References: National and Illinois EMS Scopes of Practice Models 2021; Illinois EMS Act, EMS Rules Section 515.550 Amended at 43 Ill. Reg. 4145, Emergency Rules; current Region IX and NWC EMSS edition SOPs; current NWC EMSS Procedure Manual

I. POLICY

A. Assessments and initial interventions shall be performed on all pts at the point of contact unless it is unsafe, as circumstances allow, and the patient consents. Monitoring & intervention equipment/devices for EMS personnel to function to their level of licensure, in accordance with the level of service at which the EMS vehicle is operating must be brought to the patient so complete information is obtained that will allow treatment at the appropriate level of care without delay. Perform resuscitative interventions during the primary assessment as impairments are found.

B. Care should progress from EMR to ALS services as required by patient condition, practitioner scope of practice, level of service, and System policy/procedure.

C. Appropriate patient disposition shall occur in compliance with System standards of care.

D. If a scene response, a reasonable search must be completed to determine if a patient is present – See policy A-1 (Abandonment) for full definition of a patient.

E. This policy shall be used as a guideline and should be used in conjunction with good common sense, emergency responder judgment, and/or OLMC direction.

II. DEFINITIONS

A. **ADVANCED LIFE SUPPORT (ALS) SERVICES:** *An advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the National EMS Education Standards relating to Advanced Life Support and any modifications to that curriculum or those standards specified in this Part. (Section 3.10(a) of the Act)*

B. **BASIC LIFE SUPPORT (BLS) SERVICES:** *A basic level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes medical monitoring, clinical observation, airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in the National EMS Education Standards relating to Basic Life Support and any modifications to that curriculum or standards specified in this Part. (Section 3.10(c) of the Act)*

C. ***Emergency Medical Responder Services*** *– a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the Emergency Medical Responder (EMR) curriculum of the National EMS Education standards and any modifications to that curriculum (standards) specified in this Part. (Section 3.10(d) of the Act)*

D. ***Pre-Hospital Care Participants*** *– Any EMS Personnel, Ambulance Service Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS Administrative Director, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN, Resource Hospital, Emergency Dispatch Center or physician serving on an ambulance or non-transport vehicle or giving voice orders for an EMS System and who are subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.*

E. ***Paramedic: A*** *person who has successfully completed a course in advanced life support care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)*

F. ***Pre-Hospital Registered Nurse or PHRN*** *– a Registered Professional Nurse, with an unencumbered Registered Nurse license in the state in which he or she practices who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices. Also includes a Pre-Hospital Advanced Practice Registered Nurse (PHAPRN) and Pre-Hospital Physician Assistant or PHPA.*

G. ***Emergency Medical Technician*** *or EMT: A person who has successfully completed a course in basic life support as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by* the *Act and* this Part *and practices within an EMS System.* (Section 3.50(a) of the Act)

H. **Emergency Medical Responder or EMR** *(AKA First Responder): A person who has successfully completed a course of instruction for the Emergency Medical Responder as approved by the Department, who provides Emergency Medical Responder services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the National EMS Educational Standards for Emergency Medical Responders as modified by the Department.*

I. **Police dog (law enforcement animals):** *A* specially trained *dog owned or used by a law enforcement department or agency in the course of the department's or agency's official work, including a search and rescue dog, service dog, accelerant detection canine, or other dog that is in use by a county, municipal or State law enforcement agency or official duties* (Section 3.55(e) of the Act).

J. **Service animals:** Any breed or size of **dog** that is trained to do work or perform a task directly related to a person's disability. They are working animals, not pets.

Service animals are not:

1. Required to be certified or go through a professional training program;
2. Required to wear a vest or other ID that indicates they're a service dog; or
3. Emotional support or comfort dogs, because providing emotional support or comfort is not a task related to a person's disability.

