I. PURPOSE: To define the criteria by which a Registered Nurse (RN) can be authorized to function as a Mobile Intensive Care Nurse (MICN) in the Ventura County Emergency Medical Services (VCEMS) system.

II. AUTHORITY: Health and Safety Code 1797.56 and 1797.58.

III. POLICY: Authorization as a MICN requires professional experience and appropriate training, so that appropriate medical direction can be given to Paramedics at the scene of an emergency.

IV. PROCEDURE: In order to be authorized as an MICN in Ventura County, the candidate shall:
   A. Fulfill the requirements regarding professional experience and prehospital care exposure. (Section V.A and B.)
   B. Successfully completes an approved MICN Developmental Course.
   C. Ride with an Paramedic unit for a minimum of eight (8) maximum of (16) hours and observe at least one (1) emergency response requiring Base Hospital contact.
   D. Be recommended for MICN authorization by his/her employer.
   E. Successfully complete the authorization examination process.
   F. Complete an MICN internship.

V. AUTHORIZATION REQUIREMENTS
   A. Professional Experience:
      The candidate shall hold a valid California RN license and shall have a minimum of 1040 hours (equivalent to six months’ full-time employment) critical care experience as an (RN). Critical care areas include, but are not limited to, Intensive Care Unit, Coronary Care Unit, and the Emergency Department.
   B. Prehospital Care Exposure
The candidate shall be employed in a Ventura County Base Hospital. In addition, for a minimum of 520 hours (equivalent to three (3) months full time employment) within the previous six calendar months, the candidate shall have one or more of the following assignments.

1. Be assigned to clinical duties in an Emergency Department responsible for directing prehospital care. (It is strongly recommended that this requirement be in addition to and not concurrent with the candidate’s six-(6) months’ critical care experience. A Base Hospital may recommend an MICN candidate whose critical care and/or Emergency Department experience are concurrent based on policies and procedures developed by the Base Hospital), or

2. Have responsibility for management, coordination, or training for prehospital care personnel, or

3. Be employed as a staff member of VCEMS.

C. MICN Developmental Course

The candidate shall successfully complete an approved Mobile Intensive Care Nurses Development Course (See Appendix A).

1. The MICN developmental course shall include a four (4) hour Mass Casualty Incident (MCI)-Basic training module to be administered by a VCEMS or authorized representative.

D. Field Observation

Candidates shall ride with an approved Ventura County Paramedic unit for a minimum of eight (8) maximum of (16) hours and observe at least one emergency response patient contact or simulated drill.

1. Candidates shall complete the field experience requirement prior to taking the authorization examination.

2. A completed Field Observation Form shall be submitted to the VC EMS as verification of completion of the field observation requirement (Appendix C).

E. Employer’s Recommendation

1. The candidate shall have the recommendation of the Emergency Department Medical Director or Paramedic Liaison Physician (PLP), Prehospital Care Coordinator (PCC) and Emergency Department Nurse Supervisor.

2. Candidates employed by VCEMS shall have the approval of the Emergency Medical Services Medical Director.
3. All recommendations shall be submitted in writing to VCEMS prior to the authorization examination. (Appendix B.)

The recommendation shall include:

b. Verification that the candidate has been an employee of the hospital for a minimum of three (3) months (or has successfully completed the hospital's probationary period) and will, upon certification, will be assigned to the E.D. as set forth in Section B of the MICN Authorization Criteria.
c. Verification that each candidate has successfully completed an approved MICN Developmental Course.
d. Verification that each candidate has completed the Field Observation requirement as set forth in Section II.D of the MICN Authorization criteria.

F. Examination Process

1. Written Procedure: Candidates shall successfully complete a comprehensive written examination approved by VCEMS.
   a. The examination's overall minimum passing score shall be 80%.
   b. Employers shall be notified within two (2) weeks of the examination if their candidates passed or failed the examination.
   c. The examination shall be scheduled in conjunction with class completion dates.

2. Examination Failure
   a. A candidate who fails the initial MICN exam shall complete a repeat exam within 30 days. S/he may repeat the authorization exam one (1) time.
   b. A minimum score of 80% must be attained on repeat examination.
   c. If the repeat examination is not successfully completed, the candidate shall repeat the authorization application process, including the developmental course, prior to taking the subsequent examinations.

3. Failure to Appear
   a. If a scheduled candidate fails to appear for the scheduled examination, s/he shall be considered as having failed the examination.
b. Within 24 hours of the scheduled examination, VCEMS shall notify the employer of any candidate failing to appear for testing.

c. Candidates who fail to appear for two scheduled authorization examinations shall not be eligible to take the authorization examination for one (1) calendar year from the last scheduled examination date and must repeat the entire authorization process.

G. Internship

Following notification of successful completion of the authorization examination, the candidate shall satisfactorily direct ten (10) base hospital runs under the supervision of a MICN, the PCC, and/or an Emergency Department physician.

1. The Communication Equipment Performance Evaluation Form shall be completed for each response handled by the candidate during the internship phase. (Appendix D)

2. Upon successful completion of at least ten (10) responses, the ten responses shall be evaluated by the Emergency Department Director or PLP, the Emergency Department Nursing Supervisor, and the PCC. All Communication Equipment Performance Evaluation Forms (Appendix D) and Verification of Internship Completion Form (Appendix E) shall be submitted to Ventura County EMS.

