Amended and Restated
EMS Interlocal Cooperation Agreement

WHEREAS, the State of Oklahoma, in the Interlocal Cooperation Act, 74 O.S., Sec. 1001, et seq., authorizes governmental entities to jointly exercise the power to provide governmental services for the public health and welfare with other local governmental entities; and,

WHEREAS, it is in the best interests of the public health and welfare of the people of the member jurisdictions of the EMS Interlocal Cooperation to have available to them a state-of-the-art, high quality, emergency medical services (EMS) system, with effective medical controls and accountability, with adequate response times; and,

WHEREAS, establishment of standards or specifications for vehicles and on-board equipment by numerous local jurisdictions is an inefficient allocation of scarce governmental personnel and resources, and creates an unnecessary danger to the public by the removal of ambulances from service during inspection periods; and,

WHEREAS, the repetitive credentialing and training of EMS personnel by numerous local jurisdictions imposes an unreasonable burden upon the EMS personnel and their employers, and creates an unnecessary danger to the public by removing previously licensed persons from service during the testing periods, and repetitive testing of personnel is an inefficient use of scarce resources; and,

WHEREAS, the quality of EMS services should not depend upon municipal boundary lines; and,

WHEREAS, a unified, coordinated system of medical oversight and control of EMS throughout an urban area without regard to political subdivision boundaries is in the best interests of the health, welfare, and safety of the citizens of all member jurisdictions of this EMS Interlocal Cooperative; and,

WHEREAS, it is in the best interest of the health, welfare, and safety of the citizens within the member jurisdictions of this EMS Interlocal Cooperative to continue to join together in creating a multi-jurisdictional “Regulated Service Area,” and a “Medical Control Board" to provide informed, objective, and clinically expert oversight of the quality of care and response time performance provided by the various components of the EMS system throughout the Regulated Service Area, as defined herein; and,

WHEREAS, ambulances and crews normally based in different communities are often called upon to function in concert at the scenes of multiple casualty incidents, during which times crew members become "teamed" with crew members from another area and must necessarily utilize the complex medical equipment brought to the scene by other crews; an extreme danger to the public is created when such personnel are trained and accustomed to working with different brands and types of medical equipment than those available for their use at that moment; and,

WHEREAS, the State of Oklahoma and its political subdivisions have experienced revenue shortfalls in the recent past creating hardships for the funding of governmental services; and,

WHEREAS, it is in the best interests of the citizens of Oklahoma to have their tax dollars spent in the most cost-efficient means; and,

WHEREAS, Title 74 O.S. Sec. 1001 *et seq*., allows local governmental units to make the most efficient use of their powers by enabling them to cooperate with other localities on a basis of mutual advantage and thereby to provide services and facilities in a manner and pursuant to forms of governmental organization that will accord best with geographic, economic, population, and other factors influencing the needs and development of local communities; and,

WHEREAS, it will result in substantial savings of tax dollars to designate a single entity to generally monitor and oversee the operation of the EMS system.

THEREFORE, be it resolved that the undersigned jurisdictions do hereby agree to amend and restate the existing EMS Interlocal Cooperative, and further agrees as follows:

1. **Requirements for Membership.** Requirements for joining the EMS Interlocal Cooperative shall include all of the following:

    A. The applicant jurisdiction shall approve and execute this EMS Interlocal Cooperation Agreement.

    B. The applicant jurisdiction shall adopt and enforce the Uniform EMS Ordinance, which is attached hereto as Exhibit A, “Uniform Ordinance for Emergency Medical Services”, or an abbreviated ordinance that is mutually agreeable to the applicant jurisdiction or Non-Beneficiary Member Jurisdiction and the Authority, which can include less stringent response time requirements in the Non-Beneficiary Member

Jurisdiction, and as that ordinance may be amended by the Beneficiary Jurisdictions as defined below in paragraph C of Section 2.

