



California Emergency Medical Services Law

Health & Safety Code Division 2.5
Statutes in Effect as of January 1, 2012

Emergency Medical Services Authority
Health and Human Services Agency



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Howard Backer, MD, MPH, FACEP - Director

**Emergency Medical Services Authority
Welcomes Dr. Howard Backer**

Howard Backer, MD, MPH, FACEP, was appointed to serve as Director of the California Emergency Medical Services Authority (EMSA) July 25th and has quickly taken up his duties leading the authority. Dana Bookle, Secretary of the California Health and Human Services (CHHS) Agency, announced Dr. Backer's selection and held the swearing-in ceremony July 25th in Sacramento. [Read more...](#)



EMSA's Unique Public-Private Partnership Sustains the State's Mobile Field Hospital Program



The Governor's proposed 2011-2012 budget included elimination of 21.7 million in funding that sustains the state's Mobile Field Hospital (MFH) in its present ready condition. EMSA is pleased to announce it has accomplished our mission to sustain the MFH Program through at least June 30, 2012. [Read more...](#)

Dr. Daniel Margulies appointed to Commission on EMS



EMSA welcomes Daniel Margulies to the California State Commission on EMS. Dr. Margulies is the Director of the California State Health Services and is currently serving as the Director of the California State Health Services. [Read more...](#)

EMS for Children

This...
Dr. Daniel Margulies...
EMSA for Children in Progress...
Comments on EMSA Dispatch...
Children's Protection...
California Emergency Medical Services Authority...
National Day of the...
NorCal Be Prepared!



...and connect to
EMSA on Facebook
to follow statewide
EMS issues.



**EMERGENCY MEDICAL
SERVICES AUTHORITY**

**Edmund G. Brown Jr.
Governor
State of California**

**Diana Dooley
Secretary
Health and Human Services Agency**

**Howard Backer, MD, MPH, FACEP
Director
Emergency Medical Services Authority**

**Updated January 2012
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 first half of the 2011-12 Legislative Session. Although every effort has been made to ensure that this document is accurate and complete, no guarantee is being made or implied.

This document is also accessible on the EMS Authority's home page at www.emsa.ca.gov.

A quick look at the

California EMS Authority

...Your State EMS Department

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.

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.

The department is organized into three operational 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 19,000 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.
- The EMS Systems Division coordinates the local EMS systems, the statewide trauma system, and the California Poison Control system. They establish regulations and guidelines for local EMS agencies and review and approve 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 and personnel from unaffected regions of the state to meet the needs of disaster victims. The Disaster Medical Services Division also maintains, staffs and deploys the state's mobile medical assets including more than 25 Disaster Medical Support Units for ambulance strike teams and three 200-bed mobile field hospitals.

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 32 LEMSAs - seven multi-county LEMSAs and 25 single county LEMSAs. It is principally through these agencies that the EMS Authority works to promote quality EMS services statewide.

We also work in partnership with the Commission on Emergency Medical Services, which ensures that stakeholders have a voice in decisions affecting the EMS system in California.

EMSA derives statutory authority from Division 2.5 of the Health and Safety Code (Sections 1797-1799) added in 1980 by the Emergency Medical Services and Prehospital Emergency Care Personnel Act.

This publication contains the full statutes under which we operate. An electronic version of this document including the chronological bill history is available in .pdf and in Microsoft Word on our Website at www.emsa.ca.gov. While visiting our Website, be sure to sign up for the "EMSA Dispatch" electronic newsletter and connect to EMSA on Facebook and Twitter.

The Role of the State in California's Coordinated EMS System

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 many issues, there was a consensus that a more unified approach to emergency and disaster medical services was needed.

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

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, through standard setting, consensus building, and leadership, plays a central role in improving the quality of emergency medical services available for all Californians.

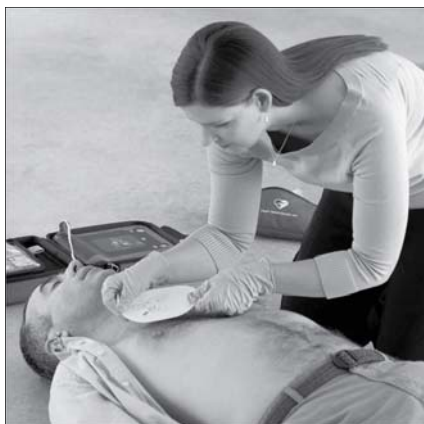
While day-to-day management of California's EMS system is the responsibility of the counties, our job is to coordinate the system statewide. In addition to establishing standards through regulation, here are a few examples of the work we do every day on behalf of Californians:

Paramedic Licensure: EMSA licenses approximately 19,000 paramedics statewide each year. We also investigate potential violations of the Health and Safety Code and take licensure action when necessary to protect the public.

EMS Personnel Registry: As of July 2010, EMSA operates the statewide EMS Personnel Central Registry - an online database containing certification/licensure status of every EMT and paramedic in the state. The system has enabled certification in one county to be good all over the state. The website receives more than 2,300 inquiries about individual providers each week.

First Aid, CPR and AED Regulations and Training:

EMSA oversees first aid and CPR training for 80,000 child care providers and school bus drivers. In addition, we write the regulations for use of an automated external difibrillator.



Mobile Medical Assets:

EMSA has more than 25 Disaster Medical Support Units filled with medical supplies and equipment that are ready to roll to re-supply ambulance strike teams anywhere in the state in the event that the local EMS resources are overwhelmed. EMSA also currently has three 200-bed mobile field hospitals that can be deployed to replace damaged hospital facilities during a disaster.

California Poison Control System: EMSA funds and oversees the statewide system that provides free, immediate answers to poisoning questions over the phone. The California Poison Control System receives more than three thousand calls per year.

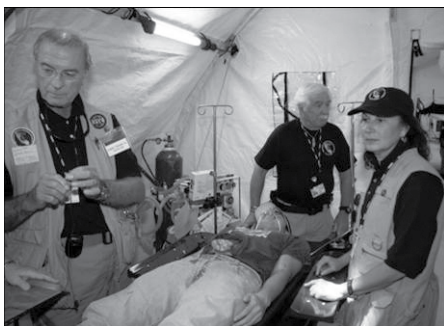
Emergency Medical Services for Children: EMSA worked with subject matter experts to develop a comprehensive model for the EMS for Children program that has been adopted for use by many local EMS agencies. We are now working on integrating EMSC into local EMS systems through the development of regulations.

