambulance permit.
 - H) In order to assure patient and crew safety, the county shall require that all ambulances be manufactured by an organization registered with the National Highway Traffic Safety Administration (NHSTA) as a final stage manufacturer. The county may adopt minimum vehicle design standards for ambulances.
 - I) The county shall verify that each ambulance is inspected annually by qualified representatives, as defined and appointed by the county commissioners, to assure compliance with these rules. Counties shall ensure that all such representatives do not have any disclosed or undisclosed actual or potential conflicts of interest with the ambulance service or inspection process.
 - J) Counties shall verify that all equipment on the ambulance is properly secured, and medications and supplies are maintained and stored according to the manufacturer's recommendations and all applicable requirements.
 - K) A county may delegate or contract the ambulance inspection process but not the responsibility of licensure as set forth in § 25-3.5-301, *et seq.*, C.R.S.

- L) An ambulance service license or vehicle permit may not be assigned, sold or otherwise transferred.

3.3.2 Every county shall establish a process by which ambulance services not licensed within the county's jurisdiction may provide transport in the event that all licensed ambulance services are unable to meet the needs of the patient.

3.4 Licensure Process

3.4.1 Ambulance Service License

An ambulance service license shall be issued by each county in which the ambulance service is based. The county shall ensure compliance with these rules and all license requirements established by that county.

3.4.2 Permits of Vehicles

- A) The county shall create a process and procedure for the issuing of permits for each ambulance used by the ambulance service.
- B) The type of permit issued will describe the level of service that could be provided at any time by that ambulance and appropriate staff. Types of permissible permits are limited to:
 - 1) Ambulance basic life support.
 - 2) Ambulance advanced life support.
- C) Each county may include in its resolution or regulations the requirements for identification of the permitted level of service on each vehicle issued a permit.

3.5 Licensure Period

3.5.1 The licensure period for all ambulance services shall be for 12 months.

3.6 License Renewal

3.6.1 Counties shall create an annual license renewal process. The licensure renewal process shall require the receipt of applications for renewal no less than 30 days before the date of license expiration.

Section 4 – Complaints

4.1 Each county shall have a written complaint and investigation policy and procedure to address:

- 4.1.1 Complaints against any ambulance service licensed in the county.
- 4.1.2 Allegations of unlicensed ambulance services or vehicles without a valid permit operating within the county.

4.2 The policy shall include, but not be limited to:

- 4.2.1 The procedures concerning complaint intake, including posted information to the public concerning how to file a complaint.

- 4.2.2 The county's duty to provide the licensee with a copy of the complaint at the time it is filed.
 - 4.2.3 Complaint validation.
 - 4.2.4. The criteria for initiating an investigation.
 - 4.2.5 The method for notifying the complainant about the resolution of the investigation.
 - 4.2.6 The method for notifying the department and medical directors regarding complaints involving EMS providers.
 - 4.2.7 The method for notifying other counties with jurisdiction over ambulance services, the department and, if applicable, the Colorado Department of Regulatory Agencies about complaints regarding other medical personnel associated with the ambulance service or the medical director.
- 4.3 The county shall notify the primary medical director of the ambulance service, in writing, of any known violation of the ambulance licensing regulations by the ambulance service or known alleged complaints or violations of the ambulance licensing regulations by individual medical providers operating on an ambulance service.

Section 5 – Denial, Revocation, Or Suspension of Licensure and Vehicle Permits

- 5.1 Each county shall develop policies and procedures for the denial, suspension or revocation of an ambulance service license or ambulance permit consistent with § 25-3.5-304, C.R.S.

Section 6 – Minimum Data Collection and Reporting Requirements

- 6.1 The county shall require that licensed ambulance services provide patient care information including the minimum pre-hospital care data set to the department pursuant to the Rules Pertaining to Emergency Medical Services Data and Information Collection and Record Keeping at 6 CCR 1015-3, Chapter Three.
- 6.2 The county shall require that each licensed ambulance service complete and submit to the department an organizational profile pursuant to the Rules Pertaining to Emergency Medical Services Data and Information Collection and Recordkeeping at 6 CCR 1015-3, Chapter Three.
- 6.3 Upon department request, the county shall verify the list of licensed ambulance services and the vehicles permitted by such services to provide emergency medical and trauma services.

Section 7 – Minimum Staffing Requirements

- 7.1 At minimum, the county shall establish by resolution or regulations the following ambulance staffing requirements:
- 7.1.1 For the person responsible for providing direct emergency medical care to patients transported in an ambulance, a current and valid certification as an EMS provider as defined in the Rules Pertaining to EMS Education and Certification at 6 CCR 1015-3, Chapter One.
 - 7.1.2 For the ambulance driver, a current and valid driver's license.

- 7.2 Consistent with § 25-3.5-202, C.R.S., in the case of an emergency in any ambulance service area where no person possessing the qualifications required by this section is present or available to respond to a call for the emergency treatment and transportation of patients by ambulance, any person may operate such ambulance to transport any sick, injured, or otherwise incapacitated or helpless person in order to stabilize the medical condition of such person.

Section 8 – Medical Oversight and Continuous Quality Management

- 8.1 The county shall require each ambulance service operating within its jurisdiction to have a primary medical director meeting the requirements as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3, Chapter Two to supervise the medical acts performed by EMS providers of the ambulance service agency. The county shall require a licensee to inform the county within fourteen (14) business days, in writing, of changes in medical oversight of the ambulance service and/or the medical director of record.
- 8.2 The county shall require each licensed ambulance service operating within its jurisdiction to have an ongoing medical CQM program consistent with the requirements as defined in the EMS practice and medical director oversight rules at 6 CCR 1015-3, Chapter Two.
- 8.3 The county ambulance service licensure application shall include an attestation by the medical director of willingness to provide medical oversight and the medical CQM program for the ambulance service.

Section 9 – Minimum Equipment Requirements

- 9.1 Counties shall ensure that permitted ambulances are in compliance with the minimum equipment list for the type of service defined by their permits as defined in Sections 9.2 and 9.3 of these rules.
- 9.2 Minimum Equipment For Basic Life Support Ambulances
- 9.2.1 Ventilation And Airway Equipment
- A) Portable suction unit, and a house (fixed system) or backup suction unit, with wide bore tubing, rigid pharyngeal curved suction tip, and soft catheter suction tips to include adult and pediatric sizes.
 - B) Bulb syringe and BBG suction catheter.
 - C) Fixed (house) oxygen and portable oxygen bottle, each with a variable flow regulator.
 - D) Transparent, non-rebreather oxygen masks and nasal cannula in adult sizes, and transparent, non-rebreather oxygen masks in pediatric sizes.
 - E). Hand operated, self-inflating bag-valve mask resuscitators with oxygen reservoirs and standard 15mm /21mm fittings in the following sizes:
 - 1) For infant and neonate.
 - 2) For children.
 - 3) For adult.
 - 4) Transparent masks for infants, neonate patients, children and adults.

- F) Nasopharyngeal airways in adult sizes 24 FR. through 32 FR.
- G) Oropharyngeal airways in adult and pediatric sizes to include: infant, child, small adult, adult and large adult.

9.2.2 Patient Assessment Equipment

- A) Blood pressure cuffs to include large adult, regular adult, child and infant sizes.
- B) Stethoscope.
- C) An illumination device capable of appropriately testing for pupillary reaction.
- D) Pulse oximeter with adult and pediatric sensors.

9.2.3 Splinting Equipment

- A) Lower extremity traction splint.
- B) Upper and lower extremity splints.
- C) Long board, scoop stretcher, vacuum mattress or equivalent with appropriate accessories to secure the patient from head to heels.
- D) Short board, extrication device or equivalent, with the ability to secure the patient from head to pelvis.
- E) Pediatric long board or adult long board that can be adapted for pediatric use.
- F) Adult and pediatric head immobilization equipment.
- G) Adult and pediatric cervical spine immobilization equipment.

9.2.4 Dressing Materials

- A) Multiple bandages and dressings of various types and sizes, including occlusive dressings.
- B) Sterile burn sheets.
- C) Adhesive tape.
- D) Arterial tourniquet.

9.2.5 Obstetrical Supplies

- A) OB kit to include: towels, 4x4 dressings, umbilical tape or cord clamps, scissors, bulb syringe, sterile gloves and thermal absorbent blanket; and
- B) Neonate stocking cap or equivalent.

9.2.6 Miscellaneous Equipment

- A) Heavy bandage scissors, shears or equivalent capable of cutting clothing, belts, boots, etc.

B) At least one working flashlight.

C) Blankets.

9.2.7 Communications Equipment

A) Two-way communications in good working order that will enable clear voice communications between ambulance personnel and the:

1) Ambulance service's dispatch;

2) Medical control facility or the medical control physician;

3) Receiving facilities; and

4) Mutual aid agencies.

9.2.8 Body Substance Isolation (BSI) Equipment Properly Sized To Fit All Personnel

A) Non-sterile disposable latex free gloves.

B) Protective eyewear.

C) Non-sterile surgical masks.

D) Sharps containers and receptacles for the appropriate disposal and storage of medical waste and biohazards.

E) National Institute of Occupational Safety and Health (NIOSH) approved N-95 or superior particulate filtering respirator (mask), which can be of universal size.

9.2.9 Safety Equipment

A) A set of three (3) warning reflectors.

B) One (1) ten pound (10 lb.) or two (2) five pound (5 lb.) ABC fire extinguishers, with a minimum of one extinguisher accessible from the patient compartment and vehicle exterior.

C) Child protective restraint system that accommodates a weight range between five (5) and ninety-nine (99) pounds.

D) Appropriate protective restraints for patients, crew, accompanying family members and other vehicle occupants.

E) Properly secured patient transport system (i.e. wheeled stretcher).

F) Department approved triage tags.

