State of California
Emergency Medical Services Law

Health & Safety Code Division 2.5
Statutes in Effect as of January 1, 2019

Emergency Medical Services Authority
Health and Human Services Agency

California EMS Awards

Medal of Valor
EMS Cross
Distinguished Service Medal
Meritorious Service Medal
Lifesaving Medal
Community Service Award
Interservice EMS Recognition
Civilian Award for EMS
EMT of the Year
EMS Educator of the Year
EMS Medical Director of the Year
EMS Administrator of the Year

Send us your heroes !

To nominate someone for recognition, visit www.emsa.ca.gov/awards

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CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

DISPATCH

NEWSLETTER

January 2016

In This Issue...

Director's Message
Paramedic Licensure Unit to Begin Same-Day Service
Paramedic Licensure Unit Welcomes New Employees
New Laws for 2016
Save the Date! 3rd California HIE in EMS Summit

— FEATURED ARTICLE —

Director's Message: Howard Backer, MD, MPH, FACEP

How Legislation and Policy Change Impacts Your EMS Practice

Each year, there is state legislation that impacts your EMS practice in California. Some of the proposed legislation is passed and becomes law, usually after much discussion and changes in the original language. Other measures never make it out of the legislature or if they are sent forward, they may not be signed by the governor. I do not want to discuss the process. Suffice it to quote an old adage: "You do not want to see how sausage or laws are made." Many new laws subsequently require regulations to describe details of implementation. Regulations must be based on the law and are created with stakeholder and public input; they do not involve the legislature. We have many different regulations that clarify portions of The EMS Act and the EMS System and Prehospital Emergency Medical Care Personnel Act. Current EMS laws and regulations can be found on the

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…and connect to EMSA on Facebook. Twitter & YouTube

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State of California

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Health and Human Services Agency

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Director
Emergency Medical Services Authority

Updated February 2019
www.emsa.ca.gov

The attached compilation of EMS Statutes (Division 2.5 of the Health and Safety Code) has been updated for your convenience to include changes made during the 2017 -18 legislative session. Although every effort has been made to ensure that this document is accurate and complete, no guarantee is being made or implied.

An electronic version of this document is available on our website. While visiting our website, please be sure to sign up for the “EMSA Dispatch” electronic newsletter and connect to EMSA on Facebook, Twitter and YouTube.

A quick look at the

California EMS Authority

State Emergency Medical Services

The Emergency Medical Services Authority (EMSA) was created in 1980 to provide leadership in developing EMS systems throughout California and to develop standards for training and scope of practice for EMS personnel. Prior to 1980, California did not have a central state agency responsible for ensuring the development and coordination of EMS services and programs statewide.

Although the many stakeholders in EMS, including local administrators, fire agencies, ambulance companies, hospitals, physicians, nurses, and other health care providers did not agree on all issues, there was a consensus that a more unified approach was needed to emergency and disaster medical services.

After several years of effort by the EMS constituents to establish a state lead agency, in 1980 Governor Jerry Brown signed into law the Emergency Medical Services System and Prehospital Emergency Care Personnel Act (SB 125) creating the Emergency Medical Services Authority and adding Division 2.5 to the Health and Safety Code (sections 1797-1799).

EMSA's mission is to ensure quality patient care by administering an effective statewide system of coordinated emergency medical care, injury prevention and disaster medical response.

Our vision encompasses strong internal and external working relationships that promote public trust and quality patient care. Emergency and disaster medical services in California are rooted in the skills and commitment of the first responders, EMTs, nurses, physicians, and administrators who deliver care to the public and operate the system. In order for high quality services to be delivered efficiently, all aspects of EMS systems must work together, mutually reinforcing and supporting each other for the benefit of the patient. The California EMS Authority plays a central role in improving the quality of emergency medical services available for all Californians by setting standards, building consensus, and providing leadership. EMSA is organized into the following three divisions:

- The EMS Personnel Standards Division develops and implements regulations for training, certification, licensing and scope of practice for emergency medical personnel, including emergency medical technician, advanced EMT, paramedic, firefighter, peace officer and lifeguard. They license, investigate and discipline paramedics

statewide for civil and criminal violations of the California Health and Safety Code. They also approve first aid and CPR training programs that are required for child care providers and school bus drivers. In addition, they approve epinephrine auto injector training programs for the general public and EMT training programs run by statewide safety agencies.

- The EMS Systems Division coordinates the local EMS systems, the statewide trauma system, and the California Poison Control System. They establish regulations and guidelines and review local EMS plans to ensure they meet minimum standards. This division also manages EMS data collection, quality assurance, dispatch and communication standards and EMS for Children efforts.

- The Disaster Medical Services Division fulfills EMSA's role as the lead agency responsible for coordinating California's medical response to disasters. The Division organizes a statewide network to provide medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies, personnel and mobile medical assets from unaffected regions of the state to meet the needs of disaster victims.

While day-to-day management of California's EMS system is the statutory responsibility of the counties, through the local EMS agencies, EMSA's job is to coordinate the system statewide. In addition to establishing standards through regulation, here are a few examples of the important work EMSA does on behalf of Californians to support the EMS system:

✓ **Paramedic Licensure and Enforcement:** EMSA licenses approximately 23,000 paramedics statewide. The enforcement unit also investigates actions by paramedics that may be violations of the professional and ethical standards for paramedics in the Health and Safety Code and take licensure action when necessary to protect the public.

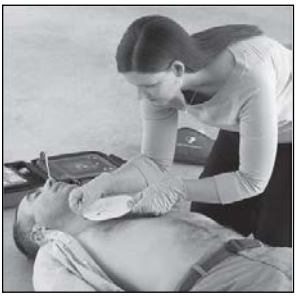
✓ **EMS Personnel Registry:** EMSA operates the statewide EMS Personnel Central Registry - an online database containing certification/licensure status of every EMT, Advanced EMT and Paramedic in the state. The system has enabled certification in one county to be verified throughout the state. The website receives more than 4,300 inquiries about individual providers each week.

- ✓ **First Aid, CPR and AED Regulations and Training:** EMSA oversees first aid and CPR training for 83,000 child care providers and school bus drivers. In addition, EMSA writes regulations for use of automated external defibrillator.

- ✓ **Mobile Medical Assets:** EMSA has 42 Disaster Medical Support Units (DMSU) filled with medical supplies and equipment strategically placed throughout the state that are ready to re-supply ambulance strike teams in the event that the local EMS resources are overwhelmed. In addition, EMSA coordinates the California Medical Assistance Team (CAL-MAT) program. CAL-MAT's are scalable teams of volunteer medical professionals capable of responding to a disaster anywhere in the state within 12 hours. EMSA also coordinates the Mission Support Team (MST) program. The MST provides oversight and logistical support for state deployed medical teams. EMSA maintains trucks, trailers, supplies & equipment caches to support the mobile medical assets, including communications equipment and a command control and communications vehicle.

- ✓ **California Poison Control System:** EMSA supports and oversees the statewide system that provides free, immediate answers to poisoning questions via telephone at 1-800-222-1222. The California Poison Control System receives more than 300,000 calls per year.

- ✓ **Emergency Medical Services for Children**: EMSA works with subject matter experts to develop a comprehensive model for the EMS for Children program that can been adopted for use by local EMS agencies.



- ✓ **California Emergency Medical Services Information System** (CEMSIS): In cooperation with the National EMS Information System, EMSA administers a statewide system to collect prehospital and trauma center data. The information is used to support local quality improvement and participate in national data collection efforts.

- ✓ **Disaster Healthcare Personnel:** More than 24,000 healthcare professionals from dozens of medical specialties have registered with California's Disaster Healthcare Volunteers (DHV) program so that when disaster strikes, they can be mobilized to help. The DHV system allows EMSA to automatically verify credentials for 48 different professions. In addition, EMSA coordinates 44 Medical Reserve Corps

units which are local teams of trained volunteers that are integrated into the DHV program.

- ✓ **Stroke and STEMI**: EMSA works with subject matter experts to develop regional systems of specialized care that address the medical needs of patients who suffer stroke and heart attacks. The workgroup is writing regulations to ensure they receive specialized prehospital and hospital emergency care that will increase their chances of survival and recovery.

- ✓ **Scope of Practice:** EMSA approves the scope of practice for EMS providers and designates training and care for specialized paramedics who serve on a tactical law enforcement team, on a helicopter or fixed-wing aircraft, or on a search and rescue team.

- ✓ **Local EMS Agency Systems Plans Review:** EMSA reviews EMS plans from local EMS agencies to ensure they meet the requirements of the Health and Safety Code and provide a coordinated system of emergency medical care. This includes evaluation of the ambulance zones.

EMSA Phone Directory by Subject

ALL NUMBERS ARE IN THE 916 AREA CODE

EMSA Main Number	322-4336
Air Transport	431-3677
Alternate Base/Receiving Hospital Information	431-3685
Ambulance Service Areas	431-3677
Ambulance Strike Team (AST)	431-3681
Automated External Defibrillator	431-3717
Base Hospital Information	431-3685
California Public Health & Medical Emergency Operations Manual	431-3726
California Health Alert Network (CAHAN)	431-3661
California Medical Assistance Teams (CAL-MATs)	431-3681
California Medical Assistance Teams - Specialized	431-3681
Central Registry Information	431-3717
Child Day Care Health & Safety Training	431-3678
Commission on EMS	431-3701
Communications Systems (Access)	431-3667
Director’s Office	431-3701
Disaster Healthcare Volunteers (DHV)	431-3683
Disaster Medical Assistance Teams (DMATs)	255-1802
Disaster Medical Communications	384-1443
Disaster Medical Supplies/Equipment	384-1443
Disaster Medical Support Units (DMSUs)	384-1443
Disaster Response Exercises	431-3726
Dispatcher Guidelines	384-0556

Do Not Resuscitate (DNR) Forms	322-4336
EMS Awards	431-3700
EMS Data (CA EMS Information System)	431-3687
EMS for Children	384-0556
Field Treatment Sites	431-3726
EMS Plan Review	431-3688
EMS Standards & Guidelines	431-3695
EMT & AEMT - *contact your local EMS Agency (LEMSA)*	page 132
EMT 2010 Enforcement Liaison	431-3707
Enforcement - Investigations	431-3703
Enforcement - Probation/Case Management	431-3668
External Affairs	431-3700
First Responder/Bystander Care	431-3717
Health Information Exchange (HIE)	431-3695
Hospital Diversion Policies	431-3685
Hospital Downgrade/Closure	431-3695
Hospital Incident Command System (HICS)	255-4702
Human Resources	431-3669
Injury Prevention/Public Education	431-3685
Interfacility Transport and Transfer Guidelines	431-3677
Legal Office - Counsel	431-3693
Legislative Affairs	431-3700
Medical Mutual Aid	431-3726
Medical Reserve Corps (MRC)	431-3673
Mission Support Team (MST)	431-3681

Mobile Medical Shelters	384-1443
Mobile Intensive Care Nurses (MICNs)	431-3649
Patient Movement Project	255-4702
Paramedic Licensure Challenge Application	431-3741
Paramedic Licensure Information	323-9875
Paramedic Licensure In-State Application	431-3690
Paramedic Licensure Out-of-State Application	431-3690
Paramedic Licensure Renewal Applications	431-3652
Paramedic Licensure Audit Renewal Applications	431-3648
Paramedic Licensure Reinstatement (Lapsed) Applications	431-3690
Paramedic Local Optional Scope of Practice	431-3689
Paramedic National Registry Exams	431-3741
Paramedic Regulations and Trial Studies	431-3689
Paramedic Training Program Information	431-3741
Poison Control Centers	431-3688
Public Information/Media	431-3700
Public Safety, First Aid, CPR, and AED	431-3717
Quality Improvement	431-3659
Regional Disaster Medical/Health Specialists	255-1826
Regional/Multi-County EMS Agencies	431-3688
Rural EMS	431-3695
School Bus Driver First Aid/CPR	431-3678
Small Business Liaison/Advocate	431-3653
So. Cal. Catastrophic Earthquake Response Plan	255-4702
Specialty Care Centers (STEMI, Stroke)	431-3685

State Agency Terrorism Awareness Group	384-1443
State Emergency Plan (SEP)	431-3726
Statewide Disaster Medical/Health Exercises	431-3726
Trauma Regulations and Plan Review	431-3649
Weapons of Mass Destruction	384-1443

CALIFORNIA HEALTH AND SAFETY CODE
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CHAPTER 1. General Provisions [1797 - 1797.9]
(Chapter 1 added by Stats. 1980, Ch. 1260.)

1797.0 (Title)
This division shall be known and may be cited as the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act. *(Amended by Stats. 1986, Ch. 248, Sec. 121.)*

1797.1. (Legislative Intent: Statewide System)
The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services. *(Amended by Stats. 1983, Ch. 1246, Sec. 6.)*

1797.2. (Legislative Intent: EMT-P v. EMT II Programs)
It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible. *(Added by Stats. 1980, Ch. 1260.)*

1797.3. (Additional Local Training Standards)
The provisions of this division do not preclude the adoption of additional training standards for EMT-II and EMT-P personnel by local EMS agencies, consistent with standards adopted pursuant to Sections 1797.171, 1797.172, and 1797.214. *(Amended by Stats. 1989, Ch. 1362, Sec. 1. Effective October 2, 1989.)*

1797.4. (Wedsworth-Townsend Reference Clarification)
Any reference in any provision of law to mobile intensive care paramedics subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid certificates under this division as an EMT-I, EMT-II, or EMT-P. Any reference in any provision of law to mobile intensive care nurses subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid authorization under this division as an MICN. *(Added by Stats. 1988, Ch. 260, Sec. 1.)*

1797.5. (Legislative Intent: Encourage Assisting Others)
It is the intent of the Legislature to promote the development, accessibility, and provision of emergency medical services to the people of the State of California.

Further, it is the policy of the State of California that people shall be encouraged and trained to assist others at the scene of a medical emergency. Local governments, agencies, and other organizations shall be encouraged to offer training in cardiopulmonary resuscitation and lifesaving first aid techniques so that people may be adequately trained, prepared, and encouraged to assist others immediately.
(Added by Stats. 1983, Ch. 1246, Sec. 8.)

1797.6. (Legislative Intent: Antitrust Immunity)
(a) It is the policy of the State of California to ensure the provision of effective and efficient emergency medical care. The Legislature finds and declares that achieving this policy has been hindered by the confusion and concern in the 58 counties resulting from the United States Supreme Court's holding in Community Communications Company, Inc. v. City of Boulder, Colorado, 455 U.S. 40, 70 L. Ed. 2d 810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust laws.

(b) It is the intent of the Legislature in enacting this section and Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state direction and supervision over emergency medical services as will provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this division. *(Added by Stats. 1984, Ch. 1349, Sec. 1.)*

1797.7. (Legislative Intent: Statewide Recognition of Prehospital Personnel)
(a) The Legislature finds and declares that the ability of some prehospital emergency medical care personnel to move from the jurisdiction of one local EMS agency which issued certification and authorization to the jurisdiction of another local EMS agency which utilizes the same level of emergency medical care personnel will be unreasonably hindered if those personnel are required to be retested and recertified by each local EMS agency.

(b) It is the intent of the Legislature in enacting this section and Section 1797.185 to ensure that EMT-P personnel who have met state competency standards for their basic scope of practice, as defined in Chapter 4 (commencing with Section 100135) of Division 9 of Title 22 of the California Code of Regulations, and are currently certified are recognized statewide without having to repeat testing or certification for that same basic scope of practice.

(c) It is the intent of the Legislature that local EMS agencies may require prehospital emergency medical care personnel who were certified in another jurisdiction to be oriented to the local EMS system and receive training and demonstrate competency in any optional skills for which they have not received accreditation. It is also the intent of the Legislature that no individual who possesses a valid California EMT-P certificate shall be

prevented from beginning working within the standard statewide scope of practice of an EMT-P if he or she is accompanied by a EMT-P who is currently certified in California and is accredited by the local EMS agency. It is further the intent of the Legislature that the local EMS agency provide, or arrange for the provision of, training and accreditation testing in local EMS operational policies and procedures and any optional skills utilized in the local EMS system within 30 days of application for accreditation as an EMT-P by the local EMS agency.

(d) It is the intent of the Legislature that subdivisions (a), (b), and (c) not be construed to hinder the ability of local EMS agencies to maintain medical control within their EMS system in accordance with the requirements of this division. *(Amended by Stats. 1989, Ch. 1362, Sec. 2. Effective October 2, 1989.)*

1797.8. (Administration of Naloxone Hydrochloride)
(a) For purposes of this section, the following definitions apply:

(1) “EMT-I” means any person who has training and a valid certificate as prescribed by Section 1797.80.

(2) “EMT certifying authority” means the medical director of the local emergency medical services agency.

(b) Any county may, at the discretion of the county or regional medical director of emergency medical services, develop a program to certify an EMT-I to administer naloxone hydrochloride by means other than intravenous injection.

(c) Any county that chooses to implement a program to certify an EMT-I to administer naloxone hydrochloride, as specified in subdivision (b), shall approve and administer a training and testing program leading to certification consistent with guidelines established by the state Emergency Medical Services Authority.

(d) On or before July 1, 2003, the state Emergency Medical Services Authority shall develop guidelines relating to the county certification programs authorized pursuant to subdivision (b).

(e) An EMT-I may be authorized by the EMT certifying authority to administer naloxone hydrochloride by means other than intravenous injection only if the EMT-I has completed training and passed an examination administered or approved by the EMT certifying authority in the area.

(f) This section shall be operative only until the operative date of regulations that revise the regulations set forth in Chapter 3 (commencing with Section 100101) of Division 9 of Title 22 of the California Code of Regulations and that authorize an EMT-I to receive EMT-II training in administering naloxone hydrochloride without having to complete the entire EMT-II certification course. *(Added by Stats. 2002, Ch. 678, Sec. 2. Effective January 1, 2003. Conditionally inoperative as provided in subd. (f).)*

1797.9. (Public Aircraft - Uses & Regulation)
(a) This division shall not be construed to regulate or authorize state or local regulation of any nonmedical aspects of the following:

(1) Public aircraft certification or configuration.

(2) Public aircraft maintenance procedures and documentation.

(3) Piloting techniques and methods of piloting public aircraft.

(4) Public aircraft crewmember qualifications.

(5) Pilot certification or qualifications for public aircraft.

(b) For purposes of this section, “public aircraft” has the same meaning as in Section 1.1 of Title 14 of the Code of Federal Regulations. *(Added by Stats. 2008, Ch. 289, Sec. 2. Effective January 1, 2009.)*

1797.10. (Emergency Medical Transport of Police Dogs)

(a) The County of San Bernardino is authorized to work with the Inland Counties Emergency Medical Agency to conduct a pilot project, commencing January 1, 2019, that would authorize emergency transportation for a police dog injured in the line of duty to a facility that is capable of providing veterinary medical services to the injured police dog if all of the following conditions apply:

(1) A request for transport is made by the injured police dog’s canine handler.

(2) An ambulance is present at the scene of the injury at the time the request for transport is made.

(3) No person at the scene of the incident requires medical attention or medical transportation at the time the request for transport is made.

(4) The owner of the ambulance has a policy that permits the transport of an injured police dog.

(5) The canine handler accompanies the injured police dog and remains in full control of the dog during transport.

(6) The canine handler provides the location of the nearest facility that is capable of providing veterinary medical services to the injured police dog.

(7) The canine handler remains responsible for any first aid rendered to the injured police dog during transport.

(b) For purposes of this section, “police dog” means a dog being used by a peace officer in the discharge or attempted discharge of his or her duties and includes, but is not limited to, a search and rescue dog or a passive alert dog.

(c) (1) The Inland Counties Emergency Medical Agency shall collect data on the number of police dogs transported pursuant to this section, the location where the police dogs were transported to, and the outcome of those transports.

(2) The Inland Counties Emergency Medical Agency shall submit a report to the Legislature that includes the data described in paragraph (1) by January 1, 2022. The report shall be submitted in compliance with Section 9795 of the Government Code.

(d) This section shall remain in effect only until January 1, 2022, and as of that date is repealed. *(Added by Stats. 2018, Ch. 272, Sec. 1. Effective January 1, 2019.)*

CHAPTER 2. Definitions [1797.50 - 1797.97]
(Chapter 2 added by Stats. 1980, Ch. 1260.)

1797.50. (Effect of Definitions)
Unless the context otherwise requires, the definitions contained in this chapter shall govern the provisions of this division. *(Amended by Stats. 1986, Ch. 248, Sec. 123.)*

1797.52. (Advanced Life Support)
"Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. *(Amended by Stats. 1984, Ch. 1391, Sec. 4.)*

1797.53. (Alternative Base Station)
"Alternative base station" means a facility or service operated and directly supervised by, or directly supervised by, a physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel, which has been approved by the medical director of the local EMS agency to provide medical direction to advanced life support or limited advanced life support personnel responding to a medical emergency as part of the local EMS system, when no qualified hospital is available to provide that medical direction. *(Added by Stats. 1988, Ch. 1390, Sec. 1.)*

1797.54. (Authority)
"Authority" means the Emergency Medical Services Authority established by this division. *(Amended by Stats. 1986, Ch. 248, Sec. 124.)*

1797.56. (Authorized Registered Nurse)
"Authorized registered nurse," "mobile intensive care nurse," or "MICN" means a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been authorized by the medical director of the local EMS agency as qualified to provide prehospital advanced life support or to issue instructions to prehospital emergency medical care personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines established by the authority. Nothing in this section shall be

deemed to abridge or restrict the duties or functions of a registered nurse or mobile intensive care nurse as otherwise provided by law. *(Amended by Stats. 1984, Ch. 1391, Sec. 5.)*

1797.58. (Base Hospital)
"Base hospital" means one of a limited number of hospitals which, upon designation by the local EMS agency and upon the completion of a written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system and prehospital care system assigned to it by the local EMS agency. *(Amended by Stats. 1984, Ch. 1391, Sec. 6.)*

1797.59. (Base Hospital Physician)
"Base hospital physician" or "BHP" means a physician and surgeon who is currently licensed in California, who is assigned to the emergency department of a base hospital, and who has been trained to issue advice and instructions to prehospital emergency medical care personnel consistent with statewide guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a physician and surgeon as otherwise provided by law. *(Added by Stats. 1984, Ch. 1391, Sec. 7.)*

1797.60. (Basic Life Support)
"Basic life support" means emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available. *(Added by Stats. 1980, Ch. 1260.)*

1797.61. (Certificate or License)
(a) "Certificate" or "license" means a specific document issued to an individual denoting competence in the named area of prehospital service.

(b) "Certificate status" or "license status" means the active, expired, denied, suspended, revoked, or placed on probation designation applied to a certificate or license issued pursuant to this division. *(Added by Stats. 2008, Ch. 274, Sec. 2. Effective January 1, 2009.)*

1797.62. (Certifying Entity)
"Certifying entity" means a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT-I personnel that is approved pursuant to the standards developed pursuant to Section 1797.109, or the medical director of a local EMS agency. *(Repealed and added by Stats. 2008, Ch. 274, Sec. 4. Effective January 1, 2009.)*

1797.63. (Certifying Examination)
"Certifying examination" or "examination for certification" means an examination designated by the authority for a specific level of prehospital emergency medical care personnel that must be satisfactorily passed prior to certification or recertification at the specific level and may include any examination or examinations designated by the authority, including, but not limited to, any of the following options determined appropriate by the authority:

(a) An examination developed either by the authority or under the auspices of the authority or approved by the authority and administered by the authority or any entity designated by the authority to administer the examination.

(b) An examination developed and administered by the National Registry of Emergency Medical Technicians.

