DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Emergency Medical Services, Trauma Center, Primary Stroke Center and Emergent Stroke Ready Hospital Code

2) Code Citation: 77 Ill. Adm. Code 515

3)

Section Numbers:	Proposed Actions:
515.220	Amendment
515.500	Amendment
515.725	Amendment
515.825	Amendment
515.830	Amendment
515.950	Amendment
515.975	Amendment
515.995	Amendment

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements PA 99-480 which requires Regional Emergency Medical Services (EMS) Systems to include administration of opioid antagonists in their standing medical orders. The Act also requires EMS personnel to be educated and trained in the administration and use of opioid antagonists. The amendments outline the requirements to fulfill the intention of the Act.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rule currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other rulemakings pending on this Part? Yes

Section Numbers:	Proposed Actions:	*Illinois Register* Citations:
515.100	Amendment	39 Ill. Reg. 14321; November 6, 2015

515.210	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.220	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.250	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.255	New Section	39 Ill. Reg. 14321; November 6, 2015
515.330	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.445	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.830	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.3090	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.4000	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.4010	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.4020	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5000	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5002	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5004	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5010	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5015	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5016	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5017	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5020	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5030	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5040	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5050	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5060	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5070	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5080	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.5083	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5085	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5087	New Section	39 Ill. Reg. 14321; November 6, 2015
515.5090	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.APPENDIX K	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.APPENDIX L	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.APPENDIX N	Amendment	39 Ill. Reg. 14321; November 6, 2015
515.APPENDIX O	Amendment	39 Ill. Reg. 14321; November 6, 2015
515. APPENDIX P	Amendment	39 Ill. Reg. 14321; November 6, 2015

11) Statement of Statewide Policy Objectives: This rulemaking creates a State mandate on units of local government and private profit and not-for-profit EMS providers.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

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13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: All EMS service providers who employ First Responders and Basic EMS personnel will need to purchase opioid antagonists and educate their staff. This will extend into law enforcement and fire departments that employ First Responders and Basic EMS personnel.

B) Reporting, bookkeeping or other procedures required for compliance: All EMS service providers, law enforcement and fire departments that employ First Responders and Basics will need policies created, purchase and storage of opioid antidotes and to conduct education pertaining to opioid antagonist and its use.

C) Types of professional skills necessary for compliance: All EMS service providers, law enforcement and fire department that employ First Responders and Basics will need to conduct education pertaining to opioid antagonists.

14) Regulatory Agenda on which this rulemaking was summarized: January 2016

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 515
EMERGENCY MEDICAL SERVICES, TRAUMA CENTER, PRIMARY STROKE CENTER AND EMERGENT STROKE READY HOSPITAL CODE

SUBPART A: GENERAL PROVISIONS

Section

SUBPART B: EMS REGIONS

Section

SUBPART C: EMS SYSTEMS

Section

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

SUBPART F: VEHICLE SERVICE PROVIDERS

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

SUBPART H: TRAUMA CENTERS

SUBPART I: EMS ASSISTANCE FUND

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

SUBPART K: PRIMARY STROKE CENTERS AND EMERGENT STROKE READY HOSPITALS

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

515.APPENDIX P Pediatric Critical Care Center (PCCC) Pediatric Equipment/Supplies/Medications Requirements

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35 Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6, 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208, effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15, 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683, effective June 25, 2013; amended at 37 Ill. Reg. 18883, effective November 12, 2013; amended at 37 Ill. Reg. 19610, effective November 20, 2013; amended at 38 Ill. Reg. 9053, effective April 9, 2014; amended at 38 Ill. Reg. 16304, effective July 18, 2014; amended at 39 Ill. Reg. 13075, effective September 8, 2015; amended at 40 Ill. Reg. _____, effective _____.