9.2.10 Pharmacological Agents

A) Pharmacological agents and delivery devices per medical director approval.

B) Pediatric "length based" device for sizing drug dosage calculations and sizing equipment.

9.2.11 Pediatric Reference Tool

- A) One (1) pediatric drug dosage chart or tape: this may include charts listing the drug dosages in milliliters per kilogram, pre-calculated doses based on weight, or a tape that generates appropriate equipment sizes and drug doses based on the patient's height or weight.
- B) Vital signs.

9.3 Minimum Equipment Requirement For Advanced Life Support Ambulances

9.3.1 All equipment and supplies Listed In Section 9.2

9.3.2 Ventilation Equipment

- A) Adult and pediatric advanced airway equipment per medical director approval.
- B) Adult and pediatric Magill forceps.
- C) End tidal CO₂ monitor or detection device for determining advanced airway device placement.

9.3.3 Patient Assessment Equipment

- A) Portable, battery operated cardiac monitor-defibrillator with strip chart recorder and adult and pediatric EKG electrodes and defibrillation capabilities.
- B) Electronic blood glucose measuring device.

9.3.4 Intravenous Equipment

- A) Adult and pediatric:
 - 1) Intravenous solutions.
 - 2) Administration equipment.
- B) Intraosseous:
 - 1) Access device.
 - 2) Administration equipment.
- C) Adult and pediatric intravenous arm boards.

9.3.5 Pharmacological Agents

- A) Pharmacological agents and delivery devices per medical director approval.
- B) Pediatric "length based" device for sizing drug dosage calculations and sizing equipment.

CHAPTER FIVE – RULES PERTAINING TO AIR AMBULANCE LICENSING

Section 1 – Purpose

- 1.1 These rules are promulgated pursuant to Section 25-3.5-307 and 25-3.5-307.5, C.R.S.
- 1.2 Pursuant to §25-3.5-307.5 (2), C.R.S., these rules do not include activities preempted by the Federal Aviation Administration or the federal “Airline Deregulation Act”, 49 U.S.C. sec. 41713 *et seq.* Therefore, any regulations adopted by the board pursuant to section 25-3.5-307 and 307.5. C.R.S establishing reasonable minimum standards for licensing and operation of an air ambulance service must:
 - 1.2.1 Except as otherwise provided in 1.2.2, be based on the medical aspects of the operation of an air ambulance, and
 - 1.2.2 Not be based on economic factors, including, without limitation, factors related to the prices, routes, or nonmedical services of an air ambulance.
- 1.3 An air ambulance service may be authorized to operate in Colorado by either:
 - A) Holding an accreditation by an accrediting organization approved by the Department and complying with section 5.1;
 - B) Meeting the standards set forth in these rules (sections 5.1 and 5.3); or
 - C) An air ambulance service may obtain a recognition instead of license if it picks up patients within the state of Colorado for out of state transport no more than 12 times per calendar year as set forth in section 4.

Section 2 – Definitions

- 2.1 Air Ambulance: A fixed-wing or rotor-wing aircraft that is equipped to provide air transportation and is specifically designed to accommodate the medical needs of individuals who are ill, injured, or otherwise mentally or physically incapacitated and who require in-flight medical supervision.
- 2.2 Air Ambulance Service or Service: Any public or private entity that uses an air ambulance to transport patients to a medical facility.
- 2.3 Aircraft: A rotor or fixed wing vehicle.
- 2.4 Base Location(s): Physical address and/or location where the crew, medical equipment and supplies, and the service’s air ambulance(s) are located.
- 2.5 Department: The Colorado Department of Public Health and Environment.
- 2.6 Licensee: The person, business entity or agency that is granted a license to operate an air ambulance service and that bears legal responsibility for compliance with all applicable federal and state statutes and regulations.
- 2.7 Medical Protocol or Guidelines: Written standards for patient medical assessment and management.
- 2.8 Patient Care Report (PCR): A medical record of an encounter between any patient and a provider of medical care.

- 2.9 Rescue Unit: Any organized group chartered by this state as a corporation not for profit or otherwise existing as a nonprofit organization whose purpose is the search for and the rescue of lost or injured persons and includes, but is not limited to, such groups as search and rescue, mountain rescue, ski patrols, (either volunteer or professional), law enforcement posses, civil defense units, or other organizations of governmental designation responsible for search and rescue.

Section 3 – Licensing

3.1 Licensing Required

Except as provided in sections 3.2, 3.3 and 4.2 of these rules, no person, agency, or entity, private or public, shall transport a sick or injured person by aircraft from any point within Colorado, to any point within or outside Colorado unless that person, agency, or entity holds a valid air ambulance license to do so that has been issued by the Department.

3.2 Exception from Licensing-Exigent Circumstances

Upon request, the Department may authorize an air ambulance service that does not hold an air ambulance license to provide a particular transport upon a showing of exigent circumstances. Exigent circumstances include but are not limited to:

- A) A humanitarian transport as determined by the Department. In determining whether to authorize a humanitarian transport, the Department shall consider the following factors:
 - 1) Whether the transport is provided directly or indirectly by an organization whose mission is primarily dedicated toward non-profit or charitable or community care services;
 - 2) Other available options for the transport;
 - 3) Whether the transport will be of no cost to the patient;
 - 4) Whether the transport is subsidized by a person or entity associated with the patient;
 - 5) The qualifications of the transport personnel;
 - 6) Information obtained from facilities and/or staff involved in the transport;
 - 7) The air ambulance service's membership in organizations that support safe medical care;
 - 8) Air ambulance service insurance coverage as applicable;
 - 9) Authorization under local and federal laws to conduct operations;
 - 10) Licensure in other states or by other governmental agencies;
 - 11) The air ambulance service's safety record;
 - 12) Whether or not the air ambulance service has been subject to disciplinary sanctions in any jurisdictions;

- 13) The air ambulance service's prior contacts with the Department, if any; and
 - 14) Any other considerations deemed relevant by the Department on a case-by-case basis.
- B) A disaster or mass casualty event in Colorado that limits or exceeds the availability of licensed air ambulance services;
 - C) A need for specialized equipment not otherwise readily available through Colorado licensed air ambulance services.

3.3 Licensing Not Required

- 3.3.1 An air ambulance service that solely transports patients from points originating outside Colorado is not required to be licensed in Colorado.
- 3.3.2 Rescue unit aircraft that are not specifically designed to accommodate the medical needs of individuals who are ill, injured, or otherwise mentally or physically incapacitated and who require in-flight medical supervision.
- 3.3.3 An air ambulance or air ambulance service operated by an agency of the United States government.

Section 4 – Out Of State Air Ambulance Services Licensing and Out of State License Recognition Requirements

- 4.1 Air ambulance services that are based outside the state, but pick up patients in Colorado, are required to be licensed in Colorado by the Department, except as provided in Sections 3.2 and 3.3, above, and 4.2, below, of these rules.
- 4.2 Application for Recognition of Out of State License in Limited Circumstances and Recognition Process
 - 4.2.1 The Department may recognize an air ambulance service license issued by another state if that air ambulance service makes no more than twelve (12) flights per calendar year to pick up a patient(s) in Colorado and transport the patient(s) out of Colorado.
 - 4.2.2 To receive out of state licensure recognition, the air ambulance service must:
 - A) Not have a base location in Colorado;
 - B) Hold a current license in good standing without restrictions or conditions from the state in which it has a base location and submit a copy of the license to the Department; and
 - C) Submit a completed application on the form required by the Department and submit the fee as set forth in section 6 to the Department prior to transporting a patient out of Colorado for the first time.
 - 4.2.3 Out of state licensure recognition is valid for one year from the date of issuance unless revoked or suspended by the Department.

- 4.2.4 An air ambulance service that is granted out of state licensure recognition shall submit an annual report to the Department detailing the number of flights, patients and the health care facilities in Colorado the patients were transported from during the previous year, in the form and manner prescribed by the Department.
- 4.2.5 As it relates to the medical aspects of the operation of an air ambulance service, the Department may conduct an inspection at any time of the air ambulance service and its aircraft to assure compliance with these rules and as needed, the Department may conduct complaint and other investigations of an air ambulance service recognized by the Department.
- 4.2.6 The air ambulance service shall immediately notify the Department of any disciplinary or licensing action taken against it by the licensing authority in any state.
- 4.2.7 If the Department deems it necessary, the Department may request and the applicant shall provide any of the information set forth in section 5.2.
- 4.2.8 If the licensee has made a timely and sufficient application for renewal of the out of state licensure recognition, the existing recognition shall not expire until the Department has acted upon the renewal application.

Section 5 – Application for Colorado Licensing, Licensing Processes, And Base Locations

5.1 Mandatory Requirements for All Applicants Seeking Colorado Licensure

5.1.1 All applicants must:

- A) Demonstrate compliance with applicable federal, state and local laws and regulations to operate an air ambulance service in Colorado, including but not limited to, laws and regulations governing medical personnel and emergency medical service providers, licensing and certifications, and professional liability insurance. Applicants are not required to prove compliance with those provisions of federal law that govern activities preempted by the Federal Aviation Act, 49 U.S.C. §40101, *et seq.*, or the federal “Airline Deregulation Act of 1978” 49 U.S.C. § 41713(b)(1).
- B) Submit to the Department a completed application form and the application fee as set forth in section 6 of these rules.
- C) Upon request, submit to the Department copies of the air ambulance service’s written policy and procedure manual, operation/medical protocols, and other documentation the Department may deem necessary.
- D) Submit a copy of air ambulance service license(s) concurrently issued and on file with other states.
- E) Provide the Department with results of any investigations, disciplinary actions, or exclusions that impact or have the potential to impact the quality of medical care provided to patients as requested by the Department.