K. An **emotional support animal (ESA)** needs to be prescribed by a licensed mental health professional to a person with a disabling mental illness. A therapist, psychologist, or psychiatrist must determine that the presence of the animal is needed for the mental health of the patient. For example, owning a pet might ease a person's anxiety or give them a focus in life. Any domesticated animal may be considered as an ESA (e.g., cats, dogs, mice, rabbits, birds, hedgehogs, rats, minipigs, ferrets, etc.) and they can be any age. However, an ESA must be able to be manageable in public and must not create a nuisance.

III. SCOPES OF PRACTICE: Licensed EMRs/EMTs/Paramedics/PHRNs

A. *Any person currently licensed as an EMR, EMT, EMT-I, A-EMT, Paramedic,* or PHRN *may only perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in this Part, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System. The Director may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not to exceed 180 days. (Section 3.55(a) of the Act)*

B. *An EMR, EMT, EMT-I, A-EMT, Paramedic* or PHRN *may only practice as an EMR, EMT, EMT-I, A-EMT, Paramedic or PHRN or utilize his or her EMR, EMT, EMT-I, A-EMT, Paramedic* or PHRN *license in pre-hospital or inter-hospital emergency care settings or non-*

emergency medical transport situations, under the written or verbal direction of the EMS MD. For purposes of this Section, a "pre-hospital emergency care setting" may include a location that is not a health care facility, which utilizes EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMR, EMT, EMT-I, A-EMT, Paramedic, or PHRN's *level of care, and the protocols of the EMS System, and shall operate only with the approval and under the direction of the EMS MD. (EMS Rules, 2019)*

C. *This does not prohibit an EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN PHAPRN, or PHPA from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS MD. This also does not prohibit an EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN, PHAPRN, or PHPA from seeking credentials other than his or her EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN, PHAPRN, or PHPA license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer. (Section 3.55(b) of the Act)*

D. **An individual may only perform a skill or role for which that person is:**

EDUCATED (has been trained to perform the skill or role), **AND**
CERTIFIED (has demonstrated competence in the skill or role), **AND**
LICENSED (has legal authority issued by the State to perform the skill or role), **AND**
CREDENTIALED (has been authorized by medical director to perform the skill or role)
(National EMS Scope of Practice Model, 2021).

E. EMRs, EMTs, Paramedics, PHRNs, PHAPRNs, and PHPAs with System privileges in good standing may perform **EMS Services** as defined by The National and Illinois EMS Scopes of Practice Models (2021), IDPH EMS Rules, and the current NWC EMSS SOPs using techniques specified in System standards of practice (Policy and Procedure Manuals).

ALS Drugs/Solutions approved in addition to those listed in the SOPs	Acceptable routes
*Lactated Ringers solution	IV, IO
*D_5W, D5/.45 NS; D5/.9 NS; D5/LR	IV/IO
*Cardizem (diltiazem)	IVP, IO
*Hydromorphone (Dilaudid)	PCA pump
Dopamine (alternate drug)	IVPB
*Furosemide	IVP/ IM/IO
*Heparin on a medication pump	IV pump
Morphine sulfate (alternate)	IVP, IM, IO, PCA pump
*Steroids (Ex: methylprednisolone)	IVPB, nebulized
*Vitamin additives to an IV	Added to IV solution

Medications noted with an * are not included in the SOPs and must be administered per transferring physician's written directions and OLMC authorization.

"Any drug listed in the SOPs and/or above that has a current abbreviation of "IV", "IVP", or "IVPB" may be transported on an IV pump by a system paramedic(s) without the assistance of a RN as long as the paramedic(s) have been trained/competencies on that IV pump"

1. **PMs/PHRNs/PHAPRNs/PHPAs ARE authorized to transport pts with the following:**
   a. Multilumen central line catheters (Hickman, Broviac); peripherally Inserted Central Catheters (PICC): (may not insert; may access based on OLMC order). EMS personnel may NOT access surgically implanted medication delivery systems such as Portacath, Medi-port, or LAS Port®.
   b. Indwelling urinary catheters (may not insert)

c. Long-term feeding tubes: Gastrostomy tube (GT) or Jejunostomy tube (JT)
d. Tracheotomy tube (may insert new tube if existing tube becomes fully dislodged; may remove and reinsert inner cannula to clear obstruction)
e. Surgical drains (may not access or manipulate)
f. Ventricular shunts (may not access or manipulate)
g. Ventricular assist devices – Always notify the VAD pager/Coordinator before any interventions. See SOP.
h. Insulin pumps (may not access or manipulate)