C. Such abbreviated ordinance requirements shall not change the system standard of care, the system status plan, the clinical quality requirements for ambulance services, the medical protocols or the medical oversight requirements ("Ordinance Standard of Care Provisions"), and any changes by such applicant jurisdiction or Non-Beneficiary Member Jurisdiction to the Ordinance Standard of Care Provisions shall result in automatic disqualification for membership in this Amended and Restated EMS Interlocal Cooperative.

2. Definitions: For purposes of the Agreement, the following definitions shall apply:

A. **Ambulance Service Provider** means EMSA, the primary ambulance service provider for the regulated service area pursuant to the Uniform Ordinance which provides that EMSA is the sole source provider.

B. **Second Amended And Restated Trust Indenture** is that document attached hereto as Exhibit B and adopted by the City of Tulsa and The City of Oklahoma City as amended or superseded by the beneficiary jurisdictions from time to time.

C. **Beneficiary Member Jurisdictions** shall have the definition set forth in Article VIII of the Second Amended and Restated Trust Indenture (Exhibit B).

D. **Contract for Special Arrangements** means the contract which operates between EMSA and a Beneficiary or Non-Beneficiary Member Jurisdiction served by EMSA which defines the terms of any special arrangements which have been agreed to regarding subsidy, fee schedules, ~~or~~ response times, and/or supplemental ambulance services within that jurisdiction and acts as a subcontractor to EMSA.

E. **Emergency Medical Services (EMS) System** means those organizations, individuals, facilities and equipment which participate directly in the delivery of EMS, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A), throughout the Regulated Service Area.

F. **EMSA** means the Emergency Medical Services Authority, a public trust whose beneficiaries are the City of Tulsa and The City of Oklahoma City.

G. **Amended and Restated EMS Interlocal Cooperation Agreement** means this agreement, hereinafter referred to as "Agreement".

H. **On-line Medical Control Physician** means an emergency department or destination facility based physician licensed to practice medicine in the State of Oklahoma, from whom ambulance and emergency medical response agency personnel may take medical direction by radio or other remote communications device.

I. **Operations Contract** means a contract for purchase of ambulance services between EMSA and any private entity (the "Operations Contractor") with which EMSA has contracted for provision of ambulance services within the Regulated Service Area and acts as a subcontractor to EMSA. Operations Contract and Operations Contractor expressly excludes a Beneficiary or Non-beneficiary member jurisdiction providing supplemental services pursuant to a Contract for Special Arrangements.

J. **Quality Assurance Fund.** That fund account which is administered by EMSA on behalf of the Medical Control Board, and which shall be used solely to fund the activities and expenses of the Medical Control Board in carrying out the purposes set forth in this Agreement.

K. **Regulated Service Area** means the geographic area which is contained within the boundaries of the municipalities and other entities which have adopted and agreed to enforce the Uniform Ordinance for Emergency Medical Services or such other ordinances or requirements agreed to by EMSA as described in paragraph I.C. above, and which have approved this Agreement.

L. **System Standard of Care** means the written body of standards, protocols, and policies governing clinical aspects of the EMS system, including:

1. **Input standards** including but not limited to personnel credentialing requirements, training requirements, equipment specifications, on-board inventory requirements, and other requirements which the system must fulfill before receipt of a request for service;

2. **Performance standards** including but not limited to medical priority dispatching protocols and pre-arrival instructions, medical protocols, standing orders, response time standards, protocols governing authority for on-scene control of patient care, and other performance specifications describing how the system should behave upon receipt of a request for service; and,

3. **Outcome standards** are results the system intends to achieve by meeting its "input" and "performance" standards.

For purposes of this definition, the response time standards set forth in the Uniform Ordinance for Emergency Medical Services (or, if applicable, in the Contract for Primary Ambulance Coverage) adopted by each jurisdiction which is a member of this EMS Interlocal Cooperative shall be automatically incorporated into the System Standard of Care as the response time standard applicable to calls originating from within each respective jurisdiction.