- F) For an air ambulance service that is not granted qualified immunity under the Colorado Governmental Immunity Act, section 24-10-101 *et seq.*, C.R.S., shall provide proof of professional malpractice and liability insurance for injuries to persons in amounts of at least \$1,000,000 for each individual claim and a total of \$3,000,000 for all claims made against the air ambulance service or its medical personnel from an insurance company authorized to write liability insurance in Colorado or through a self-insurance program.
 - 1) The air ambulance service shall provide the Department with a copy of its certificate of insurance demonstrating compliance with this section or proof of financial viability if self-insured; and
- G) Any air ambulance service that is granted qualified immunity under the Colorado Governmental Immunity Act, section 24-10-101 *et seq.*, C.R.S., shall provide proof of professional malpractice and liability insurance coverage, or proof of self-insurance to the maximum extent required by section 24-10-114, C.R.S.
- H) Provide proof of worker's compensation coverage as required by Colorado law.
- I) Provide a list of all air ambulances to be licensed and inspected for medical compliance by the Department, including tail number (n-number) and designation of (rotor or fixed wing) capabilities.
- J) Provide a statement signed and dated contemporaneously with the application stating whether, within the previous ten (10) years of the date of application, the applicant has been the subject of, or a party to, one of more of the following events, regardless of whether action has been stayed in a judicial appeal or otherwise settled between the parties.
 - 1) Been convicted of a felony or misdemeanor involving moral turpitude under the laws of any state or of the United States. A guilty verdict, a plea of guilty or a plea of *nolo contendere* (no contest) accepted by the court is considered a conviction.
 - 2) Had a state license or federal certification denied, revoked, or suspended by another jurisdiction.
 - 3) Had a civil judgment or a criminal conviction in a case brought by federal, state or local authorities that resulted from the operation, management, or ownership of a health facility or other entity related to substandard patient care or health care fraud.
- K) If applicable, provide any statement regarding the information requested in paragraph (J) to include the following:
 - 1) If the event is an action by federal, state or local authorities; the full name of the authority, its jurisdiction, the case name, and the docket, proceeding or case number by which the event is designated, and a copy of the consent decree, order or decision.
 - 2) If the event is a felony or misdemeanor conviction involving moral turpitude, the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court.

- 3) If the event involves a civil action or arbitration proceeding, the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict, the court or arbitration decision.

5.1.2 Air ambulance service licenses are not transferable.

5.1.3 The Department has the authority to conduct an inspection or reinspection of the medical aspects of the air ambulance service operation including equipment and documentation, at any time it deems necessary to ensure compliance with these rules and to protect the public health and medical safety.

5.1.4 The applicant shall provide accurate and truthful information to the Department during inspections, investigations and licensing activities.

5.2 Mandatory Reporting Requirements for all Existing Licensees

5.2.1 Except for requiring proof of compliance with those provisions of federal law that govern activities preempted by the Federal Aviation Act , 49 U.S.C. §40101, *et seq.*, or the federal "Airline Deregulation Act of 1978" 49 U.S.C. § 41713(b)(1), all licensed air ambulance services must notify the Department:

- A) At least thirty (30) calendar days prior to the effective date of the change of any name of the air ambulance service and submit a new air ambulance service application and applicable fees.
- B) At least thirty (30) calendar days prior to the effective date of any change of ownership, pursuant to section 5.8, the new owner or operator must file for and obtain an air ambulance license from the Department prior to beginning operations.
- C) Within five (5) calendar days when there has been a reduction or loss of insurance coverage.
- D) Within sixty (60) calendar days of all other changes in insurance coverage.
- E) Within seven (7) calendar days of knowing about any of the following events impacting patient medical care occurring on or during transport onto or off of an air ambulance, report to the Department and the approved accreditation organization, if applicable:
 - 1) Invasive procedure performed on the wrong site.
 - 2) Wrong other procedure performed on a patient.
 - 3) Unintended retention of a foreign object in a patient after an invasive procedure.
 - 4) Immediately post procedure death in an American society of anesthesiologists class I patient.
 - 5) Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the service.

- 6) Patient death or serious injury associated with the use or function of a device in which the device is used in a manner other than as intended.
- 7) Patient death or serious injury associated with intravascular air embolism.
- 8) Release of a patient of any age, who is unable to make decisions, to other than an authorized person.
- 9) Patient suicide, attempted suicide, or self-harm that results in serious injury.
- 10) Patient death or serious injury associated with any medication error.
- 11) Patient death or serious injury associated with any unsafe administration of blood products.
- 12) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy.
- 13) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- 14) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
- 15) Patient or staff death or serious injury associated with an electric shock in the course of patient care.
- 16) Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
- 17) Patient or staff death or serious injury associated with a burn incurred from any source in the course of patient care.
- 18) Patient death or serious injury associated with the use of physical restraints during the course of patient care.
- 19) Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
- 20) Any instance of care ordered by or provided by someone impersonating a licensed health care provider.
- 21) Any instance of alleged unlawful sexual behavior on a patient or staff member, as defined by section 18-3-401 *et seq.*, C.R.S.
- 22) Patient or staff death or serious injury resulting from a physical assault.
- 23) Appropriating or possessing without authorization medications, supplies, equipment, or personal items of a patient or employer.

5.3 State Licensing Process.

- 5.3.1 With respect to those applicants seeking to acquire licensure pursuant to this section, the Department shall review the applicant's fitness to provide appropriate medical care as a licensed air ambulance service. The Department shall determine by on-site inspection or other appropriate investigation the applicant's compliance with applicable statutes and regulations concerning the medical aspects of the air ambulance service. The Department shall consider the information contained in the air ambulance service's application and may request access to and consider other information concerning the medical aspects of the air ambulance service operation including, without limitation, aspects related to patient care, such as:
- A) Whether the applicant has legal status to provide the medical and related patient care services for which the license is sought as conferred by articles of incorporation, statute or other governmental declaration,
 - B) The applicant's previous compliance history, including compliance with requirements of other states or accreditation organizations where the applicant was licensed or accredited within the previous 5 years,
 - C) The applicant's policies and procedures as delineated in section 9 of these rules,
 - D) The applicant's quality improvement plans, other quality improvement documentation as may be appropriate, and accreditation reports,
 - E) Credentials of patient care staff,
 - F) Interviews with staff, and
 - G) Other documents deemed appropriate by the Department.
- 5.3.2 Where an air ambulance service is licensed and subject to inspection, certification, or review by other agencies, states or accrediting organizations, the air ambulance service shall provide and/or release to the Department, upon request, any correspondence, reports or recommendations concerning the air ambulance service applicant that were prepared by such organizations.
- 5.3.3 The applicant shall provide, upon request, access to such individual patient records as the Department requires for the performance of its licensing and regulatory oversight responsibilities.
- 5.3.4 An applicant shall provide, upon request, access to or copies of reports and information required by the Department including, but not limited to, medical staffing reports, statistical information, and such other records pertaining to medical and patient care objectives as the Department requires for the performance of its licensing and regulatory oversight responsibilities.
- 5.3.5 the Department shall not release to any unauthorized person any information defined as confidential under state law or the Health Insurance Portability and Accountability Act of 1996, codified at 42 U.S.C. section 300gg, 42 U.S.C. 1320d *et seq.*, and 29 U.S.C. section 1181, *et seq.*

- 5.3.6 As it relates to the medical aspects of the operation of an air ambulance service, the Department may conduct an inspection of the air ambulance service and its aircraft to assure compliance with these rules, and as needed, the Department may conduct complaint and other investigations of an air ambulance service.
- 5.3.7 The applicant shall submit to the Department the applicable fee(s) set forth in section 6 of these rules.
- 5.4 Licensure through Accreditation by Organization Approved by Department.
 - 5.4.1 In addition to meeting the requirements in 5.1, applicants that are currently accredited by an organization approved by the Department pursuant to section 5.5 may receive an air ambulance license upon completion of the documentation and payment of fees that are required by the Department. The air ambulance service shall authorize the accrediting organization to submit directly to the Department copies of any documentation within the accrediting organization's control concerning its evaluation of the air ambulance service's compliance with the organization's standards during the previous accreditation cycle. Such documentation shall include but is not limited to, surveys, inspections, final audit reports, plans of correction, and the most recent letter of accreditation showing the service has received accreditation status.
 - 5.4.2 As it relates to the medical aspects of the operation of an air ambulance service, the Department may conduct an inspection of the air ambulance service and its aircraft to assure compliance with these rules and, as needed, the Department may conduct complaint and other investigations of an air ambulance service accredited by an organization approved by the Department.
 - A) Any air ambulance service licensed under this section shall immediately notify the Department in the event that it receives any notice that its accreditation has been withdrawn, revoked, suspended or modified, or that it is no longer accredited by the accreditation organization approved by the Department.
 - B) If the licensed air ambulance service voluntarily surrenders its accreditation, or is notified by the accrediting organization that the service's accreditation is at risk of being revoked, suspended, withdrawn, preliminarily denied, deferred, or modified in any way—such as being placed on probation, placed under review or under special review, or placed on-hold--the licensed service must provide the Department within one (1) business day with information describing the circumstances the accrediting organization states for the reason(s) for the possible action. The Department may:
 - 1) Initiate appropriate actions it deems necessary to evaluate the licensed service's performance;
 - 2) Elect to revoke or summarily suspend the service's Colorado license that is based on the accreditation in section 5.4; and/or
 - 3) Require the licensed service to immediately apply for state licensure through the process set forth in section 5.3.