(c) An examination developed administered, or approved by a certifying agency pursuant to standards adopted by the authority for the certification examination. *(Added by Stats. 1989, Ch. 1362, Sec. 3. Effective October 2, 1989.)*

1797.64. (Commission)
"Commission" means the Commission on Emergency Medical Services created pursuant to the provisions of Section 1799. *(Added by Stats. 1980, Ch. 1260.)*

1797.66. (Competency Based Curriculum)
"Competency based curriculum" means a curriculum in which specific objectives are defined for each of the separate skills taught in training programs with integrated didactic and practical instruction and successful completion of an examination demonstrating mastery of every skill. *(Added by Stats. 1980, Ch. 1260.)*

1797.67. (Designated Facility)
"Designated facility" means a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority. *(Added by Stats. 1983, Ch. 1246, Sec. 12.)*

1797.68. (Director)
"Director" means the Director of the Emergency Medical Services Authority. *(Amended by Stats. 1983, Ch. 1246, Sec. 13.)*

1797.70. (Emergency)
"Emergency" means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency. *(Added by Stats. 1980, Ch. 1260.)*

1797.72. (Emergency Medical Services)
"Emergency medical services" means the services utilized in responding to a medical emergency. *(Added by Stats. 1980, Ch. 1260.)*

1797.74. (EMS Area)
"Emergency medical services area" or "EMS area" means the geographical area within the jurisdiction of the designated local EMS agency. *(Amended by Stats. 1984, Ch. 1391, Sec. 8.)*

1797.76. (EMS Plan)
"Emergency medical services plan" means a plan for the delivery of emergency medical services consistent with state guidelines addressing the components listed in Section 1797.103. *(Amended by Stats. 1983, Ch. 1246, Sec. 14.)*

1797.78. (EMS System)
"Emergency medical services system" or "system" means a specially organized arrangement which provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions. *(Added by Stats. 1980, Ch. 1260.)*

1797.80. (Emergency Medical Technician)
"Emergency Medical Technician-I" or "EMT-I" means an individual trained in all facets of basic life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part. This definition shall include, but not be limited to, EMT-I (FS) and EMT-I-A. *(Added by Stats. 1980, Ch. 1260.)*

1797.82. (Emergency Medical Technician-II)
"Emergency Medical Technician-II," "EMT-II," "Advanced Emergency Medical Technician," or "Advanced EMT" means an EMT-I with additional training in limited advanced life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part. *(Amended by Stats. 2008, Ch. 275, Sec. 2. Effective January 1, 2009.)*

1797.84. (Emergency Medical Technician-Paramedic)
"Emergency Medical Technician-Paramedic," "EMT-P," "paramedic" or "mobile intensive care paramedic" means an individual whose scope of practice to provide advanced life support is according to standards

prescribed by this division and who has a valid certificate issued pursuant to this division. *(Amended by Stats. 1986, Ch. 248, Sec. 125.)*

1797.85. (Exclusive Operating Area)
"Exclusive operating area" means an EMS area or subarea defined by the emergency medical services plan for which a local EMS agency, upon the recommendation of a county, restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. *(Added by Stats. 1984, Ch. 1349, Sec. 2.)*

1797.86. (Health Systems Agency)
"Health systems agency" means a health systems agency as defined in subsection (a) of Section 300(l)-1 of Title 42 of the United States Code. *(Added by Stats. 1980, Ch. 1260.)*

1797.88. (Hospital)
"Hospital" means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of-state acute care hospital which substantially meets the requirements of Chapter 2 (commencing with Section 1250) of Division 2, as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located. *(Amended by Stats. 1986, Ch. 1162, Sec. 1. Effective September 26, 1986.)*

1797.90. (Medical Control)
"Medical control" means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798). *(Added by Stats. 1980, Ch. 1260.)*

1797.92. (Limited Advanced Life Support)
"Limited advanced life support" means special service designed to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support and are those procedures specified pursuant to Section 1797.171. *(Added by Stats. 1980, Ch. 1260.)*

1797.94. (Local EMS Agency)
"Local EMS agency" means the agency, department, or office having primary responsibility for administration of emergency medical services in a county and which is designated pursuant to Chapter 4 (commencing with Section 1797.200). *(Added by Stats. 1980, Ch. 1260.)*

1797.97. (Poison Control Center)
“Poison control center” or “PCC” means a hospital-based facility or other facility which, as a minimum, provides information and advice regarding the management of individuals who have or may have ingested or otherwise been exposed to poisonous or possibly toxic substances, and which has been designated by the Emergency Medical Services Authority according to the standards prescribed by this division. *(Amended by Stats. 1987, Ch. 972, Sec. 1.)*

CHAPTER 2.5. The Maddy EMS Fund

[1797.98a - 1797.98g] (Heading of Chapter 2.5 amended by Stats. 1998, Ch. 58, Sec. 2.)

1797.98a. (Fund Administration)
(a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund in an amount that does not exceed the actual administrative costs or 10 percent of the amount of the fund, whichever amount is lower.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic, comprehensive, or standby emergency services pursuant to paragraph (3) or (5) of subdivision (f) of Section 1797.98e up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

(e) Of the money deposited into the fund pursuant to Section 76000.5 of the Government Code, 15 percent shall be utilized to provide funding for all pediatric trauma centers throughout the county, both publicly and privately owned and operated. The expenditure of money shall be limited to reimbursement to physicians and surgeons, and to hospitals for patients who do not make payment for emergency care services in hospitals up to the point of stabilization, or to hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment. Local emergency medical services (EMS) agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures. Counties that do not maintain a pediatric trauma center shall utilize the money deposited into the fund pursuant to Section 76000.5 of the Government Code to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children. Funds spent for the purposes of this section shall be known as Richie’s Fund. This subdivision shall remain in effect until January 1, 2027.

(f) Costs of administering money deposited into the fund pursuant to Section 76000.5 of the Government Code shall be reimbursed from the money

collected in an amount that does not exceed the actual administrative costs or 10 percent of the money collected, whichever amount is lower. This subdivision shall remain in effect until January 1, 2027. *(Amended by Stats. 2016, Ch. 147, Sec. 2. Effective January 1, 2017.)*

1797.98b. (Legislative Fund Report)
(a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the authority on the implementation and status of the Emergency Medical Services Fund. Notwithstanding Section 10231.5 of the Government Code, the authority shall compile and forward a summary of each county's report to the appropriate policy and fiscal committees of the Legislature. Each county report, and the summary compiled by the authority, shall cover the immediately preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund, or, if no moneys were deposited into the fund, the reason or reasons for the lack of deposits. The total amounts of penalty assessments shall be listed on the basis of each statute that provides the authority for the penalty assessment, including Sections 76000, 76000.5, and 76104 of the Government Code, and Section 42007 of the Vehicle Code.

(2) The amount of penalty assessment funds collected under Section 76000.5 of the Government Code that are used for the purposes of subdivision (e) of Section 1797.98a.

(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.

(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contacted to review claims payment methodologies.

(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.

(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98c.

(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.

(B) The amount of moneys available to be disbursed to hospitals.

(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.

(11) The name and contact information of the entity responsible for each of the following:

(A) Collection of fines, forfeitures, and penalties.

(B) Distribution of penalty assessments into the Emergency Medical Services Fund.

(C) Distribution of moneys to physicians and surgeons.

(b) (1) Each county, upon request, shall make available to any member of the public the report provided to the authority under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis. *(Amended by Stats. 2014, Ch. 442, Sec. 5. Effective September 18, 2014.)*

1797.98c. (Physician Reimbursement Requirements)
(a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations. *(Amended by Stats. 2005, Ch. 671, Sec. 3. Effective January 1, 2006.)*

1797.98e. (Administrative Procedures)
(a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber

sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991–92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(5) A standby emergency room in existence on January 1, 2007, in a hospital located in Los Angeles County that meets all of the following requirements:

(A) The requirements of subdivision (m) of Section 70413 and Sections 70415 and 70417 of Title 22 of the California Code of Regulations.

(B) Reported at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in 2007 and continues to report at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in each year thereafter.

(C) A hospital with a standby emergency department meeting the requirements of this paragraph shall do both of the following:

(i) Annually provide the State Department of Public Health and the local emergency medical services agency with certification that it meets the requirements of subparagraph (A). The department shall confirm the hospital’s compliance with subparagraph (A).

(ii) Annually provide to the State Department of Public Health and the local emergency medical services agency the emergency department patient encounters it reports to the Office of Statewide Health Planning and Development to establish that it meets the requirement of subparagraph (B).

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(l) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician’s assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation.

Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California. *(Amended by Stats. 2008, Ch. 288, Sec. 2. Effective January 1, 2009.)*

1797.98f. (Gross Billings Arrangement)
Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department, or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients. *(Amended by Stats. 1998, Ch. 1016, Sec. 3. Effective January 1, 1999.)*

1797.98g. (Moneys Not Subject to Article 3.5)
The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code. *(Added by Stats. 1991, Ch. 1169, Sec. 4.)*

CHAPTER 3. State Administration [1797.100 - 1797.197a]
(Chapter 3 added by Stats. 1980, Ch. 1260.)

ARTICLE 1. The Emergency Medical Services Authority [1797.100 - 1797.120] (Article 1 added by Stats. 1980, Ch. 1260.)

1797.100. (Creation)
There is in the state government in the Health and Welfare Agency, the Emergency Medical Services Authority. *(Amended by Stats. 1983, Ch. 1246, Sec. 16.)*

1797.101. (Director)
The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services. The director shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine. *(Amended by Stats. 2008, Ch. 274, Sec. 5. Effective January 1, 2009.)*

1797.102. (Assessment of Service Area)
The authority, utilizing regional and local information, shall assess each EMS area or the system's service area for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services. *(Added by Stats. 1980, Ch. 1260.)*

1797.103. (System Guidelines)
The authority shall develop planning and implementation guidelines for emergency medical services systems which address the following components:

(a) Manpower and training.

(b) Communications.

(c) Transportation.

(d) Assessment of hospitals and critical care centers.

(e) System organization and management.

(f) Data collection and evaluation.

(g) Public information and education.

(h) Disaster response.
(Added by Stats. 1980, Ch. 1260.)

1797.104. (Technical Assistance)
The authority shall provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems. *(Added by Stats. 1980, Ch. 1260.)*

1797.105. (Local EMS Plan Approval)
(a) The authority shall receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.

(b) After the applicable guidelines or regulations are established by the authority, a local EMS agency may implement a local plan developed pursuant to Section 1797.250, 1797.254, 1797.257, or 1797.258 unless the authority determines that the plan does not effectively meet the needs of the persons served and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority.

(c) A local EMS agency may appeal a determination of the authority pursuant to subdivision (b) to the commission.

(d) In an appeal pursuant to subdivision (c), the commission may sustain the determination of the authority or overrule and permit local implementation of a plan, and the decision of the commission is final.
(Amended by Stats. 1984, Ch. 1735, Sec. 1. Effective September 30, 1984.)

1797.106. (Group Practice Prepayment Health Plans)
(a) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall not prohibit hospitals which contract with group practice prepayment health care service plans from providing necessary medical services for the members of those plans.

(b) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall provide for the transport and transfer of a member of a group practice prepayment health care service plan to a hospital that contracts with the plan when the base hospital determines that the condition of the member permits the transport or when the condition of the member permits the transfer, except that when the dispatching agency determines that the transport by a transport unit would unreasonably remove the transport unit from the area,

the member may be transported to the nearest hospital capable of treating the member. *(Amended by Stats. 1986, Ch. 248, Sec. 127.)*

1797.107. (Adoption of Rules & Regulations)
The authority shall adopt, amend, or repeal, after approval by the commission and in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division and to enable the authority to exercise the powers and perform the duties conferred upon it by this division not inconsistent with any of the provisions of any statute of this state. *(Amended by Stats. 1986, Ch. 248, Sec. 128.)*

1797.108. (Funding Assistance to Local EMS Agencies)
Subject to the availability of funds appropriated therefor, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

In addition, the authority may provide special funding to multicounty EMS agencies which serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

Each local or multicounty EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation. *(Added by Stats. 1983, Ch. 191, Sec. 3. Effective July 11, 1983.)*

1797.109. (Public Safety Personnel EMT Training)
(a) The director may develop, or prescribe standards for and approve, an emergency medical technician training and testing program for the Department of the California Highway Patrol, Department of Forestry and Fire Protection, California Fire Fighter Joint Apprenticeship Committee, and other public safety agency personnel, upon the request of, and as deemed appropriate by, the director for the particular agency.

(b) The director may, with the concurrence of the Department of the California Highway Patrol, designate the California Highway Patrol Academy as a site where the training and testing may be offered.

(c) The director may prescribe that each person, upon successful completion of the training course and upon passing a written and a practical examination, be certified as an emergency medical technician of an appropriate classification. A suitable identification card may be issued to

each certified person to designate that person's emergency medical skill level.

(d) The director may prescribe standards for refresher training to be given to persons trained and certified under this section.

(e) The Department of the California Highway Patrol shall, subject to the availability of federal funds, provide for the initial training of its uniformed personnel in the rendering of emergency medical technician services to the public in specified areas of the state as designated by the Commissioner of the California Highway Patrol. *(Amended by Stats. 2000, Ch. 157, Sec. 1. Effective January 1, 2001.)*

1797.110. (Advance Payments to Local EMS Agencies)
The Legislature finds that programs funded through the authority are hindered by the length of time required for the state process to execute approved contracts and payment of vendor claims. These programs include, but are not limited to, general fund assistance to rural multicounty EMS agencies and dispersal of federal grant moneys for EMS systems development to local EMS agencies. This hardship is particularly felt by new or rural community based EMS agencies with modest reserves and cash flow problems. It is the intent of the Legislature that advance payment authority be established for the authority in order to alleviate such problems for those types of contractors to the extent possible.

Notwithstanding any other provision of law, the authority may, to the extent funds are available, provide for advanced payments under any financial assistance contract which the authority determines has been entered into with any small, rural, or new EMS agency with modest reserves and potential cash flow problems, as determined by the authority. Such programs include, but are not limited to, local county or multicounty EMS agencies.

No advance payment or aggregate of advance payments made pursuant to this section shall exceed 25 percent of the total annual contract amount. No advance payment should be made pursuant to this section if the applicable federal law prohibits advance payment. *(Added by Stats. 1983, Ch. 191, Sec. 4. Effective July 11, 1983.)*

1797.111. (Acceptance of Gifts & Grants)
With the approval of the Department of Finance, and for use in the furtherance of the work of the authority, the director may accept all of the following:

(a) Grants of interest in real property.

(b) Gifts of money from public agencies or from organizations or associations organized for scientific, educational, or charitable purpose. *(Added by Stats. 1983, Ch. 1246, Sec. 18.)*

1797.112. (EMS Personnel Fund)
(a) The Emergency Medical Services Personnel Fund is hereby created in the State Treasury, the funds in which are to be held in trust for the benefit of the authority's testing and personnel licensure program and for the purpose of making reimbursements to entities for the performance of functions for which fees are collected pursuant to Section 1797.172, for expenditure upon appropriation by the Legislature.

(b) The authority may transfer unused portions of the Emergency Medical Services Personnel Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Emergency Medical Services Personnel Fund, together with interest earned, when requested by the authority.

(c) The authority shall maintain a reserve balance in the Emergency Medical Services Personnel Fund of five percent. Any increase in the fees deposited in the Emergency Medical Services Personnel Fund shall be effective upon a determination by the authority that additional moneys are required to fund expenditures of the personnel licensure program, including, but not limited to, reimbursements to entities set forth in subdivision (a).
(Amended by Stats. 2000, Ch. 93, Sec. 14. Effective July 7, 2000.)

1797.113. (EMS Training Program Approval Fund)
The Emergency Medical Services Training Program Approval Fund is hereby established in the State Treasury and, notwithstanding Section 13340 of the Government Code, is continuously appropriated to the authority for the authority's training program review and approval activities. The fees charged by the authority under Section 1797.191 shall be deposited in this fund. The authority may transfer unexpended and unencumbered moneys contained in the Emergency Medical Services Training Program Approval Fund to the Surplus Money Investment Fund for investment pursuant to Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest, dividends, and pecuniary gains from these investments or deposits shall accrue to the Emergency Medical Services Training Program Approval Fund. *(Amended by Stats. 1998, Ch. 666, Sec. 2. Effective September 21, 1998.)*

1797.114. (EMS Transport Guidelines)
The rules and regulations of the authority established pursuant to Section 1797.107 shall include a requirement that a local EMS agency local plan

developed pursuant to this division shall require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. Emergency health care need shall be determined by the prehospital emergency medical care personnel under the direction of a base hospital physician and surgeon or in conformance with the regulations of the authority adopted pursuant to Section 1797.107. *(Added by Stats. 1998, Ch. 979, Sec. 4. Effective January 1, 1999.)*

1797.115. (California Fire Fighter Joint Apprenticeship Program)
(a) To the extent permitted by federal law and upon appropriation in the annual Budget Act or another statute, the Director of Finance may transfer any moneys in the Federal Trust Fund established pursuant to Section 16360 of the Government Code to the Emergency Medical Services Authority if the money is made available by the United States for expenditure by the state for purposes consistent with the implementation of this section.

(b) Moneys appropriated pursuant to subdivision (a) shall be allocated by the authority to the California Fire Fighter Joint Apprenticeship Program to do all of the following:

(1) Offset the cost of paramedic training course development.

(2) Enter into reimbursement contracts with eligible state and local agencies that in turn may contract with educational institutions for the delivery of paramedic training conducted in compliance with the requirements of subdivision (a) of Section 1797.172.

(3) Allocate funds, in the form of grants, to eligible state and local agencies to defray the cost of providing paramedic training for fire services personnel, including, but not limited to, instructional supplies and trainee compensation expenses.

(c) To the extent permitted by federal law, the authority shall recover its costs for administration of this section from the funds transferred pursuant to subdivision (a).

(d) In order to be eligible for a grant under paragraph (3) of subdivision (b), a state or local agency shall demonstrate a need for additional paramedics.

(e) For purposes of this section, the following definitions apply:

(1) “Fire service personnel” includes, but is not limited to, a firefighter or prehospital emergency medical worker employed by a state or local agency.

(2) “Local agency” means any city, county, city and county, fire district, special district, joint powers agency, or any other political subdivision of the state that provides fire protection services.

(3) “State agency” means any state agency that provides residential or institutional fire protection, including, but not limited to, the Department of Forestry and Fire Protection. *(Amended by Stats. 2003, Ch. 62, Sec. 180. Effective January 1, 2004.)*

1797.116. (Terrorism Response Training Standards)
(a) The authority shall establish additional training standards that include the criteria for the curriculum content recommended by the Curriculum Development Advisory Committee established pursuant to Section 8588.10 of the Government Code, involving the responsibilities of first responders to terrorism incidents and to address the training needs of those identified as first responders. Training standards shall include, but not be limited to, criteria for coordinating between different responding entities.

(b) Every EMT I, EMT II, and EMT-P, as defined in Sections 1797.80, 1797.82, and 1797.84, may receive the appropriate training described in this section. Pertinent training previously completed by any jurisdiction’s EMT I, EMT II, or EMT-P personnel and meeting the training requirements of this section may be submitted to the training program approving authority to assess its content and determine whether it meets the training standards prescribed by the authority. *(Amended by Stats. 2014, Ch. 668, Sec. 3. Effective January 1, 2015.)*

1797.117. (Central Registry)
(a) The authority shall establish and maintain a centralized registry system for the monitoring and tracking of each EMT-I and EMT-II certificate status and each EMT-P license status. This centralized registry system shall be used by the certifying entities as part of the certification process for an EMT-I and EMT-II and by the authority as part of the licensure process for an EMT-P license. The authority shall, by regulation, specify the data elements to be included in the centralized registry system, the requirements for certifying entities to report the data elements for inclusion in the registry, including reporting deadlines, the penalties for failure of a certifying entity to report certification status changes within these deadlines, and requirements for submission to the Department of Justice fingerprint images and related information required by the Department of Justice of, except as otherwise provided in this division, EMT-I and EMT-II certificate candidates or holders and EMT-P license candidates or holders for the purposes described in subdivision (c). The data elements to be included in the centralized registry system shall include, but are not limited to, data elements that are to be made publicly available pursuant to subdivision (b).

(b) The information made available to the public through the centralized registry system shall include all of the following data elements: the full name of every individual who has been issued an EMT-I or EMT-II certificate or EMT-P license, the name of the entity that issued the certificate or license, the certificate or license number, the date of issuance of the license or certificate, and the license or certificate status.

(c) (1) As part of the centralized registry system, the authority shall electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice of all EMT-I and EMT-II certificate candidates or holders, and of all EMT-P license applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this subdivision. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and electronically disseminate a primary response to the authority and electronically disseminate a dual response to one government agency certifying entity.

(3) The Department of Justice shall electronically provide the primary response to the authority and also electronically, the dual response to one certifying entity that is a government agency, pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(d) The authority shall request the Department of Justice to provide subsequent arrest notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in subdivision (c). All subsequent arrest notifications provided to the authority for persons described in subdivision (c) shall be electronically submitted to one government agency certifying entity, as a dual response by the Department of Justice.

(e) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section. *(Added by Stats. 2008, Ch. 274, Sec. 6. Effective January 1, 2009.)*

1797.118. (Fingerprinting Requirements)
(a) On and after July 1, 2010, and except as provided in subdivision (b), every EMT-I and EMT-II certificate candidate or holder shall have their fingerprint images and related information submitted to the authority for submission to the Department of Justice pursuant to the regulations adopted pursuant to Section 1797.117 for a state and federal level criminal offender record information search, including subsequent arrest information.

(b) If a state level criminal offender record information search, including subsequent arrest information, has been conducted on a currently certified EMT-I or EMT-II, who was certified prior to July 1, 2010, for the purposes of employment or EMT-I or EMT-II certification, then the certifying entity or employer as identified in paragraph (2) of subdivision (a) of Section 1798.200 shall verify in writing to the authority pursuant to regulations adopted pursuant to Section 1797.117 that a state level criminal offender record information search, including subsequent arrest information, has been conducted and that nothing in the criminal offender record information search precluded the individual from obtaining EMT-I or EMT-II certification. *(Added by Stats. 2008, Ch. 274, Sec. 7. Effective January 1, 2009.)*

1797.120. (Ambulance Patient Offload Time)
(a) The authority shall develop, using input from stakeholders, including, but not limited to, hospitals, local EMS agencies, and public and private EMS providers, and, after approval by the commission pursuant to Section 1799.50, adopt a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload time.

(b) For the purposes of this section, “ambulance patient offload time” is defined as the interval between the arrival of an ambulance patient at an emergency department and the time that the patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient. *(Added by Stats. 2015, Ch. 379, Sec. 1. Effective January 1, 2016.)*

ARTICLE 2. Reports [1797.121 - 1797.122] (Heading of Article 2 amended by Stats. 1987, Ch. 1058, Sec. 1.)

1797.121. (System Effectiveness Legislative Report)
The authority shall report to the Legislature on the effectiveness of the systems provided for in this division on or before January 1, 1984, and annually thereafter, including within this report, systems impact evaluations on death and disability. *(Added by Stats. 1980, Ch. 1260.)*

1797.122. (Sharing of Patient-Identifiable Data)
(a) Notwithstanding any other law, a health facility as defined in subdivision (a) or (b) of Section 1250 may release patient-identifiable medical information under the following circumstances:

(1) To an EMS provider, information regarding a patient who was treated, or transported to the hospital by, that EMS provider, to the extent that specific data elements are requested for quality assessment and improvement purposes.

(2) To the authority or the local EMS agency, to the extent that specific data elements are requested for quality assessment and improvement purposes.
(b) An EMS provider, local EMS agency, and the authority shall request only those data elements that are minimally necessary in compliance with Section 164.502 (b) and Section 164.514 (d) of Title 45 of the Code of Federal Regulations.

(c) The authority may develop minimum standards for the implementation of data collection for system operation, patient outcome, and performance quality improvement.

(d) For purposes of this section, “EMS provider” means an organization employing an Emergency Medical Technician-I, Advanced Emergency Medical Technician, Emergency Medical Technician-Paramedic, registered nurse, or physician for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport, or during an interfacility transfer. *(Added by Stats. 2015, Ch. 362, Sec. 2. Effective January 1, 2016.)*

1797.123. (Ambulance Patient Offload Time)
(a) Upon receipt of data reported by a local EMS agency to the authority pursuant to Section 1797.228, the authority shall calculate ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

(b) The authority shall report twice per year to the Commission on Emergency Medical Services the ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

(c) On or before December 1, 2020, the authority, in collaboration with local EMS agencies, shall submit a report to the Legislature on ambulance patient offload time and recommendations to reduce or eliminate ambulance patient offload time. The report shall be submitted in compliance with Section 9795 of the Government Code. *(Added by Stats. 2018, Ch. 656, Sec. 2. Effective January 1, 2019.)*

ARTICLE 3. Coordination With Other State Agencies [1797.130 - 1797.134] (Article 3 added by Stats. 1980, Ch. 1260.)

