

THE EMS BILL OF RIGHTS

-PROGRAM FOR NATIONAL EMS IN 2026-

PREAMBLE

This is an industry that has abandoned its workforce. It has accepted mismanagement, fissure, and defeat. Across America are a hundred ways to deploy an ambulance, and none of them are organized to serve the needs of the ambulance worker.

Across the United States, EMS professionals, those entrusted with preserving life at its most fragile, earn wages that barely exceed minimum wage, despite the complex, high-risk, and emotionally demanding nature of their work. We are treated as second-class responders in a system that relies on them as frontline providers in nearly every public health, safety, and disaster response effort. This inequity is not only morally indefensible; it is operationally unsustainable. Front and center, we need to link low pay to long hours, to the collapse of mental health and morale.

The EMS Bill of Rights is a blueprint for survival and progress for the EMS worker-professional.

It outlines essential labor standards and structural reforms necessary to stabilize, professionalize, and sustain emergency medical services nationwide. This document must be adopted by every leader, policymaker, and advocate who claims to stand for public safety and the EMS professionals who uphold it.

The Preamble asserts that EMS has been deliberately mismanaged for decades, driven by profit and billing revenue from various actors who do not prioritize the welfare of EMS workers. There are 25 objectives in total in the draft, and they combine a mix of Parity Program labor stipulations on parity with firefighters, nursing, sanitation, and/ or law enforcement. There are also policy recommendations on EMS financing, retention of staffing, educational development, mental health support, and deployment structures.

It is time to organize. Form EMSPAC chapters. Join unions. Take back control of the unions we are in. Demand representation. Demand dignity. From coast to coast, the future of EMS will be won by those willing to fight for it, together.

You can get a copy of the draft and contribute to it by actually joining the group emspac.org

Summarized Articles

1. Start Pay: EMT \$35, Paramedic \$55.
2. Fully Subsidized Health Plans.
3. 20 and out Pensions.
4. Unlimited Sick days with valid documentation.
5. 6 weeks PTO per year.
6. Differential for night 25%/ Differential for weekend is 20%
7. Longevity Pay at year 4: .+2.5% every 2 years.
8. Paid meal and bathroom breaks.
9. Differentials for each EMS credential and a B.S. in Paramedicine.
10. Standardize uniform across the country and provide individualized PPE, bulletproof vests, de-escalation training, boot stipend, and a fair uniform washing stipend.
11. Offer educational scholarships to the next highest medical title of the institution.
12. Elevate educational standards to incentivize B.S./M.S. Paramedics and bridge programs to RN/PA/RT/MD.
13. 24 weeks of maternity/paternity.
14. Death and disability benefit parity.
15. Functional and engaging CISM and peer support.
16. Make EMS a “Uniformed Service.”
17. Make EMS an “Essential Service.”
18. Federal EMS Corps.
19. Expansion of Community Paramedicine and treatment in place/alternate destination/ RMA billing. Increase in-hospital roles and usage. Reduce reliance on the 911 system for unwarranted activation and primary care.
20. Equalize pay and benefits for all EMS that are fire department-based/ law enforcement-based with the services deploying.
21. Audit, merge, consolidate volunteer ambulance corps systems, and provide \$2500 tax credits for those that are viable operations. Seek to use paid employees.
22. Complete revitalization of training/certification methods and CME
23. Demonatize Actual Emergency EMS
24. Develop Third Service EMS, supported by the Federal EMS Corps.
25. Only one labor organization should represent EMS, and that is the Healthcare Union 1199SEIU. There should only be one EMS union for all 2 million EMS workers.

ARTICLE ONE
PAY EMS FAIRLY

EMT Start Pay \$35.00/hr
Paramedic Start Pay \$55.00/hr

We must directly link low pay with long hours, hazardous work, and physically and mentally draining conditions that affect our EMTs and Paramedics. That exposes us to ongoing suffering and periodic carnage.

We must link livable wages with the retention of skilled and competent personnel.

We are not justifying this solely based on life-saving skills and the socially useful furtherance of public health and safety. We are paying for a billable, monetized service that is in high demand. No more second-class first responders. Full pay and benefits parity must be achieved with firefighters and law enforcement.

Each year, thousands of trained EMTs and paramedics leave the profession, not for lack of commitment, but because of systemic neglect, underinvestment, and a lack of institutional recognition. The result is a dangerously understaffed and unstable national EMS system teetering on the edge of collapse. The answer is inequitable pay structures.