SUBPART B: EMS REGIONS

Section 515.220 EMS Regional Plan Content

a) *The EMS Medical Directors Committee* portion of the Regional Plan *shall address at least the following:*

1) *Protocols for inter-System/inter-Region patient transports, including*

protocols for pediatric patients and pediatric patients with special health care needs, *identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional considerations (e.g., transport times and distances);*

2) *Regional standing medical orders;*

3) *Patient transfer patterns, including criteria for determining whether a patient needs the specialized service of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or Regional trauma center, Primary Stroke Center or Emergent Stroke Ready Hospital, which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;*

4) *Protocols for resolving Regional or inter-System conflict;*

5) *An EMS disaster preparedness plan which includes the actions and responsibilities of all EMS participants within the Region* for care and transport of both the adult and pediatric population;

6) *Regional standardization of continuing education requirements;*

7) *Regional standardization of Do Not Resuscitate (DNR) policies, and protocols for power of attorney for health care;*

8) *Protocols for disbursement of Department grants* (Section 3.30(a)(1-8) of the Act);

9) *Protocols for the triage, treatment, and transport of possible acute stroke patients* developed jointly with the Regional Stroke Advisory Subcommittee (Section 3.30(a)(9) of the Act);

10) *Regional standing medical orders* shall include *the administration of opioid antagonists*. (Section 3.30(a)(10) of the Act);

11~~10~~) Protocols for stroke screening;

12~~11~~) Development of protocols to improve and integrate EMS for children (or EMSC) into the current delivery of emergency services within the Region;

and

13~~12~~) Development of a policy in regard to incidents involving school buses, which shall include, but not be limited to:

A) Assessment of the incident, including mechanism and extent of damage to the vehicle;

B) Passenger assessment/extent of injuries;

C) A provision for transporting all children with special healthcare needs and those with communication difficulties;

D) Age specific issues; and

E) Use of a release form for nontransports.

b) *The Trauma Center Medical Directors or Trauma Center Medical Directors Committee* portion of the Regional Plan *shall address at least the following:*

1) *The identification of Regional Trauma Centers* and identification of trauma centers that specialize in pediatrics;

2) *Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional considerations (e.g., transport times and distances);*

3) *Regional trauma standing medical orders;*

4) *Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or Regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal* (These policies must include the criteria of Section 515.Appendix C.);

5) *The identification of which types of patients can be cared for by Level I*

and Level II Trauma Centers;

6) *Criteria for inter-hospital transfer of trauma patients,* including the transfer of pediatric patients;

7) *The treatment of trauma patients in each trauma center within the Region;*

8) *The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to the Department; and*

9) *A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients.* (Section 3.30(b)(1-9) of the Act)

A) This shall include but not be limited to all cases that have been deemed potentially preventable or preventable in the trauma center review using Resources for Optimal Care of the Injured Patient. This review should exclude trauma patients who were dead on arrival.

B) In addition, the review shall include all patients who were transferred more than two hours after time of arrival at the initial institution and who meet one or more of the following criteria at the receiving trauma center:

i) Admitted to an intensive care unit;

ii) Admitted to a bed with telemetry monitoring;

iii) Went directly to the operating room;

iv) Went to the operating room from the emergency department;

v) Discharged to a rehabilitation or skilled care facility;

vi) Died following arrival.

C) The Region shall include a review of morbidity/audit filters that have been determined by the Region.

D) Cumulative Regional reports will be made available upon request from the Department.

c) The Regional Stroke Advisory Subcommittee portion of the Region Plan shall address at least the following:

1) The identification of Primary Stroke Centers and Emergent Stroke Ready Hospitals and their incorporation in the Region Plan and the System Program Plan;

2) In conjunction with the EMS Medical Directors, development of protocols for identifying and transporting acute stroke patients to the nearest appropriate facility capable of providing acute stroke care. These protocols shall be consistent with individual System bypass or diversion protocols and protocols for patient choice;

3) Regional stroke transport protocols recommended by the Regional Stroke Advisory Subcommittee and approved by the EMS Medical Directors Committee; and

4) With the EMS Medical Directors, joint development of acute stroke patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a Primary Stroke Center or Emergent Stroke Ready Hospital, along with protocols for the bypassing of, or diversion to, any hospital, which are consistent with individual inter-system bypass or diversion protocols and protocols for patient choice or refusal.

d) *The Director shall coordinate with and assist the EMS System Medical Directors and Regional Stroke Advisory Subcommittee within each EMS Region to establish protocols related to the assessment, treatment, and transport of possible acute stroke patients by licensed emergency medical services providers. These protocols shall include regional transport plans for the triage and transport of possible acute stroke patients to the most appropriate Primary Stroke Center or Emergent Stroke Ready Hospital, unless circumstances warrant otherwise.* (Section 3.118.5(f) of the Act)

e) *The Region's EMS Medical Directors and Trauma Center Medical Directors Committees shall appoint any subcommittees which they deem necessary to address specific issues concerning Region activities.* (Section 3.30(c) of the Act)

f) Internal Disaster Plans

1) Each System hospital shall submit an internal disaster plan to the EMS Medical Directors Committee and the Trauma Center Medical Directors Committee.