1797.130. (Interdepartmental Committee on Emergency Medical Services)
The director shall chair an Interdepartmental Committee on Emergency Medical Services established pursuant to Section 1797.132. *(Added by Stats. 1980, Ch. 1260.)*

1797.132. (Interdepartmental Committee Membership, Roles)
An Interdepartmental Committee on Emergency Medical Services is hereby established. This committee shall advise the authority on the coordination and integration of all state activities concerning emergency medical services. The committee shall include a representative from each of the following state agencies and departments: the Office of Emergency Services, the Department of the California Highway Patrol, the Department of Motor Vehicles, a representative of the administrator of the California Traffic Safety Program as provided by Chapter 5 (commencing with Section 2900) of Division 2 of the Vehicle Code, the Medical Board of California, the State Department of Public Health, the Board of Registered Nursing, the State Department of Education, the National Guard, the Office of Statewide Health Planning and Development, the State Fire Marshal, the California Conference of Local Health Officers, the Department of Forestry and Fire Protection, the Chancellor's Office of the California Community Colleges, and the Department of General Services. *(Amended by Stats. 2013, Ch. 352, Sec. 332. Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)*

1797.133. (Interdepartmental Committee Consultants)
The director may appoint select resource committees of experts and may contract with special medical consultants for assistance in the implementation of this division. *(Amended by Stats. 1986, Ch. 248, Sec. 129.)*

1797.134. (EMS & Peace Officer Training Coordination)
The Interdepartmental Committee on Emergency Medical Services or another committee designated by the director shall consult with the Commission on Peace Officer Standards and Training regarding emergency medical services integration and coordination with peace officer training. *(Added by Stats. 2014, Ch. 668, Sec. 4. Effective January 1, 2015.)*

ARTICLE 4. Medical Disasters [1797.150 - 1797.153] (Article 4 added by Stats. 1980, Ch. 1260.)

1797.150. (Response to Medical Disasters)
In cooperation with the Office of Emergency Services, the authority shall respond to any medical disaster by mobilizing and coordinating emergency medical services mutual aid resources to mitigate health problems. *(Amended by Stats. 2013, Ch. 352, Sec. 333. Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)*

1797.151. (Disaster Preparedness Coordination)
The authority shall coordinate, through local EMS agencies, medical and hospital disaster preparedness with other local, state, and federal agencies and departments having a responsibility relating to disaster response, and shall assist the Office of Emergency Services in the preparation of the emergency medical services component of the State Emergency Plan as defined in Section 8560 of the Government Code. *(Amended by Stats. 2013, Ch. 352, Sec. 334. Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)*

1797.152. (Regional Disaster Medical and Health Coordinator)
(a) The director and the State Public Health Officer may jointly appoint a regional disaster medical and health coordinator for each mutual aid region of the state. A regional disaster medical and health coordinator shall be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency. Appointees shall be chosen from among persons nominated by a majority vote of the local health officers in a mutual aid region.

(b) In the event of a major disaster which results in a proclamation of emergency by the Governor, and in the need to deliver medical or public and environmental health mutual aid to the area affected by the disaster, at the request of the authority, the State Department of Public Health, or the Office of Emergency Services, a regional disaster medical and health coordinator in a region unaffected by the disaster may coordinate the acquisition of requested mutual aid resources from the jurisdictions in the region.

(c) A regional disaster medical and health coordinator may develop plans for the provision of medical or public health mutual aid among the counties in the region.

(d) No person may be required to serve as a regional disaster medical and health coordinator. No state compensation shall be paid for a regional disaster medical and health coordinator position, except as determined appropriate by the state, if funds become available. *(Amended by Stats. 2013, Ch. 352, Sec. 335. Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)*

1797.153. (Medical Health Operational Area Coordinator)
(a) In each operational area the county health officer and the local EMS agency administrator may act jointly as the medical health operational area coordinator (MHOAC). If the county health officer and the local EMS agency administrator are unable to fulfill the duties of the MHOAC they may jointly appoint another individual to fulfill these responsibilities. If an operational area has a MHOAC, the MHOAC in cooperation with the county office of emergency services, local public health department, the local office of environmental health, the local department of mental health, the local EMS agency, the local fire department, the regional disaster and medical health coordinator (RDMHC), and the regional office of the Office of Emergency Services, shall be responsible for ensuring the development of a medical and health disaster plan for the operational area. The medical and disaster plans shall follow the Standard Emergency Management System and National Incident Management System. The MHOAC shall recommend to the operational area coordinator of the Office of Emergency Services a medical and health disaster plan for the provision of medical and health mutual aid within the operational area.

(b) For purposes of this section, “operational area” has the same meaning as that term is defined in subdivision (b) of Section 8559 of the Government Code.

(c) The medical and health disaster plan shall include preparedness, response, recovery, and mitigation functions consistent with the State Emergency Plan, as established under Sections 8559 and 8560 of the Government Code, and, at a minimum, the medical and health disaster plan, policy, and procedures shall include all of the following:

(1) Assessment of immediate medical needs.

(2) Coordination of disaster medical and health resources.

(3) Coordination of patient distribution and medical evaluations.

(4) Coordination with inpatient and emergency care providers.

(5) Coordination of out-of-hospital medical care providers.

(6) Coordination and integration with fire agencies personnel, resources, and emergency fire prehospital medical services.

(7) Coordination of providers of nonfire based prehospital emergency medical services.

(8) Coordination of the establishment of temporary field treatment sites.

(9) Health surveillance and epidemiological analyses of community health status.

(10) Assurance of food safety.

(11) Management of exposure to hazardous agents.

(12) Provision or coordination of mental health services.

(13) Provision of medical and health public information protective action recommendations.

(14) Provision or coordination of vector control services.

(15) Assurance of drinking water safety.

(16) Assurance of the safe management of liquid, solid, and hazardous wastes.

(17) Investigation and control of communicable disease.

(d) In the event of a local, state, or federal declaration of emergency, the MHOAC shall assist the agency operational area coordinator in the coordination of medical and health disaster resources within the operational area, and be the point of contact in that operational area, for coordination with the RDMHC, the agency, the regional office of the agency, the State Department of Public Health, and the authority.

(e) Nothing in this section shall be construed to revoke or alter the current authority for disaster management provided under either of the following:

(1) The State Emergency Plan established pursuant to Section 8560 of the Government Code.

(2) The California standardized emergency management system established pursuant to Section 8607 of the Government Code. *(Amended by Stats. 2013, Ch. 352, Sec. 336. Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)*

ARTICLE 5. Personnel [1797.160 - 1797.197a] (Article 5 added by Stats. 1980, Ch. 1260.)

1797.160. (Ambulance Attendant Training)
No owner of a publicly or privately owned ambulance shall permit the operation of the ambulance in emergency service unless the attendant on

duty therein, or, if there is no attendant on duty therein, the operator, possesses evidence of that specialized training as is reasonably necessary to ensure that the attendant or operator is competent to care for sick or injured persons who may be transported by the ambulance, as set forth in the emergency medical training and educational standards for ambulance personnel established by the authority pursuant to this article. This section shall not be applicable in any state of emergency declared pursuant to the California Emergencies Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), when it is necessary to fully utilize all available ambulances in an area and it is not possible to have the ambulance operated or attended by persons with the qualifications required by this section. *(Added by Stats. 1983, Ch. 1246, Sec. 20.)*

1797.165. (Emergency Medical Responder)
(a) (1) Notwithstanding any other law, the Department of Forestry and Fire Protection, also known as CAL-FIRE pursuant to Section 701.6 of the Public Resources Code, may certify an individual as an Emergency Medical Responder (EMR) if he or she meets both of the following conditions:

(A) The individual is a graduate of the CAL-FIRE training program at a conservation camp under the Department of Corrections and Rehabilitation and received a letter of recommendation from the Director of CAL-FIRE.

(B) While participating in the training program described in subparagraph (A), the individual was working toward a high school diploma or its equivalent, unless he or she already earned one.

(2) Except as provided in subdivision (b), an individual certified as an EMR pursuant to this section shall meet the training requirements developed by the authority pursuant to this division, including, but not limited to, the requirements of Chapter 1.5 of Title 22 of Division 9 of the California Code of Regulations.

(b) (1) Any individual certified pursuant to paragraph (1) of subdivision (a) is not disqualified from certification as an EMR for having committed any of the actions described in subdivision (c) of Section 1798.200. This subdivision does not apply to an individual who committed any of those actions after he or she received certification pursuant to this section.

(2) The certification of an individual as an EMR pursuant to this section shall be recognized statewide as a valid EMR certification without an individual having to repeat testing or certification.

(c) The authority, in consultation with CAL-FIRE, shall, after approval by the commission pursuant to Section 1799.50, promulgate emergency regulations for the process of establishing the certification process pursuant

to this section. The emergency regulations promulgated pursuant to this section shall be adopted in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and, for purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of the regulations is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare. *(Amended by Stats. 2018, Ch. 457, Sec. 3. Effective September 17, 2018.)*

1797.170. (EMT-I: Standards)
(a) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt regulations for the training and scope of practice for EMT-I certification.

(b) (1) No later than July 1, 2019, the authority, local EMS agency, and certifying entity shall require an applicant to provide either the individual taxpayer identification number or social security number for purposes of applying for a certificate or the renewal of a certificate.

(2) If the authority, local EMS agency, or certifying entity utilizes a national examination to issue a certificate, and if a reciprocity agreement or comity exists between the State of California and the state requesting release of the individual taxpayer identification number or social security number, any deputy, agent, clerk, officer, or employee of the authority or agency may release an individual's taxpayer identification number or social security number to an examination or certifying entity, only for the purpose of verification of certification or examination status.

(3) The individual taxpayer identification or the social security number shall serve to establish the identification of persons affected by state tax laws and for purposes of establishing compliance with subsection (a) of Section 666 of Title 42 of the United States Code, Section 60.15 of Title 45 of the Code of Federal Regulations, Section 17520 of the Family Code, and Section 11105 of the Penal Code, and to that end, the information furnished pursuant to this section shall be used exclusively for those purposes.

(4) The authority, local EMS agency, and certifying entity shall not do either of the following:

(A) Require an applicant to disclose citizenship status or immigration status for purposes of the application or renewal of a certificate.

(B) Deny certification to an otherwise qualified and eligible applicant based solely on his or her citizenship status or immigration status.

(c) Any individual certified as an EMT-I pursuant to this division shall be recognized as an EMT-I on a statewide basis, and recertification shall be based on statewide standards.

(d) Effective July 1, 1990, any individual certified as an EMT-I pursuant to this act shall complete a course of training on the nature of sudden infant death syndrome which is developed by the California SIDS program in the State Department of Public Health in consultation with experts in the field of sudden infant death syndrome.

(e) On or before July 1, 2016, the authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt regulations to include the administration of naloxone hydrochloride in the training and scope of practice of EMT-I certification. These regulations shall be substantially similar to existing regulations set forth in Chapter 3 (commencing with Section 100101) of Division 9 of Title 22 of the California Code of Regulations that authorize an EMT-I to receive EMT-II training in the administration of naloxone hydrochloride without having to complete the entire EMT-II certification course. This subdivision shall be implemented in accordance with Chapter 5 (commencing with Section 1798). *(Amended by Stats. 2018, Ch. 838, Sec. 10. Effective January 1, 2019.)*

1797.171. (EMT-II: Standards)
(a) The authority shall develop, and after approval of the commission pursuant to Section 1799.50, shall adopt, minimum standards for the training and scope of practice for EMT-II.

(b) (1) No later than July 1, 2019, the authority, local EMS agency, and certifying entity shall require an applicant to provide either the individual taxpayer identification number or social security number for purposes of applying for a certificate or the renewal of a certificate.

(2) If the authority, local EMS agency, or certifying entity utilizes a national examination to issue a certificate, and if a reciprocity agreement or comity exists between the State of California and the state requesting release of the individual taxpayer identification number or social security number, any deputy, agent, clerk, officer, or employee of the authority or agency may release an individual's taxpayer identification number or social security number to an examination or certifying entity, only for the purpose of verification of certification or examination status.

(3) The individual taxpayer identification or the social security number shall serve to establish the identification of persons affected by state tax laws and for purposes of establishing compliance with subsection (a) of Section 666 of Title 42 of the United States Code, Section 60.15 of Title 45 of the Code of Federal Regulations, Section 17520 of the Family Code, and Section

11105 of the Penal Code, and to that end, the information furnished pursuant to this section shall be used exclusively for those purposes.

(4) The authority, local EMS agency, and certifying entity shall not do either of the following:

(A) Require an applicant to disclose citizenship status or immigration status for purposes of the application or renewal of a certificate.

(B) Deny certification to an otherwise qualified and eligible applicant based solely on his or her citizenship status or immigration status.

(c) An EMT-II shall complete a course of training on the nature of sudden infant death syndrome in accordance with subdivision (b) of Section 1797.170.

(d) In rural or remote areas of the state where patient transport times are particularly long and where local resources are inadequate to support an EMT-P program for EMS responses, the director may approve additions to the scope of practice of EMT-IIs serving the local system, if requested by the medical director of the local EMS agency, and if the EMT-II has received training equivalent to that of an EMT-P. The approval of the director, in consultation with a committee of local EMS medical directors named by the Emergency Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-IIs proposed by the medical director of a local EMS agency. No drug or procedure that is not part of the basic EMT-P scope of practice, including, but not limited to, any approved local options, shall be added to any EMT-II scope of practice pursuant to this subdivision.

Approval of additions to the scope of practices pursuant to this subdivision may be given only for EMT-II programs in effect on January 1, 1994.
(Amended by Stats. 2018, Ch. 838, Sec. 11. Effective January 1, 2019.)

1797.172. (EMT-P: Standards, Licensure, Renewal)
(a) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt minimum standards for the training and scope of practice for EMT-P.

(b) The approval of the director, in consultation with a committee of local EMS medical directors named by the EMS Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-Ps proposed by the medical director of a local EMS agency.

(c) (1) Notwithstanding any other provision of law, the authority shall be the agency solely responsible for licensure and licensure renewal of EMT-Ps who meet the standards and are not precluded from licensure because of any of the reasons listed in subdivision (c) of Section 1798.200. No later than July 1, 2019, the authority shall require an applicant to provide an individual taxpayer identification number or the social security number in order to establish the identity of the applicant. The information obtained as a result of a state and federal level criminal offender record information search shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure or licensure renewal pursuant to this division. Submission of fingerprint images to the Department of Justice may not be required for licensure renewal upon determination by the authority that fingerprint images have previously been submitted to the Department of Justice during initial licensure, or a previous licensure renewal, provided that the license has not lapsed and the applicant has resided continuously in the state since the initial licensure.

(2) The individual taxpayer identification or the social security number shall serve to establish the identification of persons affected by state tax laws and for purposes of establishing compliance with subsection (a) of Section 666 of Title 42 of the United States Code, Section 60.15 of Title 45 of the Code of Federal Regulations, Section 17520 of the Family Code, and Section 11105 of the Penal Code, and to that end, the information furnished pursuant to this section shall be used exclusively for those purposes.

(3) If the authority utilizes a national examination to issue a certificate, and if a reciprocity agreement or comity exists between the State of California and the state requesting release of the individual taxpayer identification number or social security number, any deputy, agent, clerk, officer, or employee of the authority may release an individual's taxpayer identification number or social security number to an examination or certifying entity, only for the purpose of verification of certification or examination status.

(4) The authority shall not do either of the following:

(A) Require an applicant to disclose citizenship status or immigration status for purposes of the application or renewal of a certificate.

(B) Deny certification to an applicant based solely on his or her citizenship status or immigration status.

(d) The authority shall charge fees for the licensure and licensure renewal of EMT-Ps in an amount sufficient to support the authority's licensure program at a level that ensures the qualifications of the individuals licensed to provide quality care. The basic fee for licensure or licensure renewal of an EMT-P shall not exceed one hundred twenty-five dollars ($125) until the

adoption of regulations that specify a different amount that does not exceed the authority's EMT-P licensure, license renewal, and enforcement programs. The authority shall annually evaluate fees to determine if the fee is sufficient to fund the actual costs of the authority's licensure, licensure renewal, and enforcement programs. If the evaluation shows that the fees are excessive or are insufficient to fund the actual costs of the authority's EMT-P licensure, licensure renewal, and enforcement programs, then the fees shall be adjusted accordingly through the rulemaking process described in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Separate additional fees may be charged, at the option of the authority, for services that are not shared by all applicants for licensure and licensure renewal, including, but not limited to, any of the following services:

(1) Initial application for licensure as an EMT-P.

(2) Competency testing, the fee for which shall not exceed thirty dollars ($30), except that an additional fee may be charged for the cost of any services that provide enhanced availability of the exam for the convenience of the EMT-P, such as on-demand electronic testing.

(3) Fingerprint and criminal record check. The applicant shall, if applicable according to subdivision (c), submit fingerprint images and related information for criminal offender record information searches with the Department of Justice and the Federal Bureau of Investigation.

(4) Out-of-state training equivalency determination.

(5) Verification of continuing education for a lapse in licensure.

(6) Replacement of a lost licensure card. The fees charged for individual services shall be set so that the total fees charged to EMT-Ps shall not exceed the authority's actual total cost for the EMT-P licensure program.

(e) The authority may provide nonconfidential, nonpersonal information relating to EMS programs to interested persons upon request, and may establish and assess fees for the provision of this information. These fees shall not exceed the costs of providing the information.

(f) At the option of the authority, fees may be collected for the authority by an entity that contracts with the authority to provide any of the services associated with the EMT-P program. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Services Personnel Fund within 30 calendar days following the last day of the calendar month in which the fees

were received by the designated entity, unless the contract between the entity and the authority specifies a different timeframe. *(Amended by Stats. 2018, Ch. 838, Sec. 11. Effective January 1, 2019.)*

1797.173. (Training Program Locations)
The authority shall assure that all training programs for EMT-I, EMT-II, and EMT-P are located in an approved licensed hospital or an educational institution operated with written agreements with an acute care hospital, including a public safety agency that has been approved by the local emergency medical services agency to provide training. The authority shall also assure that each training program has a competency-based curriculum. EMT-I training and testing for fire service personnel may be offered at sites approved by the State Board of Fire Services and training for officers of the California Highway Patrol may be provided at the California Highway Patrol Academy. *(Amended by Stats. 1983, Ch. 1246, Sec. 22.)*

1797.174. (Continuing Education & Quality Improvement Programs)
In consultation with the commission, the Emergency Medical Directors Association of California, and other affected constituencies, the authority shall develop statewide guidelines for continuing education courses and approval of continuing education courses for EMT-Ps and for quality improvement systems which monitor and promote improvement in the quality of care provided by EMT-Ps throughout the state. *(Added by Stats. 1993, Ch. 997, Sec. 5. Effective January 1, 1994.)*

1797.175. (Continuing Education Exams)
The authority shall establish the standards for continuing education and shall designate the examinations for certification and recertification of all prehospital personnel.

The authority shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS). *(Amended by Stats. 1989, Ch. 1362, Sec. 6. Effective October 2, 1989.)*

1797.176. (EMS System Medical Control Standards)
The authority shall establish the minimum standards for the policies and procedures necessary for medical control of the EMS system. *(Amended by Stats. 1988, Ch. 1390, Sec. 3.)*

1797.177. (Requirement for Certification)
No individual shall hold himself or herself out to be an EMT-I, EMT-II, EMT-P, or paramedic unless that individual is currently certified as such by the local EMS agency or other certifying authority. *(Added by Stats. 1980, Ch. 1260.)*

1797.178. (Provision of Advanced/Limited Advanced Life Support)
No person or organization shall provide advanced life support or limited advanced life support unless that person or organization is an authorized part of the emergency medical services system of the local EMS agency or of a pilot program operated pursuant to the Wedworth-Townsend Paramedic Act, Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2. *(Added by Stats. 1980, Ch. 1260.)*

1797.179. (Health Care Deposit Fund Reimbursement)
Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county or special district providing paramedic services as set forth in Section 1797.172, shall reimburse the Health Care Deposit Fund for the state costs of paying such medical claims. Funds allocated to the county from the County Health Services Fund pursuant to Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code may be utilized by the county or city to make such reimbursement. *(Added by Stats. 1980, Ch. 1322.)*

1797.180. (Advertising Prehospital Services)
No agency, public or private, shall advertise or disseminate information to the public that the agency provides EMT-II or EMT-P rescue or ambulance services unless that agency does in fact provide this service on a continuous 24 hours-per-day basis. If advertising or information regarding that agency's EMT-II or EMT-P rescue or ambulance service appears on any vehicle it may only appear on those vehicles utilized solely to provide that service on a continuous 24 hours-per-day basis. *(Added by Stats. 1983, Ch. 1246, Sec. 23.)*

1797.181. (Standardized Insignias)
The authority may, by regulation, prescribe standardized insignias or emblems for patches which may be affixed to the clothing of an EMT-I, EMT-II, or EMT-P. *(Added by Stats. 1983, Ch. 1246, Sec. 24.)*

1797.182. (First Aid/CPR Training: Firefighters & Lifeguards)
All ocean, public beach, and public swimming pool lifeguards and all firefighters in this state, except those whose duties are primarily clerical or administrative, shall be trained to administer first aid and cardiopulmonary resuscitation. The training shall meet standards prescribed by the authority, and shall be satisfactorily completed by such persons as soon as practical, but in no event more than one year after the date of employment. Satisfactory completion of a refresher course which meets the standards prescribed by the authority in cardiopulmonary resuscitation and other first aid shall be required at least every three years.

The authority may designate a public agency or private nonprofit agency to provide for each county the training required by this section. The training shall be provided at no cost to the trainee.

As used in this section, “lifeguard” means any regularly employed and paid officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state.

As used in this section, “firefighter” means any regularly employed and paid officer, employee, or member of a fire department or fire protection or firefighting agency of the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state or member of an emergency reserve unit of a volunteer fire department or fire protection district. *(Added by Stats. 1983, Ch. 1246, Sec. 25.)*

1797.183. (First Aid/CPR Training: Peace Officers)
All peace officers described in Section 13518 of the Penal Code, except those whose duties are primarily clerical or administrative, shall be trained to administer first aid and cardiopulmonary resuscitation (CPR). The training shall meet standards prescribed by the authority, in consultation with the Commission on Peace Officers Standards and Training, and shall be satisfactorily completed by those officers as soon as practical, but in no event more than one year after the date of employment. Satisfactory completion of either refresher training or appropriate testing, which meets the standards of the authority, in cardiopulmonary resuscitation and other first aid, shall be required at periodic intervals as determined by the authority. *(Added by Stats. 1983, Ch. 1246, Sec. 26.)*

1797.184. (EMT-I and EMT-II Certification, Recertification, Discipline)
The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt all of the following:

(a) Guidelines for disciplinary orders, temporary suspensions, and conditions of probation for EMT-I and EMT-II certificate holders that protects the public health and safety.

(b) Regulations for the issuance of EMT-I and EMT-II certificates by a certifying entity that protects the public health and safety.

(c) Regulations for the recertification of EMT-I and EMT-II certificate holders that protect the public health and safety.

(d) Regulations for disciplinary processes for EMT-I and EMT-II applicants and certificate holders that protect the public health and safety. These disciplinary processes shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. *(Added by Stats. 2008, Ch. 274, Sec. 10. Effective January 1, 2009.)*

1797.185. (Statewide Recognition of Prehospital Personnel)
(a) The authority shall establish criteria for the statewide recognition of the certification of EMT-P personnel in the basic scope of practice of those personnel. The criteria shall include, but need not be limited to, the following:

(1) Standards for training, testing, certification, and revocation of certification, as required for statewide recognition of certification. The standards may include designation by the authority of the specific examinations required for certification, including, at the option of the authority, an examination provided by the authority. At the option of the authority, the standards may include a requirement for registration of prehospital emergency care personnel with the authority or other entity designated by the authority.

(2) Conditions for local accreditation of certified EMT-P personnel which are reasonable in order to maintain medical control and the integrity of the local EMS system, as determined by the authority and approved by the commission.

(3) Provisions for local accreditation in approved optional scope of practice, if any, as allowed by applicable state regulations and statutes.

(4) Provisions for the establishment and collection of fees by the appropriate agency, which may be the authority or an entity designated by the authority to collect fees for the authority, for testing, certification, accreditation, and registration with the appropriate state or local agency in the appropriate scope of practice. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Services Personnel Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the designated entity.

(b) After January 1, 1991, all regulations for EMT-P personnel adopted by the authority shall, where relevant, include provisions for statewide recognition of certification or authorization for the scope of practice of those personnel.