3. The internship requirement shall be completed within six (6) weeks of the successful completion of the authorization examination.

4. If an employer is unable to complete a candidate’s internship process within six (6) weeks of the authorization examination, a BH representative shall submit a letter to Ventura County EMS explaining the situation and their intent. If the intent is to continue the authorization process for the individual, the projected date for internship completion shall be stated.

5. If an employer is unable to complete a candidate’s internship process within one year of the authorization examination, a BH representative shall resubmit a letter of recommendation and the candidate shall repeat the authorization examination.

VI. AUTHORIZATION

Authorization shall be granted and an authorization card sent to the employer within fifteen (15) working days following receipt of the Communication Equipment Performance Evaluation and Verification of Internship Completion forms. Authorization is valid for a two (2) year period.
or during employment at a Ventura County Base Hospital. The nurse must be regularly assigned as an MICN per EMS Policy 322.
LETTER OF RECOMMENDATION
INITIAL AUTHORIZATION

_______________________________________ is recommended for Mobile Intensive Care Nurse Authorization in Ventura County.

We have reviewed the attached Mobile Intensive Care Nurse Application and verify that the applicant:

_______ Holds a valid California Registered Nurse License.

_______ Has at least 1040 hours of critical care experience.

_______ Has completed the Field Observation Requirement.

_______ If authorized, will be employed in accordance with guidelines as set for the in Section V.B of the MICN Authorization Criteria

_______ Has been employed by ______________________ in the Emergency Department for at least 520 hours gaining prehospital care exposure.

_______ Has completed an approved Mobile Intensive Care Nurse Developmental Course.

_______________________________________
Emergency Department Medical Director/
Paramedic Liaison Physician

_______________________________________
Emergency Department Nursing Supervisor

_______________________________________
Prehospital Care Coordinator

Date: _______________________________
## MICN AUTHORIZATION APPLICATION

**Application processing requires a minimum of 10 days once all materials are received. Authorization cards will be mailed. Complete application in ink.**

**Name:**

**Street Address:**

**City:**

**State:**

**Zip code:**

**Home phone:**

(   )

**Work Phone:**

(   )

**Base Hospital:**

**Current/Prior Authorization Number:**

**Expiration Date:**

### Initial Authorization:
- Pass the Ventura County EMS MICN Exam with a score of 80% or higher.
- Provide a copy of a valid and current license as a registered nurse in California
- Provide a copy of a valid and current ACLS card (front and back of card)
- Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- Field Observation Verification (VCEMS Policy 321, appendix C)
- Documentation of Critical Care Experience (VCEMS Policy 321, appendix A)
- Documentation of Ventura County Emergency Department Experience
- Letter of Recommendation
- Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D)

### Reauthorization
- Provide a copy of a valid and current license as a registered nurse in California
- Provide a copy of a valid and current ACLS card (front and back of card)
- Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- Verification of employment as an MICN at a designated base hospital
- Letter of Recommendation (VCEMS Policy 322, appendix A)
- Continuing Education Log (VCEMS Policy 322, appendix D)

**Applicant Signature:**

**Date**

**Prehospital Care Coordinator Signature:**

**Date**
FIELD OBSERVATION REPORT

MICN NAME: ____________________________________ AUTH. NO.: __________

EMPLOYER: ________________________________ RIDE-ALONG DATE: __________

TIME IN: ___________ TIME OUT: ______________ TOTAL HOURS: __________

BASE CONTACT MADE WITH ALS PROCEDURES PERFORMED: YES: _____ # _____ NO _____

ALS PROVIDER: __________

SUMMARY OF FIELD OBSERVATION

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

__________________________________________ Paramedic Signature

__________________________________________ Paramedic Signature

__________________________________________ MICN Signature

__________________________________________ PCC Signature

(Use other side for additional comments)
COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Candidate’s Name: | MICN Exam Date: | Base Hospital:
---|---|---

**MICN Evaluator:** Please evaluate this MICN candidate for the following, to include but not be limited to: Proper operation of radio equipment; recommended radio protocols used; correct priorities set; additional info requested as needed; appropriate, complete, specific orders given; able to explain rationale for orders, notification of other agencies involved; and ability to perform alone or with assistance.

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident # (and Pt # of Total as needed)</th>
<th>Chief Complaint</th>
<th>Treatment</th>
<th>Evaluator’s Comments</th>
<th>Evaluator’s Signature</th>
<th>PCC’s Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VERIFICATION OF INTERNSHIP COMPLETION

________________________________________________, employed at _______________________, is/is not recommended for Authorization as a Mobile Intensive Care Nurse. S/He has achieved the following rating in the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands and operates equipment properly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sets correct priorities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requests additional information as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orders are specific, complete and appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands treatment rationale</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**
In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:

1. Poor  
2. Fair  
3. Average  
4. Good  
5. Excellent

ATTACH COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Signatures: BH Medical Director/Paramedic Liaison Physician

Prehospital Care Coordinator