California Emergency Medical Services Information System (CEMSIS): In cooperation with the National EMS Information System, EMSA has developed a statewide system to collect pre-hospital and trauma center data. The information will be used to support local quality improvement and participate in national data collection efforts.

Disaster Healthcare

Volunteers: More than 16,000 healthcare professionals from dozens of specialties have registered with California's Disaster Healthcare Volunteers program so that when disaster strikes, they are ready and able to help.

In addition, EMSA coordinates California and federal Medical Assistance Teams. The system allows EMSA to verify credentials for 48 different professions.



Stroke and STEMI: EMSA works with subject matter experts to address the special needs of patients who suffer stroke and certain kinds of heart attacks. The workgroup is writing regulations to ensure they receive the kind of prehospital care that will increase their chances of recovery.

Specialty Care: EMSA approves the local optional scope of practice for specialty care EMS providers. Specialized training is needed to serve as a medic on a tactical law enforcement team, as a critical care medic on a helicopter or fixed-wing aircraft, or as a medic on a search and rescue team.



The California Commission on Emergency Medical Services

The 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. The Commission may also hear an appeal by a local EMS agency regarding a local EMS plan.

Commissioner

Bruce Barton, EMT-P

Chuck Baucom, EMT-P

Jaison Chand, RN, BSN, EMT-P

Sheldon Gilbert, Fire Chief

Dev A. GnanaDev, MD, MBA

Aaron F. Hamilton, EMT-P

Eugene Hardin, M.D.

David Herfindahl, MD, FFAFP

Ramon Johnson, MD

Colleen Kuhn, EMT-P

Daniel Margulies, MD

Matt Powers, RN, MS, EMT-P

David Rose, EMT-P

Eric Rudnick, MD

Jane Smith, EMT-P

Lewis Stone

Dave Teter, Battalion Chief, EMT-P

Chris Van Gorder, FACHE

Representing

EMS Administrators Assn.

Representing the rural communities

Calif. Ambulance Assn.

Calif. Fire Chiefs Assn.

Calif. Medical Assn.

Representing the public

Emergency room physician

Calif. Conf. of Local Health Officers

Calif. Chapter, American College of
Emergency Physicians

Calif. Peace Officers Assn.

Calif. Chapter, American College
of Surgeons

Calif. Emergency Nurses Assn.

Representing local fire protection

EMS Medical Directors Assn. of Calif.

Calif. Rescue and Paramedic Assn.

Calif. State Firefighters Assn.

Calif. Dept. of Forestry and Fire
Protection (Cal Fire)

Calif. Healthcare Assn.

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HEALTH AND SAFETY CODE

DIVISION 2.5. EMERGENCY MEDICAL SERVICES

[Except where noted, Division 2.5 was created by SB 125 (Ch. 1260); 1980] [Originally, the heading "Part 1" followed the heading for Division 2.5 and a number of the sections in Division 2.5 referred to "this part". Because there was no Part 2, the "Part 1" heading was deleted and all references to "this part" were changed to "this division" in a number of sections, by SB 2451 (Ch. 248): 1986. This change will not be noted for each section.]

CHAPTER 1. GENERAL PROVISIONS

1797. This division shall be known and may be cited as the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act.

1797.1. 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.

[The name of the EMS Authority was technically changed from the Emergency Medical Service Authority to the Emergency Medical Services Authority in Section 1797.1 and in other sections of Division 2.5 by SB 595 (Ch. 1246; statutes of 1983) in order to be consistent with other code sections and with accepted usage. This change will not be noted for each affected section.]

1797.2. 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.

1797.3. 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 AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.4. 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. [Original Sec. 1797.4 repealed by SB 595 (Ch. 1246) 1983. New Sec. 1797.4 added by AB 1119 (Ch. 260) 1988.]

1797.5. 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. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H&S Code Section 1750.]

1797.6. (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.2d810, 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 AB 3153 (Ch. 1349) 1984.]

1797.7. (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 an 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. [Added by AB 3057 (Ch. 312) 1986. Amended by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.8. (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 SB 1695 (Ch. 678) 2002]

1797.9. (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 SB 1141 (Ch. 288) 2008.]

CHAPTER 2. DEFINITIONS

1797.50. Unless the context otherwise requires, the definitions contained in this chapter shall govern the provisions of this division.

1797.52. "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 SB 1124 (Ch. 1391) 1984.]

1797.53. "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 AB 3269 (Ch. 1390) 1988.]

1797.54. "Authority" means the Emergency Medical Services Authority established by this division.

1797.56. "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 SB 1124 (Ch. 1391) 1984.]

1797.58. "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 SB 1124 (Ch. 1391) 1984.]

1797.59. "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 SB 1124 (Ch. 1391) 1984.]

1797.60. "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.

1797.61. (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 AB 2917 (Ch. 274) 2008.]

1797.62. "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 AB 2917 (Ch. 274) 2008.]

1797.63. "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 AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989, technically, as two identical sections with the same

number. SB 2510 (Ch. 216) 1990, repealed the duplicate as part of a general code cleanup.]

1797.64. "Commission" means the Commission on Emergency Medical Services created pursuant to the provisions of Section 1799.

1797.66. "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.

1797.665. [Added by SB 595 (Ch. 1246) 1983. Repealed by AB 3269 (Ch. 1390) 1988.]

1797.67. "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 SB 595 (Ch. 1246) 1983.]

1797.68. "Director" means the Director of the Emergency Medical Services Authority.

1797.70. "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.

1797.72. "Emergency medical services" means the services utilized in responding to a medical emergency.

1797.74. "Emergency medical services area" or "EMS area" means the geographical area within the jurisdiction of the designated local EMS agency. [Amended by SB 1124 (Ch. 1391) 1984.]

1797.76. "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.

1797.78. "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.

1797.80. "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.

1797.82. "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 SB 997 (Ch. 275) 2008.]

1797.84. "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 SB 595 (Ch. 1246) 1983.]

1797.85. "Exclusive operating area" means an EMS area or sub-area 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 AB 3153 (Ch. 1349) 1984.]