(c) On or before July 1, 1991, the authority shall amend all relevant regulations for EMT-P personnel to include criteria developed pursuant to subdivision (c) of Section 1797.7 and subdivision (b) of Section 1797.172 to insure statewide recognition of certification for the scope of practice of those personnel.

(d) All future regulations for EMT-P personnel adopted by the authority shall, where relevant, include provisions for statewide recognition of certification or authorization for the scope of practice of those personnel. *(Amended by Stats. 1989, Ch. 1362, Sec. 7. Effective October 2, 1989.)*

1797.186. (Prophylactic Medical Treatment for Prehospital Personnel)
All persons described in Sections 1797.170, 1797.171, 1797.172, 1797.182, and 1797.183, whether volunteers, partly paid, or fully paid, shall be entitled to prophylactic medical treatment to prevent the onset of disease, provided that the person demonstrates that he or she was exposed, while in the service of the department or unit, to a contagious disease, as listed in Section 2500 of Title 17 of the California Administrative Code, while performing first aid or cardiopulmonary resuscitation services to any person.

Medical treatment under this section shall not affect the provisions of Division 4 (commencing with Section 3200) or Division 5 (commencing with Section 6300) of the Labor Code or the person's right to make a claim for work-related injuries, at the time the contagious disease manifests itself. *(Added by Stats. 1985, Ch. 1543, Sec. 1.)*

1797.187. (Peace Officer Exposure to Carcinogens)
A peace officer as described in Section 830.1, subdivision (a) of Section 830.2, or subdivision (g) of Section 830.3 of the Penal Code, while in the service of the agency or local agency which employs him or her, shall be notified by the agency or local agency if the peace officer is exposed to a known carcinogen, as defined by the International Agency for Research on Cancer, or as defined by its director, during the investigation of any place where any controlled substance, as defined in Section 11007 is suspected of being manufactured, stored, transferred, or sold, or any toxic waste spills, accidents, leaks, explosions, or fires.

The Commission on Peace Officers Standards and Training basic training course, and other training courses as the commission determines appropriate, shall include, on or before January 1, 1990, instruction on, but not limited to, the identification and handling of possible carcinogenic materials and the potential health hazards associated with these materials, protective equipment, and clothing available to minimize contamination, handling, and disposing of materials and measures and procedures that can be adopted to minimize exposure to possible hazardous materials. *(Amended by Stats. 1998, Ch. 606, Sec. 4. Effective January 1, 1999.)*

1797.188. (Notification of Exposure: Hospital)
(a) As used in this section:

(1) “Prehospital emergency medical care person or personnel” means any of the following: an authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(2) “Reportable disease or condition” or “a communicable disease or condition listed as reportable” means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Code of Regulations, as may be amended from time to time.

(3) “Exposed” means at risk for contracting the disease, as defined by regulations of the state department.

(4) “Health facility” means a health facility, as defined in Section 1250, including a publicly operated facility.

(5) “Health facility infection control officer” means the official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

(6) “Designated officer” means the official or officer of an employer of a prehospital emergency medical care person or personnel who has been designated by the state’s public health officer or the employer.

(7) “Urgency reporting requirement” means a disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

(b) In addition to the communicable disease testing and notification procedures applicable under Chapter 3.5 (commencing with Section 120260) of Part 1 of Division 105, all prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid, who have provided emergency medical or rescue services and have been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through physical or oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease or condition in accordance with the following:

(1) If the prehospital emergency medical care person, who has rendered emergency medical or rescue services and believes that he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a reportable communicable disease or condition, and provides the health facility infection control officer with his or her name and telephone number at the time the patient is transferred from that prehospital emergency medical care person to the admitting health facility; or the party transporting the person afflicted with the reportable communicable disease or condition provides that health facility with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services and believes he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a communicable disease or condition, the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of emergency medical or rescue services, shall immediately notify the designated officer of the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The health facility infection control officer shall also report the name and telephone number of the prehospital emergency medical care person to the county health officer. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(2) If the prehospital emergency medical care person who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable communicable disease or condition, but has not

provided the health facility infection control officer with his or her name and telephone number pursuant to paragraph (1), the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition that may have been transmitted during provision of emergency medical or rescue services, shall immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). Otherwise, the county health officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations. The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

(d) An employer of a prehospital emergency medical care person or personnel that maintains an Internet Web site shall post the title and telephone number of the designated officer in a conspicuous location on its Internet Web site accessible from the home page. A health facility that maintains an Internet Web site shall post the title and telephone number of the health facility infection control officer in a conspicuous location on its Internet Web site accessible from the home page.

(e) (1) The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(2) The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(f) An employer of a health facility infection control officer and an employer of a prehospital emergency medical care person or personnel shall inform those employees of this law as part of the Cal-OSHA Injury and Illness Prevention Program training required by paragraph (7) of subdivision (a) of Section 3203 of Title 8 of the California Code of Regulations.

(g) Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the health facility, the designated officer, or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

(h) In the event of the demise of the person afflicted with the reportable communicable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable communicable disease or condition prior to the release of the decedent from the health facility to the funeral director.

(i) Notwithstanding Section 1798.206, a violation of this section is not a misdemeanor. *(Amended by Stats. 2018, Ch. 424, Sec. 4. Effective January 1, 2019.)*

1797.189. (Notification of Exposure: Coroner)
(a) As used in this section:

(1) “Chief medical examiner-coroner” means the chief medical examiner or the coroner as referred to in subdivision (m) of Section 24000, Section 24010, subdivisions (k), (m), and (n) of Section 24300, subdivisions (k), (m), and (n) of Section 24304, and Sections 27460 to 27530, inclusive, of the Government Code, and Section 102850.

(2) “Prehospital emergency medical care person or personnel” means any of the following: authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(3) “Reportable disease or condition” or “a disease or condition listed as reportable” means those diseases specified in Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Administrative Code, as may be amended from time to time.

(4) “Exposed” means at risk for contracting a disease, as defined by regulations of the state department.

(5) “Health facility” means a health facility, as defined in Section 1250, including a publicly operated facility.

(b) Any prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid who have provided emergency medical or rescue services and have been exposed to a person afflicted with a disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease and should contact the county health officer if all of the following conditions are met:

(1) The prehospital emergency medical care person, who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable disease or condition, provides the chief medical examiner-coroner with his or her name and telephone number at the time the patient is transferred from that prehospital medical care person to the chief medical examiner-coroner; or the party transporting the person afflicted with the reportable disease or condition provides that chief medical examiner-coroner with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services.

(2) The chief medical examiner-coroner reports the name and telephone number of the prehospital emergency medical care person to the county health officer upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable disease or condition.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the chief medical examiner-coroner or any of the prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

The chief medical examiner-coroner, or the county health officer shall notify the funeral director, charged with removing or receiving the decedent afflicted with a reportable disease or condition from the chief medical examiner-coroner, of the reportable disease prior to the release of the decedent from the chief medical examiner-coroner to the funeral director. Notwithstanding Section 1798.206, violation of this section is not a misdemeanor. *(Amended by Stats. 1996, Ch. 1023, Sec. 173. Effective September 29, 1996.)*

1797.190. (AED Training for Non-EMS Personnel)
The authority may establish minimum standards for the training and use of automatic external defibrillators. *(Amended by Stats. 2002, Ch. 718, Sec. 2. Effective January 1, 2003.)*

1797.191. (Pediatric First Aid & CPR Training Programs)
(a) The authority shall establish minimum standards for the training in pediatric first aid, pediatric cardiopulmonary resuscitation (CPR), and preventive health practices required by Section 1596.866.

(b) (1) The authority shall establish a process for the ongoing review and approval of training programs in pediatric first aid, pediatric CPR, and preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866 to ensure that those programs meet the minimum standards established pursuant to subdivision (a). The authority shall charge fees equal to its costs incurred for the pediatric first aid and pediatric CPR training standards program and for the ongoing review and approval of these programs.

(2) The authority shall establish, in consultation with experts in pediatric first aid, pediatric CPR, and preventive health practices, a process to ensure the quality of the training programs, including, but not limited to, a method for

assessing the appropriateness of the courses and the qualifications of the instructors.

(c) (1) The authority may charge a fee equal to its costs incurred for the preventive health practices program and for the initial review and approval and renewal of approval of the program.

(2) If the authority chooses to establish a fee process based on the use of course completion cards for the preventive health practices program, the cost shall not exceed seven dollars ($7) per card for each training participant until January 1, 2001, at which time the authority may evaluate its administrative costs. After evaluation of the costs, the authority may establish a new fee scale for the cards so that revenue does not exceed the costs of the ongoing review and approval of the preventive health practices training.

(d) For the purposes of this section, “training programs” means programs that apply for approval by the authority to provide the training in pediatric first aid, pediatric CPR, or preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866. Training programs include all affiliated programs that also provide any of the authority-approved training required by this division. “Affiliated programs” means programs that are overseen by persons or organizations that have an authority-approved training program in pediatric first aid, pediatric CPR, or preventive health practices. Affiliated programs also include programs that have purchased an authority-approved training program in pediatric first aid, pediatric CPR, or preventive health practices. Training programs and their affiliated programs shall comply with this division and with the regulations adopted by the authority pertaining to training programs in pediatric first aid, pediatric CPR, or preventive health practices.

(e) The director of the authority may, in accordance with regulations adopted by the authority, deny, suspend, or revoke any approval issued under this division or may place any approved program on probation, upon the finding by the director of the authority of an imminent threat to the public health and safety as evidenced by the occurrence of any of the actions listed in subdivision (f).

(f) Any of the following actions shall be considered evidence of a threat to the public health and safety, and may result in the denial, suspension, probation, or revocation of a program’s approval or application for approval pursuant to this division.

(1) Fraud.

(2) Incompetence.

(3) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of training program directors and instructors.

(4) Conviction of any crime that is substantially related to the qualifications, functions, and duties of training program directors and instructors. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

(5) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, this division or the regulations promulgated by the authority pertaining to the review and approval of training programs in pediatric first aid, pediatric CPR, and preventive health practices as specified in paragraph (2) of subdivision (a) of Section 1596.866.

(g) In order to ensure that adequate qualified training programs are available to provide training in the preventive health practices course to all persons who are required to have that training, the authority may, after approval of the Commission on Emergency Medical Services pursuant to Section 1799.50, establish temporary standards for training programs for use until permanent standards are adopted pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Persons who, prior to the date on which the amendments to this section enacted in 1998 become operative, have completed a course or courses in preventive health practices as specified in subparagraph (C) of paragraph (2) of subdivision (a) of Section 1596.866, and have a certificate of completion card for a course or courses in preventive health practices, or certified copies of transcripts that identify the number of hours and the specific course or courses taken for training in preventive health practices shall be deemed to have met the requirement for training in preventive health practices. *(Amended by Stats. 1999, Ch. 83, Sec. 106. Effective January 1, 2000.)*

1797.192. (EMT-P Training & Certification Scope of Practice Standard)
On or before July 1, 1991, the authority shall adopt standards for a standard statewide scope of practice which shall be utilized for the training and certification testing of EMT-P personnel for certification as EMT-P's. Local EMS systems shall not be required to utilize the entire standard scope of practice. Testing of EMT-P personnel for local accreditation to practice shall only include local operational policies and procedures, and drug, device, or treatment procedures being utilized within that local EMS system pursuant

to Sections 1797.172 and 1797.221. *(Added by Stats. 1989, Ch. 1362, Sec. 8. Effective October 2, 1989.)*

1797.193. (Prehospital Personnel SIDS Training)
(a) By July 1, 1992, existing firefighters in this state shall complete a course on the nature of sudden infant death syndrome taught by experts in the field of sudden infant death syndrome. All persons who become firefighters after January 1, 1990, shall complete a course on this topic as part of their basic training as firefighters. The course shall include information on the community resources available to assist families who have lost children to sudden infant death syndrome.

(b) For purposes of this section, the term “firefighter” has the same meaning as that specified in Section 1797.182.

(c) When the instruction and training are provided by a local agency, a fee shall be charged sufficient to defray the entire cost of the instruction and training. *(Added by renumbering Section 1797.192 (as added by Stats. 1989, Ch. 1111) by Stats. 1990, Ch. 216, Sec. 61.)*

1797.194. (State Licensure of EMT-P Personnel)
The purpose of this section is to provide for the state licensure of EMT-P personnel. Notwithstanding any provision of law, including, but not limited to, Sections 1797.208 and 1797.214, all of the following applies to EMT-P personnel:

(a) Any reference to EMT-P certification pursuant to this division shall be equivalent to EMT-P licensure pursuant to this division, including, but not limited to, any provision in this division relating to the assessment of fees.

(b) The statewide examination designated by the authority for licensure of EMT-P personnel and the licensure issued by the authority shall be the single sufficient examination and licensure required for practice as an EMT-P.

(c) EMT-P licenses shall be renewed every two years upon submission to the authority of proof of satisfactory completion of continuing education or other educational requirements established by regulations of the authority, upon approval by the commission. If the evaluation and recommendations of the authority required pursuant to Section 8 of Chapter 997 of the Statutes of 1993, so concludes, the renewal of EMT-P licenses shall, in addition to continuing education requirements, be contingent upon reexamination at 10-year intervals to ensure competency.

(d) Every EMT-P licensee may be disciplined by the authority for violations of this division. The proceedings under this subdivision shall be conducted

in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the authority shall have all the powers granted therein for this purpose.

(e) Nothing in this section shall be construed to extend the scope of practice of an EMT-P beyond prehospital settings, as defined by regulations of the authority.

(f) Nothing in this section shall be construed to alter or interfere with the local EMS agency's ability to locally accredit licensed EMT-Ps.

(g) Nothing in this section shall be construed to hinder the ability of the medical director of the local EMS agency to maintain medical control within the local EMS system in accordance with this division, including, but not limited to, Chapter 5 (commencing with Section 1798). *(Added by Stats. 1994, Ch. 709, Sec. 4. Effective January 1, 1995.)*

1797.195. (Use of EMS Personnel in Small & Rural Hospitals)
(a) Notwithstanding any other provision of law to the contrary, an EMT-I, EMT-II, or EMT-P may provide emergency medical care pursuant to this section in the emergency department of a hospital that meets the definition of small and rural hospital pursuant to Section 1188.855, except that in the case of a hospital meeting the definition contained in Section 1188.855 the population of the incorporated place or census designated place where the hospital is located shall not have increased to more than 20,000 since 1980, and all of the following conditions are met:

(1) The EMT-I, EMT-II, or EMT-P is on duty as a prehospital emergency medical care provider.

(2) The EMT-I, EMT-II, or EMT-P shall function under direct supervision as defined in hospital protocols that have been issued pursuant to paragraph (3), and only where the physician and surgeon or the registered nurse determines that the emergency department is faced with a patient crisis, and that the services of the EMT-I, EMT-II, or EMT-P are necessary to temporarily meet the health care needs of the patients in the emergency department.

(3) The utilization of an EMT-I, EMT-II, or EMT-P in the emergency department is done pursuant to hospital protocols that have been developed by the hospital's nursing staff, the physician and surgeon medical director of the emergency department, and the administration of the hospital, with the approval of the medical staff, and that shall include at least all of the following:

(A) A requirement that the EMT-I, EMT-II, or EMT-P successfully complete a hospital training program on the protocols and procedures of the hospital emergency department. The program shall include, but not be limited to, features of the protocols for which the EMT-I, EMT-II, or EMT-P has not previously received training and a postprogram evaluation.

(B) A requirement that the EMT-I, EMT-II, or EMT-P annually demonstrates and documents to the hospital competency in the emergency department procedures.

(C) The emergency medical care to be provided in the emergency department by the EMT-I, EMT-II, or EMT-P shall be set forth or referenced in the protocols and shall be limited to that which is otherwise authorized by their certification or licensure as defined in statute or regulation. The protocols shall not include patient assessment in this setting, except when the assessment is directly related to the specific task the EMT-I, EMT-II, and EMT-P is performing.

(D) A process for continuity of patient care when the EMT-I, EMT-II, or EMT-P is called to an off-site emergency situation.

(E) Procedures for the supervision of the EMT-I, EMT-II, or EMT-P.

(4) The protocols for utilization of an EMT-I, EMT-II, or EMT-P in the emergency department are developed in consultation with the medical director of the local EMS agency and the emergency medical care committee, if a committee has been formed.

(5) A written contract shall be in effect relative to the services provided pursuant to this section, between the ambulance company and the hospital, where the EMT-I, EMT-II, or EMT-P is employed by an ambulance company that is not owned by the hospital.

(b) When services of emergency personnel are called upon pursuant to this section, responsibility for the medical direction of the EMT-I, EMT-II, or EMT-P rests with the hospital, pursuant to the hospital protocols as set forth in paragraph (3) of subdivision (a).

(c) Although this section authorizes the provision of services in an emergency department of certain small and rural hospitals, nothing in this section is intended to expand or restrict the types of services or care to be provided by EMT-I, EMT-II, or EMT-P pursuant to this article. *(Added by Stats. 1995, Ch. 239, Sec. 2. Effective January 1, 1996.)*

1797.196. (Civil Liability Protections: AED)
(a) For purposes of this section, “AED” or “defibrillator” means an automated external defibrillator.

(b) (1) In order to ensure public safety, a person or entity that acquires an AED shall do all of the following:

(A) Comply with all regulations governing the placement of an AED.

(B) Notify an agent of the local EMS agency of the existence, location, and type of AED acquired.

(C) Ensure that the AED is maintained and tested according to the operation and maintenance guidelines set forth by the manufacturer.

(D) Ensure that the AED is tested at least biannually and after each use.

(E) Ensure that an inspection is made of all AEDs on the premises at least every 90 days for potential issues related to operability of the device, including a blinking light or other obvious defect that may suggest tampering or that another problem has arisen with the functionality of the AED.

(F) Ensure that records of the maintenance and testing required pursuant to this paragraph are maintained.

(2) When an AED is placed in a building, the building owner shall do all of the following:

(A) At least once a year, notify the tenants as to the location of the AED units and provide information to tenants about who they can contact if they want to voluntarily take AED or CPR training.

(B) At least once a year, offer a demonstration to at least one person associated with the building so that the person can be walked through how to use an AED properly in an emergency. The building owner may arrange for the demonstration or partner with a nonprofit organization to do so.

(C) Next to the AED, post instructions, in no less than 14-point type, on how to use the AED.

(3) A medical director or other physician and surgeon is not required to be involved in the acquisition or placement of an AED.

(c) (1) When an AED is placed in a public or private K–12 school, the principal shall ensure that the school administrators and staff annually receive information that describes sudden cardiac arrest, the school’s

emergency response plan, and the proper use of an AED. The principal shall also ensure that instructions, in no less than 14-point type, on how to use the AED are posted next to every AED. The principal shall, at least annually, notify school employees as to the location of all AED units on the campus.

(2) This section does not prohibit a school employee or other person from rendering aid with an AED.

(d) A manufacturer or retailer supplying an AED shall provide to the acquirer of the AED all information governing the use, installation, operation, training, and maintenance of the AED.

(e) A violation of this section is not subject to penalties pursuant to Section 1798.206.

(f) Nothing in this section or Section 1714.21 of the Civil Code may be construed to require a building owner or a building manager to acquire and have installed an AED in any building.

(g) For purposes of this section, “local EMS agency” means an agency established pursuant to Section 1797.200.

(h) This section does not apply to facilities licensed pursuant to subdivision (a), (b), (c), or (f) of Section 1250. *(Amended by Stats. 2015, Ch. 264, Sec. 2. Effective January 1, 2016.)*

1797.197. (Epinephrine Use Guidelines)
(a) The authority shall establish training and standards for all prehospital emergency medical care personnel, as defined in paragraph (2) of subdivision (a) of Section 1797.189, regarding the characteristics and method of assessment and treatment of anaphylactic reactions and the use of epinephrine. The authority shall promulgate regulations regarding these matters for use by all prehospital emergency medical care personnel.

(b) (1) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt training and standards for all prehospital emergency medical care personnel, as defined in paragraph (2) of subdivision (a) of Section 1797.189, regarding the use and administration of naloxone hydrochloride and other opioid antagonists. The authority shall promulgate regulations regarding these matters for use by all prehospital emergency medical care personnel. The authority may adopt existing training and standards for prehospital emergency medical care personnel regarding the statewide use and administration of naloxone hydrochloride or another opioid antagonist to satisfy the requirements of this section.

(2) The medical director of a local EMS agency may, pursuant to Section 1797.221, approve or conduct a trial study of the use and administration of naloxone hydrochloride or other opioid antagonists by any level of prehospital emergency medical care personnel. Training received by prehospital emergency medical care personnel specific to the use and administration of naloxone hydrochloride or another opioid antagonist during this trial study may be used towards satisfying the training requirements established pursuant to paragraph (1) regarding the use and administration of naloxone hydrochloride and other opioid antagonists by prehospital emergency medical care personnel.

(3) The training described in paragraphs (1) and (2) shall satisfy the requirements of paragraph (1) of subdivision (d) of Section 1714.22 of the Civil Code. *(Amended by Stats. 2014, Ch. 491, Sec. 2. Effective January 1, 2015.)*

1797.197a. (Epinephrine Auto-Injectors)
(a) For purposes of this section, the following definitions shall apply:

(1) “Anaphylaxis” means a potentially life-threatening hypersensitivity or allergic reaction to a substance.

(A) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.

(B) Causes of anaphylaxis may include, but are not limited to, insect stings or bites, foods, drugs, and other allergens, as well as idiopathic or exercise-induced anaphylaxis.

(2) “Authorized entity” means any for-profit, nonprofit, or government entity or organization that employs at least one person or utilizes at least one volunteer or agent that has voluntarily completed a training course as described in subdivision (c).

(3) “Epinephrine auto-injector” means a disposable delivery device designed for the automatic injection of a premeasured dose of epinephrine into the human body to prevent or treat a life-threatening allergic reaction.

(4) “Lay rescuer” means any person who has met the training standards and other requirements of this section but who is not otherwise licensed or certified to use an epinephrine auto-injector on another person.

(5) “Prehospital emergency medical care person” has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1797.189.

(b) A prehospital emergency medical care person or lay rescuer may use an epinephrine auto-injector to render emergency care to another person if all of the following requirements are met:

(1) The epinephrine auto-injector is legally obtained by prescription from an authorized health care provider or from an authorized entity that acquired the epinephrine auto-injector pursuant to subdivision (e).

(2) The epinephrine auto-injector is used on another, with the expressed or implied consent of that person, to treat anaphylaxis.

(3) The epinephrine auto-injector is stored and maintained as directed by the manufacturer's instructions for that product.

(4) The person using the epinephrine auto-injector has successfully completed a course of training with an authorized training provider, as described in subdivision (c), and has current certification of training issued by the provider.

(5) The epinephrine auto-injectors obtained by prehospital emergency medical care personnel pursuant to Section 4119.3 of the Business and Professions Code shall be used only when functioning outside the course of the person's occupational duties, or as a volunteer, pursuant to this section.

(6) The Emergency Medical Services System is activated as soon as practicable when an epinephrine auto-injector is used.

(c) (1) The authorized training providers shall be approved, and the minimum standards for training and the use and administration of epinephrine auto-injectors pursuant to this section shall be established and approved, by the authority. The authority may designate existing training standards for the use and administration of epinephrine auto-injectors by prehospital emergency medical care personnel to satisfy the requirements of this section.

(2) The minimum training and requirements shall include all of the following components:

(A) Techniques for recognizing circumstances, signs, and symptoms of anaphylaxis.

(B) Standards and procedures for proper storage and emergency use of epinephrine auto-injectors.

(C) Emergency followup procedures, including activation of the Emergency Medical Services System, by calling the emergency 911 telephone number

or otherwise alerting and summoning more advanced medical personnel and services.

(D) Compliance with all regulations governing the training, indications, use, and precautions concerning epinephrine auto-injectors.

(E) Written material covering the information required under this provision, including the manufacturer product information sheets on commonly available models of epinephrine auto-injectors.

(F) Completion of a training course in cardiopulmonary resuscitation and the use of an automatic external defibrillator (AED) for infants, children, and adults that complies with regulations adopted by the authority and the standards of the American Heart Association or the American Red Cross, and a current certification for that training.

(3) Training certification shall be valid for no more than two years, after which recertification with an authorized training provider is required.