- C) If the licensed air ambulance service's accreditation has been withdrawn or revoked, the licensed service must provide the Department with information describing the circumstances the accrediting organization states for the reason(s) for the action. The service shall immediately cease operations. If the air ambulance service wishes to continue to operate it must submit an application and receive a state license as set forth in section 5.3, before it may continue to operate under these rules as a licensed air ambulance service.
 - 1) The Department may allow the service to continue operating under a provisional license as described in section 5.6, below.
 - 2) If the Department allows the service to operate under a provisional license, the provisional license period shall begin on the date of the accreditation withdrawal or revocation. In no event shall the service be allowed to operate under a provisional license for more than one hundred eighty (180) days.
- 5.4.3 If the Department deems it necessary, the Department may request, and the applicant shall provide, any of the information set forth in section 5.2.
- 5.4.4 The Department shall publish a list of the accrediting organizations that it has approved on its website.
- 5.4.5 The applicant shall submit to the Department the applicable fee(s) set forth in section 6 of these rules.
- 5.4.6 If the licensed air ambulance has made a timely and sufficient application for renewal of the license, the existing license shall not expire until the Department has acted upon the renewal application.
- 5.5. Requirements for Approval of Accreditation Organization
 - 5.5.1 To be approved by the Department as an acceptable accreditation organization for the purposes of section 5.4, the accrediting organization must meet the following minimum standards:
 - A) Has standards that are equivalent to or exceed the standards in this chapter.
 - B) Provides accreditation for no more than three consecutive years without an updated inspection and reaccreditation.
 - C) Has a multidisciplinary board of directors with members consisting of, at a minimum, individuals who are medical transport professionals and related health professionals that:
 - 1) Seek input and guidance from national professional medical organizations in the development of its standards, and
 - 2) Assure that the organization allows for multidisciplinary input in the development and implementation of its standards and review processes.
 - D) Uses trained site-surveyors with experience in medical transport at the level of accreditation and license.

- E) Assures that air ambulance services with identified deficiencies will implement corrective action or improvement plans to correct any deficiencies.
- F) Has an open process that encourages and accepts comments on its accreditation standards.
- G) Provides transparency to the public on its standards and procedures.
- H) Maintains insurance (general liability, medical professional liability, directors & officers and travel) and be able to present its current certificates of insurance to the Department.
- I) In addition to its right to conduct independent inspections of equipment and documentation pursuant to section 5.1.3 of these rules, allows a Department representative to accompany accreditation surveyors on site surveys or during any accreditation inspections at the request of the Department.
- J) Has a clear conflict of interest policy.

5.6 Provisional License.

5.6.1 The Department may issue a provisional license to an applicant for an initial license to operate an air ambulance service if:

- A) The applicant is temporarily unable to conform to all the minimum standards required under title 25, part 3.5 and these rules;
- B) The operation of the applicant's air ambulance service will not adversely affect patient care or the health, safety and welfare of the public; and
- C) The applicant air ambulance service demonstrates it is making its best efforts to achieve compliance with the applicable rules.

5.6.2 A provisional license issued by the Department shall be valid for a period not to exceed ninety (90) calendar days, except that the Department may issue a second provisional license for the same duration and shall charge the same fee as for the first provisional license. If the licensee has made a timely and sufficient application for renewal of the provisional license, the existing license shall not expire until the Department has acted upon the renewal application. The Department may not issue a third or subsequent provisional license to the applicant, and in no event shall a service be provisionally licensed for a period to exceed one hundred eighty (180) calendar days.

5.6.3 The applicant shall submit to the Department the applicable fee(s) set forth in section 6 of these rules.

5.7 Conditional License

5.7.1 The Department may impose conditions or limitations upon a license prior to issuing an initial or renewal license or during an existing license term. If the Department imposes conditions or limitations on a license, the licensee shall immediately comply with all conditions or limitations until and unless said conditions are overturned or stayed on appeal.

- A) If conditions or limitations are imposed at the same time as an initial or renewal license, the applicant shall pay the applicable initial or renewal license fee plus the conditional fee as set forth in section 6 of these rules. If conditions or limitations are imposed during the license term, the licensee shall pay the conditional fee and the conditions or limitations shall run concurrently with the existing license term. If the conditions are renewed in whole or in part for the next license term, the licensee shall pay the applicable renewal fee along with the conditional fee in effect at the time of renewal.
- B) If the Department imposes conditions or limitations of continuing duration that require only minimal administrative oversight, it may waive the conditional fee after the licensee has complied with the conditions or limitations for a full license term.

5.7.2 Unless consented to by the air ambulance service, a limitation imposed prior to issuance of an initial or renewal license shall be treated as a denial. A modification of an existing license during its term, unless consented to by the air ambulance service, shall be treated as a revocation.

5.8 Change of Ownership/Management

5.8.1 When a currently licensed air ambulance service anticipates a change of ownership, the current licensee shall notify the Department within the specified time frame and the prospective new licensee shall submit an application for change of ownership along with the requisite fees and documentation within the same time frame. The time frame for submittal of such notification and documentation shall be at least thirty (30) calendar days before a change of ownership involving any air ambulance service.

5.8.2 in general, the conversion of an air ambulance service's legal structure, or the legal structure of an entity that has a direct or indirect ownership interest in the air ambulance service is not a change of ownership unless the conversion also includes a transfer of at least 50 percent of the licensed air ambulance service's direct or indirect ownership interest to one or more new owners. Specific instances of what does or does not constitute a change of ownership are set forth below in section 5.8.3.

5.8.3 The Department shall consider the following criteria in determining whether there is a change of ownership of an air ambulance service that requires a new license:

- A) Sole proprietors:
 - 1) The transfer of at least 50 percent of the ownership interest in an air ambulance service from a sole proprietor to another individual, whether or not the transaction affects the title to real property, shall be considered a change of ownership.
 - 2) Change of ownership does not include forming a corporation from the sole proprietorship with the proprietor as the sole shareholder.
- B) Partnerships:
 - 1) Dissolution of the partnership and conversion into any other legal structure shall be considered a change of ownership if the conversion also includes a transfer of at least 50 percent of the direct or indirect ownership to one or more new owners.

- 2) Change of ownership does not include dissolution of the partnership to form a corporation with the same persons retaining the same shares of ownership in the new corporation.

C) Corporations:

- 1) Consolidation of two or more corporations resulting in the creation of a new corporate entity shall be considered a change of ownership if the consolidation includes a transfer of at least 50 percent of the direct or indirect ownership to one or more new owners.
- 2) Formation of a corporation from a partnership, a sole proprietorship or a limited liability company shall be considered a change of ownership if the change includes a transfer of at least 50 percent of the direct or indirect ownership to one or more new owners.
- 3) The transfer, purchase or sale of shares in the corporation such that at least 50 percent of the direct or indirect ownership of the corporation is shifted to one or more new owners shall be considered a change of ownership.

D) Limited liability companies:

- 1) The transfer of at least 50 percent of the direct or indirect ownership interest in the company shall be considered a change of ownership.
- 2) The termination or dissolution of the company and the conversion thereof into any other entity shall be considered a change of ownership if the conversion also includes a transfer of at least 50 percent of the direct or indirect ownership to one or more new owners.
- 3) Change of ownership does not include transfers of ownership interest between existing members if the transaction does not involve the acquisition of ownership interest by a new member. For the purposes of this subsection, "member" means a person or entity with an ownership interest in the limited liability company.

5.8.4. Management contracts, leases or other operational arrangements:

- A) If the owner of an air ambulance service enters into a lease arrangement or management agreement whereby the owner retains no authority or responsibility for the operation and management of the air ambulance service, the action shall be considered a change of ownership that requires a new license.

5.8.5 Each applicant for a change of ownership shall provide the following information:

- A) The legal name of the entity and all other names used by it to provide health care services. The applicant has a continuing duty to notify the Department of all name changes at least thirty (30) calendar days prior to the effective date of the change.
- B) Contact information for the entity including mailing address, telephone and facsimile numbers, e-mail address and website address, as applicable.

- C) The identity of all persons and business entities with a controlling interest in the air ambulance service, including administrators, directors, managers and management contractors.
 - 1) A non-profit corporation shall list the governing body and officers.
 - 2) A for-profit corporation shall list the names of the officers and stockholders who directly or indirectly own or control five percent or more of the shares of the corporation.
 - 3) A sole proprietor shall include proof of lawful presence in the united states in compliance with section 24-76.5-103(4), C.R.S.
- D) The name, address and business telephone number of every person identified in section 5.8.5 (C) and the individual designated by the applicant as the chief executive officer of the entity.
 - 1) If the addresses and telephone numbers provided above are the same as the contact information for the entity itself, the applicant shall also provide an alternate address and telephone number for at least one individual for use in the event of an emergency or closure of the air ambulance service.
- E) Proof of professional liability insurance obtained and held in the name of the license applicant as required by section 5.1.1 (F) & (G) of these rules. Such coverage shall be maintained for the duration of the license term and the Department shall be notified of any change in the amount, type or provider of professional liability insurance coverage during the license term.
- F) Articles of incorporation, articles of organization, partnership agreement, or other organizing documents required by the secretary of state to conduct business in Colorado; and by-laws or equivalent documents that govern the rights, duties and capital contributions of the business entity.
- G) The address of the entity's physical location and the name(s) of the owner(s) of each structure on the campus where licensed services are provided if different from those identified in paragraph (C) of this section.
- H) A copy of any management agreement pertaining to operation of the entity that sets forth the financial and administrative responsibilities of each party.
- I) If an applicant leases one or more building(s) to operate as a licensed air ambulance service, a copy of the lease shall be filed with the license application and show clearly in its context which party to the agreement is to be held responsible for the physical condition of the property.
- J) A statement signed and dated contemporaneously with the application stating whether, within the previous ten (10) years, any of the new owners have been the subject of, or a party to, one of more of the following events, regardless of whether action has been stayed in a judicial appeal or otherwise settled between the parties.