2) The hospital internal disaster plan shall be coordinated with, or a part of, the hospital's overall disaster plan.

3) The plan shall be coordinated with local and State disaster plans.

4) The hospital internal disaster plan shall be developed by a hospital committee and shall at a minimum:

A) Identify the authority to implement the internal disaster plan, including the chain of command and how notification shall be made throughout the hospital;

B) Identify the critical operational elements required in the hospital in an internal disaster;

C) If the facility needs to go on bypass or resource limitation status, identify the person responsible for notification and the persons both outside and within the hospital who should be notified;

D) Identify a person or group responsible for ensuring that needed resources and supplies are available;

E) Identify a person to communicate with representatives from other agencies, organizations, and the EMS System;

F) Identify a person who is responsible for procuring all supplies required to manage the facility and return the facility to the pre-incident status;

G) Identify the plan and procedure for educating facility employees on their role and responsibilities during the disaster;

H) Designate a media spokesperson;

I) Establish a method for resource coordination between departments and individuals to address management of staff, patients and patient flow patterns;

J) Designate a person (safety officer) with responsibility for establishing safety policies to include, but not be limited to, decontamination operations, safety zones, site safety plans, evacuation parameters, and traffic patterns;

K) Designate a location where personnel, not actually committed to the incident, will report for assignments, as needed (i.e., a staging area);

L) Include notification procedures to EMS Systems, area ambulances, both public and private, and police and fire authorities of the type of incident that caused the hospital to implement its internal disaster plan and of any special instructions, e.g., use of a different driveway or entrance;

M) Establish a designated form of communication, both internal and external, to maintain two-way communication (e.g., Mobile Emergency Communications of Illinois (MERCI), ham radio, walkie talkies);

N) Include a policy to call in additional nursing staff when an identified staffing shortage exists;

O) Include the policy developed pursuant to Section 515.315(f);

P) *Include contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to a power failure* (Section 3.30 of the Act); and

Q) Address biological and chemical incidents and the availability of

decontamination.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section 515.500 Emergency Medical Technician-Basic Training

a) Applications for approval of EMT-B Training Programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, lead instructor's name and address, dates of the training program, and name and signature of EMS MD.

b) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days before the first scheduled class. A description of the clinical requirements, textbook being used and passing score for the class shall be included with the application.

c) The EMS MD shall attest on the application form that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum (minimum sections shall include #1 through #7 of the National Curriculum for EMT Basic), and that all instructors are knowledgeable in the material and capable of instructing at the EMT-B level. The curriculum shall include, at a minimum, training in the use of epinephrine for both adults and children for application in the treatment of allergic reactions and anaphylaxis, and in the administration and use of opioid antagonists.

d) The EMT-B training program shall designate an EMS Lead Instructor who, shall be responsible for the overall management of the training program, shall be approved by the Department based on requirements of Section 515.700.

e) The lead Instructor for the training class shall be responsible for ensuring that no EMT training class begins until after the Department issues its formal written pre-approval, which shall be in the form of a numeric site approval code.

f) The lead instructor for the training class shall be responsible for ensuring that all materials presented to EMT students conform to all curriculum requirements of both the Department and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both the Department and the

EMS System shall not be taught or presented.

g) Any change, except for an emergency change (e.g., weather or instructor illness) in the EMT-B training program's EMS MD or EMS Lead Instructor, shall require an amendment to be filed with the Department.

h) Questions for all quizzes and tests to be given during the EMT-B training program shall be prepared by the EMS Lead Instructor and available upon the Department's request.

i) Each approved training program shall submit a student roster within 10 days after the first class as well as a student roster indicating successful or unsuccessful completion within 10 days after the last class. An examination roster shall be submitted to the Department prior to the deadline date for examination.

j) All approved programs shall maintain class and student records for seven years, and these shall be made available to the Department upon request.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section 515.725 First Responder/Emergency Medical Responder

a) A First Responder/Emergency Medical Responder training program shall be pre-approved by the Department and conducted only by an EMS System or a community college under the direction of the EMS System.