(4) The director may, in accordance with regulations adopted by the authority, deny, suspend, or revoke any approval issued under this subdivision or may place any approved training provider on probation upon a finding by the director of an imminent threat to public health and safety, as evidenced by any of the following:

(A) Fraud.

(B) Incompetence.

(C) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of training program directors or instructors.

(D) Conviction of any crime that is substantially related to the qualifications, functions, or duties of training program directors or instructors. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

(E) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this section or the regulations promulgated by the authority pertaining to the review and approval of training programs in anaphylaxis and the use and administration of epinephrine auto-injectors, as described in this subdivision.

(d) (1) The authority shall assess a fee pursuant to regulation sufficient to cover the reasonable costs incurred by the authority for the ongoing review and approval of training and certification under subdivision (c).

(2) The fees shall be deposited in the Specialized First Aid Training Program Approval Fund, which is hereby created in the State Treasury. All moneys deposited in the fund shall be made available, upon appropriation, to the authority for purposes described in paragraph (1).

(3) The authority may transfer unused portions of the Specialized First Aid Training Program Approval Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Specialized First Aid Training Program Approval Fund, together with the interest earned, when requested by the authority.

(4) The authority shall maintain a reserve balance in the Specialized First Aid Training Program Approval Fund of 5 percent of annual revenues. Any increase in the fees deposited in the Specialized First Aid Training Program Approval Fund shall be effective upon determination by the authority that additional moneys are required to fund expenditures pursuant to subdivision (c).

(e) (1) An authorized health care provider may issue a prescription for an epinephrine auto-injector to a prehospital emergency medical care person or a lay rescuer for the purpose of rendering emergency care to another person upon presentation of a current epinephrine auto-injector certification card issued by the authority demonstrating that the person is trained and qualified to administer an epinephrine auto-injector pursuant to this section or any other law.

(2) An authorized health care provider may issue a prescription for an epinephrine auto-injector to an authorized entity if the authorized entity submits evidence it employs at least one person, or utilizes at least one volunteer or agent, who is trained and has a current epinephrine auto-injector certification card issued by the authority demonstrating that the person is qualified to administer an epinephrine auto-injector pursuant to this section.

(f) An authorized entity that possesses and makes available epinephrine auto-injectors shall do both of the following:

(1) Create and maintain on its premises an operations plan that includes all of the following:

(A) The name and contact number for the authorized health care provider who prescribed the epinephrine auto-injector.

(B) Where and how the epinephrine auto-injector will be stored.

(C) The names of the designated employees or agents who have completed the training program required by this section and who are authorized to administer the epinephrine auto-injector.

(D) How and when the epinephrine auto-injector will be inspected for an expiration date.

(E) The process to replace the expired epinephrine auto-injector, including the proper disposal of the expired epinephrine auto-injector or used epinephrine auto-injector in a sharps container.

(2) Submit to the authority, in a manner identified by the authority, a report of each incident that involves the use of an epinephrine auto-injector, not more than 30 days after each use. The authority shall annually publish a report that summarizes all reports submitted to it under this subdivision.

(g) This section does not apply to a school district or county office of education, or its personnel, that provides and utilizes epinephrine auto-injectors to provide emergency medical aid pursuant to Section 49414 of the Education Code.

(h) This section shall not be construed to limit or restrict the ability of prehospital emergency medical care personnel, under any other statute or regulation, to administer epinephrine, including the use of epinephrine auto-injectors, or to require additional training or certification beyond what is already required under the other statute or regulation. *(Amended by Stats. 2017, Ch. 561, Sec. 109. Effective January 1, 2018.)*

CHAPTER 3.75. Trauma Care Fund [1797.198 - 1797.199]
(Chapter 3.75 added by Stats. 2001, Ch. 171, Sec. 2.5.)

1797.198. (Legislative Intent: Trauma Care)
The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the “golden hour,” when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers. *(Amended by Stats. 2005, Ch. 80, Sec. 1.1. Effective July 19, 2005.)*

1797.199. (Trauma Care Fund Creation & Distribution)
(a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section 100257 of Title 22 of the California Code of Regulations. However, the local EMS agency's report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center's emergency department without being admitted to the hospital unless the nonadmission is due to the patient's death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the

authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(l) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars ($280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process. *(Amended by Stats. 2005, Ch. 80, Sec. 1.2. Effective July 19, 2005.)*

CHAPTER 4. Local Administration [1797.200 - 1797.276]
(Chapter 4 added by Stats. 1980, Ch. 1260.)

ARTICLE 1. Local EMS Agency [1797.200 - 1797.227] (Article 1 added by Stats. 1980, Ch. 1260.)

1797.200. (Designation of Local EMS Agency)
Each county may develop an emergency medical services program. Each county developing such a program shall designate a local EMS agency which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties pursuant to the provisions of Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. *(Added by Stats. 1980, Ch. 1260.)*

1797.201. (Contracts with Local Government for EMS Services)
Upon the request of a city or fire district that contracted for or provided, as of June 1, 1980, prehospital emergency medical services, a county shall enter into a written agreement with the city or fire district regarding the provision of prehospital emergency medical services for that city or fire district. Until such time that an agreement is reached, prehospital emergency medical services shall be continued at not less than the existing level, and the administration of prehospital EMS by cities and fire districts presently providing such services shall be retained by those cities and fire districts, except the level of prehospital EMS may be reduced where the city council, or the governing body of a fire district, pursuant to a public hearing, determines that the reduction is necessary.

Notwithstanding any provision of this section the provisions of Chapter 5 (commencing with Section 1798) shall apply. *(Added by Stats. 1980, Ch. 1260.)*

1797.202. (Medical Director Requirement)
(a) Every local EMS agency shall have a full-or part-time licensed physician and surgeon as medical director, who has substantial experience in the practice of emergency medicine, as designated by the county or by the joint powers agreement, to provide medical control and to assure medical accountability throughout the planning, implementation and evaluation of the EMS system. The authority director may waive the requirement that the medical director have substantial experience in the practice of emergency medicine if the requirement places an undue hardship on the county or counties.

(b) The medical director of the local EMS agency may appoint one or more physicians and surgeons as assistant medical directors to assist the medical director with the discharge of the duties of medical director or to assume those duties during any time that the medical director is unable to carry out those duties as the medical director deems necessary.

(c) The medical director may assign to administrative staff of the local EMS agency for completion under the supervision of the medical director, any administrative functions of his or her duties which do not require his or her professional judgment as medical director. *(Amended by Stats. 1989, Ch. 1362, Sec. 9. Effective October 2, 1989.)*

1797.204. (EMS System Requirements)
The local EMS agency shall plan, implement, and evaluate an emergency medical services system, in accordance with the provisions of this part, consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures. *(Added by Stats. 1980, Ch. 1260.)*

1797.206. (Implementation of ALS & LALS Systems)
The local EMS agency shall be responsible for implementation of advanced life support systems and limited advanced life support systems and for the monitoring of training programs. *(Amended by Stats. 1983, Ch. 1246, Sec. 27.)*

1797.208. (Compliance of EMT Training Programs)
The local EMS agency shall be responsible for determining that the operation of training programs at the EMT-I, EMT-II, and EMT-P levels are in compliance with this division, and shall approve the training programs if they are found to be in compliance with this division. The training program at the California Highway Patrol Academy shall be exempt from the provisions of this section. *(Amended by Stats. 1986, Ch. 248, Sec. 131.)*

1797.210. (Certification of Personnel by Medical Director)
(a) The medical director of the local EMS agency shall issue a certificate, except an EMT-P certificate, to an individual upon proof of satisfactory completion of an approved training program, passage of the certifying examination designated by the authority, completion of any other requirements for certification established by the authority, and a determination that the individual is not precluded from certification for any of the reasons listed in Section 1798.200. The certificate shall be proof of the individual's initial competence to perform at the designated level.

(b) The medical director of the local EMS agency shall, at the interval specified by the authority, recertify an EMT-I or EMT-II upon proof of the individual's satisfactory passage of the examination for recertification

designated by the authority, completion of any continuing education or other requirements for recertification established by the authority, and a determination that the individual is not precluded from recertification because of any of the reasons listed in Section 1798.200. *(Amended by Stats. 1993, Ch. 64, Sec. 5. Effective June 30, 1993.)*

1797.211. (Certification Status Updates by Local EMS Agencies)
Each local EMS agency shall submit certificate status updates to the authority within three working days after a final determination is made regarding a certification disciplinary action taken by the medical director that results in a change to an EMT-I or EMT-II certificate status. *(Added by Stats. 2008, Ch. 274, Sec. 11. Effective January 1, 2009.)*

1797.212. (Local EMS Agency Certification Fees)
The local EMS agency may establish a schedule of fees for certification in an amount sufficient to cover the reasonable cost of administering the certification provisions of this division. However, a local EMS agency shall not collect fees for the certification or recertification of an EMT-P. *(Amended by Stats. 1993, Ch. 64, Sec. 6. Effective June 30, 1993.)*

1797.213. (Training Program Fees)
(a) Any local EMS agency conducting a program pursuant to this article may provide courses of instruction and training leading to certification as an EMT-I, EMT-II, EMT-P, or authorized registered nurse. When such instruction and training are provided, a fee may be charged sufficient to defray the cost of such instruction and training.

(b) Effective July 1, 1990, any courses of instruction and training leading to certification as an EMT-I, EMT-II, EMT-P, or authorized registered nurse shall include a course of training on the nature of sudden infant death syndrome which is developed by the California SIDS program in the State Department of Health Services in consultation with experts in the field of sudden infant death syndrome, and effective January 1, 1990, any individual certified as an EMT-I, EMT-II, EMT-P, or authorized registered nurse shall complete that course of training. The course shall include information on the community resources available to assist families who have lost a child to sudden infant death syndrome. An individual who was certified as an EMT-I, EMT-II, EMT-P, or authorized registered nurse prior to January 1, 1990, shall complete supplementary training on this topic on or before January 1, 1992. *(Amended by Stats. 1989, Ch. 1111, Sec. 6.)*

1797.214. (Local EMS Agency Additional Training Requirements)
A local EMS agency may require additional training or qualifications, for the use of drugs, devices, or skills in either the standard scope of practice or a local EMS agency optional scope of practice, which are greater than those provided in this chapter as a condition precedent for practice within such

EMS area in an advanced life support or limited advanced life support prehospital care system consistent with standards adopted pursuant to this division. *(Amended by Stats. 1989, Ch. 1362, Sec. 11. Effective October 2, 1989.)*

1797.215. (CPR Renewal Requirements: Prehospital Personnel)
Notwithstanding any other provision of law, EMT-I's, EMT-II's, and EMT-P's shall be required to renew their cardiopulmonary resuscitation certificate no more than once every two years. *(Added by Stats. 1983, Ch. 774, Sec. 1.)*

1797.216. (Public Safety Agency EMT Certification)
Public safety agencies that are certifying entities may certify and recertify public safety personnel as EMT-I. The state fire marshal, subject to policy guidance and advice from the State Board of Fire Services, may certify and recertify fire safety personnel as EMT-I. All persons certified shall have completed a program of training approved by the local EMS agency or the authority and have passed a competency-based examination. *(Amended by Stats. 2008, Ch. 274, Sec. 12. Effective January 1, 2009.)*

1797.217. (EMT Certification Fund)
(a) Every certifying entity shall submit to the authority certification data required by Section 1797.117.

(b) The authority shall collect fees from each certifying entity for the certification and certification renewal of each EMT-I and EMT-II in an amount sufficient to support the authority's central registry program and the local EMS agency administrative law judge reimbursement program. Separate additional fees may be charged, at the option of the authority, for services that are not shared by all applicants.

(c) The authority's fees shall be established in regulations, and fees charged for individual services shall be set so that the total fees charged shall not exceed the authority's actual total cost for the authority's central registry program, state and federal criminal offender record information search response program, and the local EMS agency administrative law judge reimbursement program.

(d) In addition to any fees collected by EMT-I or EMT-II certifying entities to support their certification, recertification, or enforcement programs, EMT-I or EMT-II certifying entities shall collect fees to support the authority's central registry program, and the local EMS agency administrative law judge reimbursement program. In lieu of collecting fees from an individual, pursuant to an employer choice, a collective bargaining agreement, or other employment contract, the certifying entity shall provide the appropriate fees to the authority pursuant to this subdivision.

(e) All fees collected for or provided to the authority in a calendar month by an EMT-I or EMT-II certifying entity pursuant to this section shall be transmitted to the authority for deposit into the Emergency Medical Technician Certification Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the certifying entity, unless a contract between the certifying entity and the authority specifies a different timeframe.

(f) At the option of the authority, fees may be collected for the authority by an entity that contracts with the authority to provide any of the services associated with the registry program, or the state and federal criminal offender record information search response program, or the local EMS agency administrative law judge reimbursement program. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Technician Certification Fund within 30 calendar days following the last day of the calendar month in which the fees were received by the designated entity, unless the contract between the entity and the authority specifies a different timeframe.

(g) The authority shall annually evaluate fees to determine if the fee is sufficient to fund the actual costs of the authority's central registry program, state and federal criminal offender record information search response program, and local EMS agency administrative law judge reimbursement program. If the evaluation shows that the fees are excessive or are insufficient to fund the actual costs of these programs, then the fees will be adjusted accordingly through the rulemaking process as outlined in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(h) The Emergency Medical Technician Certification Fund is hereby created in the State Treasury. All moneys deposited in the fund shall be made available, upon appropriation, to the authority for purposes of the central registry program, state and federal criminal offender record information search response program, and the local EMS agency administrative law judge reimbursement program. The local EMS agency administrative law judge reimbursement program is solely for the purpose of making reimbursements to local emergency medical service agencies for actual administrative law judge costs regarding EMT-I or EMT-II disciplinary action appeals. Reimbursement to the local emergency medical service agencies shall only be made if adequate funds are available from fees collected for the authority's local EMS agency administrative law judge reimbursement program.

(i) The authority may transfer unused portions of the Emergency Medical Technician Certification Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Emergency Medical Technician Certification Fund, together with interest earned, when requested by the authority.

(j) The authority shall maintain a reserve balance in the Emergency Medical Technician Certification Fund of 5 percent of annual revenues. Any increase in the fees deposited in the Emergency Medical Technician Certification Fund shall be effective upon a determination by the authority that additional moneys are required to fund expenditures of this section. *(Amended by Stats. 2011, Ch. 296, Sec. 150. Effective January 1, 2012.)*

1797.218. (Local EMS Agency Approval of ALS & LALS Programs)
Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general acute care hospital until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital. *(Amended by Stats. 1983, Ch. 1246, Sec. 34.)*

1797.219. (EMT-I & EMT-II Investigation & Discipline)
All investigatory and disciplinary processes for EMT-I and EMT-II certificate holders shall be, subject to Chapter 9.6 (commencing with Section 3250) of Division 4 of Title 1 of the Government Code, with respect to certificate holders who are firefighters otherwise subject to these provisions, and Chapter 9.7 (commencing with Section 3300) of Division 4 of Title 1 of the Government Code, with respect to certificate holders who are peace officers otherwise subject to these provisions. *(Added by Stats. 2008, Ch. 274, Sec. 14. Effective January 1, 2009.)*

1797.220. (Local Medical Control Policies, Procedures)
The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. *(Amended by Stats. 1988, Ch. 1390, Sec. 5.)*

1797.221. (Trial Studies Utilizing EMS Personnel)
The medical director of the local EMS agency may approve or conduct any scientific or trial study of the efficacy of the prehospital emergency use of any drug, device, or treatment procedure within the local EMS system, utilizing any level of prehospital emergency medical care personnel. The study shall be consistent with any requirements established by the authority for scientific or trial studies conducted within the prehospital emergency medical care system, and, where applicable, with Article 5 (commencing with Section 111550) of Chapter 6 of Part 5 of Division 104. No drug, device, or treatment procedure which has been specifically excluded by the authority from usage in the EMS system shall be included in such a study. *(Amended by Stats. 1996, Ch. 1023, Sec. 174. Effective September 29, 1996.)*

1797.222. (Adoption of Local Ordinances for Patient Transport)
A county, upon the recommendation of its local EMS agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local EMS agency.

The ordinances shall, to the extent possible, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources. These ordinances shall be consistent with Sections 1797.106, 1798.100, and 1798.102, and shall not conflict with any state regulations or any guidelines adopted by the Emergency Medical Service Authority.

This section shall not be construed as prohibiting the helicopter program of the Department of the California Highway Patrol from a role in providing emergency medical services when the best medically qualified person at the scene of an accident determines it is in the best interests of any injured party. *(Added by Stats. 1983, Ch. 1237, Sec. 2.)*

1797.224. (Creation of Exclusive Operating Areas)
A local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more exclusive operating areas in the development of a local plan shall develop and submit for approval to the authority, as part of the local EMS plan, its competitive

process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. Nothing in this section supersedes Section 1797.201. *(Added by Stats. 1984, Ch. 1349, Sec. 3.)*

1797.225. (Ambulance Patient Offload Time)
(a) A local EMS agency may adopt policies and procedures for calculating and reporting ambulance patient offload time, as defined in subdivision (b) of Section 1797.120.

(b) A local EMS agency that adopts policies and procedures for calculating and reporting ambulance patient offload time pursuant to subdivision (a) shall do all of the following:

(1) Use the statewide standard methodology for calculating and reporting ambulance patient offload time developed by the authority pursuant to Section 1797.120.

(2) Establish criteria for the reporting of, and quality assurance followup for, a nonstandard patient offload time, as defined in subdivision (c).

(c) (1) For the purposes of this section, a “nonstandard patient offload time” means that the ambulance patient offload time for a patient exceeds a period of time designated in the criteria established by the local EMS agency pursuant to paragraph (2) of subdivision (b).

(2) “Nonstandard patient offload time” does not include instances in which the ambulance patient offload time exceeds the period set by the local EMS agency due to acts of God, natural disasters, or manmade disasters. *(Added by Stats. 2015, Ch. 379, Sec. 2. Effective January 1, 2016.)*

1797.226. (San Bernardino County Definition of Exclusive Operating Area)
Without altering or otherwise affecting the meaning of any portion of this division as to any other county, as to San Bernardino County only, it shall be competent for any local EMS agency which establishes exclusive operating areas pursuant to Section 1797.224 to determine the following:

(a) That a minor alteration in the level of life support personnel or equipment, which does not significantly reduce the level of care available, shall not constitute a change in the manner and scope of providing services.

(b) That a successor to a previously existing emergency services provider shall qualify as an existing provider if the successor has continued uninterrupted the emergency transportation previously supplied by the prior provider. *(Added by Stats. 1986, Ch. 965, Sec. 1.)*

1797.227. (Provider Data System Requirements)
(a) An emergency medical care provider shall do both of the following when collecting and submitting data to a local EMS agency:

(1) Use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency.

(2) Ensure that the electronic health record system can be integrated with the local EMS agency's data system, so that the local EMS agency may collect data from the provider.

(b) A local EMS agency shall not mandate that a provider use a specific electronic health record system to collect and share data with the local EMS agency.

(c) This section does not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider. *(Added by Stats. 2015, Ch. 377, Sec. 1. Effective January 1, 2016.)*

1797.228. (Ambulance Patient Offload Time Data)
(a) (1) On or before July 1, 2019, a local EMS agency shall transmit ambulance patient offload time data quarterly to the authority, consistent with the policies and procedures developed pursuant to Section 1797.225.

(2) The data must be sufficient for the authority to calculate ambulance patient offload time, as defined in subdivision (b) of Section 1797.120, by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

(b) Notwithstanding Section 1797.122, the local EMS agency shall ensure that personally identifying patient data is not included in the submission of data to calculate patient offload time. *(Added by Stats. 2018, Ch. 656, Sec. 3. Effective January 1, 2019.)*

1797.229. (EMT-I and EMT-II Applicants with a Prior Criminal Conviction)
(a) Each local EMS agency and other certifying entities shall annually submit to the authority, by July 1 of each year, data on the approval or denial of EMT-I or EMT-II applicants. The data submitted to the authority shall include, at a minimum, all of the following information with respect to the preceding calendar year:

(1) The total number of applicants who applied for initial certification.

(2) The total number of applicants with a prior criminal conviction who applied for initial certification.

(3) The number of applicants who were denied, the number of applicants who were approved, and the number of applicants who were approved with restrictions.

(4) The number of applicants with a prior criminal conviction who were denied, the number of applicants with a prior criminal conviction who were approved, and the number of applicants with a prior criminal conviction who were approved with restrictions.

(5) The reason or reasons stated for denying an applicant with a prior criminal conviction, or the reason or reasons stated for approving with restrictions an applicant with a prior criminal conviction.

(6) The restrictions imposed on approved applicants with a prior criminal conviction, and the duration of those imposed restrictions.

(7) Race, ethnicity, gender, and age demographic data for all applicants who were denied, approved, or approved with restrictions.

(b) The authority shall annually report to the commission on the extent to which prior criminal history may be an obstacle to certification as an EMT-I or EMT-II. The authority shall annually submit the same report to the Legislature, in compliance with Section 9795 of the Government Code, and shall make the report easily accessible on the authority's Internet Web site.

(c) Data submitted to the authority pursuant to subdivision (a) and the reports described in subdivision (b) shall not contain any personal identifying information of the EMT-I or EMT-II applicants.

(d) This section shall become inoperative on July 1, 2024, and, as of January 1, 2025, is repealed. *(Added by Stats. 2018, Ch. 342, Sec. 1. Effective January 1, 2019.)*

ARTICLE 2. Local Emergency Medical Services Planning [1797.250 - 1797.258] (Article 2 added by Stats. 1980, Ch. 1260.)

1797.250. (Development of EMS System Plan)
In each designated EMS area, the local EMS agency may develop and submit a plan to the authority for an emergency medical services system according to the guidelines prescribed pursuant to Section 1797.103. *(Added by Stats. 1980, Ch. 1260.)*

1797.252. (EMS System Coordination)
The local EMS agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop the emergency medical services system. *(Added by Stats. 1980, Ch. 1260.)*

1797.254. (Annual Submission of EMS Plan)
Local EMS agencies shall annually submit an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority. *(Amended by Stats. 1996, Ch. 197, Sec. 2. Effective July 22, 1996.)*

1797.256. (Review of Applications for Grants, Contracts)
A local EMS agency may review applications for grants and contracts for federal, state, or private funds concerning emergency medical services or related activities in its EMS area. *(Added by Stats. 1980, Ch. 1260.)*

1797.257. (Initial Trauma Care System Plan Submission)
A local EMS agency which elects to implement a trauma care system on or after the effective date of the regulations adopted pursuant to Section 1798.161 shall develop and submit a plan for that trauma care system to the authority according to the requirements of the regulations prior to the implementation of that system. *(Added by Stats. 1984, Ch. 1735, Sec. 3. Effective September 30, 1984.)*

1797.258. (Annual Trauma Care System Plan Submission)
After the submission of an initial trauma care system plan, a local EMS agency which has implemented a trauma care system shall annually submit to the authority an updated plan which identifies all changes, if any, to be made in the trauma care system. *(Added by Stats. 1984, Ch. 1735, Sec. 4. Effective September 30, 1984.)*

ARTICLE 3. Emergency Medical Care Committee [1797.270 - 1797.276]
(Article 3 added by Stats. 1983, Ch. 1246, Sec. 35.)

1797.270. (Emergency Medical Care Committee Formation)
An emergency medical care committee may be established in each county in this state. Nothing in this division should be construed to prevent two or more adjacent counties from establishing a single committee for review of emergency medical care in these counties. *(Amended by Stats. 1993, Ch. 64, Sec. 7. Effective June 30, 1993.)*

1797.272. (Emergency Medical Care Committee Membership)
The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of

supervisors shall jointly prescribe the membership, and appoint the members of the committee. *(Added by Stats. 1983, Ch. 1246, Sec. 35.)*

1797.274. (Emergency Medical Care Committee Duties)
The emergency medical care committee shall, at least annually, review the operations of each of the following:

(a) Ambulance services operating within the county.

(b) Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.

(c) First aid practices in the county.
(Added by Stats. 1983, Ch. 1246, Sec. 35.)

1797.276. (Emergency Medical Care Committee Annual Report)
Every emergency medical care committee shall, at least annually, report to the authority, and the local EMS agency its observations and recommendations relative to its review of the ambulance services, emergency medical care, and first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The emergency medical care committee shall submit its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board or boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors.
(Amended by Stats. 1988, Ch. 260, Sec. 5.)