M. Uniform Ordinance for Emergency Medical Services means that ordinance attached hereto as Exhibit A of even date herewith by the Beneficiary Member Jurisdictions, and as adopted, amended or superseded thereafter by those jurisdictions.

3. Emergency Physician's Foundation -- Creation and Purpose. There is hereby created a governmental administrative agency, created pursuant to 74 O.S §1001, et seq., called the Emergency Physicians Foundation (hereinafter called the "EPF"). The EPF shall have the powers and duties set forth and described in Section 9, below. It is the purpose of the EPF, acting through its elected Medical Control Board, to oversee clinical aspects of the EMS system throughout the Regulated Service Area. The Medical Control Board shall be established as provided in Section 12, below; and shall have the powers and duties set forth and described in Section 13, below.

4. Duration of the EPF. The EPF shall continue to exist so long as this Agreement remains in effect between two or more jurisdictions which meet the qualifications set forth in Section 1, above.

5. Chapters of EPF. There shall be two chapters or the EPF, one for the "Eastern Division" and one for the "Western Division," as those Divisions are geographically

defined in the "Second Amended and Restated Trust Indenture," which is attached hereto as Exhibit B.

6. Membership of EPF Chapter. Membership of each Chapter of the EPF shall be limited to physicians who are board certified in emergency medicine, pediatric emergency medicine, or both by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

A. **Eastern Chapter.** The Eastern Chapter shall be composed of the Medical Director (or his/her permanent physician designee) of the emergency department from each Hospital in the Eastern Division.

B. **Western Chapter.** The Western Chapter shall be composed of the Medical Director (or his/her permanent physician designee) of the emergency department of each community wide trauma rotation hospital in the Western Division Beneficiary Member Jurisdiction.

7. Changes in Membership Requirements. Over time, changes may occur in certain federal, state, or hospital industry standards applicable to emergency receiving facilities, and in the official mechanisms by which compliance with such standards is judged. When and if such changes do occur, the Medical Control Board, subject to a 2/3 affirmative vote by the both chapters of the EPF, may recommend an amendment to the facility-related qualifications for EPF membership as set forth in Section 6, above, to be consistent with then-current federal, state, or industry standards, which amendment shall become effective 30 days after receipt and filing with the clerk of each beneficiary and non-beneficiary member jurisdiction.

8. EPF • Chapters • Bylaws and Officers. Each Chapter of the EPF may adopt its own bylaws and elect its own officers.

9. Powers and Duties of the Chapters. Each Chapter of the EPF shall have the following powers and duties:

A. To participate as members of the Medical Control Board;

B. To approve patient transport protocols applicable in the Regulated Service Area; and

C. To enter into a contract for medical oversight consistent with the duties and responsibilities of the Medical Director described herein.

10. Medical Control Board Established. The Medical Control Board shall serve as the regulatory, policy-setting and fact-finding body for the EPF in providing medical oversight of the clinical standard of care of the EMS System throughout the Regulated Service Area, and shall constitute the Board of Directors of the EPF.

11. Membership on the Medical Control Board. Except for the "eleventh" member of the Medical Control Board (as specified in Subsection 12, C below), membership on the Medical Control Board shall be limited to physicians who: are members of their respective chapters of the EPF; are board-certified in emergency medicine, pediatric emergency medicine, or both by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine; and, are actively engaged in the practice of emergency medicine or pediatric emergency medicine.

12. Membership on the Medical Control Board. There shall be eleven (11) members of the Medical Control Board, which are as follows:

A. The members of the Eastern and Western Chapters of the EPF shall represent and serve their respective EPF chapters on the Medical Control Board.

B. All terms of office on the Medical Control Board shall be for a period of four years without any limitations on the number of consecutive terms.

C. The ten (10) elected members of Medical Control Board representing the Eastern and Western Chapters of the EPF shall meet and elect one physician, licensed in Oklahoma, who is board-certified in another specialty involved with emergency medicine (e.g., surgery, cardiology), to represent the views and interests of non-emergency physician and shall be selected for a four-year term, on the Medical Control Board, without any limitations on the number of consecutive terms. Each member of the Medical Control Board shall have one vote.