b) Applications for approval of First Responder/Emergency Medical Responder training programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS Medical Director (EMS MD) and EMS System Coordinator.

c) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days in advance of the first scheduled class.

d) The EMS MD of the EMS system shall attest on the application form that the training program shall be conducted according to the National EMS Educational Curriculum. The First Responder or Emergency Medical Responder training program shall include all components of the National EMS Educational Curriculum and education and training in the administration and use of opioid antagonists. The course hours shall minimally include 52~~40~~ hours of didactic education.

e) The First Responder/Emergency Medical Responder training program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the training program and shall be approved by the Department based on requirements of Section 515.700.

f) The EMS MD shall electronically submit to the Department approval for licensure for a First Responder/Emergency Medical Responder candidate who is at least 18 years of age and has completed and passed all components of the training program, has passed the Final Examination, and has paid the appropriate initial licensure fee. The initial licensure fee may be waived pursuant to Section 515.460(c).

g) All approved programs shall maintain class and student records for seven years, which shall be made available to the Department upon request.

h) Continuing education classes, seminars, workshops, or other types of programs shall be approved by the Department before being offered to First Responder/Emergency Medical Responder candidates. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department at least 60 days prior to the scheduled event.

i) Approval will be granted provided that the application is complete and the content of the program is based on topics or materials from the National EMS Educational Curriculum for the Emergency Medical Responder.

j) A First Responder/Emergency Medical Responder shall be responsible for submitting written proof of continuing education attendance to the EMS System Coordinator or, for independent renewals, to the Department Regional EMS

Coordinator. The EMS System Coordinator or Department Regional EMS Coordinator shall verify whether specific continuing education hours submitted by the First Responder/Emergency Medical Responder qualify for renewal.

k) A First Responder/Emergency Medical Responder shall maintain copies of all documentation concerning continuing education programs that he or she has completed.

l) A First Responder/Emergency Medical Responder license shall be valid for a period of four years. To be re-licensed as a First Responder/Emergency Medical Responder, the First Responder/Emergency Medical Responder shall submit an application for renewal with the Department, on a form prescribed by the Department, and the $20 licensure renewal fee at least 30 days prior to the license expiration date. The renewal licensure fee may be waived pursuant to Section 515.460(c).

1) The submission of an electronic transaction by the EMS MD will satisfy the renewal application requirement for a First Responder/Emergency Medical Responder who has been recommended for re-licensure by the EMS MD.

2) A First Responder/Emergency Medical Responder who has not been recommended for re-licensure by the EMS MD shall-independently submit to the Department an application for renewal. The EMS MD shall provide the First Responder/Emergency Medical Responder with a copy of the application form.

m) A written recommendation signed by the EMS MD shall be provided to the Department regarding completion of the following requirements:

1) 24 hours of continuing education every four years. The System shall define in the EMS Program Plan the number of continuing education hours to be accrued each year for re-licensure; and

2) Current certification in CPR for Healthcare Providers in accordance with the standards of a nationally recognized organization such as the American Heart Association or American Red Cross, which includes both a didactic and clinical skills station.

n) A First Responder/Emergency Medical Responder whose licensure has expired may, within 60 days after licensure expiration, submit all re-licensure material as required in this Part and a fee of $50 in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in compliance with this Section and there is no disciplinary action pending against the First Responder/Emergency Medical Responder, the Department will re-license the First Responder/Emergency Medical Responder.

o) First Responders who are not affiliated with an EMS system shall have equipment immediately available to provide the standard of care established by the National EMS Educational Curriculum for the First Responder.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.825 Alternate Response Vehicle

a) Ambulance assistance vehicles
Ambulance assistance vehicles are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. These assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by this Section. These vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available. The agency shall identify these vehicles as a program plan amendment outlining the type and level of response that is planned. The vehicle shall not transport or be a primary response vehicle but a supplementary vehicle to support EMS services. The vehicle shall be dispatched only if needed. Ambulance assistance vehicles shall be classified as either:

1) Advanced ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-P and shall have all of the required equipment; or

2) Intermediate ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-I and shall have all of the required equipment; or

3) Basic ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-B and shall have all of the required equipment; or

4) First Responder assistance vehicles. These vehicles shall be staffed with a minimum of one First Responder and shall have all of the required equipment.

b) Non-transport vehicles
Non-transport vehicles are dispatched prior to dispatch of a transporting ambulance. These vehicles include ambulances and fire engines that contain the staff and equipment required by this Section. The vehicle service provider shall identify these vehicles as a program plan amendment outlining the type and level of response that is planned. These vehicles shall be staffed 24 hours per day, every day of the year.