2. **EMRs, EMTs, and PMs without Critical Care Paramedic certification, may NOT perform and/or independently monitor/transport patients with the following:**
   a. Chest tubes; arterial lines
   b. Intra-aortic balloon pumps; hemodynamic monitoring catheters;
   c. Ventilators (other than those approved on Drug & Supply list);
   d. Blood or blood products infusing
   e. Fetal monitoring: internal or external;
   f. Intracranial pressure monitors; or
   g. Cervical traction devices (Garner-Wells tongs, halo devices, etc.)
3. EMRs, EMTs, and PMs without Critical Care certification may NOT independently transport critically ill neonates in isolettes.
4. Patients with appliances/devices or transport needs as listed in 2 and 3 above must be accompanied by a qualified nurse, physician, respiratory therapist, perfusionist, or C.T. tech. unless the PM has Critical Care certification and an expanded scope of practice and is authorized to provide that care by the EMS MD.
5. **EMRs, EMTs, and PMs are NOT authorized to perform the following:**
   a. Bimanual vaginal exams
   b. Rectal exams

F. *A student enrolled in a Department-approved EMS Personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the System and the Department, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified RN or a qualified EMS Personnel, only when authorized by the EMS MD. (Section 3.55(d) of the Act)*

G. After appropriate education, credentialing, and approval by IDPH and the EMS MD, EMTs, paramedics, PHRNs, PHAPRNs, and PHPAs may be authorized to provide healthcare within their scope of practice using patient-centered, mobile resources in the out-of-hospital environment that may include, but not be limited to, services such as conducting safety and wellness checks, providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care locations, not limited to hospital emergency departments.

IV. INITIATION OF EMS Services / CARE

A. Upon scene arrival, all EMS responders shall follow system SOPs with respect to responder safety, patient access, recognition and abatement of risk, application of personal protective devices/body substance isolation, patient assessment and initial interventions.

B. **The EMS MD has determined that the following minimum equipment should be taken with EMS personnel to the patient for use at point of patient contact:**

1. Assessment tools: Stethoscope, light source, BP cuff, glucose meter

2. Airway bag consistent with the responder's scope of practice. All responders should bring oral and nasal airways, suction | ALS response: full ADV airway equipment.
3. O_2 delivery and ventilatory devices per SOP (appropriate for scope of practice) and at least one cylinder (D or E) of oxygen filled to at least minimum inventory requirements.
4. Open chest wound vented/channeled dressings and bleeding control supplies and equipment
5. EMR, BLS, and AEMT/ILS response: AED
6. ALS response: ECG monitor/defibrillator capable transthoracic pacing, synchronized cardioversion, manual defibrillation, noninvasive BP (MAP) monitoring; SpO_2 and $EtCO_2$ monitoring; 12 L transmission capability and at least one set of pace/defib pads; real-time CPR feedback device/capability.
7. AEMT/ALS response: Vascular access (IV/IO) and IV fluid supplies and equipment
8. EMR to ALS response: Drugs as specified in scope of practice.
9. Patient conveyance equipment/spine motion restriction devices if indicated
10. EMS Providers may expand on this minimum point of care response requirement as they find practical or necessary based on preliminary dispatch information.