CHAPTER 5. Medical Control [1798 - 1798.6]
(Chapter 5 added by Stats. 1980, Ch. 1260.)

1798.0. (Medical Director Responsibilities)
(a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall promptly convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall remain in effect only until the authority adopts more comprehensive regulations that supersede this subdivision. *(Amended by Stats. 1988, Ch. 1390, Sec. 6.)*

1798.2. (Base Hospital Direction of Prehospital Personnel)
The base hospital shall implement the policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency for medical direction of prehospital emergency medical care personnel. *(Amended by Stats. 1988, Ch. 1390, Sec. 7.)*

1798.3. (Alternative Base Station Direction of Prehospital Personnel)
Advanced life support and limited advanced life support personnel may receive medical direction from an alternative base station in lieu of a base hospital when the following conditions are met:

(a) The alternative base station has been designated by the local EMS agency and approved by the medical director of the local EMS agency, pursuant to Section 1798.105, to provide medical direction to prehospital personnel because no base hospital is available to provide medical direction for the geographical area assigned.

(b) The medical direction is provided by either of the following:

(1) A physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel.

(2) A mobile intensive care nurse who has been authorized by the medical director of the local EMS agency, pursuant to Section 1797.56, as qualified to issue instructions to prehospital emergency medical care personnel. *(Added by Stats. 1988, Ch. 1390, Sec. 8.)*

1798.6. (Medical Control in an Emergency)
(a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

(b) If any county desires to establish a unified command structure for patient management at the scene of an emergency within that county, a committee may be established in that county comprised of representatives of the agency responsible for county emergency medical services, the county sheriff's department, the California Highway Patrol, public prehospital-care provider agencies serving the county, and public fire, police, and other affected emergency service agencies within the county. The membership and duties of the committee shall be established by an agreement for the joint exercise of powers under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(c) Notwithstanding subdivision (a), authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks. *(Added by Stats. 1983, Ch. 206, Sec. 2.)*

CHAPTER 6. Facilities [1798.100 - 1798.183] (Chapter 6 added by Stats. 1980, Ch. 1260.)

ARTICLE 1. Base Hospitals [1798.100 - 1798.105] (Heading of Article 1 amended by Stats. 1984, Ch. 1391, Sec. 5.)

1798.100. (Designation by Local EMS Agency)
In administering the EMS system, the local EMS agency, with the approval of its medical director, may designate and contract with hospitals or other entities approved by the medical director of the local EMS agency pursuant to Section 1798.105 to provide medical direction of prehospital emergency medical care personnel, within its area of jurisdiction, as either base hospitals or alternative base stations, respectively. Hospitals or other entities so designated and contracted with as base hospitals or alternative base stations shall provide medical direction of prehospital emergency medical care provided for the area defined by the local EMS agency in accordance with policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency pursuant to Sections 1797.220 and 1798. *(Amended by Stats. 1988, Ch. 1390, Sec. 10.)*

1798.101. (Base Hospital/Receiving Facility Alternatives)
(a) In rural areas, as determined by the authority, where the use of a base hospital having a basic emergency medical service special permit pursuant to subdivision (c) of Section 1277 is precluded because of geographic or other extenuating circumstances, a local EMS agency, in order to assure medical direction to prehospital emergency medical care personnel, may utilize other hospitals which do not have a basic emergency medical service permit but which have been approved by the medical director of the local EMS agency for utilization as a base hospital, if both of the following apply:

(1) Medical control is maintained in accordance with policies and procedures established by the local EMS agency, with the approval of the medical director of the local EMS agency.

(2) Approval is secured from the authority.

(b) (1) In rural areas, as determined by the authority, when the use of a hospital having a basic emergency medical service special permit is precluded because of geographic or other extenuating circumstances, as determined by the authority, the medical director of the local EMS agency may authorize another facility which does not have this special permit to receive patients requiring emergency medical services if the facility has adequate staff and equipment to provide these services, as determined by the medical director of the local EMS agency.

(2) A local EMS agency which utilizes in its EMS system any facility which does not have a special permit to receive patients requiring emergency medical care pursuant to paragraph (1) shall submit to the authority, as part of the plan required by Section 1797.254, protocols approved by the medical director of the local EMS agency to ensure that the use of that facility is in the best interests of patient care. The protocols addressing patient safety and the use of the nonpermit facility shall take into account, but not be limited to, the following:

(A) The medical staff, and the availability of the staff at various times to care for patients requiring emergency medical services.

(B) The ability of staff to care for the degree and severity of patient injuries.

(C) The equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries.

(D) The availability of more comprehensive emergency medical services and the distance and travel time necessary to make the alternative emergency medical services available.

(E) The time of day and any limitations which may apply for a nonpermit facility to treat patients requiring emergency medical services.

(3) Any change in the status of a nonpermit facility, authorized pursuant to this subdivision to care for patients requiring emergency medical services, with respect to protocols and the facility's ability to care for the patients shall be reported by the facility to the local EMS agency. *(Amended by Stats. 1988, Ch. 1390, Sec. 11.)*

1798.102. (Base Hospital Supervision)
The base hospital shall supervise prehospital treatment, triage, and transport, advanced life support or limited advanced life support, and monitor personnel program compliance by direct medical supervision. *(Amended by Stats. 1984, Ch. 1391, Sec. 17.)*

1798.104. (Personnel Training & Continuing Education)
The base hospital shall provide, or cause to be provided, EMS prehospital personnel training and continuing education in accordance with local EMS policies and procedures. *(Amended by Stats. 1984, Ch. 1391, Sec. 18.)*

1798.105. (Alternative Base Station Approval)
The medical director of the local EMS agency may approve an alternative base station, as defined in Section 1798.53, to provide medical direction to advanced life support or limited advanced life support personnel for an area

of the local EMS system for which no qualified base hospital is available, to provide that medical direction, providing that both the following conditions are met:

(a) Medical control is maintained in accordance with policies and procedures established by the local EMS agency, with the approval of the medical director of the local EMS agency.

(b) Any responsibilities of a base station hospital, including review of run reports or provision of continuing education, which are not assigned to the alternative base station, are assigned to either the local EMS agency, a base hospital for another area of the local EMS system, or a receiving hospital which has been approved by the medical director to, and has agreed to, assume the responsibilities. *(Added by Stats. 1988, Ch. 1390, Sec. 12.)*

ARTICLE 2. Critical Care [1798.150- 1798.150.] (Article 2 added by Stats. 1980, Ch. 1260.)

1798.150. (Guidelines for Critical Care Facilities)
The authority may establish, in cooperation with affected medical organizations, guidelines for hospital facilities according to critical care capabilities. *(Added by Stats. 1980, Ch. 1260.)*

ARTICLE 2.5. Regional Trauma Systems [1798.160 - 1798.169] (Article 2.5 added by Stats. 1983, Ch. 1067, Sec. 2.)

1798.160. (Definitions)
Except where the context otherwise requires, the following definitions govern the construction of this article:

(a) “Trauma case” means any injured person who has been evaluated by prehospital personnel according to policies and procedures established by the local EMS agency pursuant to Section 1798.163 and who has been found to require transportation to a trauma facility.

(b) “Trauma facility” means a health facility, as defined by regulation, which is capable of treating one or more types of potentially seriously injured persons and which has been designated as part of the regional trauma care system by the local EMS agency. A facility may be a trauma facility for one or more services, as designated by the local EMS agency.

(c) “Trauma care system” means an arrangement under which trauma cases are transported to, and treated by, the appropriate trauma facility. *(Amended by Stats. 1984, Ch. 1735, Sec. 5. Effective September 30, 1984.)*

1798.161. (EMSA Required to Establish Regulations)
(a) The authority shall submit draft regulations specifying minimum standards for the implementation of trauma care systems to the commission on or before July 1, 1984, and shall adopt the regulations on or before July 1, 1985. These regulations shall provide specific requirements for the care of trauma cases and shall ensure that the trauma care system is fully coordinated with all elements of the existing emergency medical services system. The regulations shall be adopted as provided in Section 1799.50, and shall include, but not be limited to, all of the following:

(1) Prehospital care management guidelines for triage and transportation of trauma cases.

(2) Flow patterns of trauma cases and geographic boundaries regarding trauma and nontrauma cases.

(3) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(4) The resources and equipment needed by trauma facilities to treat trauma cases.

(5) The availability and qualifications of the health care personnel, including physicians and surgeons, treating trauma cases within a trauma facility.

(6) Data collection regarding system operation and patient outcome.

(7) Periodic performance evaluation of the trauma system and its components.

(b) The authority may grant an exception to a portion of the regulations adopted pursuant to subdivision (a) upon substantiation of need by a local EMS agency that, as defined in the regulations, compliance with that requirement would not be in the best interests of the persons served within the affected local EMS area. *(Amended by Stats. 1984, Ch. 1735, Sec. 6. Effective September 30, 1984.)*

1798.162. (Trauma Care System Implementation)
(a) A local emergency medical services agency may implement a trauma care system only if the system meets the minimum standards set forth in the regulations for implementation established by the authority and the plan required by Section 1797.257 has been submitted to, and approved by, the authority. Prior to submitting the plan for the trauma care system to the authority, a local emergency medical services agency shall hold a public hearing and shall give adequate notice of the public hearing to all hospitals and other interested parties in the area proposed to be included in the

system. This subdivision does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations.

(b) Notwithstanding subdivision (a) or any other provision of this article, the Santa Clara County Emergency Medical Services Agency may implement a trauma care system prior to the adoption of regulations by the authority pursuant to Section 1798.161. If the Santa Clara County Emergency Medical Services Agency implements a trauma care system pursuant to this subdivision prior to the adoption of those regulations by the authority, the agency shall prepare and submit to the authority a trauma care system plan which conforms to any regulations subsequently adopted by the authority. *(Amended by Stats. 1984, Ch. 1735, Sec. 7. Effective September 30, 1984.)*

1798.163. (Trauma Care System Policies & Procedures)
A local emergency medical services agency implementing a trauma care system shall establish policies and procedures which are concordant and consistent with the minimum standards set forth in the regulations adopted by the authority. This section does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations. *(Amended by Stats. 1984, Ch. 1735, Sec. 8. Effective September 30, 1984.)*

1798.164. (Trauma Care Facility Fees)
(a) A local emergency medical services agency may charge a fee to an applicant seeking initial or continuing designation as a trauma facility in an amount sufficient to cover the costs directly related to the designation of trauma facilities pursuant to Section 1798.165 and to the development of the plans prepared pursuant to Sections 1797.257 and 1797.258, and subdivision (b) of Section 1798.162.

(b) Each local emergency medical services agency charging fees pursuant to subdivision (a) shall annually provide a report to the authority and to each trauma facility having paid a fee to the agency. The report shall contain sufficient detail to apprise facilities of the specific application of fees collected and to assure the authority that fees collected were expended in compliance with subdivision (a).

(c) The authority may establish a prescribed format for the report required in subdivision (b). *(Amended by Stats. 1988, Ch. 768, Sec. 1.)*

1798.165. (Trauma Facility Designation)
(a) Local emergency medical services agencies may designate trauma facilities as part of their trauma care system pursuant to the regulations promulgated by the authority.

(b) The health facility shall only be designated to provide the level of trauma care and service for which it is qualified and which is included within the system implemented by the agency.

(c) No health care provider shall use the terms “trauma facility,” “trauma hospital,” “trauma center,” “trauma care provider,” “trauma vehicle,” or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the local EMS agency. *(Amended by Stats. 1985, Ch. 570, Sec. 1.)*

1798.166. (Trauma Care System Plan)
A local emergency medical services agency which elects to implement a trauma care system on or after January 1, 1984, shall develop and submit a plan to the authority according to the regulations established prior to the implementation. *(Added by Stats. 1983, Ch. 1067, Sec. 2.)*

1798.167. (Licensed Health Facility Not Restricted)
Nothing in this article shall be construed to restrict the authority of a health care facility to provide a service for which it has received a license pursuant to Chapter 2 (commencing with Section 1250) of Division 2. *(Added by Stats. 1983, Ch. 1067, Sec. 2.)*

1798.168. (Local EMS Agency Boundaries)
Nothing in this article shall be construed as changing the boundaries of any local emergency medical services agency in existence on January 1, 1984. *(Added by Stats. 1983, Ch. 1067, Sec. 2.)*

1798.169. (CHP Helicopter Unrestricted)
Nothing in this article shall be construed as restricting the use of a helicopter of the Department of the California Highway Patrol from performing missions which the department determines are in the best interests of the people of the State of California. *(Added by Stats. 1983, Ch. 1067, Sec. 2.)*

ARTICLE 3. Transfer Agreements [1798.170 - 1798.172] (Article 3 added by Stats. 1980, Ch. 1260.)

1798.170. (Development of Triage & Transfer Protocols)
A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital’s consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements. *(Amended by Stats. 1987, Ch. 1240, Sec. 16.)*

1798.172. (Patient Transfer Agreement Guidelines)
(a) The local EMS agency shall establish guidelines and standards for completion and operation of formal transfer agreements between hospitals with varying levels of care in the area of jurisdiction of the local EMS agency consistent with Sections 1317 to 1317.9a, inclusive, and Chapter 5 (commencing with Section 1798). Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, initial patient care treatments, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient.

(b) Notwithstanding subdivision (a), and in addition to Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the transfer. *(Amended by Stats. 1988, Ch. 888, Sec. 6. Effective September 14, 1988.)*

ARTICLE 3.5. Use of "Emergency" [1798.175- 1798.175.] (Article 3.5 added by Stats. 1986, Ch. 1377, Sec. 1.)

1798.175. (Use of "Emergency" in Advertising)
(a) No person or public agency shall advertise itself as, or hold itself out as, providing emergency medical services, by using in its name or advertising the word "emergency," or any derivation thereof, or any words which suggest that it is staffed and equipped to provide emergency medical services, unless the person or public agency satisfies one of the following requirements:

(1) Is a general acute care hospital providing approved standby, basic, or comprehensive emergency medical services regulated by this chapter.

(2) Meets all of the following minimum standards:

(A) Emergency services are available in the facility seven days a week, 24 hours a day.

(B) Has equipment, medication, and personnel experienced in the provision of services needed to treat life-, limb-, or function-threatening conditions.

(C) Diagnostic radiology and clinical laboratory services are provided by persons on duty or on call and available when needed.

(D) At least one physician who is trained and experienced in the provision of emergency medical care who is on duty or on call so as to be immediately available to the facility.

(E) Medical records document the name of each patient who seeks care, as well as the disposition of each patient upon discharge.

(F) A roster of speciality physicians who are available for referral, consultation, and speciality services is maintained and available.

(G) Policies and procedures define the scope and conduct of treatment provided, including procedures for the management of specific types of emergencies.

(H) The quality and appropriateness of emergency services are evaluated at least annually as part of a quality assurance program.

(I) Provides information to the public that describes the capabilities of the facility, including the scope of services provided, the manner in which the facility complies with the requirements of this section pertaining to the availability and qualifications of personnel or services, and the manner in which the facility cooperates with the patient's primary care physician in followup care.

(J) Clearly identifies the responsible professional or professionals and the legal owner or owners of the facility in its promotion, advertising, and solicitations.

(K) Transfer agreements are in effect at all times with one or more general acute care hospitals which provide basic or comprehensive emergency medical services wherein patients requiring more definitive care will be expeditiously transferred and receive prompt hospital care. Reasonable care shall be exercised to determine whether an emergency requiring more definitive care exists and the person seeking emergency care shall be assisted in obtaining these services, including transportation services, in every way reasonable under the circumstances.

(b) Nothing in this article shall be construed to require the licensing or certification of any person or public agency meeting the minimum standards

of paragraph (2) of subdivision (a), nor to exempt from licensure those health facilities covered by paragraph (1) of subdivision (a).

(c) Nothing in this article shall be construed to:

(1) Prohibit a physician in private practice, an outpatient department of a general acute care hospital whether located on or off the premises of the hospital, or other entity authorized to offer medical services from advertising itself as, or otherwise holding itself out as, providing urgent, immediate, or prompt medical services, or from using in its name or advertising the words “urgent,” “prompt,” “immediate,” any derivative thereof, or other words which suggest that it is staffed and equipped to provide urgent, prompt, or immediate medical services.

(2) Prohibit prehospital emergency medical care personnel certified pursuant to, or any state or local agencies established pursuant to, this division, or any emergency vehicle operating within the emergency medical services system from using the word “emergency” in the title, classification, or designation of the personnel, agency, or vehicle.

(d) Any person or public agency using the word “emergency” or any derivation thereof in its name or advertising on January 1, 1987, but which would be prohibited from using the word or derivation thereof by this article, shall have until January 1, 1988, to comply with this article. *(Added by Stats. 1986, Ch. 1377, Sec. 1.)*

ARTICLE 4. Poison Control Centers [1798.180 - 1798.183] (Article 4 added by Stats. 1984, Ch. 1391, Sec. 19.)

1798.180. (Establishment of Poison Control Center Standards)
(a) The authority shall establish minimum standards for the operation of poison control centers.

(b) The authority shall establish geographical service areas and criteria for designation of regional poison control centers. The authority may designate poison control centers which have met the standards established pursuant to subdivision (a), in accordance with the criteria adopted pursuant to this subdivision.

(c) No person or persons, business, agency, organization, or other entity, whether public or private, shall hold itself out as providing a poison advice service or use the term poison control center, poison advice center, or any other term which implies that it is qualified to provide advice on the treatment or handling of poisons in its advertising, name, or in printed materials and information it furnishes to the general public unless that entity meets one of the following conditions:

(1) Has been designated as a poison control center by the authority.

(2) Is a company or organization which provides a poison information service for products or chemicals which it manufactures or distributes.

(d) Nothing in this section shall prohibit a qualified health care professional, within his or her level of professional expertise, from providing advice regarding poisoning or poisons to his or her patient or patients upon request or whenever he or she deems it warranted in the exercise of his or her professional judgment, as otherwise permitted by law. *(Amended by Stats. 1987, Ch. 972, Sec. 2.)*

1798.181. (Poison Control Centers Consolidation)
The authority shall consolidate the number of poison control centers if it is determined by the authority that the consolidation will result in cost savings. *(Added by Stats. 1992, Ch. 1366, Sec. 1. Effective October 27, 1992.)*

1798.182. (Out-Of-State Poison Control Centers)
The authority may authorize a poison control center, instead of providing poison control services directly, to contract with an entity in another state to provide poison control services during any part of the 24-hour period for which the center is required to provide poison control services, if both of the following conditions are met:

(a) The center is unable to provide poison control services 24 hours a day.

(b) The entity in the other state provides substantially the same poison control services as required under Section 1798.180, and regulations adopted pursuant thereto. An entity in another state shall not be deemed not to provide substantially the same poison control services solely because the staff of the entity is licensed in the other state, and not licensed in the State of California. *(Added by Stats. 1993, Ch. 236, Sec. 1. Effective January 1, 1994.)*

1798.183. (Operating Less Than 24 Hours/Day)
The authority may authorize a poison control center to provide poison control services for fewer than 24 hours a day, as the authority deems necessary. *(Added by Stats. 1993, Ch. 236, Sec. 2. Effective January 1, 1994.)*

CHAPTER 7. Penalties [1798.200 - 1798.211]
(Chapter 7 added by Stats. 1980, Ch. 1260.)

1798.200. (Grounds for Action Against License Holder)
(a) (1) (A) Except as provided in paragraph (2), an employer of an EMT-I or EMT-II may conduct investigations, as necessary, and take disciplinary action against an EMT-I or EMT-II who is employed by that employer for conduct in violation of subdivision (c). The employer shall notify the medical director of the local EMS agency that has jurisdiction in the county in which the alleged violation occurred within three days when an allegation has been validated as a potential violation of subdivision (c).

(B) Each employer of an EMT-I or EMT-II employee shall notify the medical director of the local EMS agency that has jurisdiction in the county in which a violation related to subdivision (c) occurred within three days after the EMT-I or EMT-II is terminated or suspended for a disciplinary cause, the EMT-I or EMT-II resigns following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or the EMT-I or EMT-II is removed from EMT-related duties for a disciplinary cause after the completion of the employer's investigation.

(C) At the conclusion of an investigation, the employer of an EMT-I or EMT-II may develop and implement, in accordance with the guidelines for disciplinary orders, temporary suspensions, and conditions of probation adopted pursuant to Section 1797.184, a disciplinary plan for the EMT-I or EMT-II. Upon adoption of the disciplinary plan, the employer shall submit that plan to the local EMS agency within three working days. The employer's disciplinary plan may include a recommendation that the medical director of the local EMS agency consider taking action against the holder's certificate pursuant to paragraph (3).

(2) If an EMT-I or EMT-II is not employed by an ambulance service licensed by the Department of the California Highway Patrol or a public safety agency or if that ambulance service or public safety agency chooses not to conduct an investigation pursuant to paragraph (1) for conduct in violation of subdivision (c), the medical director of a local EMS agency shall conduct the investigations, and, upon a determination of disciplinary cause, take disciplinary action as necessary against the EMT-I or EMT-II. At the conclusion of these investigations, the medical director shall develop and implement, in accordance with the recommended guidelines for disciplinary orders, temporary orders, and conditions of probation adopted pursuant to Section 1797.184, a disciplinary plan for the EMT-I or EMT-II. The medical director's disciplinary plan may include action against the holder's certificate pursuant to paragraph (3).

(3) The medical director of the local EMS agency may, upon a determination of disciplinary cause and in accordance with regulations for disciplinary processes adopted pursuant to Section 1797.184, deny, suspend, or revoke any EMT-I or EMT-II certificate issued under this division, or may place any EMT-I or EMT-II certificate holder on probation, upon the finding by that medical director of the occurrence of any of the actions listed in subdivision (c) and the occurrence of one of the following:

(A) The EMT-I or EMT-II employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the medical director makes a determination that the discipline imposed was not according to the guidelines for disciplinary orders and conditions of probation and the conduct of the EMT-I or EMT-II certificate holder constitutes grounds for disciplinary action against the certificate.

(B) Either the employer of an EMT-I or EMT-II further determines, after an investigation conducted under paragraph (1), or the medical director determines after an investigation conducted under paragraph (2), that the conduct requires disciplinary action against the certificate.

(4) The medical director of the local EMS agency, after consultation with the employer of an EMT-I or EMT-II, may temporarily suspend, prior to a hearing, any EMT-I or EMT-II certificate or both EMT-I and EMT-II certificates upon a determination that both of the following conditions have been met:

(A) The certificate holder has engaged in acts or omissions that constitute grounds for revocation of the EMT-I or EMT-II certificate.

(B) Permitting the certificate holder to continue to engage in the certified activity without restriction would pose an imminent threat to the public health or safety.

(5) If the medical director of the local EMS agency temporarily suspends a certificate, the local EMS agency shall notify the certificate holder that his or her EMT-I or EMT-II certificate is suspended and shall identify the reasons therefor. Within three working days of the initiation of the suspension by the local EMS agency, the agency and employer shall jointly investigate the allegation in order for the agency to make a determination of the continuation of the temporary suspension. All investigatory information not otherwise protected by law held by the agency and employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend. The local EMS agency shall decide, within 15 calendar days, whether to serve the certificate holder with an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. If the certificate

holder files a notice of defense, the hearing shall be held within 30 days of the local EMS agency's receipt of the notice of defense. The temporary suspension order shall be deemed vacated if the local EMS agency fails to make a final determination on the merits within 15 days after the administrative law judge renders the proposed decision.

(6) The medical director of the local EMS agency shall refer, for investigation and discipline, any complaint received on an EMT-I or EMT-II to the relevant employer within three days of receipt of the complaint, pursuant to subparagraph (A) of paragraph (1) of subdivision (a).

(b) The authority may deny, suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P licenseholder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c). Proceedings against any EMT-P license or licenseholder shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial, suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate holder or licenseholder under this division:

(1) Fraud in the procurement of any certificate or license under this division.

(2) Gross negligence.

(3) Repeated negligent acts.

(4) Incompetence.

(5) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

(6) Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

(7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

(8) Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.

(9) Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

(10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.

(11) Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

(12) Unprofessional conduct exhibited by any of the following:

(A) The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT-I, EMT-II, or EMT-P from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT-I, EMT-II, or EMT-P, from using that force that is reasonably necessary to effect a lawful arrest or detention.

(B) The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(C) The commission of any sexually related offense specified under Section 290 of the Penal Code.