1) ALS/ILS non-transport vehicles. These vehicles shall have a minimum of either one EMT-P, or one EMT-I and one other EMT-B, and shall have all of the required equipment.

2) BLS non-transport vehicles. These vehicles shall have a minimum of two EMT-Bs and have all of the required equipment.

c) Equipment requirements
Each vehicle used as an alternate response vehicle shall meet the following equipment requirements, as determined by the Department by an inspection.

1) Full portable oxygen cylinder, with a capacity of not less than 350 liters

2) Dial flowmeter/regulator for 15 liters per minute

3) Delivery tubes

4) Adult, child and infant masks

5) Adult squeeze bag and valve, with adult and child masks

6) Child squeeze bag and valve, with child, infant and newborn size masks

7) Airways, oropharyngeal − adult, child and infant (sizes 00-5)

8) Airways, nasopharyngeal with lubrication (sizes 12-30F)

9) Manually operated suction device

10) Triangular bandages or slings

11) Roller bandages, self-adhering (4" by 5 yds)

12) Trauma dressings

13) Sterile gauze pads (4" by 4")

14) Vaseline gauze (3" by 8")

15) Bandage shears

16) Adhesive tape rolls

17) Blanket

18) Long backboard

19) Cervical collars − adult, child and infant

20) Extremity splints − adult/child, long/short

21) Adult/child/infant blood pressure cuffs and gauge

22) Stethoscope

23) Burn sheet, individually wrapped

24) Sterile saline or water solution (1,000ml), plastic bottles or bags

25) Obstetrical kit, sterile − minimum one, pre-packaged with instruments, bulb syringe and cord clamps

26) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

27) Cold packs

28) EMS run reports

29) Nonporous disposable gloves

30) Eye/nose/mouth protection or face shields

31) Flashlight

32) Equipment to allow reliable communications with hospital

33) ILS/ALS System-approved equipment

A) Drug box

B) Airway equipment, including laryngoscope and assorted blades

C) Monitor/defibrillator, equipped with pediatric size defibrillation pads or paddles

34) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care

e) Registration of non-transport agencies
Each non-transport provider shall complete and submit to the Department one of the following: the First Responder Provider Initial EMS System Application (Form First 10/97), the Non-Transport Provider EMS System Application (Form NT 5/97), or the Non-Transport Provider Application (Form NT 6/99).

f) Inspection of non-transport EMS providers
The Regional EMS Coordinator will perform initial inspections. Thereafter, non-transport ambulance assist providers shall perform annual self-inspections, using forms provided by the Department, and shall submit the form to the Department upon completion of the inspection. The Regional EMS Coordinator will perform inspections randomly or as the result of a complaint.

g) Issuance and renewal of license
Upon payment of the appropriate fee, qualifying non-transport providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual non-transport vehicles. Providers shall inform the EMS System and the Department of any modifications to the

application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 515.830 Ambulance Licensing Requirements

a) Vehicle Design

1) Each new vehicle used as an ambulance shall comply with the criteria established by the U.S. General Services Administration's Specification for Ambulance (KKK-A-1822F), with the exception of Section 3.16.2, Color, Paint and Finish.

2) *A licensed vehicle* shall be exempt *from subsequent vehicle design standards or specifications required by the Department* in this Part, *as long as* the *vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until* the *vehicle's title of ownership is transferred*. (Section 3.85(b)(8) of the Act)

3) The following requirements listed in Specification KKK-A-1822F shall be considered mandatory in Illinois even though they are listed as optional in that publication:

A) 3.7.7.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item 7).

B) 3.8.5.2 Patient compartment checkout lights will be provided (see 3.15.3 item 9).

C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).

D) 3.15.4M3 Electric clock with sweep second hand will be provided.

b) Equipment Requirements – Basic Life Support Vehicles
Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Stretchers, Cots and Litters

   A) Primary Patient Cot
   Shall meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822F.

   B) Secondary Patient Stretcher
   Shall meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822F.

2) Oxygen, portable
Shall meet the operational requirements of section 3.12.2 of KKK-A-1822-F.

3) Suction, portable

   A) Shall meet the operational requirements of section 3.12.4 of KKK-A-1822F.