ARTICLE TWO
FULL COVERAGE MEDICAL BENEFITS

EMS must be cared for when we are sick or injured, on or off the job.
EMS is the driving force of American Healthcare. Our members deserve adequate and affordable coverage when we are sick and hurt.

Fully paid healthcare for members by the employer must be provided, with dental, vision, and equitable family coverage, with no copays.

There must be employer-subsidized health care plans. There must be employer-subsidized accident, injury, and short-term disability insurance.
EMS has high instances of injury, behavioral health problems, cancer, premature death, and mortality. We require subsidized health care.

ARTICLE THREE
20-YEAR EMS PENSIONS
A PENSION AFTER 20 YEARS OF FULL-TIME SERVICE

This is a highly difficult job, physically and mentally, and it should be covered by a pension after 20 years of service.

Contributions are to be made by both the employer and the employee, and managed by the State. This EMS Pension will be fully transferable between agencies. A full Transfer of Pension in the event of a Line of Duty Death will occur to the Surviving Spouse, Child, or an Elderly Parent.

ARTICLE FOUR

UNLIMITED SICK LEAVE WITH VALID DOCUMENTATION

All illness that occurs while fully employed will be assumed to have been contracted on the job. An injury on or off the job will be covered by paid sick leave until the member can return to light-duty or is deemed unable to return to work and placed on long-term disability.

Preliminary annual banks will be separated from other types of PTO:

- **5 critical stress/mental health days**
- **5 unplanned time off sick, no note needed.**

Unlimited sick leave with valid medical documentation.

Agencies will allow their members to use mental health days, unplanned time off, or PTO to attend the funerals of their EMS colleagues.

All agencies will treat area EMS Deaths within a specific system as if it were their own member and facilitate the attendance of the funeral as long as it does not result in a complete shutdown of all operations.

ARTICLE FIVE

ADEQUATE PAID TIME OFF AND VACATION TIME

6 weeks per year with an additional week for every 4 years worked. It will be fully prohibited to dock it as a disciplinary measure.

This is paid leave for rest, leisure, and family time. **A total of 12 holidays** will accrue time-and-a-half if worked, or 2 days of “Comp time”, or be paid a regular rate if off-duty. With documentation of religious observance, the 11 Federal Holidays +1 may be swapped for those of a specific religious observance, but will not accrue a time-and-a-half/2-day comp rate.

ARTICLE SIX

PREMIUM SHIFT DIFFERENTIALS

Shift work has a proven harmful effect on the body and mind.

30% Nocturnist: when all shifts are night shifts

25% for Night Shifts

20% for Weekend Shifts

15% for Field Training ride-alongs (FT)

10% Hazard Pay for MCI and all Working Fires

Double time will be paid for any “Mandation” to disincentivize this inefficient and stressful arrangement of shift coverage. All shift work lowers the years of one's life.

ARTICLE SEVEN

IMPROVED LONGEVITY PAY

The average EMT leaves the field within 4 years due to low pay, high stress, and lack of upward mobility.

Beginning at year 5 at the employer, increasing every 3 years by a 3% interval if one remains at the same employer, one gains an improved longevity stipend.

You will retain State-regulated EMS Longevity between employers at year 9. The State Dept./Bureau of EMS will regulate a mandatory industrial longevity system that incentivizes remaining in the field. This rate will be half the accrual rate if the member changes employers.

Longevity at 5 years: 3% annual increase, Longevity at 8 years: 6%, 11 years: 9%, 14 years: 12%, 17 years 15%, 20 years: 18%, 23 years: 21%, 26 years of service: 25%.

ARTICLE EIGHT

PAID MEAL AND BATHROOM BREAKS WITH CLEAN AND DECENT QUARTERS

At every turnout location, garage, station, or EMS base, certain standards have to be met. So-called “Facilities”: Meal or bathroom breaks will be granted for every 8 hours worked, in a not to be interrupted in a 30-minute bank. Units will be put out of service completely until it is over. Bases are to be kept clean and organized by the employer. The employer will provide basic cooking, hydration, showers, bunking, and a gym.

There should be some stipulation that a unit must come off a meal break for a cardiac arrest, major trauma, or other actually critical call if no other unit is available, and they can resume their break time after completing the call.