(d) The information shared among EMT-I, EMT-II, and EMT-P employers, medical directors of local EMS agencies, the authority, and EMT-I and EMT-II certifying entities shall be deemed to be an investigative communication that is exempt from public disclosure as a public record pursuant to subdivision (f) of Section 6254 of the Government Code. A formal disciplinary action against an EMT-I, EMT-II, or EMT-P shall be considered a public record available to the public, unless otherwise protected from disclosure pursuant to state or federal law.

(e) For purposes of this section, “disciplinary cause” means an act that is substantially related to the qualifications, functions, and duties of an EMT-I, EMT-II, or EMT-P and is evidence of a threat to the public health and safety

described in subdivision (c). *(Amended by Stats. 2010, Ch. 328, Sec. 127. Effective January 1, 2011.)*

1798.201. (EMT-P Disciplinary Action: Evaluation & Recommendation)
(a) When information comes to the attention of the medical director of the local EMS agency that an EMT-P licenseholder has committed any act or omission that appears to constitute grounds for disciplinary action under this division, the medical director of the local EMS agency may evaluate the information to determine if there is reason to believe that disciplinary action may be necessary.

(b) If the medical director sends a recommendation to the authority for further investigation or discipline of the licenseholder, the recommendation shall include all documentary evidence collected by the medical director in evaluating whether or not to make that recommendation. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by Section 6254 of the Government Code. In deciding what level of disciplinary action is appropriate in the case, the authority shall consult with the medical director of the local EMS agency. *(Added by Stats. 1994, Ch. 709, Sec. 6. Effective January 1, 1995.)*

1798.202. (Suspension of EMT-P License)
(a) The director of the authority or the medical director of the local EMS agency, after consultation with the relevant employer, may temporarily suspend, prior to hearing, any EMT-P license upon a determination that: (1) the licensee has engaged in acts or omissions that constitute grounds for revocation of the EMT-P license; and (2) permitting the licensee to continue to engage in the licensed activity, or permitting the licensee to continue in the licensed activity without restriction, would present an imminent threat to the public health or safety. When the suspension is initiated by the local EMS agency, subdivision (b) shall apply. When the suspension is initiated by the director of the authority, subdivision (c) shall apply.

(b) The local EMS agency shall notify the licensee that his or her EMT-P license is suspended and shall identify the reasons therefor. Within three working days of the initiation of the suspension by the local EMS agency, the agency shall transmit to the authority, via facsimile transmission or overnight mail, all documentary evidence collected by the local EMS agency relative to the decision to temporarily suspend. Within two working days of receipt of the local EMS agency's documentary evidence, the director of the authority shall determine the need for the licensure action. Part of that determination shall include an evaluation of the need for continuance of the suspension during the licensure action review process. If the director of the authority determines that the temporary suspension order should not continue, the authority shall immediately notify the licensee that the

temporary suspension is lifted. If the director of the authority determines that the temporary suspension order should continue, the authority shall immediately notify the licensee of the decision to continue the temporary suspension and shall, within 15 calendar days of receipt of the EMS agency's documentary evidence, serve the licensee with a temporary suspension order and accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The director of the authority shall initiate a temporary suspension with the filing of a temporary suspension order and accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code and shall notify the director of the local EMS agency, and the relevant employer.

(d) If the licensee files a notice of defense, the hearing shall be held within 30 days of the authority's receipt of the notice of defense. The temporary suspension order shall be deemed vacated if the authority fails to make a final determination on the merits within 15 days after the administrative law judge renders the proposed decision. *(Repealed and added by Stats. 1994, Ch. 709, Sec. 8. Effective January 1, 1995.)*

1798.204. (Proceedings According to EMSA Guidelines)
Proceedings for probation, suspension, revocation, or denial of a certificate, or a denial of a renewal of a certificate, under this division shall be conducted in accordance with guidelines established by the Emergency Medical Services Authority. *(Amended by Stats. 1986, Ch. 248, Sec. 135.)*

1798.205. (Violation of Local EMS Agency Transfer Protocols)
Any alleged violations of local EMS agency transfer protocols, guidelines, or agreements shall be evaluated by the local EMS agency. If the local EMS agency has concluded that a violation has occurred, it shall take whatever corrective action it deems appropriate within its jurisdiction, including referrals to the district attorney under Sections 1798.206 and 1798.208 and shall notify the State Department of Health Services if it concludes that any violation of Sections 1317 to 1317.9a, inclusive, has occurred. *(Added by Stats. 1987, Ch. 1240, Sec. 18.)*

1798.206. (Violation of Statutes, Rules, Regulations)
Any person who violates this part, the rules and regulations adopted pursuant thereto, or county ordinances adopted pursuant to this part governing patient transfers, is guilty of a misdemeanor. The Attorney General or the district attorney may prosecute any of these misdemeanors which falls within his or her jurisdiction. *(Amended by Stats. 1987, Ch. 1225, Sec. 17.)*

1798.207. (Security of Examinations)
(a) It is a misdemeanor for any person to knowingly and willfully engage in conduct that subverts or attempts to subvert any licensing or certification examination, or the administration of any licensing or certification examination, conducted pursuant to this division, including, but not limited to, any of the following:

(1) Conduct that violates the security of the examination material.

(2) Removing from the examination room any examination materials without authorization.

(3) The unauthorized reproduction by any means of any portion of the actual licensing or certification examination.

(4) Aiding by any means the unauthorized reproduction of any portion of the actual licensing or certification examination.

(5) Paying or using professional or paid examination-takers, for the purpose of reconstructing any portion of the licensing or certification examination.

(6) Obtaining or attempting to obtain examination questions or other examination material from examinees or by any other method, except by specific authorization either before, during, or after an examination.

(7) Using or purporting to use any examination questions or materials that were improperly removed or taken from any examination for the purpose of instructing or preparing any applicant for examination.

(8) Selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered licensing or certification examination.

(9) Communicating with any other examinee during the administration of a licensing or certification examination.

(10) Copying answers from another examinee or permitting one’s answers to be copied by another examinee.

(11) Having in one’s possession during the administration of the licensing or certification examination any books, equipment, notes written or printed materials, or data of any kind, other than the examination materials distributed, or otherwise authorized to be in one’s possession during the examination.

(12) Impersonating any examinee or having an impersonator take the licensing or certification examination on one's behalf.

(b) The penalties provided in this section are not exclusive remedies and shall not preclude remedies provided pursuant to any other provision of law.

(c) In addition to any other penalties, a person found guilty of violating this section shall be liable for the actual damages sustained by the agency administering the examination not to exceed ten thousand dollars ($10,000) and the costs of litigation. *(Added by Stats. 1992, Ch. 215, Sec. 1. Effective January 1, 1993.)*

1798.208. (AG or DA Injunction, Restraining Order)
Whenever any person who has engaged, or is about to engage, in any act or practice which constitutes, or will constitute, a violation of any provision of this division, the rules and regulations promulgated pursuant thereto, or local EMS agency mandated protocols, guidelines, or transfer agreements, the superior court in and for the county wherein the acts or practices take place or are about to take place may issue an injunction or other appropriate order restraining the conduct on application of the authority, the Attorney General, or the district attorney of the county. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required. *(Amended by Stats. 1987, Ch. 1240, Sec. 19.)*

1798.209. (Medical Director Discretion: Training Programs)
The local EMS agency may place on probation, suspend, or revoke the approval under this division of any training program for failure to comply with this division or any rules or regulations adopted pursuant thereto. *(Added by Stats. 1994, Ch. 709, Sec. 9. Effective January 1, 1995.)*

1798.210. (Administrative Fines)
(a) The authority may impose an administrative fine of up to two thousand five hundred dollars ($2,500) per violation on any licensed paramedic found to have committed any of the actions described by subdivision (c) of Section 1798.200 that did not result in actual harm to a patient. Fines may not be imposed if a paramedic has previously been disciplined by the authority for any other act committed within the immediately preceding five-year period.

(b) The authority shall adopt regulations establishing an administrative fine structure, taking into account the nature and gravity of the violation. The administrative fine shall not be imposed in conjunction with a suspension for the same violation, but may be imposed in conjunction with probation for the same violation except when the conditions of the probation require a paramedic's personal time or expense for training, clinical observation, or related corrective instruction.

(c) In assessing the fine, the authority shall give due consideration to the appropriateness of the amount of the fine with respect to factors that include the gravity of the violation, the good faith of the paramedic, the history of previous violations, any discipline imposed by the paramedic's employer for the same occurrence of that conduct, as reported pursuant to Section 1799.112, and the totality of the discipline to be imposed. The imposition of the fine shall be subject to the administrative adjudication provisions set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) If a paramedic does not pay the administrative fine imposed by the authority and chooses not to renew his or her license, the authority may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the authority may have to require a paramedic to pay costs.

(e) In any action for collection of an administrative fine, proof of the authority's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(f) (1) Except as provided in paragraph (2), the authority shall not license or renew the license of any paramedic who has failed to pay an administrative fine ordered under this section.

(2) The authority may, in its discretion, conditionally license or renew for a maximum of one year the license of any paramedic who demonstrates financial hardship and who enters into a formal agreement with the authority to reimburse the authority within that one-year period for the unpaid fine.

(g) All funds recovered under this section shall be deposited into the state General Fund.

(h) Nothing in this section shall preclude the authority from imposing an administrative fine in any stipulated settlement.

(i) For purposes of this section, "licensed paramedic" includes a paramedic whose license has lapsed or has been surrendered. *(Added by Stats. 2004, Ch. 513, Sec. 1. Effective January 1, 2005.)*

1798.211. (Disciplinary Action Decisions)
When making a decision regarding a disciplinary action pursuant to Section 1798.200 or Section 1798.210, the authority, and when applicable the administrative law judge, shall give credit for discipline imposed by the employer and for any immediate suspension imposed by the local EMS

agency for the same conduct. *(Added by Stats. 2004, Ch. 513, Sec. 2. Effective January 1, 2005.)*

CHAPTER 8. The Commission on EMS [1799 - 1799.56]
(Chapter 8 added by Stats. 1980, Ch. 1260.)

ARTICLE 1. The Commission [1799 - 1799.8] (Article 1 added by Stats. 1980, Ch. 1260.)

1799.0 (Creation)
The Commission on Emergency Medical Services is hereby created in the California Health and Human Services Agency. *(Amended by Stats. 2008, Ch. 275, Sec. 3. Effective January 1, 2009.)*

1799.2. (Membership)
The commission shall consist of 18 members appointed as follows:

(a) One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Committee on Rules from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(b) One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.

(c) One physician and surgeon appointed by the Senate Committee on Rules from a list of three names submitted by the California Medical Association.

(d) One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers.

(e) One registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a list of three names submitted by the Emergency Nurses Association.

(f) One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Committee on Rules from a list of three names submitted by the California Rescue and Paramedic Association.

(g) One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.

(h) One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.

(i) One physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues appointed by the Speaker of the Assembly.

(j) One hospital administrator of a base hospital who is appointed by the Governor from a list of three names submitted by the California Association of Hospitals and Health Systems.

(k) One full-time peace officer, who is either an EMT-II or a paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.

(l) Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the authority, and who are appointed by the Governor.

(m) One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrator's Association of California.

(n) One medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California and who is appointed by the Governor.

(o) One person appointed by the Governor, who is an active member of the California State Firemen's Association.

(p) One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(q) One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters. *(Amended by Stats. 2008, Ch. 275, Sec. 4. Effective January 1, 2009.)*

1799.3. (Reappointment of Members)
At the discretion of the appointing power or body, a member of the commission may be reappointed or may continue to serve if he or she no longer continues to function in the capacity which originally qualified him or her for appointment. However, where Section 1799.2 requires that an

appropriate organization submit names to the appointing power or body, a person shall not be reappointed pursuant to this section unless his or her name is submitted by that appropriate organization. *(Added by Stats. 1985, Ch. 42, Sec. 2. Effective May 15, 1985.)*

1799.4. (Membership Terms)
(a) Except as otherwise provided in this section, the terms of the members of the commission shall be three calendar years, commencing January 1 of the year of appointment. No member shall serve more than two consecutive full terms; provided, however, that a term or part of a term served pursuant to paragraph (1) or (2) of subdivision (b) shall not be included in this limitation.

(b) (1) The first members appointed on or after January 1, 1985, pursuant to subdivisions (a), (b), (c), and (d) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus one additional year.

(2) The first members appointed on or after January 1, 1985, pursuant to subdivisions (e), (f), (g), (h), and (i) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus two additional years.

(3) The first members appointed on or after January 1, 1985, pursuant to subdivisions (j), (k), and (m) of Section 1799.2 shall be from the date of appointment to the end of that calendar year, plus three additional years.

(4) The first member appointed on or after January 1, 1985, pursuant to subdivision (l) of Section 1799.2 shall serve from the date of appointment to the end of that calendar year, plus one additional year, and the second member shall serve from the date of appointment to the end of that calendar year, plus two additional years.

(5) The first member appointed pursuant to subdivision (n) of Section 1799.2 shall serve from the date of appointment to the end of the 1991 calendar year.

(6) It is the purpose of this subdivision to provide for staggered terms for the members of the commission. *(Amended by Stats. 1987, Ch. 1102, Sec. 3.)*

1799.6. (Compensation)
The members of the commission shall receive no compensation for their services, but shall be reimbursed for their actual, necessary, traveling and other expenses incurred in the discharge of their duties. *(Added by Stats. 1980, Ch. 1260.)*

1799.8. (Chairperson, Meeting Frequency)
The commission shall select a chairperson from its members and shall meet at least quarterly on the call of the director, the chairperson, or three members of the commission. *(Added by Stats. 1980, Ch. 1260.)*

ARTICLE 2. Duties of the Commission [1799.50 - 1799.56] (Article 2 added by Stats. 1980, Ch. 1260.)

1799.50. (Approval of Regulations & Guidelines)
The commission shall review and approve regulations, standards, and guidelines to be developed by the authority for implementation of this division. *(Amended by Stats. 1986, Ch. 248, Sec. 138.)*

1799.51. (Advise EMSA: Data Collection)
The commission shall advise the authority on the development of an emergency medical data collection system. *(Added by Stats. 1980, Ch. 1260.)*

1799.52. (Advise Director: Facilities & Services)
The commission shall advise the director concerning the assessment of emergency facilities and services. *(Added by Stats. 1980, Ch. 1260.)*

1799.53. (Advise Director: EMS System Components)
The commission shall advise the director with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system. *(Added by Stats. 1980, Ch. 1260.)*

1799.54. (Review Health Facilities & Service Plan)
The commission shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed pursuant to Section 127155. *(Amended by Stats. 1996, Ch. 1023, Sec. 175. Effective September 29, 1996.)*

1799.55. (Recommendations for Development of EMS)
Based upon evaluations of the EMS systems in the state and their coordination, the commission shall make recommendations for further development and future directions of the emergency medical services in the state. *(Added by Stats. 1980, Ch. 1260.)*

1799.56. (Technical Advisory Panels)
The commission may utilize technical advisory panels established pursuant to the provisions of Section 1797.133 as are needed to assist in developing standards for emergency medical services. *(Added by Stats. 1980, Ch. 1260.)*

CHAPTER 9. Liability Limitation [1799.100 - 1799.112]
(Chapter 9 added by Stats. 1980, Ch. 1260.)

1799.100. (EMS Training Programs)
In order to encourage local agencies and other organizations to train people in emergency medical services, no local agency, entity of state or local government, private business or nonprofit organization included on the statewide registry that voluntarily and without expectation and receipt of compensation donates services, goods, labor, equipment, resources, or dispensaries or other facilities, in compliance with Section 8588.2 of the Government Code, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of people, or certifies those people, excluding physicians and surgeons, registered nurses, and licensed vocational nurses, as defined, in emergency medical services, shall be liable for any civil damages alleged to result from those training programs. *(Amended by Stats. 2008, Ch. 363, Sec. 3. Effective January 1, 2009.)*

1799.102. (Liability Protections)
(a) No person who in good faith, and not for compensation, renders emergency medical or nonmedical care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered. This subdivision applies only to the medical, law enforcement, and emergency personnel specified in this chapter.

(b) (1) It is the intent of the Legislature to encourage other individuals to volunteer, without compensation, to assist others in need during an emergency, while ensuring that those volunteers who provide care or assistance act responsibly.

(2) Except for those persons specified in subdivision (a), no person who in good faith, and not for compensation, renders emergency medical or nonmedical care or assistance at the scene of an emergency shall be liable for civil damages resulting from any act or omission other than an act or omission constituting gross negligence or willful or wanton misconduct. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered. This subdivision shall not be construed to alter existing protections from liability for licensed medical or other personnel specified in subdivision (a) or any other law.

(c) Nothing in this section shall be construed to change any existing legal duties or obligations, nor does anything in this section in any way affect the provisions in Section 1714.5 of the Civil Code, as proposed to be amended by Senate Bill 39 of the 2009–10 Regular Session of the Legislature.

(d) The amendments to this section made by the act adding subdivisions (b) and (c) shall apply exclusively to any legal action filed on or after the effective date of that act. *(Amended by Stats. 2009, Ch. 77, Sec. 1. Effective August 6, 2009. Note: As referenced in subd. (d), subds. (b) and (c) were added in the amendment by Stats. 2009, Ch. 77.)*

1799.103. (Prohibition of Workplace Policies Prohibiting Provision of EMS Services)
(a) An employer shall not adopt or enforce a policy prohibiting an employee from voluntarily providing emergency medical services, including, but not limited to, cardiopulmonary resuscitation, in response to a medical emergency, except as provided in subdivisions (b) and (c).

(b) Notwithstanding subdivision (a), an employer may adopt and enforce a policy authorizing employees trained in emergency services to provide those services. However, in the event of an emergency, any available employee may voluntarily provide emergency medical services if a trained and authorized employee is not immediately available or is otherwise unable or unwilling to provide emergency medical services.

(c) Notwithstanding subdivision (a), an employer may adopt and enforce a policy prohibiting an employee from performing emergency medical services, including, but not limited to, cardiopulmonary resuscitation, on a person who has expressed the desire to forgo resuscitation or other medical interventions through any legally recognized means, including, but not limited to, a do-not-resuscitate order, a Physician Orders for Life Sustaining Treatment form, an advance health care directive, or a legally recognized health care decisionmaker.

(d) This section does not impose any express or implied duty on an employer to train its employees regarding emergency medical services or cardiopulmonary resuscitation. *(Added by Stats. 2013, Ch. 591, Sec. 1. Effective January 1, 2014.)*

1799.104. (Immunity Clause: Physician or Nurse)
(a) No physician or nurse, who in good faith gives emergency instructions to an EMT-II or mobile intensive care paramedic at the scene of an emergency, shall be liable for any civil damages as a result of issuing the instructions.

(b) No EMT-II or mobile intensive care paramedic rendering care within the scope of his duties who, in good faith and in a nonnegligent manner, follows the instructions of a physician or nurse shall be liable for any civil damages as a result of following such instructions. *(Added by Stats. 1980, Ch. 1260.)*

1799.105. (Poison Control Center Liability)
(a) A poison control center which (1) meets the minimum standards for designation and operation established by the authority pursuant to Section 1798.180, (2) has been designated a regional poison control center by the authority, and (3) provides information and advice for no charge on the management of exposures to poisonous or toxic substances, shall be immune from liability in civil damages with respect to the emergency provision of that information or advice, for acts or omissions by its medical director, poison information specialist, or poison information provider as provided in subdivisions (b) and (c).

(b) Any poison information specialist or poison information provider who provides emergency information and advice on the management of exposures to poisonous or toxic substances, through, and in accordance with, protocols approved by the medical director of a poison control center specified in subdivision (a), shall only be liable in civil damages, with respect to the emergency provision of that information or advice, for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. This subdivision shall not be construed to immunize the negligent adoption of a protocol.

(c) The medical director of a poison control center specified in subdivision (a) who provides emergency information and advice on the management of exposures to poisonous or toxic substances, where the exposure is not covered by an approved protocol, shall be liable only in civil damages, with respect to the emergency provision of that information or advice, for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. This subdivision shall neither be construed to immunize the negligent failure to adopt adequate approved protocols nor to confer liability upon the medical director for failing to develop or approve a protocol when the development of a protocol for a specific situation is not practical or the situation could not have been reasonably foreseen. *(Added by Stats. 1988, Ch. 1192, Sec. 1.)*

1799.106. (Employers: Liability Protections)
(a) In addition to the provisions of Section 1799.104 of this code, Section 2727.5 of the Business and Professions Code, and Section 1714.2 of the Civil Code, and in order to encourage the provision of emergency medical services by firefighters, police officers or other law enforcement officers, EMT-I, EMT-II, EMT-P, or registered nurses, a firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse who renders emergency medical services at the scene of an emergency or during an emergency air or ground ambulance transport shall only be liable in civil damages for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. A public agency employing such a firefighter, police officer or other law enforcement officer,

EMT-I, EMT-II, EMT-P, or registered nurse shall not be liable for civil damages if the firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse is not liable.

(b) For purposes of this section, “registered nurse” means a registered nurse trained in emergency medical services and licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code. *(Amended by Stats. 2012, Ch. 69, Sec. 2. Effective January 1, 2013.)*

1799.107. (Emergency Rescue Personnel)
(a) The Legislature finds and declares that a threat to the public health and safety exists whenever there is a need for emergency services and that public entities and emergency rescue personnel should be encouraged to provide emergency services. To that end, a qualified immunity from liability shall be provided for public entities and emergency rescue personnel providing emergency services.

(b) Except as provided in Article 1 (commencing with Section 17000) of Chapter 1 of Division 9 of the Vehicle Code, neither a public entity nor emergency rescue personnel shall be liable for any injury caused by an action taken by the emergency rescue personnel acting within the scope of their employment to provide emergency services, unless the action taken was performed in bad faith or in a grossly negligent manner.

(c) For purposes of this section, it shall be presumed that the action taken when providing emergency services was performed in good faith and without gross negligence. This presumption shall be one affecting the burden of proof.

(d) For purposes of this section, “emergency rescue personnel” means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services as defined by subdivision (e).

(e) For purposes of this section, “emergency services” includes, but is not limited to, first aid and medical services, rescue procedures and transportation, or other related activities necessary to insure the health or safety of a person in imminent peril. *(Amended by Stats. 1998, Ch. 617, Sec. 1. Effective January 1, 1999.)*

1799.108. (Persons Certified to Provide Emergency Field Care)
Any person who has a certificate issued pursuant to this division from a certifying agency to provide prehospital emergency field care treatment at the scene of an emergency, as defined in Section 1799.102, shall be liable for civil damages only for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. *(Amended by Stats. 1986, Ch. 248, Sec. 139.)*

1799.109. (Basic First Aid to Dogs and Cats)
(a) The Legislature finds and declares all of the following:

(1) California residents receive comfort and unconditional love on a daily basis from their household pets, particularly dogs and cats.

(2) California residents benefit from the special support, comfort, guidance, companionship, and therapy provided by dogs and cats.

(3) Pets provide critical support to many California residents with disabilities.

(4) Pets provide assistance and aid in the official duties of military personnel, peace officers, law enforcement agencies, fire departments, and search-and-rescue agencies.

(5) Personnel of some fire districts and other first responder agencies currently provide stabilizing, life-saving emergency care to dogs and cats, which violates the Veterinary Medicine Practice Act.

(6) In enacting this section, it is the intent of the Legislature to authorize emergency responders to provide, on a voluntary basis, basic first aid to dogs and cats without exposure to criminal prosecution or professional discipline for the unlawful practice of veterinary medicine.

(b) Notwithstanding the Veterinary Medicine Practice Act, as set forth in Chapter 11 (commencing with Section 4800) of Division 2 of the Business and Professions Code, an emergency responder may provide basic first aid to dogs and cats to the extent that the provision of that care is not prohibited by the responder's employer, and the responder shall not be subject to criminal prosecution for a violation of Section 4831 of the Business and Professions Code.

(c) Civil liability for a person who provides care to a pet or other domesticated animal during an emergency is governed by the following:

(1) Section 4826.1 of the Business and Professions Code governs care provided by a veterinarian.

(2) Subdivision (a) of Section 1799.102 governs care provided by an emergency responder, or law enforcement and emergency personnel specified in this chapter.

(3) Subdivision (b) of Section 1799.102 governs care provided by any person other than an individual described in paragraph (1) or (2).