   B) A manually operated suction device is acceptable if approved by the Department.

4) Medical Equipment

   A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask and child size bag-valve-mask ventilation unit with child, infant and newborn size transparent masks

   B) Lower-extremity traction splint, adult and pediatric sizes

   C) Blood pressure cuff, one each, adult, child and infant sizes and gauge

   D) Stethoscopes, two per vehicle

   E) Pneumatic counterpressure trouser kit, adult size, optional

   F) Long spine board with three sets of torso straps, 72" x 16" minimum

G) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional

H) Airway, oropharyngeal – adult, child, and infant, sizes 00-5

I) Airway, nasopharyngeal with lubrication, sizes 12-34F

J) Two adult and two pediatric sized non-rebreather oxygen masks per vehicle

K) Two infant partial re-breather oxygen masks per vehicle

L) Three nasal cannulas, adult and child size, per vehicle

M) Bandage shears, one per vehicle

N) Extremity splints, adult, two long and short per vehicle

O) Extremity splints, pediatric, two long and short per vehicle

P) Rigid cervical collars – one pediatric, small, medium, and large sizes or adjustable size collars per vehicle. Shall be made of rigid material to minimize flexion, extension, and lateral rotation of the head and cervical spine when spine injury is suspected

Q) Patient restraints, arm and leg, sets

R) Pulse oximeter with pediatric and adult probes

S) AED or defibrillator that includes pediatric capability

5) Medical Supplies

A) Trauma dressing – six per vehicle

B) Sterile gauze pads – 20 per vehicle, 4 inches by 4 inches

C) Bandages, soft roller, self-adhering type, 10 per vehicle, 4 inches by 5 yards

D) Vaseline gauze – two per vehicle, 3 inches by 8 inches

E) Adhesive tape rolls – two per vehicle

F) Triangular bandages or slings – five per vehicle

G) Burn sheets – two per vehicle, clean, individually wrapped

H) Sterile solution (normal saline) – four per vehicle, 500 cc or two per vehicle, 1,000 cc plastic bottles or bags

I) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

J) Obstetrical kit, sterile – minimum one, pre-packaged with instruments and bulb syringe

K) Cold packs, three per vehicle

L) Hot packs, three per vehicle, optional

M) Emesis basin – one per vehicle

N) Drinking water – one quart, in non-breakable container; sterile water may be substituted

O) Ambulance emergency run reports – 10 per vehicle, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515.Appendix E or electronic documentation with paper backup

P) Pillows – two per vehicle, for ambulance cot

Q) Pillowcases – two per vehicle, for ambulance cot

R) Sheets – two per vehicle, for ambulance cot

S) Blankets – two per vehicle, for ambulance cot

T) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care~~CPR mask – one per vehicle, with safety valve to prevent backflow of expired air and secretions~~

U) Urinal

V) Bedpan

W) Remains bag, optional

X) Nonporous disposable gloves

Y) Impermeable red biohazard-labeled isolation bag

Z) Face protection through any combination of masks and eye protection and field shields

AA) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall have a thumb suction control port

BB) Child and infant or convertible car seats

CC) Current equipment/drug dosage sizing tape or pediatric equipment/drug age/weight chart

DD) Flashlight, two per vehicle, for patient assessment

EE) Current Illinois Department of Transportation Safety Inspection sticker in accordance with Section 13-101 of the Illinois Vehicle Code

FF) Illinois Poison Center telephone number

GG) Department of Public Health Central Complaint Registry telephone number posted where visible to the patient

HH) Medical Grade Oxygen

c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS Medical Director in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

d) Equipment Requirements – Rescue and/or Extrication
The following equipment shall be carried on the ambulance, unless the ambulance is routinely accompanied by a rescue vehicle:

1) Wrecking bar, 24"

2) Goggles for eye safety

3) Flashlight – one per vehicle, portable, battery operated

4) Fire Extinguisher – two per vehicle, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment

e) Equipment Requirements – Communications Capability
Each ambulance shall have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400 of this Part.

f) Equipment Requirements – Epinephrine
A person currently licensed as an EMT-B, EMT-I, or EMT-P who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) *with him or her* in the ambulance or drug box *as part of the EMT medical supplies whenever he or she is performing the duties of an emergency medical technician,* within the context of the EMS System plan. (Section 3.55(a-7) of the Act)

g) Personnel Requirements

1) Each Basic Life Support ambulance shall be staffed by a minimum of one EMT Basic, Intermediate, Paramedic or Pre-Hospital RN and one other

EMT Basic, Intermediate, Paramedic, Pre Hospital RN or physician on all responses.

2) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one Intermediate, Paramedic or Pre-Hospital RN and one other EMT Basic, Intermediate, Paramedic, Pre-Hospital RN or physician on all responses.

3) Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one Paramedic or Pre-Hospital RN and one other EMT Basic, Intermediate, Paramedic, Pre-Hospital RN or physician on all responses.

h) Alternate Rural Staffing Authorization-

1) A Vehicle Service Provider *that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers or paid-on-call personnel or a combination* to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMT licensed at or above the level at which the vehicle is licensed, plus one First Responder/Emergency Medical Responder when two licensed Emergency Services Personnel are not available to respond. (Section 2.85(b)(3) of the Act)

2) The EMT licensed at or above the level at which the ambulance is licensed shall be the primary patient care provider in route to the health care facility.

3) The Vehicle Service Provider shall obtain the prior written approval for alternate rural staffing from the EMS MD. The EMS MD shall submit to the Department a request for an amendment to the existing EMS System plan that clearly demonstrates the need for alternate rural staffing in accordance with subsection (h)(4) and that the alternate rural staffing will not reduce the quality of medical care established by the Act and this Part.

4) A Vehicle Service Provider requesting alternate rural staffing authorization shall clearly demonstrate all of the following:

A) That it has undertaken extensive efforts to recruit and train licensed

EMS personnel;

B) That, despite its exhaustive efforts, licensed EMS personnel are not available; and

C) That, without alternate rural staffing authorization, the rural or semi-rural population of 10,000 or fewer inhabitants served will be unable to meet staffing requirements as specified in subsection (g).

5) The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates not to exceed 48 months. The EMS MD shall re-evaluate subsequent requests for authorization for compliance with subsections (h)(4)(A) through (C). Subsequent requests for authorization shall be submitted to the Department for approval in accordance with this Section.

6) Alternate rural staffing authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate rural staffing authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate rural staffing authorization presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing.

7) Vehicle Service Providers that cannot meet the alternate rural staffing authorization requirements of this Section may apply through the EMS MD to the Department for a staffing waiver pursuant to Section 515.150.

i) Alternate Response Authorization

1) A Vehicle Service Provider that exclusively uses volunteers or paid-on-call personnel or a combination to provide patient care who are not required to be stationed with the vehicle may apply to the Department for alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed by at least one licensed Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician,

Emergency Medical Technician-Intermediate, Paramedic or Pre-Hospital RN ("Emergency Services Personnel").

2) A Vehicle Service Provider operating under alternate response authorization shall ensure that a second licensed Emergency Services Personnel is on scene or in route to the emergency response location.

3) The Vehicle Service Provider shall demonstrate to the Department that it has safeguards to ensure that no patient will be transported with fewer than two EMTs, at least one of whom shall be licensed at or above the level of the license for the vehicle, unless the Vehicle Service Provider is approved for alternate rural staffing authorization.

4) Alternate response authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization presents an immediate threat to the health or safety of the public. After summary suspension, the licensee shall have the opportunity for an expedited hearing (see Section 515.180).

j) Alternate Response Authorization – Secondary Response Vehicles

1) A Vehicle Service Provider that uses volunteers or paid-on-call personnel or a combination to provide patient care, and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one licensed Emergency Services Personnel.

2) A Vehicle Service Provider operating under the alternate response authorization shall ensure that a second licensed Emergency Services Personnel provider is on the scene or in route to the emergency response location.

3) The Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with fewer than two EMTs, at least one of whom shall be licensed at or above the level of the license for the ambulance, unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h).

4) Alternate response authorization for secondary response vehicles may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization for secondary response vehicles may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization for secondary vehicles presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing (see Section 515.180).

k) Operational Requirements

1) An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the Act and this Part.

2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required in this subsection (k), each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS, ILS or BLS level, and the coverage shall meet the requirements of this Section.