- 1) Been convicted of a felony or misdemeanor involving moral turpitude under the laws of any state or of the United States. A guilty verdict, a plea of guilty or a plea of nolo contendere (no contest) accepted by the court is considered a conviction.
 - 2) Had a state license or federal certification denied, revoked, or suspended by another jurisdiction.
 - 3) had a civil judgment or a criminal conviction in a case brought by federal, state or local authorities that resulted from the operation, management, or ownership of a health facility or other entity related to substandard patient care or health care fraud.
 - K) Any statement regarding the information requested in paragraph (J) shall include the following, if applicable:
 - 1) If the event is an action by federal, state or local authorities; the full name of the authority, its jurisdiction, the case name, and the docket, proceeding or case number by which the event is designated, and a copy of the consent decree, order or decision.
 - 2) If the event is a felony or misdemeanor conviction involving moral turpitude, the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court.
 - 3) If the event involves a civil action or arbitration proceeding, the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict, the court or arbitration decision.
- 5.8.6 The existing licensee shall be responsible for correcting all rule violations and deficiencies in any current plan of correction before the change of ownership becomes effective. In the event that such corrections cannot be accomplished in the time frame specified, the prospective licensee shall be responsible for all uncorrected rule violations and deficiencies including any current plan of correction submitted by the previous licensee unless the prospective licensee submits a revised plan of correction, approved by the Department, before the change of ownership becomes effective.
- 5.8.7 If the Department issues a license to the new owner, the previous owner shall return its license to the Department within five (5) calendar days of the new owner's receipt of its license.
- 5.9 Base Locations in Colorado
- 5.9.1 If an air ambulance service has a base located within Colorado, the air ambulance service shall at all times:
- A) Maintain or have readily available records of operation;
 - B) Have security measures in place to protect the air ambulance from tampering and the unauthorized access to medical equipment and supplies, including pharmaceuticals. This would include direct visual monitoring or closed circuit television or the air ambulance must be in a secured location with locked perimeter fencing or hangar;

- C) Display its Colorado air ambulance service license within a building at the base location;
- D) Display its drug enforcement agency registration in the building where controlled substances, if any, are stored;
- E) Maintain a current post-accident incident plan;
- F) Comply with applicable state and local building and fire codes;
- G) Maintain or have readily available documentation of the professional certifications and/or licenses and continuing education documentation for staff responsible for providing patient care.

5.9.2 An air ambulance service that has a base location in Colorado is not eligible for out of state licensure recognition pursuant to section 4 of these rules.

Section 6 – Fees

6.1 All applicants seeking air ambulance licensure by the Department under these rules shall submit the non-refundable fees required by this section 6.

6.2 Licensing Fees

6.2.1 Each air ambulance service seeking initial or renewal licensure pursuant to section 5.3 or 5.4 shall submit a licensing fee of \$3,400 to the Department.

6.2.2 All applicants seeking an initial or renewal recognition of out of state licensure pursuant to section 4 shall pay an annual fee of \$1700 to the Department.

6.2.3 All applicants seeking a provisional license pursuant to section 5.6 shall pay a fee of \$1700 to the Department. An applicant seeking a second provisional license shall pay the same fee amount as rendered for the first provisional license.

6.2.4 All applicants subject to a conditional license pursuant to section 5.7 may be assessed a fee based on the direct and indirect costs incurred by the Department in addition to the required initial or renewal fee in section 6.2.1 of these rules.

6.3 Per Aircraft Fees

6.3.1 In addition to licensing fees set forth in 6.2.1, each air ambulance service seeking initial or renewal licensure pursuant to sections 5.3 and 5.4 of these rules shall pay a per aircraft fee of \$400 to the Department for each aircraft used by the air ambulance service.

6.3.2 In addition to the licensing fees set forth in 6.2.2, each air ambulance service seeking an initial or renewal recognition of out of state licensure pursuant to section 4 shall pay a per aircraft fee of \$200 to the Department for each aircraft used by the air ambulance service in the state.

6.3.3 In addition to the licensing fees set forth in 6.2.3, each air ambulance service seeking an initial or second provisional license pursuant to 5.6 shall pay a per aircraft fee of \$400 to the Department for each aircraft used by the air ambulance service.

- 6.3.4 In addition to the licensing fees set forth in 6.2.4, each air ambulance service subject to a conditional license pursuant to section 5.7 shall pay a per aircraft fee of \$400 to the Department for each aircraft used by the air ambulance service.
- 6.4 In addition to the applicable fees set forth in 6.2 and 6.3 of these rules, the Department shall assess a variable on-site inspection fee for all applicants seeking state licensure pursuant to section 5.3.
- 6.5 If, after obtaining a license, an air ambulance service expands its fleet of aircraft licensed in Colorado, the service shall pay the appropriate per aircraft fee as set forth in 6.2 for every additional aircraft at the time it is placed in service. Moreover, if the Department deems it necessary to inspect the additional aircraft it shall assess upon the licensee the inspection fee as set forth in 6.4.
- 6.6 Any air ambulance service changing ownership pursuant to section 5.8 shall pay the Department a fee of \$3400.
- 6.7 Any air ambulance service changing its name shall pay the Department a fee of \$600.

Section 7 – Licensing Period

- 7.1 Except as provided in sections 4.2.3 and 5.6.2, any air ambulance license issued by the Department shall be valid for a period not to exceed two (2) years.

Section 8 – Licensing Renewal and Recognition of Out of State License Renewal

- 8.1 To renew an existing air ambulance license, the licensee shall submit a renewal application and fees, as set by the Department, no later than thirty (30) calendar days prior to the date of air ambulance license expiration.
- 8.2 A renewal inspection may be required by the Department to assure air ambulance service compliance with these rules.
- 8.3 Except as otherwise provided in section 5.6 of these rules, the Department shall renew a license when it is satisfied that the requirements of these rules have been met. If the licensee has made a timely and sufficient application for renewal of the license, the existing license shall not expire until the Department has acted upon the renewal application.
- 8.4 If an air ambulance service is authorized to operate in Colorado because of the Department's recognition of out of state licensure pursuant to section 4, the licensee shall submit a renewal application, documentation of current out of state licensure and fees, as set forth in section 6, no later than thirty (30) calendar days prior to the date of the Colorado air ambulance recognition expiration.
- 8.5 [Emergency rule expired 08/08/2020]

Section 9 – General Medical Operational Requirements for Air Ambulance Services Licensed by the Department

- 9.1 Policies and Procedures
 - 9.1.1 To assess the adequacy of patient care, every applicant or licensee shall make available for reference and inspection a detailed manual of its policies and procedures. Service personnel shall be familiar and comply with policies contained within the manual. The manual shall include:

- A) Procedures for acceptance of requests, referrals, and/or denial of service for medically related reasons;
- B) A written description of the geographical boundaries and features for the service area, and a copy of the service area map;
- C) Scheduled hours of operation;
- D) Criteria for the medical conditions and indications or medical contraindications for flight;
- E) Field triage criteria for all trauma patients;
- F) Medical communication procedures, including but not limited to medically-related dispatch protocol, call verification and advisories to the requesting party, to include procedures for informing requesting party of flight procedures, anticipated time of aircraft arrival, and cancellation of flight;
- G) Criteria regarding acceptable destinations based upon medical needs of the patient;
- H) Non-aviation safety procedures for medical crew assignments and notification, including rosters of medical personnel;
- I) Written policy that ensures air medical personnel shall not be assigned or assume cockpit duties concurrent with patient care duties and responsibilities;
- J) Written policy that directs air ambulance personnel to honor a patient request for a specific service or destination when the circumstances will not jeopardize patient safety;
- K) On-ground medical communications procedures;
- L) Flight referral procedures;
- M) A written plan that addresses the actions to be taken in the event of an emergency, diversion, or patient crisis during transport operations;
- N) Patient tracking procedures that shall assure air/ground position reports at intervals not to exceed fifteen (15) minutes inflight and forty-five (45) minutes while landed on the ground;
- O) Written procedures governing the air ambulance service's medical complaint resolution process and protocols. At minimum, the air ambulance service shall designate personnel responsible for its dispute resolution process and provide the protocols it shall follow when investigating, tracking, documenting, reviewing and resolving the complaint. The service's complaint resolution procedures shall emphasize resolution of complaints and problems within a specified period of time; and
- P) Policy for delineating methods for maintaining medical communications during power outages and in disaster situations.

- 9.1.2. To ensure proper patient care and the effective coordination of statewide emergency medical and trauma services, services that respond to incident scenes and/or support disaster response shall provide aircraft safety and landing zone procedures in a written format to all fire, rescue, ems, public safety, law enforcement agencies and medical facility personnel who interface with the medical service that includes but is not limited to the following:
 - A) The identification, designating and preparation of appropriate landing zones;
 - B) Provider safety in and around the aircraft;
 - C) Air to ground communications; and
 - D) crash recovery procedures
- 9.2. Each licensed air ambulance service shall complete and submit to the Department a profile that includes information to be used by the Department to provide effective communications, planning and coordination of statewide emergency medical and trauma services.
 - 9.2.1 All air ambulance service agencies licensed in Colorado shall provide the Department with the required data and information as specified below in a format determined by the Department or in an alternate media acceptable to the Department.
 - 9.2.2 Air ambulance service agencies shall provide organizational profile data in a manner designated by the Department.
 - 9.2.3 Agencies shall update organizational profile data whenever changes occur and at least annually.
- 9.3 Medical Transport Plans
 - 9.3.1 To ensure proper patient care and the effective coordination of statewide emergency medical and trauma services, all air ambulance services shall have an integrated medical transport plan for each air ambulance licensed by the Department that describes the following:
 - A) Base location
 - B) Hours of operation
 - C) Emergency (dispatch) and non-emergency (business) contact Information
 - D) Description of primary and secondary service areas
 - E) Medical criteria for utilization
 - F) Description of medical capabilities (including availability of specialized medical transport equipment)
 - G) Communications capabilities including (but not limited to) radio frequencies and talk groups.
 - H) Procedures for communicating with the air medical crew
 - I) Mutual aid or backup procedures when the service is not available

9.4 Medically-Related Dispatch Protocols

- 9.4.1 When air ambulance transport is indicated, requests shall be appropriately coordinated after consultation with the requesting party. All air ambulance services shall maintain communication with all appropriate entities involved in the response, including the receiving facility.