1797.86. "Health systems agency" means a health systems agency as defined in subsection (a) of Section 300(1) 1 of Title 42 of the United States Code.

1797.88. "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 SB 1791 (Ch. 1162) 1986.]

1797.90. "Medical control" means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798).

1797.92. "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.

1797.94. "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).

1797.97. "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. [Added by SB 1124 (Ch. 1391) 1984. Amended by AB 580 (Ch. 972) 1987.]

CHAPTER 2.5 MADDY EMERGENCY MEDICAL SERVICES FUND [Added by SB 12 (Ch. 1240) 1987.]

1797.98a. (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 only until January 1, 2014, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2014, deletes or extends that date.

(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 only until January 1, 2014, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2014, deletes or extends that date. [Amended by SB 612 (Ch. 945) 1988; SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; SB 1683 (Ch. 1143) 1994; AB 2021 (Ch. 58) 1998; SB 476 (Ch. 707) 2003; SB 941 (Ch. 671) 2005, and SB 1773 (Ch. 841) 2006; SB 1236 (Ch. 60) 2008; AB 2702 (Ch. 288) 2008; and by AB 1475 (Ch. 537) 2009.]

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the 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 required 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 SB 623 (Ch. 679) 1999; SB 476 (Ch. 707) 2003; and AB 1059 (Ch. 403) 2011.]

1797.98c. (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 SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; AB 1833 (Ch. 430) 2002; SB 476 (Ch. 707) 2003; and SB 941 (Ch. 671) 2005.]

1797.98d. [Repealed by AB 1257 (Ch. 237) 1989.]

1797.98e. 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.

SEC. 3. Section 16953 of the Welfare and Institutions Code is amended to read:

16953. (a) For purposes of this chapter "emergency services" means physician services in one of the following:

(1) A general acute care hospital which provides basic or comprehensive emergency services for emergency medical conditions.

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

(3) Beginning in the 1991-92 fiscal year and each fiscal year thereafter, in a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services, for emergency medical conditions.

(4) A standby emergency room in a hospital specified in Section 124840 of the Health and Safety Code, for emergency medical conditions.

(5) A standby emergency room in a hospital in existence on January 1, 2007, 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).

(b) For purposes of this chapter, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient's health in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction to any bodily organ or part.

(c) It is the intent of this section to allow reimbursement for all inpatient and outpatient services which are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider. [Amended by SB 2098 (Ch. 1171) 1990; SB 946 (Ch. 1169) 1991; SB 1497 (Ch. 1023) 1996; AB 1833 (Ch. 430) 2002; SB 476 (Ch. 707) 2003; SB 635 (Ch. 524) 2004; SB 941 (Ch. 671) 2005; and AB 2702 (Ch. 288) 2008.] [Section 1797.98e of the Health and Safety Code, as added by Section 3 of Chapter 524 of the Statutes of 2004, was repealed by SB 941 (Ch. 671) of 2005.]

1797.98f. 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. [Added by SB 2098 (Ch. 1171) 1990. Amended by SB 277 (Ch. 1016) 1998.]

1797.98g. 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 SB 946 (Ch. 1169) 1991.]

1797.98h. [Automatically repealed on January 1, 2000 as stated in SB 1683 (Ch. 1143) 1994.]

CHAPTER 3. STATE ADMINISTRATION

Article 1. The Emergency Medical Services Authority

1797.100. There is in the state government in the Health and Welfare Agency, the Emergency Medical Services Authority. [Name amended by SB 595 (Ch. 1246) 1983.]

1797.101. 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 SB 898 (Ch. 1074) 1981; AB 2917 (Ch. 274) 2008.]

1797.102. 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.

1797.103. 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.

1797.104. The authority shall provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems.

1797.105. (a) The authority shall receive plans for the implementation of emergency medical services and trauma care systems from 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 AB 1235 (Ch. 1735) 1984.]

1797.106. (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 dispatch-

ing 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 SB 1124 (Ch. 1391) 1984.]

1797.107. 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.

1797.108. Subject to the availability of funds appropriated therefore, 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 multi-county 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 multi-county 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 SB 1157 (Ch. 191) 1983.]

1797.109. (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. [Added by SB 898 (Ch. 1074) 1981; amended by AB 3355 (Ch. 427) 1992; and amended by AB 2469 (Ch. 157) 2000.]

1797.110. 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 multi-county 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 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 advance payment 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 multi-county 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 SB 1157 (Ch. 191) 1983.]

1797.111. 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 SB 595 (Ch. 1246) 1983.]

1797.112. (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).

[Added by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989; technically, as two identical sections with the same number. SB 2510 (Ch. 216) 1990, repealed the duplicate as part of a general code cleanup. Amended by SB 463 (Ch. 100) 1993 which provided authority from July 13, 1993 through December 31, 1993 for EMSA to temporarily certify EMT-Ps. AB 1980 (Ch. 997) 1993, extended the authority to certify EMT-Ps through December 31, 1993.

Note that AB 1980 (Ch. 997) 1993, also amends this section back to its pre July 1993 language effective January 1, 1995. Amended by AB 3123 (Ch. 709) 1994 to remove continuous appropriation, establish a trust and authority to maintain a reserve; amended by AB 2877 (Ch. 93) 2000 to reduce the reserve to five percent.]

1797.113. 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 such investments or deposits shall accrue to the Emergency Medical Services Training Program Approval Fund.

[Added by AB 243 (Ch. 246) 1994 to correspond with Health & Safety Code Section 1596.866. Amended by SB 1524 (Ch. 666) 1998.]

1797.114. 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 AB 984 (Ch. 979) 1998.]

1797.115. (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. [Added by SB 1629 (Ch. 1050) 2002; amended by SB 600 (Ch. 62) 2003.]

1797.116. (a) The authority shall establish additional training standards that include the criteria for the curriculum content recommended by the Emergency Response Training 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.

(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. [Added by SB 1629 (Ch. 1050) 2002.]

1797.117. (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 AB 2917 (Ch. 274) 2008.]

1797.118. (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 AB 2917 (Ch. 274) 2008.]

Article 2. Recodifications

1797.120. [Repealed by AB 1123 (Ch. 1058); 1987.]

1797.121. 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.

Article 3. Coordination With Other State Agencies

1797.130. The director shall chair an Interdepartmental Committee on Emergency Medical Services established pursuant to Section 1797.132.