A) At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

i) A current roster shall also be submitted that lists the EMS Personnel, Pre-Hospital RNs and physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's

name, license number, license expiration date and daytime telephone number, and shall state whether the person is scheduled to be on site or on call.

ii) An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

B) Licensees shall obtain the EMS MD's approval of their vehicles' hours of operation prior to submitting an application to the Department. An EMS MD may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

C) A Vehicle Service Provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.

3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Section 515.Appendix E.

4) A Vehicle Service Provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.

5) A Vehicle Service Provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h).)

6) A Vehicle Service Provider shall not operate its ambulance at a level exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless the vehicle is operated pursuant to an EMS System-approved in-field service level

upgrade or ambulance service upgrades – rural population.

7) The Department will inspect ambulances each year. If the Vehicle Service Provider has no violations of this Section that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it, the Department will inspect the Vehicle Service Provider's ambulances in alternate years, and the Vehicle Service Provider may, with the Department's prior approval, self-inspect its ambulances in the other years. The Vehicle Service Provider shall use the Department's inspection form for self-inspection. Nothing contained in this subsection (k)(7) shall prevent the Department from conducting unannounced inspections.

l) A licensee may use a replacement vehicle for up to 10 days without a Department inspection, provided that the Department is notified of the use of the vehicle by the second working day.

m) *Patients, individuals who accompany a patient, and emergency services personnel may not smoke while inside an ambulance or SEMSV. The Department of Public Health* shall *impose a civil penalty on an individual who violates this subsection* (m) *in the amount of $100.* (Section 3.155(h) of the Act)

n) Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section 515.950 Aircraft Medical Equipment and Drugs

a) Each helicopter or fixed-wing aircraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) The SEMSV Medical Director shall submit for approval to the Department a list of medical equipment and drugs to be taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route. This shall include, but not be

limited to:

1) Cardiac monitor with extra battery;

2) Defibrillator that is adjustable for all age groups;

3) External pacemaker;

4) Advanced airway equipment, including laryngoscope and tracheal intubation supplies for all age ranges;

5) Mechanical ventilator available;

6) Two suction sources; one must be portable;

7) Pulse oximeter;

8) End tidal CO_2 − electronic or chemical;

9) Automatic blood pressure monitor;

10) Doppler with dual capacity to obtain fetal heart tones as well as systolic blood pressure;

11) Invasive pressure monitor;

12) Intravenous pumps with adjustable rates for appropriate age groups;

13) Two sources of oxygen; one must be portable;

14) A stretcher that is large enough to carry the 95^{th} percentile adult, full length in supine position, and that is rigid enough to support effective cardiopulmonary resuscitation and has the capability of raising the head 30°;

15) Electrical power source provided by an inverter or appropriate power source of sufficient output to meet the requirements of the complete specialized equipment package without compromising the operation of any electrical aircraft equipment;

16) If the patient weighs less than 60 lbs. (27 kg.), an appropriate (for height and weight) restraint device shall be used, which shall be secured by a devise approved by the Federal Aviation Administration (14 CFR 135); ~~and~~

17) An isolette if the service mission profile includes neonate transports; and~~.~~

18) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care of the SEMSV.

c) The Department's approval shall be based on, but not limited to:

1) Length of time of the mission;

2) Possible environmental or weather hazards;

3) Number of individuals served; and

4) Medical condition of individuals served.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 515.975 Watercraft Medical Equipment and Drugs

a) Each watercraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) Opioid antagonist, including, but not limited to, Naloxone, appropriate for the licensed level of care of the SEMSV.

c~~b~~) For ALS operations, the SEMSV Medical Director shall submit for approval a list of supplies available for each mission used. The SEMSV Medical Director shall decide on the medical equipment and drugs taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

d~~c~~) The Department's approval shall be based on, but not limited to:

1) length of time of the mission;

2) possible environmental or weather hazards;

3) number of individuals served; and

4) medical condition of individuals served.

(Source: Amended at 40 Ill. Reg. _____, effective _____)

Section 515.995 Off-Road Medical Equipment and Drugs

a) Each off-road SEMSV shall be equipped with medical equipment and drugs for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) Opioid antagonist, including, but not limited to, Naloxone, appropriate for the licensed level of care of the SEMSV.

c~~b~~) For Advanced Life Support (ALS) operations, the SEMSV Medical Director shall submit for approval a list of supplies available for each mission. The SEMSV Medical Director shall decide what medical equipment and drugs are taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

(Source: Amended at 40 Ill. Reg. _____, effective _____)