9.5 Medical Communications

- 9.5.1 An air ambulance service shall have a two-way wireless communication system with reliable equipment that will allow clear voice communication among and between all agencies necessary for the safe and effective transport and medical care of the patient and crew.
- 9.5.2 An air ambulance service's two-way communication equipment system shall allow for or have:
- A) Real-time patient tracking that shall be maintained and documented every fifteen (15) minutes including the time the air ambulance returns to service following transport.
 - B) Appropriate wireless communications capabilities with local first responders, to include fire, rescue, emergency medical services (EMS), and law enforcement as published in the State EMS Telecommunications Plan.
 - C) A system of communications, exclusive of the air traffic control system, that must be capable of communications with medical services (EMS), and law enforcement as published in the State EMS Telecommunications Plan.
 - D) Dedicated telephone number for the air ambulance service dispatch center.
 - E) The air ambulance service communications center must be staffed during all phases of patient treatment and transport.
 - F) An emergency plan for communications during power outages and in disaster situations.

9.6 Medical Personnel

- 9.6.1 At a minimum an air ambulance service must have the following medical personnel:
- A) An air ambulance service medical director who oversees the practice of emergency medical services during patient transport for a Colorado licensed service must be familiar with Colorado state medical standards, practices, and licensing requirements. Therefore, except as provided in section 9.6.1(B), a medical director must be a Colorado licensed physician in good standing to supervise the medical care provided in an air medical environment. The medical director must also:
 - 1) Be board certified or board-eligible in EMS, emergency medicine, or other specialty serving the patient population involved;
 - 2) Have experience in the care of patients consistent with the licensing and mission profile of the air ambulance service;

- 3) Have access to medical specialists for consultation regarding patients whose illness and care needs are outside the medical director's area of practice;
 - 4) Have a current DEA registration; and
 - 5) Have current credentials achieved through active participation in patient care and continuing medical education activities appropriate for the role of an air ambulance service medical director.
 - B) For air ambulance services operating pursuant to section 4 of these rules, the medical director who is licensed and in good standing, without restrictions or conditions, in the state in which the service is based, and who is exempt from Colorado licensure requirements pursuant to section 12-36-106(3)(b), C.R.S., may supervise the medical care provided to a patient in an air medical transport that either originates or terminates in Colorado. Under these circumstances the medical director must:
 - 1) Be board certified or board-eligible in EMS, emergency medicine, or other specialty serving the patient population involved;
 - 2) Have experience in the care of patients consistent with the licensing and mission profile of the air ambulance service;
 - 3) Have access to medical specialists for consultation regarding for patients whose illness and care needs are outside the medical director's area of practice;
 - 4) Have a current DEA registration; and
 - 5) Have current credentials achieved through active participation in patient care and CME activities appropriate for the role of an air ambulance service medical director.
 - C) An air ambulance service medical director who oversees the practice of emergency medical services during transport of a patient that originates and terminates in Colorado must be a Colorado licensed physician in good standing that meets the requirements set forth in section 9.6.1(A).
 - D) Medically qualified Colorado licensed, or certified, individuals appropriate to the scope and mission of the air ambulance service, or providers recognized under an interstate compact of which Colorado is a member. Acceptable medical personnel include, but are not limited to physicians, certified emergency medical services providers, registered nurses, registered nurse practitioners, advanced practice nurses, physician assistants, respiratory therapists, or other allied health professionals.
- 9.6.2 Each patient transport by a licensed air ambulance service shall be staffed by a minimum of two (2) medical personnel who are licensed or certified according to Colorado and/or providers recognized under an interstate compact of which Colorado is a member who provide direct patient care, plus a vehicle operator.
- A) One of the medical personnel must be the primary care provider, who, as the team leader with a higher level of license, is ultimately responsible for the patient.

- 1) The primary care provider may be a licensed nurse, a resident or staff physician, or a paramedic.
 - 2) If the primary care provider is a licensed nurse, s/he must have CEN, CCRN, CFRN or CTRN [or equivalent national certification] within two (2) years of hire and must have pre-hire experience in the medications and interventions listed necessary for the service's scope of care. The licensed nurse must also have three (3) years critical care experience, which is no less than 4000 hours experience in an ICU or an emergency department.
 - 3) If the primary care provider is a paramedic, s/he must have pre-hire experience in the medications and interventions listed necessary for the service's scope of care. The paramedic must also have 3 years critical care experience, which is no less than 4000 hours experience in an ICU or an emergency department.
- B) If the second medical provider is a paramedic, then the paramedic must have a FP-C or CCP-C, or Colorado critical care endorsement, or equivalent required within two (2) years of hire, along with three (3) years (minimum of 4000 hours) of advanced life support experience.
- C) If the second medical provider is a registered respiratory therapist (RRT), the RRT is required to have a minimum of 4000 hours of emergency department or ICU experience.
- D) The composition of the medical team may be altered for specialty missions and teams upon approval and credentialing by the air ambulance service medical director.
- E) The medical team must demonstrate affective and psychomotor education sufficient to meet the clinical needs for the type of patient served in an air ambulance medical environment without restrictions.
- F) Medical personnel shall operate only within their scope of practice, including an emergency medical service provider acting in accordance with a waiver granted pursuant to Chapter Two, 6 CCR 1015-3.

9.6.3 Training Requirements

- A) An air ambulance service shall have a training and educational program that is required for all medical air ambulance personnel, including the medical director.
- B) At a minimum, the training and educational program shall contain program orientation, initial and recurrent training which is consistent with the air ambulance service's scope of care, patient population, mission statement and medical direction. The air ambulance service shall document that its air ambulance medical personnel have completed training, met the learning objectives and have ongoing clinical experience in the following:
- 1) Care of patients in the air medical environment including the impact of altitude and other stressors;
 - 2) Advanced airway management;

- 3) Applicable medical device specific training (automatic implantable cardioverter defibrillator (AICD), extracorporeal membrane oxygenation (ECMO), intra-aortic balloon pump (IABP), left ventricular assist device (LVAD), medication pumps, ventilators, etc.;
 - 4) Cardiology;
 - 5) Mechanical ventilation and respiratory physiology for adult, pediatric, and neonatal patients as it relates to the mission statement and scope of care of the medical transport service specific to the equipment;
 - 6) High risk obstetrical emergencies and obstetrics care;
 - 7) Pediatrics and neonatal care;
 - 8) Emergency/critical care for all applicable patient populations, including special needs populations;
 - 9) Hazardous materials recognition and response;
 - 10) Management of disaster and mass casualty events;
 - 11) Infection control and prevention; and
 - 12) Ethical and legal issues.
- C) The air ambulance service medical director shall have familiarity in the following areas:
- 1) Care of patients in the air medical environment, including the impact of altitude and other patient stressors, in-flight assessment and care, monitoring capabilities, and limitations of the flight environment;
 - 2) Hazardous materials recognition and response;
 - 3) Management of disaster and mass casualty events;
 - 4) Infection control and prevention;
 - 5) Advanced resuscitation and care of adult, pediatric and neonatal patients with both traumatic and non-traumatic diagnoses;
 - 6) Quality improvement theories and applications;
 - 7) Principles of adult learning;
 - 8) Capabilities and limitations of care in an air ambulance;
 - 9) Applicable federal, state and local law, rules and protocols related to air medical services and state trauma rule guidelines;
 - 10) Air medical dispatch and communications; and
 - 11) Ethical and legal issues.

9.6.4 Air Ambulance Service Medical Director Roles and Responsibilities

- A) The air ambulance service medical director roles and responsibilities shall include:
- 1) Responsibility for oversight of medical care provided by the air medical service and ensure competency and currency of all medical personnel;
 - 2) Active engagement in the evaluation, credentialing, initial training and continuing education of all personnel who provide patient care;
 - 3) Development and/or approval of written patient care guidelines (when available), policies and protocols including but not limited to those addressing the adverse impact of altitude on patient physiology and stresses of transport; and
 - 4) Active engagement in quality management, utilization review and patient care and safety reviews.

9.7 Medical Equipment

9.7.1 Each air ambulance operator shall ensure that all medical equipment is appropriate to the air medical service's scope and mission and maintained in working order according to the manufacturer's recommendations. Medical equipment shall be available on the aircraft to meet the local/state protocols for ems providers in which the service intends to operate and in line with the mission of the air ambulance service.