1797.131. [Repealed by AB 1153 (Ch. 477) 1987.]

1797.132. 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 Health Services, 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 SB 595 (Ch. 1246) 1983; AB 184 (Ch. 886) 1989; and SB 3355 (Ch. 427) 1992.]

1797.133. The director may appoint select resource committees of experts and may contract with special medical consultants for assistance in the implementation of this division.

Article 4. Medical Disasters

1797.150. 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.

1797.151. 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.

1797.152. (a) The director, and the Director of Health Services 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 Health Services, 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. [Added by AB 1390 (Ch. 185) 1989.]

1797.153. (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 (OES), 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 diseases.

(d) In the event of a local, state, or federal declaration of emergency, the MHOAC shall assist the OES 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 OES, the regional office of the OES, 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. [Added by AB 586 (Ch. 703) 2006. Amended by SB 1039 (Ch. 483) 2007.]

Article 5. Personnel

1797.160. 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. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1760.5.]

1797.170. (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) 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. 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. [Amended by SB 1124 (Ch. 1391) 1984; SB 1067 (Ch. 1111) 1989; and AB 2917 (Ch. 274) 2008.]

1797.171. (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) 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.

(c) 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 AB 1123 (Ch. 1058) 1987; SB 1067 (Ch. 1111) 1989; and AB 3123 (Ch. 709) 1994.]

1797.172. (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) 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 (d) of Section 1798.200. Each application for licensure or licensure renewal shall require the applicant's 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.

(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 Procedures 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 SB 595 (Ch. 1246) 1983; AB 1123 (Ch. 1058) 1987; SB 1067 (Ch. 1111), AB 1558 (Ch. 1134), AB 2159 (Ch. 1362) 1989; SB 463 (Ch. 100) 1993; and AB 1980 (Ch. 997) 1993. Note that AB 1980 (Ch. 997) 1993, did not take effect until January 1, 1995. Provisions of SB 1067 not given effect because of later signing of AB 1558 and AB 2159. AB 1558 and AB 2159 amended this section in an identical manner. Amended by AB 3123 (Ch. 709) 1994 to establish EMT-P licensure program under EMS Authority, places a maximum limit on fees except for special services; Amended by AB 1215 (Ch. 549) 1999 and Amended by AB 2917 (Ch. 274) 2008.]

1797.173. 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 SB 595 (Ch. 1246) 1983.]

1797.174. 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 for 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. [Repealed by AB 1123 (Ch. 1058) 1987. Added by AB 1980 (Ch. 997) 1993.]

1797.175. 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 SB 1552 (Ch. 1213) 1988; and AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.176. The authority shall establish the minimum standards for the policies and procedures necessary for medical control of the EMS system. [Amended by AB 3269 (Ch. 1390) 1988.]

1797.177. 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.

1797.178. 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.

1797.179. 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 SB 735 (Ch. 1322) 1980.]

1797.180. 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. [Relocated and amended by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1484.3.]

1797.181. 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. [Relocated and by SB 595 (Ch. 1246); 1983. Formerly H & S Code Section 1481.5.]

1797.182. 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. [Relocated and updated by SB 595 (Ch. 1246) 1983. Formerly H&S Code Section 217.]

1797.183. 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 SB 595 (Ch. 1246) 1983.]

1797.184. 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 AB 2917 (Ch. 274) 2008.]

1797.185. (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 care personnel to include criteria developed pursuant to subdivision (c) of Section 1797.7 and subdivision (b) of Section 1797.172 to ensure 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. [Added by AB 3057 (Ch. 312) 1986. Amended by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989. Provisions from AB 2159 given effect over those from AB 1558.]

1797.186. 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 (com-

mencing 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 AB 140 (Ch. 1543) 1985.]

1797.187. 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. [This section was added to Division 2.5 in error by AB 2376 (Ch. 947) 1988. Amended by SB 1880 (Ch. 606) 1998.]

1797.188. (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 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 Administrative Code, 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.

(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 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, shall be notified that they have been exposed to the disease and should contact the county health officer if all the following are satisfied:

(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 health facility 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 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.

(2) The health facility 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, which 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 health facility or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

In the event of the demise of the person afflicted with the reportable 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 disease prior to the release of the decedent from the health facility to the funeral director.

Notwithstanding Section 1798.206, violation of this section is not a misdemeanor. [Added by SB 1518 (Ch. 999) 1986. Amended by AB 1119 (Ch. 260) 1988; and AB 2056 (Ch. 102) 2006.]

1797.189. (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 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. [Added by AB 2356 (Ch. 992) 1987. Amended by AB 1119 (Ch. 260) 1988; and SB 1497 (Ch. 1023) 1996.]

1797.190. The authority may establish minimum standards for the training and use of automatic external defibrillators. [Added by AB 3037 (Ch. 217) 1988. Amended by AB 2041 (Ch. 718) 2002.]

1797.191. (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.

[Added by AB 243 (Ch. 246) 1994 to establish standards for training required in Health and Safety Code 1596.866. Urgency clause, effective July 21, 1994. Amended by SB 1524 (Ch. 666) 1998. Urgency clause, effective September 20, 1998; Amended by SB 966 (Ch. 83).]

1797.192. 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 AB 1558 (Ch. 1134), AB 2159 (Ch. 1362) 1989; technically, as two identical sections with the same number. SB 1510 (Ch. 216) 1990; repealed the duplicate as part of a general code cleanup.]

1797.193. (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 SB 1067 (Ch. 1111) 1989 as Section 1797.192. Renumbered as 1797.193 by SB 2510 (Ch. 216) 1990.]

1797.194. 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, Section 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 AB 3123 (Ch. 709) 1994.]

1797.195. (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 completes 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 post program 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, or 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. * Due to the unique circumstances concerning the very limited resources of small and rural hospitals and the need for temporary personnel in emergency departments of those hospitals, it is necessary to permit the use of EMS personnel to meet this need, and the Legislature finds and declares that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution. [Added by SB 422 (Ch. 239) 1995. *Intent language to clarify need and limited uses for EMS personnel in small and rural hospitals was not included in code.]

1797.196. There are two separate versions of this code section. The first one is effective January 1, 2007, and the second one, which is italicized, takes effect January 1, 2013.