13. Powers and Duties of the Medical Control Board. The Medical Control Board shall have the following powers and duties:

A. To approve the appointment of and to contract with a Medical Director, who shall

serve at the pleasure of the Medical Control Board.

B. To establish System Standard of Care, as defined herein and in Exhibit A, Uniform Ordinance for Emergency Medical Services; provided, however, that such System Standard of Care shall not be less than the level of service required within the Regulated Service Area or in contravention of the minimum standards required by the laws of the State of Oklahoma and shall be consistent with the level of care required for the credentialed EMS personnel in the system. Such System Standard of Care shall be submitted to the credentialed EMS agencies operating in the Beneficiary and Non-Beneficiary Member Jurisdictions.

C. To enhance the System Standard of Care by incorporating evidence-based clinical medical research findings, or to correct defects in the System Standard of Care discovered as a result of the quality assurance monitoring program, as described in Subsection E of this Section. However, no change shall be made in the System Standard of Care which results in a standard that is less than or in contravention of the minimum standards required by the laws of the State of Oklahoma. Changes in the System Standard of Care may be approved by the Medical Control Board subject to the following process:

Step 1. The Medical Director, and his/her clinical staff, may identify desirable clinical standard of care changes via a variety of sources (eg. peer-reviewed published medical research, didactic content at relevant professional medical conferences, system-specific clinical data review). As a part of determining applicability and appropriateness for the EMS system, the Medical Director, and his/her clinical staff, may obtain input from personnel within credentialed agencies and/or specialty physicians within the regulated service area, including those they identify as having unique knowledge, expertise, and/or experience specific to the content of the clinical standard of care change.

Step 2. After the Medical Director, and his/her clinical staff, discern that there is a clinical basis for the identified change, the Medical Director, and

his/her clinical staff, shall give consideration to the logistical and operational impact(s) of such change to the credentialed agencies within the regulated service area.

Step 3. Once the clinical, logistical and operational impacts have been established, the Medical Director, and his/her clinical staff, shall identify the fiscal impact of the clinical change on the credentialed agencies within the regulated service area, which may including obtaining input from leadership personnel within credentialed agencies within the regulated service are. If the projected/estimated annual fiscal impact to any credentialed agency exceeds $50,000.00, then written notice of such change shall be provided to each such affected credentialed agency, advising of the clinical, logistical, and operational bases established for the clinical standard of care change and asking for fiscal analysis by each such affected agency. Those agencies involved will have 60 days to respond to the notice, and such response shall detail their agency's fiscal analysis of the impact of such change.

Step 4. Upon the completion of these processes, the Medical Director, and his/her clinical staff, shall present the suggested clinical standard of care change to the Medical Control Board for review, consideration, and possible action based on such procedures adopted by the Medical Control Board.

Any credentialed agencies impacted by the suggested clinical change shall be entitled to present their fiscal concerns or analysis at the meeting of the Medical Control Board when such change is considered. The Medical Control Board shall take into consideration such fiscal concerns or analysis by the credentialed agencies when approving such clinical change, including the option of implementing such change over a defined period of time (e.g. multiple budget cycles/year) to lessen the otherwise immediate fiscal impact of the change.

If a clinical standard of care change is approved by the Medical Control Board which would require for expenditures exceeding $50,000.00 annually to be incurred by EMSA, such change shall be presented to the EMSA Board of Trustees for consideration prior to implementation, and a determination of whether such change will require increases in ambulance transportation rates or user fees should be considered by EMSA and the beneficiary member jurisdictions.

If a clinical standard of care change is approved by the Medical Control Board which would require for expenditures exceeding $50,000.00 annually to be incurred by emergency medical response agencies within the regulated service area, such change shall be presented to the governing body of the beneficiary or non-beneficiary member jurisdictions for consideration prior to implementation.