C. **INITIATION OF EMR and BLS Services**

Provided that scene safety is confirmed, EMR and BLS services **shall be initiated at the point of patient contact per the SOPs** for all patients requiring interventions consistent with the definition of EMR and BLS services per EMS Rules and this policy. Patients requiring the initiation of EMR and BLS care (that may or may not require further ALS interventions) may include, but not be limited to, the following:

1. Initial assessment findings within normal limits or not requiring ALS interventions.
2. Pts with an impaired airway requiring positioning, suctioning, dislodgement strategies, and BLS noninvasive adjuncts
3. Hypoxic patients requiring supplemental oxygen where hypoxia can be reversed by BLS O_2 delivery devices and not requiring ALS interventions per SOP
4. Hypoventilating/apneic pts that require BVM ventilations pending an ALS response
5. Need to convert an open pneumothorax to closed
6. Patients in cardiac or respiratory arrest pending an ALS response
7. Bleeding controllable by direct pressure, hemostatic dressings and/or tourniquet and not requiring venous access and fluid resuscitation
8. Patients with altered mental status (AMS) and S&S consistent with opiate OD requiring administration of naloxone pending an ALS response
9. Patients with AMS and S&S consistent with hypoglycemia requiring administration of oral glucose or glucagon (pending an ALS response)
10. Patients with severe nausea requiring administration of ondansetron via ODT.
11. Patients with severe allergic reaction/anaphylaxis requiring administration of IM epinephrine per SOP pending an ALS response
12. Patients with mild respiratory distress and wheezing with a history of asthma or COPD requiring inhaled bronchodilators.
13. Isolated musculoskeletal trauma and soft tissue trauma requiring basic wound care and splinting pending an ALS response
14. Patients with suspected acute spine injury requiring extrication and/or spine motion restriction pending an ALS response
15. Childbirth and newborn care pending an ALS response
16. Acute illness or trauma without systemic implications and presenting in minimal distress
17. Long-term (chronic) diseases without new or acute distress

D. **INITIATION OF ALS CARE**

1. After scene safety is confirmed, any patient with an actual or potential life-threatening condition or one requiring ALS services shall have the following assessments/interventions initiated/attempted per SOP/Procedure, **if indicated**, **at the point of patient contact *prior to removal*** to the ambulance:
   a. Advanced airway access unless attempts are contraindicated
   b. O_2 per transport ventilators if available and unless contraindicated, needle pleural decompression
   c. **Cardiac arrest management**: System recommends at least 5-7 EMS responders for each cardiac arrest worked at the ALS level using the Bundled Care (Pit Crew) approach.
   d. **ECG rhythm/12 L interpretation/synchronized cardioversion/ defibrillation/ cardiac pacing**. See SOP for details.
   e. **Vascular (IV/IO) access** if actual/potential volume replacement and/or IV medications needed immediately. Vascular access should generally be performed enroute on patients meeting criteria for transport to a Level I or Level II Trauma Center and/or as specified in the SOPs.
   f. **First line medications as listed in the SOPs**
2. If initial attempts at ALS interventions are unsuccessful, attempt a recommended back-up procedure and contact OLMC for further orders. DO NOT prolong scene time with persistent unsuccessful efforts at airway or vascular access.
3. **Patients requiring ALS services include, but may not be limited to, conditions covered by the System SOP's; PLUS the following:**
   a. Any persistent deviation from expected norms for patient in the primary assessment or breath sounds
   b. Patients with abnormal VS accompanied by signs of severe hypoxia (SpO2 <90%), hyper- or hypocarbia ($ETCO_2$ <35 or >45), and/or hypoperfusion ($ETCO_2$ 31 or less plus altered mental status, VS and skin changes)

Guidelines for abnormal vital signs: ADULTS	
Pulse:	< 60 or > 100 or irregular rhythm; poor quality
Respiration:	< 10 or > 20 or abnormal pattern/effort/expansion
Systolic BP:	< 90 or > 150 mmHg (MAP < 65)

   c. **PEDIATRICS** - See SOPs for normal and abnormal values
   d. Chest/abdominal pain with positive assessment findings or GI bleeding
4. **ALS care should never be discontinued** once initiated unless a patient with legal and decisional capacity refuses further intervention, they are given full disclosure of risk, a Refusal of Service has been appropriately executed, the patient's wishes are shared with OLMC while on the scene, and a physician or his/her designee grants permission to discontinue care.
5. If a patient has required any continuous monitoring during transport (ECG, SpO_2, $EtCO_2$), or any other continuous interventions while under EMS care (CPR, oxygen, assisted ventilations, etc.), those assessments and/or interventions shall continue until responsibility for the patient is transferred to ED personnel unless specially authorized to stop by OLMC. They shall not be discontinued in the ambulance for transfer into the hospital.
6. If scene, patient and/or rescuer safety is questionable or if EMS personnel are confronted with an uncooperative patient, the requirements to initiate BLS or ALS

