

Southeastern Massachusetts Emergency Medical Services Council, Inc.
Commonwealth of Massachusetts EMS Region V
Community Resource Survey

This survey has been developed, in accordance with EMS 2000, so that the Regional Council has accurate data regarding the communities and EMS providers within the region. This data will be used to aid communities in the development of Service Zone Planning.

Part I Demographics

Survey Completed By: _____ Title: _____

Name of Agency: _____ Date of Survey: _____

Address of Agency: _____

City/Town: _____

State: _____ Zip: _____

Mailing Address (if different): _____

City/Town: _____

State: _____ Zip: _____

Do you have a Satellite location? Yes No

If yes, address of Satellite location: _____

City/Town: _____

State: _____ Zip: _____

Primary Office Phone Number: _____

Satellite Office Phone Number: _____

Office Fax Number: _____

Satellite Office Phone Number: _____

PART II Provider Demographics

Type of Service: Fire Police Volunteer Hospital Based 3rd Service Private Other

EMS Level of Care:

(Please check all that apply)

First Responder Intermediate Life-Support Advanced Life Support – Transporting

Basic Life Support Advanced Life Support – Non Transporting

Contacts:

Executive Officer/Chief: _____

Director of Operations: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Service Medical Director: _____

EMS Officer/Director: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Training Officer/Coordinator: _____

Communications Director: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

QA/QI Manager: _____

DICO: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

PART III Personnel

Total Number of First Responders: _____ Total Number of EMT-Basics: _____
AED: _____ AED: _____
Epi-pen: _____
Medication Assist: _____

Total Number of EMT-Intermediates: _____ Total Number of EMT-Paramedics: _____
AED: _____ Inter-facility Transfer: _____
Epi-Pen: _____ Critical Care Paramedic: _____

Part IV Apparatus In-Service

Total Number of First Responder Units: (cruiser, engine, harbor patrol, etc.) _____
Total Number of Basic Life Support Units: (Transporting / Dedicated BLS) _____
Total Number of Basic Life Support Units (Non-transporting / Dedicated BLS) _____
Total Number of EMT-Intermediate Level Units: (Transporting / Dedicated ILS) _____
Total Number of EMT-Intermediate Level Units: (Non-transporting / Dedicated ILS) _____
Total Number of Advanced Life Support Units: (Transporting / Dedicated ALS) _____
Total Number of Advanced Life Support Units: (Non-Transporting / Dedicated ALS) _____

PART V Responses & Transports

Total Number of EMS Responses: _____ Total Number of EMS Transports: _____
Total Number of Patients treated at the BLS level: _____ 911: _____ Inter-facility Transfer: _____
Total Number of Patients treated at the Intermediate Level: _____ 911: _____ Inter-facility Transfer: _____
Total Number of Patients treated at the Paramedic Level: _____ 911: _____ Inter-facility Transfer: _____
Total Number of Critical Care Transfers: _____

PART VI Hospitals / Physicians

Hospital Affiliation(s) _____

Medical Control Facility(s)

PART VIII EPI-Pen Program

Participation in the EPI-pen program: Yes No

If yes, what levels? EMT-Basic EMT-Intermediate EMT-Paramedic

Total Number: Total Number: Total Number:

Affiliate Hospital: _____

Address: _____

Medical Director: _____ QA/QI Contact: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

Number of EPI-pens in service: _____

(Please complete)

Model of EPI-Pen	Type (PEDI / ADULT)	Number in stock

PART IX EMS Resources

(Please include agency name, coverage area, and number of units):

Primary First Response Agency: _____

First Back up: _____

Second Back up: _____

Primary BLS Ambulance Service: _____

First Back up: _____

Second Back up: _____

Primary Intermediate Level Ambulance Service: _____

First Back up: _____

Second Back up: _____

Primary ALS Ambulance Service: _____

- Transporting
- Non – transporting

ALS First Back up: _____

- Transporting
- Non – transporting

ALS Second Back up: _____

- Transporting:
- Non - transporting

PART X Community Medical Facilities

List all Medical Facilities within your community:

(This includes Hospitals, Group Medical Offices, Urgent Care Facilities, Skilled Nursing Facilities, Rehabilitation Facilities, Specialty Facilities, etc.)

Name of Facility: _____ Type of Facility: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of Facility: _____ Type of Facility: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of Facility: _____ Type of Facility: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of Facility: _____ Type of Facility: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Please attach extra sheets of paper as needed to complete this section.

PART XI Public Safety Access Point (PSAP) 911 Center

Who operates the 911 Center: Police Fire EMS Public Civilian

Other _____

How many 911 operators do you employ: _____

Are 911 operators Emergency Medical Dispatch trained? Yes No Number Trained: _____

What EMD program did they complete? (check all that apply) Medical Priority APCO Other

Name of agency operating 911 center: _____

Address: _____

Phone: _____ Fax: _____

911 Center Director: _____

Phone: _____ Fax: _____

Does 911 center have internet access: Yes No

If yes, is it dedicated to displaying the diversion status board: Yes No

Primary Radio Frequency: _____ Secondary Radio Frequency: _____

UHF: _____ UHF: _____

VHF: _____ VHF: _____

800 Trunked: _____ 800 Trunked: _____

Other: _____ Other: _____

Mutual Aid Frequency: _____

UHF: _____

VHF: _____

800 Trunked: _____

Other: _____

Does your agency utilize the UHF CMED System: (Med 1-8 cables) Yes No

Where: Ambulance Fire Unit Police Cruiser Supervisor Unit Communications Center

Base Base Base Base

Portable Portable Portable Portable

Does your agency provide Community EMS Education & Awareness Programs?

Yes

No

Part XIV Other Resources

Please list other local resources available to your Agency:

(ie., Specialized Search & Rescue teams, CISM, HazMat/Decon Teams, Public Access AED Programs, other Ambulance Services, Pharmacies, Home Depot, Office of Emergency Medical Management, LEPC, Mall Security, etc.)

Name of resource: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of resource: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of resource: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Name of resource: _____

Address: _____

Phone: _____ Fax: _____ Contact Person: _____

Please attach extra sheets of paper as needed to complete this section.

PART XV Other First Response Resources

Other first response resources include, but is not limited to, park rangers, harbor patrols, lifeguards, etc.

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Contact person: _____ # of responders: _____ AED: Yes No

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Contact person: _____ # of responders: _____ AED: Yes No

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Contact person: _____ # of responders: _____ AED: Yes No

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Contact person: _____ # of responders: _____ AED: Yes No

Agency: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Contact person: _____ # of responders: _____ AED: Yes No

Please attach extra sheets of paper as needed to complete this section.