Any changes to the clinical standard of care adopted by the Medical Control Board shall be communicated in accordance with applicable state laws and regulations as well as to all credentialed agencies within the regulated service area.

D. **Waiver of System Standard of Care Change Process Due to an Emergency**.

1. "Emergency" as used in this section shall be limited to conditions resulting from a sudden unexpected happening or unforeseen occurrence or unforeseen condition wherein the public health, safety, or welfare is endangered.

2. The provisions of this section with reference to changes in the System Standard of Care (C, above) shall not apply whenever the Medical Director recommends to the Medical Control Board and the Medical Control Board declares by a majority vote of all of its members that an emergency exists. The Medical Control Board shall then proceed to consider recommendations

made by the Medical Director and temporarily amend the System Standard of Care due to the emergency, and such temporary amendment shall be effective until such time as the conditions or circumstances giving rise to the emergency declaration has been resolved. If the Medical Director determines in his sole discretion that temporary amendment to the System Standard of Care cannot wait until such time as the Medical Control Board can meet due to the nature of the emergency and in order to avoid loss of life or damage to the public peace and safety, the Medical Director is authorized to make such temporary amendment until such time as the Medical Control Board is able to consider the emergency and need for the temporary amendment.

3. Such temporary amendments to the System Standard of Care shall be delivered to each credentialed agency within the Beneficiary and Non-beneficiary member jurisdictions.

E. To develop and conduct an on-going program of medical quality assurance capable of promoting that all components of the EMS System, as defined herein, are functioning in conformance with the then-current System Standard of Care. In this regard, EMSA, its Operations Contractor, and such other supplement service providers as may then be serving as components of the EMS System shall be subjected to identical standards of licensure, performance, reporting, and monitoring, except that the Operations Contractor's permit shall be valid solely in regard to services rendered in the Operations Contractor's capacity as subcontractor to EMSA, and under EMSA's state EMS license.

F. To develop and administer written and practical tests for purposes of credentialing EMS personnel in the Regulated Service Area or any entity which contracts with the EPF for medical oversight.

G. To develop and administer standards applicable to vehicles and on-board equipment used in the delivery of emergency medical responder services and ambulance services within the Regulated Service Area, as regulated pursuant to the Uniform Ordinance for Emergency Medical Services (Exhibit A).

H. To develop and administer rules for fair hearing for any denial, suspension or

revocation of credentials of EMS personnel operating within the Regulated Service Area or any entity which contracts with the EPF for medical oversight. Such procedures in any event, shall contain at least the following:

1) Written notice of the action (denial, suspension or revocation) pending against the person or entity whose credentials are being denied, suspended or revoked;

2) Written notice of any final action by the Medical Director which results in the denial, suspension or revocation of credentials;

3) A right to an appeal, of any adverse action by the Medical Director to the Medical Control Board, requested in writing within 30 days from the date of final action. Notice of final action shall be delivered by certified mail. Refusal of said certified mail shall be considered receipt;

4) The appeal to the Medical Control Board shall be a de novo hearing which shall include a right to cross-examine witnesses, and to present witnesses and evidence on the person's own benefit;

I. To prepare an annual budget, and to review and approve expenditures from the Quality Assurance Fund as defined in Section 16, below;

14. Medical Director/Chief Medical Officer. The Medical Director/Chief Medical Officer shall be selected by, directed by, and shall serve at the pleasure of the Medical Control Board. The Medical Director shall be Board Certified in EMS Medicine by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine. The Medical Director shall have the following duties and authority:

A. To develop, recommend, and oversee implementation of an appropriate System Standard of Care to be adopted as provided in this Agreement and to make temporary amendments to the System Standard of Care when deemed medically appropriate and seek approval at any subsequent meetings of the Medical Control Board;

B. To administer the credentialing of EMS personnel, and to establish and promulgate written regulations in connection therewith, subject to approval by the Medical

Control Board;