care at point of patient contact or during transport may be waived in favor of assuring that safety is protected and the patient is transported to an appropriate facility. Contact OLMC to discuss the situation prior to leaving the scene. Clearly document the circumstances leading to an abbreviation of customary practice.

E. **In-field service level upgrades**

1. All transfer of care decisions shall be made under the immediate direction of the nearest system hospital OLMC who shall determine the risk/benefit and appropriateness of a service level upgrade. Also see policy A-1.
2. BLS personnel at the scene of an emergency shall allow any EMT-Is/AEMTs or ALS personnel at the scene access to the patient, for the purpose of assessing whether a higher level of care is warranted and if transfer care of that patient to the ILS or ALS personnel is appropriate.
3. If a patient is being initially treated in the field by BLS personnel and they identify that a higher level of monitoring or interventions are necessary, the BLS crew shall request an ALS response from the local municipal EMS agency, unless the initial responders are employees of a private provider and the private provider can provide an ALS response within six minutes.
4. Transfer of care shall not be initiated in either of the above scenarios if it would appear to jeopardize the patient's condition. If the BLS crew can transport to the nearest hospital faster than the local municipal ALS team can arrive, the BLS team shall contact the nearest System hospital OLMC, inform them of the patient's situation and ETA to the nearest hospital, seeking authorization to transport the patient immediately, providing BLS care enroute.
5. **When care is transferred from one EMS crew to another, the first responding personnel shall**
   a. remain with the patient and continue to provide appropriate care within their scope of practice according to System standards of care until patient responsibility is transferred to the transporting team;
   b. provide a verbal report to the transporting personnel that includes assessment and treatment data current to the point of transfer;
   c. complete a patient care report which notes patient assessment and treatment data current to the point of transfer; and
   d. provide a copy of their written report to the receiving hospital as soon as possible. See Policy A-1 Abandonment and R6 Refusal of Care policy.

V. **CHRONICALLY DISABLED/IMPAIRED PATIENTS**

If EMS is dispatched to a patient who has a chronic, debilitating condition, but who appears stable with no new or acute findings, and the total scene and transport time is less than five minutes, they shall advise the receiving hospital of the situation and may request permission to abort ALS care in favor of immediate transport. At all times, the patient's needs, based on the present medical condition, must dictate the level of care delivered.

VI. **Law Enforcement animals (POLICE DOGS):** *An EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN, PHAPRN and PHPA may transport a* ***police dog injured in the line of duty t****o a veterinary clinic or similar facility if there are no persons requiring any medical attention or transport at that time.* (Section 3.55(e) of the Act eff. 1-1-18.) EMS Systems that choose to transport police dogs injured in the line of duty shall develop written policies or procedures for all of the following:

A. Basic level first aid and safe handling procedures for injured police dogs, including the use of a box muzzle, developed in consultation with a local veterinarian. The provision of Intermediate and Advanced Life Support care is not authorized and shall not be permitted unless the individual EMS provider is also appropriately licensed under the Illinois Veterinary Medicine and Surgery Practice Act [225 ILCS 115];

B. Identification of local veterinary facilities that will provide emergency treatment of injured police dogs on short notice (See SOP p. 63 - Veterinary Specialty Center 2051 Waukegan Rd, Bannockburn, IL 60015 | Hours: 24/7 | Phone: (847) 459-7535 (call ahead);

C. Proper and complete decontamination of stretchers, the patient compartment, and all contaminated medical equipment, when a police dog has been transported by ambulance or other EMS vehicle; and

D. The sterilization of the interior of an ambulance, including complete sanitizing of all allergens and disinfecting to a standard safe for human transport before being returned to human service. (Source: Amended at 43 Ill. Reg. 4145, effective March 19, 2019)

E. **EMS personnel in the NWC EMSS may give the dog** O_2, apply pressure to stop blood loss, stabilize broken bones, and apply bandages in consultation with the dog's handler if available.