1797.196. (a) For purposes of this section, "AED" or "defibrillator" means an automated or automatic external defibrillator.

(b) In order to ensure public safety, any person or entity that acquires an AED is not liable for any civil damages resulting from any acts or omissions in the rendering of the emergency care under subdivision (b) of Section 1714.21 of the Civil Code, if that person or entity does all of the following:

(1) Complies with all regulations governing the placement of an AED.

(2) Ensures all of the following:

(A) That the AED is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, the American Heart Association, and the American Red Cross, and according to any applicable rules and regulations set forth by the governmental authority under the federal Food and Drug Administration and any other applicable state and federal authority.

(B) That the AED is checked for readiness after each use and at least once every 30 days if the AED has not been used in the preceding 30 days. Records of these checks shall be maintained.

(C) That any person who renders emergency care or treatment on a person in cardiac arrest by using an AED activates the emergency medical services system as soon as possible, and reports any use of the AED to the licensed physician and to the local EMS agency.

(D) For every AED unit acquired up to five units, no less than one employee per AED unit shall complete a training course in cardiopulmonary resuscitation and AED use that complies with the regulations adopted by the Emergency Medical Services Authority and the standards of the American Heart Association or the American Red Cross. After the first five AED units are acquired, for each additional five AED units acquired, one employee shall be trained beginning with the first AED unit acquired. Acquirers of AED units shall have trained employees who should be available to respond to an emergency that may involve the use of an AED unit during normal operating hours.

(E) That there is a written plan that describes the procedures to be followed in the event of an emergency that may involve the use of an AED, to ensure compliance with the requirements of this section. The written plan shall include, but not be limited to, immediate notification of 911 and trained office personnel at the start of AED procedures.

(3) When an AED is placed in a building, building owners shall ensure that tenants annually receive a brochure, approved as to content and style by the American Heart Association or American Red

Cross, which describes the proper use of an AED, and also ensure that similar information is posted next to any installed AED.

(4) When an AED is placed in a building, no less than once a year, building owners shall notify their tenants as to the location of AED units in the building.

(5) 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 a brochure, approved as to contents and style by the American Heart Association or the American Red Cross, that describes the proper use of an AED. The principal shall also ensure that similar information is 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. The principal shall designate the trained employees who shall be available to respond to an emergency that may involve the use of an AED during normal operating hours. As used in this paragraph, "normal operating hours" means during the hours of classroom instruction and any school-sponsored activity occurring on school grounds.

(c) Any person or entity that supplies an AED shall do all of the following:

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

(2) Provide to the acquirer of the AED all information governing the use, installation, operation, training, and maintenance of the AED.

(d) A violation of this provision is not subject to penalties pursuant to Section 1798.206.

(e) The protections specified in this section do not apply in the case of personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of the person who renders emergency care or treatment by the use of an AED.

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

(g) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

[Added by SB 911 (Ch. 163) 1999. Amended and repealed by AB 2041 (Ch. 718) 2002. Amended, by SB 600 (Ch. 62) 2003; AB 254 (Ch. 111) 2005, and AB 2083 (Ch. 85) 2006.]

1797.196. (Effective January 1, 2013.)

1797.196. (a) For purposes of this section, "AED" or "defibrillator" means an automated or automatic external defibrillator.

(b) In order to ensure public safety, any person who acquires an AED shall do all of the following:

(1) Comply with all regulations governing the training, use, and placement of an AED.

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

(3) Ensure all of the following:

(A) That expected AED users complete a training course in cardiopulmonary resuscitation and AED use that complies with regulations adopted by the Emergency Medical Services (EMS) Authority and the standards of the American Heart Association or the American Red Cross.

(B) That the defibrillator is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, the American Heart Association, and the American Red Cross, and according to any applicable rules and regulations set forth by the governmental authority under the federal Food and Drug Administration and any other applicable state and federal authority.

(C) That the AED is checked for readiness after each use and at least once every 30 days if the AED has not been used in the preceding 30 days. Records of these periodic checks shall be maintained.

(D) That any person who renders emergency care or treatment on a person in cardiac arrest by using an AED activates the emergency medical services system as soon as possible, and reports any use of the AED to the licensed physician and to the local EMS agency.

(E) That there is involvement of a licensed physician in developing a program to ensure compliance with regulations and requirements for training, notification, and maintenance.

(c) A violation of this provision is not subject to penalties pursuant to Section 1798.206.

(d) This section shall become operative on January 1, 2013.

[Added by SB 911 (Ch. 163) 1999. Amended and repealed by AB 2041 (Ch. 718) 2002. Amended, by SB 600 (Ch. 62) 2003; AB 254 (Ch. 111) 2005, and AB 2083 (Ch. 85) 2006.]

1797.197. The authority shall establish training and standards for all prehospital emergency care personnel, as defined pursuant to paragraph (2) of subdivision (a) of Section 1797.189, regarding the characteristics and method of assessment and treatment of anaphylactic reactions and the use epinephrine. The authority shall promulgate regulations regarding these matters for use by all prehospital emergency care personnel. [Added by AB 559 (Ch. 458) 2001.]

1797.198. 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. [Added by AB 430 (Ch. 171) 2001. Amended by AB 131 (Ch. 80) 2005.]

1797.199. (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. [Added by AB 430 (Ch. 171) 2001. Amended by AB 131 (Ch. 80) 2005]

Uncodified Language from AB 430 (Ch. 171), 2001 added in Section 50.5

Local emergency medical services agencies that do not have existing trauma care system plans may submit proposals for funding their preparation of a trauma care system plan to the Emergency Medical Services Authority by January 15, 2002. Upon the receipt of all local EMS agency proposals, the authority shall establish an appropriate funding level for a one-time payment to fund preparation and implementation of their trauma care system plans, contingent upon funding for this purpose in the Budget Act or another statute.

The authority may retain from any state appropriation for the purpose of this section an amount sufficient to implement this section, up to one hundred seven thousand dollars (\$107,000) subject to approval in the budget process.

Uncodified Language Contained in AB 1988 (Ch. 333), 2002

SECTION 1. (a) Access to trauma and emergency medical services has been greatly reduced in recent years due to emergency department closures and a great increase in uninsured patients without access to primary care. As a result, ambulance diversion and waiting time has dramatically increased.