- A) Required equipment
- 1) Isolation equipment including isolation goggles and masks or mask/shield combination, isolation gowns and isolation gloves
 - 2) High particulate filter washes (HEPA filter or n95 mask-assorted sizes)
 - 3) Containers (bags) for infectious medical waste
 - 4) Sharps container
 - 5) Disinfectant/germicidal cleaners, wipes or solutions
 - 6) Waterless hand cleaner
 - 7) Airway equipment, consisting of:
 - a. Complete set of oropharyngeal airway devices: adult and pediatric,
 - b. Complete set of nasopharyngeal airway devices: adult, pediatric, and infant
 - c. Complete set of intubation equipment-adult, pediatric, and infant
 - 8) Syringes, assorted sizes
 - 9) Magill forceps (adult and pediatric sizes)

- 10) Thermometer
- 11) Intubation equipment
- 14) Pediatric weight based drug tape, chart or wheel
- 15) Water soluble lubricant
- 16) End-tidal CO2 monitor
- 17) Advanced airway procedure kit, as applicable
- 18) Appropriate medications as defined by clinical guidelines or per medical treatment guidelines.
- 19) ECG monitor/defibrillator and appropriate adult and pediatric pads, including external pacemaker pads (secure positioning of cardiac monitors, defibrillators, and external pacers so that displays are visible to medical personnel)
- 20) Pulse oximeter with adult and pediatric probes
- 21) Spare batteries as appropriate for powered medical devices
- 22) Ventilator as approved by medical director
- 23) Bandages and dressings
- 24) Suction equipment including tubing
 - a. Wall mounted suction unit
 - b. Portable suction unit powered or hand operated
- 25) Pharyngeal hard tip suction
- 26) Soft tip suction catheter set
 - a. Adult sizes
 - b. Pediatric sizes
- 27) Suction bags or replaceable reservoirs
- 28) Sterile gloves
- 29) Oxygen equipment - oxygen flow capable of being stopped at the oxygen source from inside the air ambulance and measurement of the liter flow and quantity of oxygen remaining is accessible to air medical personnel while in flight:
 - a. Main oxygen source
 - b. Wall mounted oxygen flow meter 0-15 l/min. minimum

- i. Oxygen equipment shall be furnished capable of adjustable flow from 0 to 15 liters per minute. Masks and supply tubing for adult and pediatric patients shall allow administration of variable oxygen concentrations from 24% to 95% fraction inspired oxygen. Medical oxygen shall be provided for 150% of the scheduled flight time by a unit secured within the air ambulance.
- 30) Compressed air as appropriate (each gas outlet clearly marked for identification)
- 31) Portable oxygen cylinder with portable variable flow regulator 0-15 l/min. Minimum
- 32) Bag-valve-mask with reservoir to provide one hundred per cent oxygen flow (adult, pediatric and infant sizes)
- 33) Oxygen masks (adult, pediatric and infant sizes)
- 34) Nasal cannulas (adult and pediatric sizes)
- 35) Nebulizer and appropriate connecting tubing
- 36) Adjunct equipment
 - a. Trauma shears
 - b. Stethoscope (adult and pediatric)
 - c. Tourniquets
- 37) Blood pressure cuffs: (large adult, adult, pediatric, infant)
- 38) Patient hearing protection
- 39) Assorted tape
- 40) Exam gloves
- 41) Obstetrical kit
- 42) Nasogastric tubes (adult and pediatric)
- 43) Patient restraints
- 44) Pediatric restraining system
- 45) Intravenous equipment, including but limited to:
 - a. Alcohol, chlorhexidine, or betadine skin cleanser (preferably prep pads)
 - b. IV administration sets
 - c. IV infusion pump tubing

- d. IV catheters, assorted sizes 24-14
 - e. Intraosseous needles
 - f. IV solutions, per protocol
- 46) Needles, assorted sizes
- 47) Associated adjunct equipment
 - a. Invasive line set-up
 - b. Pressure bags
- 48) One or more cots/stretchers capable of being secured in the aircraft that meet the following criteria:
 - a. Accommodates an adult of a height and weight appropriate for the capacity of the air ambulance, and restraining devices or additional appliances available to provide adequate restraint of all patients including those under 60 pounds or 36 inches in height.
 - b. The head of the primary stretcher is capable of being elevated up to 30 degrees. The elevating section shall not interfere with or require that the patient or stretcher securing straps and hardware be removed or loosened.
 - c. Sturdy and rigid enough that it can support cardiopulmonary resuscitation. If a backboard or equivalent device is required to achieve this, such device will be readily available.
 - d. A pad or mattress impervious to moisture and easily cleaned and disinfected according to occupational safety and health administration (OSHA) blood borne pathogen requirements (29 C.F.R § 1910.1030 2016).
 - e. A supply of linen for each patient.
- 49) Survival kit for all medical crew members and patient

9.8 Patient Compartment

9.8.1 An applicant or licensee shall ensure that an air ambulance has the following:

- A) A climate control system to prevent temperature variations that would adversely affect patient care.
- B) An adequate interior lighting system so that patient care can be given and the patient's status monitored.
- C) For each place where a patient may be positioned, at least one electrical power outlet or other power source that is capable of operating all electrically powered medical equipment without compromising the operation of any electrical air ambulance equipment.

- D) A back-up source of electrical power or batteries capable of operating all electrically powered life-support equipment for at least one hour.
- E) An appropriate power source that is sufficient to meet the requirements of the complete specialized equipment package without compromising the operation of any electrical air ambulance equipment.
- F) An entry that allows for patient loading and unloading without excessive maneuvering and without compromising the operation of monitoring systems, intravenous lines, or manual or mechanical ventilation.
- G) If an isolette is used during patient transport, an isolette that is able to be opened from its secured in-flight position in order to provide full access to the patient.
- H) Adequate access and necessary space to maintain the patient's airway and to provide adequate ventilator support by an attendant from the secured, seat-belted position within the air ambulance.
- I) A configuration that allows for rapid exit of personnel and patients, without obstruction from stretchers and medical equipment.
- J) An interior that is sanitary and in good working order at all times.
- K) Appropriate storage for medications that maintains temperatures within manufacturer recommendations. Glass containers shall not be used unless required by medication specifications and properly vented. Medications, fluids and controlled substances shall be securely maintained by air ambulance licensees in compliance with local, state, and federal drug laws.
- L) Secure positioning of cardiac monitors, defibrillators, and external pacers so that displays are visible to medical personnel.

9.9 Data Collection and Submission

- 9.9.1 All services shall have a system in place to collect, submit, monitor, and track all flight requests that result in patient transport. This information shall be submitted and made readily available to the Department upon request.
- 9.9.2 Colorado licensed air ambulance services shall submit data and information as required in 6 CCR 1015-3, Chapter Three Rules Pertaining to Emergency Medical Services Data and Information Collection and Record Keeping and section 18 of these rules, to the extent data collection and submission serve a medical or quality improvement purpose.

9.10 Continuous Quality Improvement Program

- 9.10.1 Air ambulance services shall establish a quality management team and a program implemented by this team to assess and improve the quality and appropriateness of patient care provided by the air ambulance service. The program shall include:
 - A) Development of protocols, standing orders, training, policies, procedures.
 - B) Approval of medications and techniques permitted for field use by service personnel in accordance with regulations of the Department.

- C) Direct observation, field instruction, in-service training or other means available to assess quality of field performance.

9.10.2 All services shall have a written policy that outlines a process to identify, document and analyze sentinel events, adverse medical events or potentially adverse events with specific goals to improve patient medical safety and/or quality of patient care. Goals shall include the following:

- A) Review of events should address the effectiveness and efficiency of the organization, its support systems, as well as that of individuals within the organization.
- B) When a sentinel event is identified, a method of information gathering shall be developed. This shall include outcome studies, chart review, case discussion, or other methodology.
- C) Findings, conclusions, recommendations and actions shall be made and recorded. Follow-up, if necessary, shall be determined, recorded, and performed.
- D) Training and education needs, individual performance evaluations, equipment or resource acquisition, patient medical safety and risk management issues all shall be integrated with the continuous quality improvement process.

9.10.3 All services shall have a written policy outlining a utilization review process.

9.11 Medical Staff and Patient Safety Welfare

9.11.1. Medical personnel scheduling and individual work schedules must demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation.

9.11.2 On-site shifts scheduled for a period to exceed twenty-four (24) hours are not acceptable under most circumstances. The following criteria must be met for shifts scheduled more than twelve (12) hours.

- A) Medical personnel are not required to routinely perform any duties beyond those associated with the transport service.
- B) Medical personnel are provided with access to and permission for uninterrupted rest after daily medical personnel duties are met.
- C) The physical base of operations includes an appropriate place for uninterrupted rest.
- D) Medical personnel must have the right to call "time out" and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue duty, no matter the shift length. There must be no adverse personnel action or undue pressure to continue in this circumstance.
- E) Management must monitor transport volumes and personnel's use of a "time out" policy.

- 9.11.3 Shifts extended over several days may be scheduled to address long commutes at programs with low volumes. The program must clearly demonstrate and document it meets the above criteria for shifts over twelve (12) hours. In addition:
- A) A program's base averages less than one (1) transport per day.
 - B) Provides at least ten (10) hours of rest in each twenty-four (24) hour period.
 - C) Location of the base or program is remote and one-way commutes are more than two (2) hours.
 - D) Fatigue risk management tools are utilized.
- 9.11.4. Scheduling of on-call shifts must be evaluated to address fatigue in a written policy based on monitoring of duty times by managers, quality management tracking and fatigue risk management.
- 9.11.5. Physical well-being is promoted through:
- A) Protective clothing and dress code pertinent to:
 - 1) Mission profile such as turn-out gear available at scene for medical personnel who assist with heavy extrication
 - 2) Safe operations, which shall include:
 - a. Boots or sturdy footwear,
 - b. Appropriate outerwear to protect the provider from adverse environmental conditions and
 - c. If medical crews and vehicle operators respond to night scenes, the ambulance medical crew members must wear high visibility reflective vests or Department of Transportation-approved clothing that meets industry standards.
 - 3) In addition to the mandatory requirements in 9.11.5(A), safe operations may include:
 - a. Wearing reflective material or striping on uniforms for night operations; and
 - b. Flame retardant clothing (strongly encouraged for rotor wing services according to a risk assessment)
- 9.11.6. The air ambulance service shall establish an infection control protocol that complies with occupational safety and health administration (OSHA) standards, including 29 C.F.R. § 1910.1030 (2016), 29 C.F.R. § 1910.132 (2016), and 29 C.F.R. 1910.134 (2016).
- 9.11.7 The air ambulance services shall have an appropriate dress code that addresses jewelry, hair and other personal items of medical personnel that may interfere with patient care.