C. To develop and administer standards applicable to vehicles and on-board equipment used in the delivery of emergency medical responder services and ambulances services within the Regulated Service Area, as defined in the Uniform Ordinance for Emergency Medical Services (Exhibit A), in accordance with procedures approved by the Medical Control Board;

D. To initiate the suspension or revocation of any credentialed EMS personnel or entity within the Regulated Service Area or any entity under contract with the EPF;

E. To cause to be established and maintained an on-line version of protocols and regulations established by the Medical Control Board which are available to any facilities who have on-line medical control physician or base station physicians;

F. To report monthly on the clinical aspects of the quality of care by all credentialed agencies within the EMS System to the EMSA Board of Trustees, and the City Manager for the City of Oklahoma City and the Mayor of The City of Tulsa, such report to be relied upon by EMSA in carrying out its role as defined in the Seconded Amended and Restated Trust Indenture (Exhibit B);

G. To report semi-annually to the governing body of each Beneficiary member jurisdiction of this Agreement, in writing, on the quality of care being provided by all credentialed agencies within the EMS System in each Beneficiary and Non-beneficiary member jurisdiction;

H. To monitor all aspects of system performance, including clinical quality of care and response time performance reported by emergency medical ~~first~~ responders and ambulance service providers;

I. To attend meetings of the Board of Trustees of EMSA, and of the Medical Control Board, and to represent the EMS System at appropriate regional and national EMS-related meetings, seminars, and conferences in order to stay abreast of developments in emergency medical care (e.g., ACEP and NAEMSP).

J. To recruit and hire appropriate personnel to assist in carrying out the duties and responsibilities of the Medical Director, subject to budget approval by the Medical

Control Board, and availability of funds, as determined by the Quality Assurance Fund Administrator, as defined in Paragraph 16 below;

K. The Medical Director shall annually recommend to the Medical Control Board a budget for the operation of the EPF and the Medical Control Board, for approval and adoption by the Medical Control Board for purposes of financing the Quality Assurance Fund described herein below.

L. To conduct EMS-related research projects, to seek outside funding for such purposes, and to periodically publish in EMS-related journals and trade publications so as to enable the EMS System to be a visible and active participant in the advancement of the body of knowledge available throughout the EMS industry.

15. Medical Director/Chief Medical Officer -- Responsible Solely to Medical Control Board; It is recognized that the Medical Director shall be approved by, directed by, and serve solely at the pleasure of the Medical Control Board; and that no other party, including but not limited to the Trustees nor the Chief Executive Officer of EMSA shall have any right or authority to discipline, direct, or terminate the Medical Director or his/her staff. However, for administrative convenience and efficiency:

A. The salaries, fringe benefits, and other related payroll expenses of the Medical Director's staff shall be paid to them by EMSA from the Quality Assurance Fund, either directly or through a party designated by the Medical Control Board, and for purposes of federal and state employment law, and health insurance purposes.

1) The Medical Director or the Medical Director's staff shall be considered employees of EMSA, if such salary, fringe benefits, and other payroll expenses are paid by EMSA to the Medical Director or the Medical Director's staff directly,

2) The Medical Director or the Medical Director's staff shall be considered employees of a party designated by the Medical Control Board, if such salary, fringe benefits, and other related payroll expenses are paid by EMSA to the Medical Director or the Medical Director's staff through such party designated by the Medical Control Board.

16. Quality Assurance Fund. The Trustees of EMSA, acting through its Chief Executive

Officer, shall establish and administer a Quality Assurance Fund:

A. As provided for in the Uniform Ordinance for Emergency Medical Services (Exhibit A), the Quality Assurance Fund shall be financed by the Beneficiary member jurisdictions, the Non-beneficiary member jurisdictions, and EMSA as requested by the Medical Control Board and approved by the Beneficiary Jurisdictions as defined in the Amended and Restated Trust Indenture (Exhibit B);

B. The Quality Assurance Fund shall be administered by the Quality Assurance Fund Administrator, who shall be the Chief Executive Officer of EMSA;

C. The Quality Assurance Fund shall be used exclusively for the payment of salaries, fringe benefits, and other related payroll expenses of the Medical Director and his/her assistants; for research and development activities approved by the Medical Control Board, which are intended to develop optimal quality of care provided by the EMS System; to pay all other expenses reasonably incurred in establishing and monitoring the quality of emergency medical care delivered by the EMS system; and to have or hold any real or personal property reasonably necessary to accomplish the purposes set forth herein.