(d) Notwithstanding any other law, this section does not impose a duty or obligation upon an emergency responder or any other person to transport or provide care to an injured pet or other domesticated animal during an emergency.

(e) For purposes of this section, the following definitions apply:

(1) “Cat” means a small domesticated feline animal that is kept as a pet. “Cat” does not include nondomesticated wild animals.

(2) “Dog” means a domesticated canine animal owned for companionship, service, therapeutic, or assistance purposes.

(3) “Emergency responder” means a person who is certified or licensed to provide emergency medical services.

(4) “Employer” means an entity or organization that employs or enlists the services of an emergency responder.

(5) “Basic first aid to dogs and cats” means providing immediate medical care to a dog or cat by an emergency responder, in an emergency situation to which the emergency responder is responding, that is intended to stabilize the dog or cat so that the dog or cat can be transported by the owner as soon as practical to a veterinarian for treatment and which is provided through the following means:

(A) Administering oxygen.

(B) Managing ventilation by mask.

(C) Manually clearing the upper airway, not including tracheal intubation or surgical procedures.

(D) Controlling hemorrhage with direct pressure.

(E) Bandaging for the purpose of stopping bleeding.

(f) This section does not require or authorize the provision of emergency services to dogs or cats in response to a telephone call to the 911

emergency system and is not a basis for liability for the failure to provide emergency services to dogs or cats in response to a telephone call to the 911 emergency system. *(Added by Stats. 2018, Ch. 900, Sec. 1. (SB 1305) Effective January 1, 2019.)*

1799.110. (Physician Providing Emergency Care)
(a) In any action for damages involving a claim of negligence against a physician and surgeon arising out of emergency medical services provided in a general acute care hospital emergency department, the trier of fact shall consider, together with all other relevant matters, the circumstances constituting the emergency, as defined herein, and the degree of care and skill ordinarily exercised by reputable members of the physician and surgeon's profession in the same or similar locality, in like cases, and under similar emergency circumstances.

(b) For the purposes of this section, "emergency medical services" and "emergency medical care" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

(c) In any action for damages involving a claim of negligence against a physician and surgeon providing emergency medical coverage for a general acute care hospital emergency department, the court shall admit expert medical testimony only from physicians and surgeons who have had substantial professional experience within the last five years while assigned to provide emergency medical coverage in a general acute care hospital emergency department. For purposes of this section, "substantial professional experience" shall be determined by the custom and practice of the manner in which emergency medical coverage is provided in general acute care hospital emergency departments in the same or similar localities where the alleged negligence occured. *(Added by Stats. 1983, Ch. 1246, Sec. 41.)*

1799.111. (Liability Protections for General Acute Care Hospital Staff)
(a) Subject to subdivision (b), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for detaining a person if all of the following conditions exist during the detention:

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, “gravely disabled” means an inability to provide for his or her basic personal needs for food, clothing, or shelter.

(2) The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(A) Telephone calls or other contacts required pursuant to this paragraph shall commence at the earliest possible time when the treating physician and surgeon has determined the time at which the person will be medically stable for transfer.

(B) In no case shall the contacts required pursuant to this paragraph begin after the time when the person becomes medically stable for transfer.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(b) If the person is detained pursuant to subdivision (a) beyond eight hours, but less than 24 hours, both of the following additional conditions shall be met:

(1) A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(2) In the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(c) In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital as defined by subdivision (b) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon,

providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:

(1) The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

(2) The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the person detained, that the person does not present a danger to himself or herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

(d) Nothing in this section shall affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(e) A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

(f) The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapists contained in Section 43.92 of the Civil Code.

(g) Nothing in this section is intended to expand the scope of licensure of clinical psychologists. *(Amended by Stats. 2009, Ch. 612, Sec. 1. Effective January 1, 2010.)*

1799.112. (Employer Notification of Discipline)
(a) EMT-P employers shall report in writing to the local EMS agency medical director and the authority and provide all supporting documentation within 30 days of whenever any of the following actions are taken:

(1) An EMT-P is terminated or suspended for disciplinary cause or reason.

(2) An EMT-P resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.

(3) An EMT-P is removed from paramedic duties for disciplinary cause or reason following the completion of an internal investigation.

(b) The reporting requirements of subdivision (a) do not require or authorize the release of information or records of an EMT-P who is also a peace officer protected by Section 832.7 of the Penal Code.

(c) For purposes of this section, “disciplinary cause or reason” means only an action that is substantially related to the qualifications, functions, and duties of a paramedic and is considered evidence of a threat to the public health and safety as identified in subdivision (c) of Section 1798.200.

(d) Pursuant to subdivision (i) of Section 1798.24 of the Civil Code, upon notification to the paramedic, the authority may share the results of its investigation into a paramedic’s misconduct with the paramedic’s employer, prospective employer when requested in writing as part of a preemployment background check, and the local EMS agency.

(e) The information reported or disclosed in this section shall be deemed in the nature of an investigative communication and is exempt from disclosure as a public record by subdivision (f) of Section 6254 of the Government Code.

(f) A paramedic applicant or licensee to whom the information pertains may view the contents, as set forth in subdivision (a) of Section 1798.24 of the Civil Code, of a closed investigation file upon request during the regular business hours of the authority. *(Added by Stats. 2004, Ch. 513, Sec. 3. Effective January 1, 2005.)*

CHAPTER 11. Emergency and Critical Care Services for Children
[1799.200 - 1799.201] (Chapter 11 added by Stats. 1989, Ch. 1206, Sec. 2.)

1799.200. (Pediatric Critical Care System Trial Studies)
(a) The State Department of Health Services shall contract with an organization with expertise in program evaluation, pediatric emergency medical services, and critical care, for the purposes specified in subdivision (b).

(b) The contractor, in consultation with a professional pediatric association, a professional emergency physicians association, a professional emergency medical services medical directors association, the Emergency Medical Services Authority, and the State Department of Health Services, shall perform a study that will identify the outcome criteria which can be used to evaluate pediatric critical care systems. This study shall include, but not be limited to, all of the following:

(1) Development of criteria to identify how changes in pediatric critical care systems affect the treatment of critically ill and injured children.

(2) Development of criteria to compare the systems in place in various areas of the state.

(3) Determination of whether the necessary data is currently available.

(4) Estimate of the cost to providers, such as emergency medical service agencies and hospitals, of collecting this data.

(5) Recommendations concerning the most reliable and cost-effective monitoring plan for use by agencies and facilities at the state, regional, and local levels. *(Added by renumbering Section 1199.200 by Stats. 1991, Ch. 1091, Sec. 68.)*

1799.201. (Requirement to Report to Legislature)
The contractor shall submit the results of the study to the Legislature and the Governor not later than January 1, 1991. *(Added by renumbering Section 1199.201 by Stats. 1991, Ch. 1091, Sec. 69.)*

CHAPTER 12. EMS System for Children [1799.202 - 1799.207]
(Chapter 12 added by Stats. 1996, Ch. 197, Sec. 3.)

1799.202. (Title)
This chapter shall be known and may be cited as the California Emergency Medical Services for Children Act of 1996. *(Added by Stats. 1996, Ch. 197, Sec. 3. Effective July 22, 1996.)*

1799.204. (Definitions)
(a) For purposes of this chapter, the following definitions apply:

(1) “EMSC Program” means the Emergency Medical Services For Children Program administered by the authority.

(2) “Technical advisory committee” means a multidisciplinary committee with pediatric emergency medical services, pediatric critical care, or other related expertise.

(3) “EMSC component” means the part of the local agency’s EMS plan that outlines the training, transportation, basic and advanced life support care requirements, and emergency department and hospital pediatric capabilities within a local jurisdiction.

(b) Contingent upon available funding, an Emergency Medical Services For Children Program is hereby established within the authority.

(c) The authority shall do the following to implement the EMSC Program:

(1) Employ or contract with professional, technical, research, and clerical staff as necessary to implement this chapter.

(2) Provide advice and technical assistance to local EMS agencies on the integration of an EMSC Program into their EMS system.

(3) Oversee implementation of the EMSC Program by local EMS agencies.

(4) Establish an EMSC technical advisory committee.

(5) Facilitate cooperative interstate relationships to provide appropriate care for pediatric patients who must cross state borders to receive emergency and critical care services.

(6) Work cooperatively and in a coordinated manner with the State Department of Health Services and other public and private agencies in the development of standards and policies for the delivery of emergency and critical care services to children.

(7) On or before March 1, 2000, produce a report for the Legislature describing any progress on implementation of this chapter. The report shall contain, but not be limited to, a description of the status of emergency medical services for children at both the state and local levels, the recommendation for training, protocols, and special medical equipment for emergency services for children, an estimate of the costs and benefits of the services and programs authorized by this chapter, and a calculation of the number of children served by the EMSC system. *(Amended by Stats. 2001, Ch. 171, Sec. 3. Effective August 10, 2001.)*

1799.205. (Local EMS Agencies Implementing EMSC)
A local EMS agency may develop an EMSC Program in its jurisdiction, contingent upon available funding. If a local EMS agency develops an EMSC Program in its jurisdiction, the local EMS agency shall develop and incorporate in its EMS plan an EMSC component that complies with EMS plan requirements. The EMSC component shall include, but need not be limited to, the following:

(a) EMSC system planning, implementation, and management.

(b) Injury and illness prevention planning, that includes, among other things, coordination, education, and data collection.

(c) Care rendered to patients outside the hospital.

(d) Emergency department care.

(e) Interfacility consultation, transfer, and transport.

(f) Pediatric critical care and pediatric trauma services.

(g) General trauma centers with pediatric considerations.

(h) Pediatric rehabilitation plans that include, among other things, data collection and evaluation, education on early detection of need for referral, and proper referral of pediatric patients.

(i) Children with special EMS needs outside the hospital.

(j) Information management and system evaluation. *(Added by Stats. 1996, Ch. 197, Sec. 3. Effective July 22, 1996.)*

1799.207. (Permission to Supplement State Funds)
The authority may solicit and accept grant funding from public and private sources to supplement state funds. *(Added by Stats. 1996, Ch. 197, Sec. 3. Effective July 22, 1996.)*

California Commission on EMS

The California Commission on Emergency Medical Services exists to ensure that stakeholders have a voice in decisions affecting the EMS system in California. The duties of the Commission include approving regulations and guidelines developed by the Authority and providing advice to the Authority on the assessment of emergency facilities and services, communications, medical equipment, training personnel, and components of an emergency medical services system. Visit our EMS Commission web page for additional information: http://bit.ly/1wbsSSA

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Jaison Chand, EMT-P, RN, BSN	CA Ambulance Assn. [A]
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[G] Appointed by the Governor
[S] Appointed by the Senate Rules Committee
[A] Appointed by the Speaker of the Assembly

EMS Statutes Outside of the EMS Act

Administrative Procedures Act	Gov. Code §11400
Ambulance Operation	Vehicle Code §2512, 13372
Authority of EMSA Director in use of Health Care Personnel During Disaster	Bus. and Prof. Code §900
Automated Drug Delivery System	Bus. and Prof. Code §§4034.5, 4119, 4119.01, 4202.5
Automated External Defibrillator	H&SC §104113, Civil Code §§1714.2-1714.2, Gov. Code §8455, Education Code §49417
California Earthquake Hazard Program	Gov. Code §8871.4
California Hazardous Substances Incident Response Training Program	Gov. Code §8574.21
Child Care First Aid, CPR, Preventive Health Training	H&SC §§1596.798, 1596.7996, 1596.865-6, 1596.8661, 1597.16
CHP Emergency Medical Dispatcher	Vehicle Code §2422
Do Not Resuscitate/POLST	Probate Code §§4780-4786
Emergency Ambulance Employee Safety and Preparedness Act	Labor Code §§880-889
Emergency Response to Terrorism Training Advisory Committee	Gov. Code §8588.10, Penal Code §13514.1, 13519.12
Emergency Response Training in SEMS	Gov. Code §8607
Epinephrine Auto-Injectors	Education Code §49414, Bus. And Prof. Code §4119.3, Civil Code §1714.23
Firefighters Procedural Bill of Rights	Gov. Code §3250-3262
Group Homes and Crisis Nurseries	H&SC §1530.8

Immunity for EMT-Is and EMT-IIs	Civil Code §1714.2
Investigative Information Exempt	Gov. Code §6254
Leave Provisions for Volunteer Emergency Rescue Personnel	Labor Code §230.3, 230.4
Maddy EMS Fund	Gov. Code §76000.5, Vehicle Code §42007
Mandating Reporting by EMS Providers	Penal Code §11160
Paramedic Blood Draws for DUI	Vehicle Code §23158
Parents in Arrears on Child Support	Family Code §17520
Public Safety Communication Act	Gov. Code §8592-8592.9
Public Safety First Aid Standards	Penal Code §13518
Public Safety Radio Strategic Planning	Gov. Code §8592.1
School Bus Driver First Aid	Vehicle Code §12522
Sexually Related Offenses	Penal Code §290
Sharing of Investigative Information	Civil Code §1798.24
Teacher Training in CPR and Heimlich	Education Code §44277
Trial Studies	H&SC §111550 et seq.
Use of Dangerous Drugs or Devices by EMS in Ambulances	Bus. and Prof. Code §4119
Use of Opioid Antagonists	Civil Code §1714.22

California Code of Regulations

In addition to statutes, EMS in California is governed by regulations that are developed by the EMS Authority with assistance by stakeholders with subject matter expertise, and then approved by the Commission on EMS. The regulations are available on the EMSA website at: https://www.emsa.ca.gov/regulations

For reference, an outline of the EMS regulations chapters is below:

California Code of Regulations, Title 22, Division 9: Prehospital Emergency Medical Services

Chapter 1: Conflict of Interest Code
Chapter 1.1: Training Standards for Child Care Providers
Chapter 1.2: First Aid Testing for School Bus Drivers
Chapter 1.5: First Aid Standards for Public Safety Personnel
Chapter 1.9: Lay Rescuer Epinephrine Injector Training
Chapter 2: EMT
Chapter 3: Advanced EMT
Chapter 4: EMT-P
Chapter 5: Process for Applicant Verification
Chapter 6: Process for EMT and Advanced EMT Disciplinary Action
Chapter 7: Trauma Care Systems
Chapter 8: Pre-Hospital EMS Aircraft
Chapter 9: Poison Control Center
Chapter 10: California EMT Central Registry
Chapter 11: EMS Continuing Education
Chapter 12: EMS System Quality Improvement
Chapter 13: EMS Systems, Appeal Proceedings to the Commission

Participating in the Rulemaking Process

Pursuant to Government Code §11340.85, EMS Authority's proposed regulation documents and information are made available to the public on the EMSA website at: https://emsa.ca.gov/public_comment/

The public may submit comments by mail, email, or fax, or by attending the public hearing. All comments must be submitted on or by the last day of the public comment period as shown in the respective "Notice of Proposed Rulemaking" or "Notice of Modified Text" document.

If you would like to receive notification of all EMS Authority regulatory activities, please sign up for EMSA's Interested Parties Mailing List. (A printable copy of the mailing list form is available here.)

For questions related to the mailing list, EMSA's regulations, proposed regulatory actions, or the rulemaking process, please contact External.Affairs@emsa.ca.gov.

Index of EMSA Publications and Guidelines

All of these publications are posted on EMSA's website at
https://www.emsa.ca.gov/Guidelines

- EMSA #101: EMS System Standards and Guidelines Part I
- EMSA #102: EMS System Standards and Guidelines Part II
- EMSA #103: EMS System Standards and Guidelines Part III
- EMSA #104: Funding of Regional EMS Agencies with State General Funds
- EMSA #105: EMSA Policy for the Provision of Federal Block Grant Funding to Local EMS Agencies
- EMSA #114: EMSA Policy for Funding Disaster Medical Assistance Team (DMAT) with State General Funds
- EMSA #115: Funding of Regional Disaster Medical Health Specialist (RDMHS) with State General Funds
- EMSA #125: Procedure to Add Items to Local Optional Scope of Practice
- EMSA #127: Application for Authorization as an Approved CE Provider for EMS Personnel
- EMSA #130: EMT-P Accreditation Policy
- EMSA #132: Emergency Medical Services Dispatch Program Guidelines
- EMSA #133: Advanced EMT Model Curriculum
- EMSA #134: Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMTs and AEMTs
- EMSA #135: Recommended Guidelines for Disciplinary Orders and Conditions of Probation for Paramedics
- EMSA #141: Competitive Process for Creating Exclusive Operating Areas
- EMSA #144: Pre-Hospital EMS Aircraft Guidelines
- EMSA #145: Statewide EMS Operations and Communications Resource Manual
- EMSA #151: Trauma Plan Development Guidelines
- EMSA #152: Paramedic Inter-Facility Transport Guidelines
- EMSA #162: Management Information Systems Resource Guide
- EMSA #163: EMS System Quality Improvement Indicators (Appendix M)
- EMSA #164: CEMSIS Data System Standards with code values
- EMSA #166: EMS System Quality Improvement Guidelines
- EMSA #181: Guidelines For Pediatric Inter-Facility Transport Programs

- EMSA #182: Administration, Personnel and Policy Guidelines for the Care of Pediatric Patients in the Emergency Department
- EMSA #183: Inter-Facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines
- EMSA #184: Guidelines For Pediatric Critical Care Centers
- EMSA #185: Guideline for Prehospital Pediatric Protocol
- EMSA #187: Pediatric Education Guidelines For Paramedics
- EMSA #188: Pre-Hospital Pediatric Equipment For BLS/ALS Support Units
- EMSA #194: Intensive Care Services for the Pediatric Trauma Patient
- EMSA #196: Emergency First Aid Guidelines for California Schools
- EMSA #197: EMSC Pediatric Disaster Preparedness Guidelines for LEMSAs
- EMSA #198: EMSC Pediatric Disaster Preparedness Guidelines for Hospitals
- EMSA #214: Disaster Medical Systems Guidelines
- EMSA #216: Minimum Personal Protective Equipment (PPE)
- EMSA #218A: California Disaster Medical Response Plan
- EMSA #218B: Medical Mutual Aid Plan Annex
- DMS #219: California Disaster Medical Operations Manual
- EMSA #233: Patient Decontamination Recommendations For Hospitals
- EMSA #300: Scope of Practice
- EMSA #301: EMS Personnel Mutual Aid Compendium
    - EMSA #920: Out of State Mutual Aid Form

- EMSA #311: Do-Not -Resuscitate (DNR) Guidelines
    - DNR Form
    - Physician’s Order for Life Sustaining Treatment (POLST)

- EMSA #331: California’s EMS Personnel Programs
- EMSA #370: Tactical Casualty Care- Tactical First Aid/Tactical Emergency Medical Support (TEMS) First Responder Operational (FRO) Training Standards Guidelines

- Hospital Emergency Department Downgrade or Closure Impact Evaluation Policy Guidelines

Local EMS Agencies

as of February 2019

Alameda County (510) 618-2050 – ems.acgov.org
Anne Kronenberg, Interim Administrator; Dr. Karl Sporer, Medical Director

Contra Costa County (925) 608-5454 - www.cchealth.org/ems
Patricia Frost, Administrator; Dr. David Goldstein, Medical Director

El Dorado County (530) 621-6500 - www.edcgov.us/EMS
Richard W. Todd, Administrator; Dr. David Brazzel, Medical Director

Imperial County (442) 265-1364 - www.icphd.org
Christopher Herring, Administrator; Dr. Bruce Haynes, Medical Director

Kern County (661) 868-5216 - www.kernpublichealth.com/ems
Jeff Fariss, Administrator; Dr. Kristopher Lyon, Medical Director

Los Angeles County (562) 378-1500 - dhs.lacounty.gov/wps/portal/dhs/ems
Cathy Chidester, Administrator; Dr. Marianne Gausche-Hill, Medical Director

Marin County (415) 473-6833 - https://ems.marinhhs.org/
Mike Giannini, Administrator; Dr. Dustin Ballard, Medical Director

Merced County (209) 381-1250 - https://bit.ly/2MTt3DC
Jim Clark, Administrator; Dr. Ajinder Singh, Medical Director

Monterey County (831) 755-5013 - https://bit.ly/2GlziP4
Mike Petrie, Administrator; Dr. James Stubblefield, Medical Director

Napa County (707) 253- 4341 - www.countyofnapa.org/ems
Brian Henricksen, Administrator. Dr. Zita Konik, Medical Director

Orange County (714) 834-3500 - www.healthdisasteroc.org/ems
Tammi McConnell, Administrator; Dr. Sam Stratton, Medical Director

Riverside County (951) 358-5029 - www.rivcoems.org
Bruce Barton, Administrator; Dr. Reza Zaezazizi, Medical Director

Sacramento County (916) 875-9753 - www.dhhs.saccounty.net/pri/ems
David Magnino, Administrator; Dr. Hernando Garzon, Medical Director

San Benito County (831) 636-4168 - https://bit.ly/2TC0tJz
Kris Mangano, Acting Administrator; Dr. David Ghilarducci, Medical Director

San Diego County (619) 285-6429 - http://bit.ly/14SB3h6
Andrew Parr, Administrator; Dr. Kristi Koenig, Medical Director

City and County of San Francisco (415) 487-5000 - https://bit.ly/2GojZVP
James Duren, Administrator; Dr. John Brown, Medical Director

San Joaquin County (209) 468-6818 - www.sjgov.org/EMS
Dan Burch, Administrator; Dr. Katherine Shafer, Medical Director

San Luis Obispo County (805) 788-2512 - http://sloemsa.org
Vince Pierucci, Administrator; Dr. Thomas Ronay, Medical Director

San Mateo County (650) 573-2564 - www.smchealth.org/EMS
Nancy Lapolla, Administrator; Dr. Greg Gilbert, Medical Director

Santa Barbara County (805) 681-5274 - https://countyofsb.org/phd/ems/
Nick Clay, Administrator; Dr. Angelo Salvucci, Medical Director

Santa Clara County (408) 794-0610 - www.sccgov.org/sites/ems
Jackie Lowther, Administrator; Dr. Kenneth Miller, Medical Director

Santa Cruz County (831) 454-4751 - http://bit.ly/1yGz509
Brenda Brenner, Administrator; Dr. David Ghilarducci, Medical Director

Solano County (707) 784-8155 - www.solanocounty.com/depts/ems/
Ted Selby, Administrator; Dr. Bryn Mumma, Medical Director

Tuolumne County (209) 533-7460 - www.tuolumnecounty.ca.gov/302/ems
Clarence Teem, Administrator; Dr. Kimberly Freeman, Medical Director

Ventura County (805) 981-5301 - www.vchca.org/ems
Steve Carroll, Administrator; Dr. Daniel Shepherd, Medical Director

Yolo County (530) 666-8671 - https://bit.ly/2BkYF0p
Kristin Weivoda, Administrator; Dr. John Rose, Medical Director

Multi-County EMS Agencies

as of February 2019

Central California (559) 600-3387 - www.ccemsa.org
Dan Lynch, Administrator; Dr. Jim Andrews, Medical Director

Coastal Valleys (707) 565-6501 - www.coastalvalleysems.org
Bryan Cleaver, Administrator; Dr. Mark Luoto, Medical Director

Inland Counties (909) 388-5823 - www.sbcounty.gov/icema
Tom Lynch, Administrator; Dr. Reza Vaezazizi, Medical Director

Mountain Valley (209) 566-7211 - www.mvemsa.org
Lance Doyle, Administrator; Dr. Kevin Mackey, Medical Director

North Coast (707) 445-2081 - www.northcoastems.com
Larry Karsteadt, Administrator; Dr. Ken Stiver, Medical Director

Northern California (530) 229-3979 - www.norcalems.org
Dan Spiess, Administrator; Dr. Eric Rudnick, Medical Director

Sierra-Sacramento Valley (916) 625-1702 - www.ssvems.com
Victoria Pinette, Administrator; Dr. Troy Falck, Medical Director

Map of California's Local EMS Agencies

In California, day-to-day EMS system management is a local responsibility. Each county developing an EMS system must designate a local EMS agency (LEMSA). Currently, California has 33 LEMSAs - seven multi-county LEMSAs and 26 single county LEMSAs. It is principally through these agencies that the EMS Authority works to promote quality EMS services statewide.

Are you on the list?

Disaster Healthcare Volunteers (DHV) is an online registry of health care professionals who want to put their training to work when disaster strikes. It's easy to register on our secure website, and your credentials will be verified now so when you're needed you'll be ready to go. Visit our website for answers to all of your questions and to register.

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www.healthcarevolunteers.ca.gov