Section 10 – Complaints

- 10.1 Complaints relating to the quality and conduct of any air ambulance service may be made by any person or may be initiated by the Department. The Department may make inquiry as to the validity of such complaint prior to initiating an investigation. If the Department determines that the complaint warrants a more extensive review, an investigation may be initiated. If the complaint does not warrant further review or the inquiry determines that the complaint is not within regulatory jurisdiction of the Department, the Department will notify the complainant of the results of the inquiry.
- 10.2 The Department does not have jurisdiction over billing disputes or aviation complaints.
- 10.3 Every licensed service shall report patient medical care complaints to the Department within seven (7) calendar days of its receipt. Every licensed service shall provide the Department with any response it makes to the complaint within seven (7) calendar days of its issuance. If the Department determines that the complaint warrants review, it may initiate an investigation.
- 10.4 Nothing in this section prohibits the Department from conducting a complaint investigation under circumstances it deems necessary.
- 10.5 The Department may refer complaints that are related to the requirements an accrediting organization approved by the Department to that accrediting for investigation. The Department may forward complaints to other regulatory agencies.

Section 11 – Plans of Correction

- 11.1 After any Department inspection or complaint investigation, the Department may request a plan of correction from an air ambulance service.
 - 11.1.1 A plan of correction shall be in the format prescribed by the Department and shall include but not be limited to, the following:
 - A) Identification of the problem(s) with the current activity and what the air ambulance service will do to correct each deficiency,
 - B) A description of how the air ambulance service will accomplish the corrective action,
 - C) A description of how the air ambulance service will monitor the corrective action to ensure the deficient practice is remedied and will not recur, and
 - D) A timeline with the expected implementation and completion date. The completion date is the date that the air ambulance service deems it can achieve compliance.
 - 11.1.2 Completed plans of correction shall be:
 - A) Submitted to the Department in the form and manner required by the Department,
 - B) Submitted within ten (10) calendar days after the date of the Department's mailing of the written notice of deficiencies to the air ambulance service, unless otherwise required or approved by the Department, and
 - C) Signed by the air ambulance service program director and medical director.

11.1.3 The Department has the discretion to approve, modify or reject plans of correction.

- A) If the plan of correction is accepted, the Department shall notify the air ambulance service by issuing a written notice of acceptance within thirty (30) calendar days of receipt of the plan.
- B) If the plan of correction is unacceptable, the Department shall notify the air ambulance service in writing, and the service shall re-submit a revised plan of correction to the Department within fifteen (15) calendar days of the date of the written notice.
- C) If the air ambulance service fails to comply with the requirements or deadlines for submission of a plan or fails to submit a revised plan of correction, the Department may reject the plan of correction and impose disciplinary sanctions as set forth in sections 12 or 13.
- D) If the air ambulance service fails to timely implement the actions agreed to in the plan of correction, the Department may impose disciplinary sanctions as set forth in sections 12 or 13.

Section 12 – Denial, Revocation, Suspension, Summary Suspension, or Limitations of Air Ambulance Licenses and Out of State License Recognitions

12.1 For good cause shown, the Department may deny, revoke, suspend limit, or condition the license or out of state recognition of an air ambulance service, or impose civil penalties as set forth in section 13 of these rules.

12.2 Good cause for sanctions include but are not limited to:

12.2.1 An applicant or licensee who fails to meet the requirements as set forth in these rules.

12.2.2 An applicant or licensee who has committed fraud, misrepresentation, or deception in applying for a license or out of state license recognition.

12.2.3 Falsifying reporting information provided to the Department.

12.2.4 Violating any state or federal statute, rule or regulation that would jeopardize or may impact the health or medical safety of a patient or the public.

12.2.5 Unprofessional conduct, which hinders, delays, eliminates, or deters the provision of medical care to the patient or endangers the public.

12.2.6 Failure to maintain accreditation without obtaining a state license pursuant to section 5.3.

12.2.7 Altering, removing or obliterating any portion of or any official entry on an application or other document.

12.2.8 Interfering with the Department in the performance of its duties.

12.2.9 Failing to reapply for a license or out of state licensure recognition in a timely manner and in accordance with these rules.

12.2.10 Providing patient care that fails to meet acceptable minimum standards.

12.2.11 Being disciplined by a licensing authority or approved accreditation agency.

12.2.12 Failing to maintain confidentiality of protected patient information.

12.2.13 Failing to comply with the terms of any agreement or stipulation regarding licensing or recognition entered into with the Department.

12.3 In accordance with section 24-4-104(4) C.R.S., the Department may summarily suspend an air ambulance license or out of state license recognition when the Department has objective and reasonable grounds to believe and finds, upon a full investigation, that the holder of the license or recognition has been guilty of deliberate and willful violation or that the public health, safety or welfare imperatively requires emergency action by the Department. If the Department summarily suspends a license or out of state license recognition, the Department shall provide the air ambulance service with notice of such suspension in writing. The notice shall state that the air ambulance service is entitled to a prompt hearing on the matter.

12.4 Notice of Appeal

12.4.1 The Department shall notify the air ambulance service of its right to appeal the denial, revocation, suspension, summary suspension, or limitation, and the procedure for appealing. Appeals of Departmental denials, revocations, suspensions, summary suspensions, or limitations shall be conducted in accordance with the State Administrative Procedure Act, section 24-4-101, *et seq.*, C.R.S.

Section 13 – Civil Penalties

13.1 The Department may impose a civil penalty of up to five thousand dollars per violation or for each day of a continuing violation upon an air ambulance operator, service, or provider or other person who:

13.1.1 Violates section 25-3.5-307, C.R.S.;

13.1.2 Violates section 25-3.5-307.5, C.R.S.;

13.1.3 Violates any rule of the board; or

13.1.4 Operates without a current and valid license.

13.2 The Department shall assess and collect these penalties.

13.3 Notice and hearing. Before collecting a penalty, the Department shall provide the alleged violator with notice and the opportunity for a hearing in accordance with the State Administrative Procedure Act, section 24-4-101, *et seq.*, C.R.S, and all applicable rules of the board.

Section 14 – Waivers

14.1 The Department may grant a waiver of a rule if the applicant satisfactorily demonstrates:

14.1.1 The proposed waiver does not adversely affect the health and safety of a patient; and

14.1.2 In the particular situation, the requirement serves no beneficial purpose; or

14.1.3 Circumstances indicate that the public benefit of waiving the requirement outweighs the public benefit to be gained by strict adherence to the requirement.

14.2 To apply for a waiver, the applicant must submit a completed application in the form and manner determined by the Department. The application shall contain the following information:

- 14.2.1 The text or substance of the regulation that the applicant wants waived;
- 14.2.2 The nature and extent of the relief sought;
- 14.2.3 Any facts, views and data available to support the waiver, including an explanation of why the application satisfies the criteria set forth in section 14.1.
- 14.3 An application shall not be considered complete until the required information is submitted.
- 14.4 The completed waiver application shall be submitted to the Department in a timely fashion as specified by the Department.
- 14.5 The application and supporting information shall be a matter of public record and is subject to disclosure under the Colorado Open Records Act (§24-72-200.1 *et seq.*, C.R.S.)
- 14.6 The Department may also consider any other information it deems relevant, including but not limited to complaint investigation reports, compliance history, including in other states, related to the applicant.
- 14.7 Waivers are generally granted for a limited term and shall be granted for a period no longer than the license term. Waivers cannot be granted for any statutory requirement under state or federal law, or for requirements under local codes or ordinances.

Section 15 – Incorporation by Reference

- 15.1 These rules incorporate by reference the following materials:
 - 15.1.1 Occupational Safety and Health Administration (OSHA) standards, including 29 C.F.R. § 1910.1030 (2016), 29 C.F.R. § 1910.132 (2016), and 29 C.F.R. § 1910.134 (2016) are incorporated by reference.
 - 15.1.2 Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment maintains copies of the incorporated federal regulations for public inspection during regular business hours and 29 C.F.R. § 1910.132 (2016), and 29 C.F.R. § 1910.134 (2016) may be accessed at <https://www.gpo.gov/fdsys/pkg/CFR-2016-title29-vol5/pdf/CFR-2016-title29-vol5-part1910.pdf> and 29 C.F.R. § 1910.1030 (2016) may be accessed at <https://www.gpo.gov/fdsys/pkg/CFR-2016-title29-vol6/pdf/CFR-2016-title29-vol6-part1910.pdf> . Interested persons may obtain certified copies of any non-copyrighted material from the Department at cost upon request. Information regarding how the incorporated materials may be obtained or examined is available from the division by contacting:

EMTS Branch Chief
Health Facilities and EMS Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530
- 15.2 These materials have been submitted to the state publications depository and distribution center and are available for interlibrary loans. The incorporated material may be examined at any state publications depository library.

Editor's Notes

History

Section 13 eff. 03/01/2008.

Section 11 eff. 05/30/2008.

Sections 1-6 eff. 12/30/2009.

Chapter Two eff. 12/15/2010.

Entire rule eff. 06/30/2011.

Chapter One eff. 03/17/2013.

Chapter Two eff. 06/14/2013.

Chapters One, Two eff. 07/15/2014.

Chapter Five Section 6.2 eff. 12/15/2014.

Chapter One Section 5.2 eff. 01/14/2016.

Chapters One, Five eff. 07/01/2017.

Chapter One Sections 2, 3, 5, 7, Chapter Two Sections 2, 3, 4, 8, 10, 11, 12, 14, Appendices A, B, Section 15, Appendix D, Section 16, Appendix F, Section 17, Appendix G, Chapter Five eff. 01/01/2018.

Chapter Four eff. 01/14/2019.

Chapter One Section 5.5, Chapter Five Section 8.5 emer. rules eff. 04/10/2020; expired 08/08/2020.

Chapters One, Two eff. 01/01/2021.

Chapter Two Sections 1.1, 3.2, 3.2.1, Appendix B.3, Appendix F.1 eff. 12/30/2021.

Chapter Three eff. 06/14/2022.

Annotations

Rule 5.4.1.D (adopted 11/18/2009) was not extended by Senate Bill 11-078 and therefore expired 05/15/2011.