(b) Eighty percent of licensed emergency departments reported monetary losses during the 1999-2000 fiscal year.

(c) Hospitals and physicians provided over four hundred fifty million dollars (\$450,000,000) in uncompensated emergency medical services last year.

(d) California lacks a statewide trauma and emergency medical services plan.

SECTION 2. (a) The Emergency Medical Services Authority (EMSA) shall convene a task force of interested parties to study the delivery and provision of emergency medical services in California.

(b) The task force shall do all of the following:

(1) (A) Develop a plan to ensure that all Californians are served by appropriate coverage areas for emergency and trauma services and that sufficient numbers of emergency departments and trauma centers exist to serve each area's population. If the task force determines that some areas lack coverage, it shall develop recommendations to extend coverage to those areas.

(B) The plan developed pursuant to subparagraph (A) shall include specific consideration of, and recommendations developed by the task force for, ensuring access to emergency and trauma services for uninsured patients.

(2) Review emergency department and trauma center standards to ensure appropriate levels of care that maximize state resources and ensure coverage for all Californians including, but not limited to, the State Department of Health Services emergency department regulations and EMSA trauma center regulations.

(3) Review the roles, responsibilities, and interactions of the EMSA and the State Department of Health Services related to emergency medical service oversight and administration.

(4) Submit a report that includes the plan described in paragraph (1) and the recommendations of the task force with regard to paragraphs (1), (2), and (3) to the Legislature within two years from the date that funding and positions have been provided for the project.

(c) The task force shall be comprised of all the following members:

(1) Three members appointed by the Senate Committee on Rules, at least one of whom is a member of the Senate, and at least one of whom is a public member.

(2) Three members appointed by the Speaker of the Assembly, at least one of whom is a member of the Assembly, and at least one of whom is a public member.

(3) One representative appointed by EMSA from a list provided by the California Medical Association.

(4) One representative appointed by EMSA from a list provided by the California Healthcare Association.

(5) One representative appointed by EMSA from a list provided by the California Chapter of the American College of Emergency Physicians.

(6) One representative appointed by EMSA from a list provided by the California Professional Firefighters.

(7) One representative appointed by EMSA from a list provided by the Emergency Medical Services Administrators Association of California.

(8) One representative appointed by EMSA from a list provided by the California Nurses Association.

(9) One representative appointed by EMSA from a list provided by the California Ambulance Association.

(10) One representative appointed by EMSA from a list provided by consumer organizations.

(11) One representative appointed by EMSA from a list provided by the Rural Healthcare Center.

(12) One representative appointed by EMSA from a list provided by the California Children's Hospital Association.

(13) One representative appointed by EMSA from a list provided by the Children's Specialty Care Coalition.

(14) One representative appointed by EMSA from a list provided by the California Association of Public Hospitals and Health Systems.

(15) One representative of organized labor, appointed by EMSA.

(16) One representative appointed by EMSA from a list provided by the California Emergency Nurses Association.

(17) One representative appointed by EMSA from a list provided by the California State Firefighters' Association.

(18) One representative from the State Department of Health Services appointed by the director of the department.

(19) One representative appointed by EMSA from a list provided by the California Fire Chiefs Association.

(20) One representative appointed by EMSA from a list provided by the California Dental Association.

(d) The task force shall terminate after issuing the report required by subdivision (b).

(e) This section shall be implemented only to the extent that the authority obtains private funding needed to support and monitor the work of the task force for the purposes of this section.

CHAPTER 4. LOCAL ADMINISTRATION

Article 1. Local EMS Agency

1797.200. 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.

1797.201. 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.

1797.202. (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 AB 2329 (Ch. 567) 1987; and AB 2159 (Ch. 1362) 1989.]

1797.204. 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.

1797.206. 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 SB 595 (Ch. 1246) 1983.]

1797.208. 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 SB 595 (Ch. 1246) 1983.]

1797.210. (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 SB 595 (Ch. 1246) 1983; by AB 3269 (Ch. 1390) 1988; by AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989; and SB 627 (Ch. 64) 1993.]

1797.211. 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 AB 2917 (Ch. 274) 2008.]

1797.212. 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 SB 595 (Ch. 1246) 1983; and SB 627 (Ch. 64) 1993.]

1797.213. (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. [Relocated and amended by SB 595 (Ch. 1246) 1983. Formerly H&S Code 1481.3. Amended by SB 1067 (Ch. 1111) 1989.]

1797.214. 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 SB 595 (Ch. 1246) 1983; and AB 1558 (Ch. 1134) and AB 2159 (Ch. 1362) 1989.]

1797.215. 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 SB 916 (Ch. 774) 1983.]

1797.216. 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 SB 595 (Ch. 1246) 1983 and amended by AB 2917 (Ch. 274) 2008.]

1797.217. (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 reimburse-

ment 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 time frame.

(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 Procedures 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 services 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. [Added by AB 2917 (Ch. 274) 2008.]

1797.218. 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 SB 595 (Ch. 1246) 1983.]

1797.219. 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 AB 2917 (Ch. 274) 2008.]

1797.220. 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 AB 3269 (Ch. 1390) 1988.]

1797.221. 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. [Added by AB 3119 (Ch. 299) 1988. Provisions became effective July 8, 1988. Amended by SB 1497 (Ch. 1023) 1996.]

1797.222. 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 Services 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 SB 358 (Ch. 1237) 1983.]

1797.224. 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 AB 3153 (Ch. 1349) 1984.]

1797.226. 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 service.

(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 AB 3434 (Ch. 965) 1986.]

Article 2. Local Emergency Medical Services Planning

1797.250. 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.

1797.251. [Added by SB 534 (Ch. 1067) 1983. Repealed by AB 1235 (Ch. 1735) 1984.]

1797.252. The local EMS agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop the emergency medical services system.

1797.254. 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 AB 1119 (Ch. 260) and AB 3483 (Ch. 197) 1996.]

1797.256. 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.

1797.257. 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 AB 1235 (Ch. 1735) 1984.]

1797.258. 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 AB 1235 (Ch. 1735) 1984.]

Article 3. Emergency Medical Care Committee

[Article 3 was relocated and amended by SB 595 (Ch. 1246) 1983. Article 3 sections were formerly located in Article 1 of Chapter 9 of Division 2 of H & S Code.]