VII. SERVICE ANIMALS

A. Examples of service animal tasks

1. A person who uses a wheelchair may have a dog that is trained to retrieve objects for them.
2. A person with depression may have a dog that is trained to perform a task to remind them to take their medication.
3. A person with PTSD may have a dog that is trained to lick their hand to alert them to an oncoming panic attack.
4. A person who has epilepsy may have a dog that is trained to detect the onset of a seizure and then help the person remain safe during the seizure.

B. If it is unclear whether a dog is a service dog, **EMS may ask two questions:**

1. Is the dog a service animal required because of a disability?
2. What work or task has the dog been trained to perform?

C. **EMS is not allowed to:**

1. Request any documentation that the animal is registered, licensed, or certified as a service animal.
2. Require that the dog demonstrate its task, or inquire about the nature of the person's disability.

D. **Service animal policies**

1. Generally, entities (including EMS providers) must permit service animals to accompany people with disabilities in all areas where members of the public are allowed to go. This is true even if they have a "no pets" policy. For example, service dogs can go into restaurants, shops, hospitals, schools and hotels.
2. Ambulances are only required to accommodate service dogs and EMS can legally deny transporting all other types of emotional support animals.
3. The decision to allow the patient and dog to remain together ultimately rests with the EMS crew, and is based on the patient's need and ability to control the animal, as well as the crew's ability to transport the dog safely.
4. EMS personnel are not responsible for the care, comfort or securing of the service dog in the ambulance. Unless a specific location is required for the dog's work, the service dog must be kept in a location in the ambulance where they will not interfere with medical care or pose a danger to EMS personnel or the patient.
5. The patient is required to maintain control of the service dog at all times. This means that the service dog must be harnessed, leashed or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls (Brainard, 2017).

6. A business or state/local government does not need to allow a service animal if the dog's presence would fundamentally alter the nature of the goods, services, programs, or activities provided to the public. When the patient is unconscious or in a condition requiring critical lifesaving treatment and the dog's presence would compromise care or safety during transport, it's best to make other transport arrangements for the dog.
7. A business or state/local government can ask someone to remove their service animal if the dog is not housebroken, the dog is out of control, and the person cannot get the dog under control.
8. EMS should alert the ED before arrival that a service animal is accompanying the patient. Upon arrival at the hospital, the service dog can accompany the patient into the ED. Service dogs are allowed in areas of the hospital where the general public travels. Hospital staff is not responsible for care of the animal.
9. The ADA doesn't allow exclusion of a service dog for allergies, personal bias, fears, or other reasons not covered above. Once patient care has been turned over, the crew is responsible for cleaning/decontaminating their ambulance according to their agency policy and procedures. Document the completion of ambulance cleaning.
10. The ADA doesn't specifically define who's responsible for the service dog should it not be transported, but best practices would encourage EMS crews to make every effort to reunite the dog with the patient as soon as reasonably possible (e.g., private car transport with family, friends, law enforcement, etc.).

The following technical assistance documents provide more helpful information about service animals:

- Frequently Asked Questions about Service Animals and the ADA
- ADA Requirements: Service Animals
- Brainard, C. (2017). EMS transport of service dogs & support animals. JEMS on line.

VIII. **Emotional support animals**

A. Dogs (or any other animal) whose sole function is to provide comfort, therapy or emotional support do not qualify as service animals. They haven't been trained to perform a specific job or task, and therefore do not qualify as service animals under the ADA.

B. There's no Federal legal obligation to allow emotional support dogs to accompany a patient in the ambulance. However, some state or local governments have laws allowing people to take emotional support animals into public places and those laws may also apply to ambulance transport.

Matthew T. Jordan, MD, FACEP
EMS Medical Director

Connie J. Mattera, MS, RN, PM
EMS Administrative Director