17. Termination.

A. Termination for Convenience-Unilateral: Each Beneficiary and Non-beneficiary member jurisdiction's participation in this Agreement may be separately terminated upon 180 days advance notice to the EMSA Board of Trustees and the other member jurisdictions and entities. Such termination shall render that jurisdiction ineligible to qualify as a Non-Beneficiary Member Jurisdiction, as defined by the Amended and Restated Trust Indenture (Exhibit B), and ineligible for distribution of any portion of the Quality Assurance Fund; unless the member jurisdiction's participation in this Agreement is terminated under either of the circumstances delineated in subsections B or C below;

B. Termination for Convenience – Bi-lateral: In the event this Agreement is terminated simultaneously by all then-remaining Beneficiary member jurisdictions, and any money remains in the Quality Assurance Fund, all such money shall be distributed, pro rata, based upon the number of transports originating within each member-jurisdiction, within the immediately preceding twelve-month period, to the governing body of each

member jurisdiction;

C. Termination for Default/Non-Compliance: In the event this Agreement is terminated by a Beneficiary member jurisdiction due to EMSA or any of its Operations Contractors' a) non-compliance with the terms of the quality of care standards as adopted by the Medical Control Board, or b) failure to cure response time non-compliance following the process delineated in the Second Amended and Restated Trust Indenture, the Beneficiary member jurisdiction may terminate its participation in this agreement.

D. Termination of a Non-Beneficiary member jurisdiction by EMSA: The EMSA Board of Trustees may determine, in its sole discretion, that in the interest of public health and safety, resource constraints, or other financial reasons that a Non-Beneficiary member jurisdiction's participation should be terminated upon the following terms:

a. EMSA shall give written notice to the governing body of the non-beneficiary member jurisdiction that EMSA intends to invoke Article X, subsection 7 of the Trust Indenture;

b. Upon such determination pursuant to Article X, subsection 7 of the Trust Indenture that the jurisdiction's participation shall be terminated, EMSA and the non-beneficiary member jurisdiction will work cooperatively to transition operations to that non-beneficiary member jurisdiction or its selected provider within a period of time not to exceed six (6) months.

18. Signatures. The Cities of Tulsa and Oklahoma City are the initial signatories to this EMS Interlocal Cooperation Agreement, and recognize that additional jurisdictions may join with Oklahoma City and Tulsa in this EMS Interlocal Cooperation Agreement. Provided such newly added entities shall meet the Requirements for Membership, approved by the governing body of that entity, shall automatically entitle that entity to the benefits and responsibilities of membership in this EMS Interlocal Cooperative.

IN WITNESS WHEREOF, the parties have hereunto set their hands and seals this ____ day of

_____, 2022.

APPROVED:

THE CITY OF TULSA, OKLAHOMA

ATTEST:

City Clerk

MAYOR

APPROVED:

City Attorney

THE CITY OF OKLAHOMA CITY, OKLAHOMA

ATTEST:

City Clerk

MAYOR

REVIEWED as to form and legality:

Assistant Municipal Counselor

EMSA BOARD OF TRUSTEES

MICHAEL BAKER, Trustee

RICHARD KELLEY, Trustee

DR. JEFFREY GOODLOE, Trustee

PHIL LAKIN, Trustee

ALLISON PETERSEN, Trustee

TAMMY POWELL, Trustee

JAN SLATER, Trustee

SCOT RIGBY, Trustee

R. SCOTT VAUGHN, Trustee

WILEY WILLIAMS, Trustee

BRYAN WOOD, Trustee