1797.270. 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. [Formerly H & S Code Section 1751. Amended by SB 627 (Ch. 64) 1993.]

1797.272. 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 committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee. [Formerly H & S Code Section 1752.]

1797.274. 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. [Formerly H & S Code Section 1755.]

1797.276. 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. [Formerly H & S Code Section 1756. Amended by AB 1119 (Ch. 260) 1988.]

CHAPTER 5. MEDICAL CONTROL

1798. (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 SB 1124 (Ch. 1391) 1984. Subsection (c) added by AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987. Paragraphs (1), (2), and (3) under subsection (a) deleted by AB 3269 (Ch. 1390) 1988.]

1798.2. 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 SB 1124 (Ch. 1391) 1984; and AB 3269 (Ch. 1390) 1988.]

1798.3. 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 AB 3269 (Ch. 1390) 1988.]

1798.4. [Repealed by AB 3269 (Ch. 1390) 1988.]

1798.6. (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. [Relocated by AB 334 (Ch. 206) 1983. Formerly H & S Code Section 1482.5.]

CHAPTER 6. FACILITIES

Article 1. Base Hospitals

[Heading amended by SB 1124 (Ch. 1391); 1984.]

1798.100. 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 medi-

cal 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 SB 1124 (Ch. 1391) 1984; and AB 3269 (Ch. 1390) 1988.]

1798.101. (a) In rural areas, as determined by the authority, where the use of a base hospital having a basic emergency medical services 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 hospital 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 non-permit 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. [Added by SB 1791 (Ch. 1162) 1986. Amended by AB 3269 (Ch. 1390) 1988.]

1798.102. 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 SB 1124 (Ch. 1391) 1984.]

1798.104. 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 1124 (Ch. 1391) 1984.]

1798.105. The medical director of the local EMS agency may approve an alternative base station, as defined in Section 1797.53, 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 AB 3269 (Ch. 1390) 1988.]

Article 2. Critical Care

1798.150. The authority may establish, in cooperation with affected medical organizations, guidelines for hospital facilities according to critical care capabilities.

Article 2.5 Regional Trauma Systems

[Article 2.5 was added by SB 534 (Ch. 1067) 1983.]

1798.160. Except where the context otherwise requires, the following definitions in this section govern 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 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.

(c) "Trauma care system" means an arrangement under which trauma cases are transported to, and treated by, the appropriate trauma facility. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.161. (a) The authority shall submit draft regulations specifying minimum standards for the implementation of regional trauma 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 non-trauma cases.

(3) The number 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 with 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 the requirement would not be in the best interests of the persons served within the affected local EMS area. [Amended by AB 1235 (Ch. 1735) 1984.]

1798.162. (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 AB 1235 (Ch. 1735) 1984.]

1798.163. 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 AB 1235 (Ch. 1735) 1984.]

1798.164. (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 AB 1235 (Ch. 1735) 1984, and AB 2934 (Ch. 768) 1988.]

1798.165. (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 AB 1235 (Ch. 1735) 1984; and SB 702 (Ch. 570) 1985.]

1798.166. 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.

1798.167. 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.

1798.168. Nothing in this article shall be construed as changing the boundaries of any local emergency medical services agency in existence on January 1, 1984.

1798.169. 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.

Article 3. Transfer Agreements

1798.170. 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 AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987.]

1798.172. (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 AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987; and AB 3217 (Ch. 888) 1988.]

Article 3.5. Use of "Emergency"

1798.175. (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 specialty physicians who are available for referral, consultation, and specialty services is maintained and available.

(G) Policies and procedures define the scope and conduct of treatment provided, including procedures to manage 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) Provide 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 follow-up 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 SB 2162 (Ch. 1377) 1986.]

Article 4. Poison Control Centers

[Article 4. was added by SB 1124 (Ch. 1391); 1984.]

1798.180. (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 AB 580 (Ch. 972) 1987.]

1798.181. 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 AB 861 (Ch. 1366) 1992.]

1798.182. 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 SB 66 (Ch. 236) 1993.]

1798.183. 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 SB 66 (Ch. 236) 1993.]

CHAPTER 7. PENALTIES

1798.200. (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. [Amended by SB 1330 (Ch. 328) Statutes of 2010.] 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 a 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 Sections 56) of Division 1 of the Civil Code. [Amended by SB 1330 (Ch. 328) Statutes of 2010.]

(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).

SEC. 16. This act shall become operative only if Senate Bill 997 of the 2007-08 Regular Session is enacted and becomes effective on or before January 1, 2009.

SEC. 17. This act shall not be construed to limit or otherwise impair the medical control of the medical director of a local EMS agency granted pursuant to Section 1798 of the Health and Safety Code.

SEC. 18. The Legislature finds and declares that Section 15 of this act, which amends Section 1798.200 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest: emergency medical technicians serve a critical role in the state's emergency response network. The public safety is best protected when appropriate and consistent disciplinary standards are applied. When accusations have been made against a certified EMT-I or EMT-II, the individual

must be given the investigatory and due process protection that is offered to other licensed and certified professionals such as paramedics, physicians, nurses, and other health care providers. The public shall have certification, licensure, disciplinary and other information readily available with the implementation of the EMT-I, EMT-II, and EMT-P registry as created by Section 1797.117 of the Health and Safety Code.

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution. However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. [Amended by AB 1853 (Ch. 1156) 1983; AB 3269 (Ch. 1390) 1988; and SB 463 (Ch. 100) 1993. AB 1980 (Ch. 997) 1993; amended this section as well but would not take effect until January 1, 1995. Amended by AB 3123 (Ch. 709) 1994; AB 1215 (Ch. 549) 1999; AB 2917 (Ch. 274) 2008; and by AB 1164 (Ch. 140) 2009.]

1798.201. (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 AB 3123 (Ch. 709) 1994.]

1798.202. (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 therefore. 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. [Amended by SB 595 (Ch. 1246) 1983. Repealed by AB 3123 (Ch.

709) 1994 and language moved to new Section 1798.209. Added new Section 1798.202 by AB 3123 (Ch. 709) 1994.]

1798.204. 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 AB 1853 (Ch. 1156) 1983.]

1798.205. 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 Section 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 AB 214 (Ch. 1225). Substantially duplicate section was added by SB 12 (Ch. 1240) 1987 and was repealed by AB 1910 (Ch. 1360) 1990, as part of a general code cleanup.]

1798.206. 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 AB 214 (Ch. 1225) 1987.]

1798.207. (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 AB 3138 (Ch. 215) 1992.]

1798.208. 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 AB 214 (Ch. 1225) and SB 12 (Ch. 1240) 1987.]

1798.209. 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 AB 3123 (Ch. 709) 1994; language was formerly in Section 1798.202.]

1798.210. (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 AB 1655 (Ch. 513) 2004.]

1798.211. 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 AB 1655 (Ch. 513) 2004.]

CHAPTER 8. COMMISSION ON EMERGENCY MEDICAL SERVICES

Article 1. The Commission

1799. The Commission on Emergency Medical Services is hereby created in the Health and Human Services Agency. [Amended by SB 997 (Ch. 275) 2008.]

1799.2. 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 knowledge-

able 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.

SEC. 5. This act shall become operative only if Assembly Bill 2917 of the 2007-08 Regular Session is enacted and becomes effective on or before January 1, 2009. [Amended by SB 1124 (Ch. 1391) 1984;

AB 99 (Ch. 42) 1985; AB 1017 (Ch. 1102) 1987; SB 217 (Ch. 220) 1989; and by SB 997 (Ch. 275) 2008.]

1799.3. 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 AB 99 (Ch. 42) 1985.]

1799.4. (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 sub-divisions (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 sub-divisions (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 sub-divisions (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 AB 2840 (Ch. 1726) 1984; AB 99 (Ch. 42) 1985; and AB 1017 (Ch. 1102) 1987.]

1799.6. 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.

1799.8. 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.

Article 2. Duties of the Commission

1799.50. The commission shall review and approve regulations, standards, and guidelines to be developed by the authority for implementation of this division.

1799.51. The commission shall advise the authority on the development of an emergency medical data collection system.

1799.52. The commission shall advise the director concerning the assessment of emergency facilities and services.

1799.53. The commission shall advise the director with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system.

1799.54. 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 SB 1497 (Ch. 1023) 1996.]

1799.55. 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.

1799.56. 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.

CHAPTER 9. LIABILITY LIMITATION

1799.100. 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.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution. [Amended by SB 595 (Ch. 1246) 1983; AB 2796 (Ch. 363) 2008.]

1799.102. (a) No person who in good faith, and not for compensation, renders emergency 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.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

Because the state has long encouraged Californians to assist others facing danger in an emergency, and the ability to do so without fear of potential suit has been thrown into question by the recent California Supreme Court decision of *Van Horn v. Watson*, (2008) 45 Cal.4th 322, decided on December 18, 2008, this legislation clarifying the intent of the Legislature needs to go into effect immediately so as to avoid any confusion in this important area of the law. [Amended by AB 83 (Ch. 77) 2009.]

1799.104. (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.

1799.105. (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 omission 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 AB 4587 (Ch. 1192) 1988.]

1799.106. In addition to the provisions of Section 1799.104 of this code and of 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, or EMT-P, a firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, or EMT-P who renders emergency medical services at the scene of an emergency 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, or EMT-P shall not be liable for civil damages if the firefighter, police officer or other law enforcement officer, EMT-I, EMT-II, or EMT-P is not liable. [Amended by SB 595 (Ch. 1246) 1983.]

1799.107. (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 such 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. [Added by SB 1120 (Ch. 275) 1984. Amended by AB 2173 (Ch. 617) 1998.]

1799.108. 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.

1799.110. (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 cov-

erage 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 experiences" 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 occurred. [Relocated by SB 595 (Ch. 1246) 1983. Formerly H & S Code Section 1768.]

1799.111. (a) A licensed general acute care hospital, as defined by 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 who is subject to detention pursuant to Section 5150 of the Welfare and Institutions Code, 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 of food, clothing, or shelter.

(2) The hospital staff, treating physician and surgeon, or appropriate licensed medical health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(5) If the person is detained beyond eight hours, but less than 24 hours, all of the following additional conditions shall be met:

(A) A transfer for appropriate mental health treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(B) 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 medical disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(b) In addition to the conditions set forth in subdivision (a), a licensed general acute care hospital, as defined by 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 Section 5150 of the Welfare and Institutions Code 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 the 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 the 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.

(c) 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 re-

straint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(d) 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.

(e) 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.

(f) Nothing in this section is intended to expand the scope of licensure of clinical psychologists. [Added by SB 2003 (Ch. 716) 1996. Amended by SB 1111 (Ch. 547) 1997, and by SB 916 (Ch. 608) 2007.]

1799.112. (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 (j) 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 AB 1655 (Ch. 513) 2004.]

CHAPTER 11. EMERGENCY AND CRITICAL CARE SERVICES FOR CHILDREN

[Chapter 11 added by SB 1170 (Ch. 1206) 1989.]

1799.200. (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 services 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.

1799.201. The contractor shall submit the results of the study to the Legislature and the Governor not later than January 1, 1991.

[*These sections were numbered 1199.200 and 1199.201 in SB 1170, but were apparently intended to be numbered 1799.200 and 1799.201, respectively, as indicated by the placement of Chapter 11 in Division 2.5.]

CHAPTER 12. EMERGENCY MEDICAL SERVICES FOR CHILDREN [Chapter 12 added by AB 3483 (Ch. 197) 1996.]

1799.202. This chapter shall be known and may be cited as the California Emergency Medical Services for Children Act of 1996. [Added by AB 3483 (Ch. 197) 1996.]

1799.204. (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. [Added by AB 3483 (Ch. 197) 1996 and amended by AB 430 (Ch. 171) 2001.]

1799.205. 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 AB 3483 (Ch. 197) 1996.]

1799.207. The authority may solicit and accept grant funding from public and private sources to supplement state funds. [Added by AB 3483 (Ch. 197) 1996.]

California EMS Awards

Medal of Valor

EMS Cross

Distinguished Service Medal

Meritorious Service Medal

Lifesaving Medal

Community Service Award

Inter-service EMS Recognition Medal

Civilian Award for EMS

EMT of the Year

EMS Educator of the Year

EMS Medical Director of the Year

EMS Administrator of the Year

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





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