ARTICLE NINE

CREDENTIAL DIFFERENTIALS

Added to base pay when operating in the specialized capacities below:

CLI: +\$10

CIC: +\$20

FTO +\$3

Hazmat +\$3

Rescue +\$10

Critical Care (CC) +\$10

Community Paramedicine(CP)+ \$10

Flight Medic Fixed Wing (FP-C) +\$10

Flight Medic Helicopter (FP-C) +\$20

ARTICLE TEN

UNIFORM STANDARDIZATION AND ALLOWANCE

All EMS Providers should be clad in a standardized regional uniform, not dressed in unique colors by the deploying agency.

Standardized uniforms will be provided for all members, one for each day of the week they work. Individualized Bunker Gear, including high-quality boots, helmets, eye protection, and all necessary respiratory PPE, will be provided by the employer. The agency will also provide a \$1000 annual stipend for washing the uniforms. All ripped or damaged uniforms will be replaced on a one-for-one basis. Bulletproof vests will be made available on request.

Personal Protective Equipment Requirements: EMS providers must be issued and trained in at least Level C protection as the minimum standard. This includes respiratory protection options such as disposable N95s, half-face respirators, full-face CBRNE masks, and Self-Contained Breathing Apparatus when necessary. These protections shall be standardized and mandated for all EMS personnel to ensure safety in high-risk environments.

Action item to enact state legislation or a state-level regulatory mandate requiring all EMS employers, regardless of service delivery model (public, private, nonprofit, or volunteer), to provide and maintain Level C personal protective equipment (PPE) as the minimum standard for field operations in hazardous or contaminated environments for all 9-1-1 providers. This regulation shall include respiratory protection such as N95 respirators, half-face elastomeric masks, full-face CBRNE-rated respirators, and Self-Contained Breathing Apparatus (SCBA) when risk assessments warrant higher protection. Additionally, all EMS personnel must receive annual training and fit testing to ensure proper use and deployment of issued PPE. This requirement shall be enforced by the state EMS office to ensure standardized protections for all frontline responders.

ARTICLE ELEVEN

INCREASE EMS EDUCATIONAL OPPORTUNITY

Every agency will establish Study Grants and Health Service Scholarships to allow a greater number of EMTs to advance to Paramedic.

There is always a health worker shortage. We must de-silo healthcare; that is to say, remove prohibitive barriers to advance from one health trade into another. Nursing is not a radically different set of skills and patient care activities. EMS does not gain strong clinical judgement unless they can learn from RNs and MDs in the ER. We recommend Paramedic to RN/RT/PA/NP/MD Bridge Programs. RN/RT/PA/NP/MD scholarships shall be made by the state and the employer.

Public Health, Emergency Management, and Healthcare Administration MA tracks are to be built into the programs. We seek tuition reimbursement programs. We seek public service debt forgiveness to be expanded to the entire profession in all sectors, and PreMed/ Post Bacc Premed Programs to be sponsored by the employer and the state, using Paramedic certification as the primary building block.

Incentives for teaching/clinical precepting roles by EMS clinicians should be enacted. When employers leverage the clinical expertise and knowledge of experienced EMS clinicians without adequate compensation, it is inherently unfair and unrealistic.

ARTICLE TWELVE

ELEVATE EDUCATIONAL STANDARDS

We will elevate the academic standards of this profession without creating unnecessary barriers to entry. It should be a more seamless and less cynical course design to achieve a career as Paramedic. EMS Retention across this country is disintegrating.

We recommend a separate longer track of 2 (ASA), 4 (B.S.), or 6-year (M.S.) Paramedic programs resulting in the 6-year “Paramedic Practitioner.” We will streamline recertification, offer licensure, and create more value through a higher educational standard.

A Modular EMT progression program will be established to allow the EMT to progress while working to EMT-I, EMT-CC/AEMT, and then to Paramedic Basic. A Paramedic Licensure Program will be developed, and a relevant, unified system of Continuing Education. A Paramedic Practitioner BS/MS degree program will be established, allowing pay and benefits parity with PAs and NPs.

Hazmat, Rescue, Critical Care, Flight, and Officer Upgrades will be better and more seamlessly incorporated into the coursework. We seek a more seamless transition within the medical titles through the incorporation of EMT-B, EMT-I, and EMT-CC into one unified 3/6/9-month EMT course. The student may then bridge into Paramedic through additional hours, tests, and practical skill competencies. EMT-B, EMT-I, EMT-CC to Paramedic Bridge Programs will be established.

Certification Recognition and Compensation: Increased levels of certification (HAZMAT, Critical Care, etc.) will be formally recognized within EMS structures. These advanced roles will require added training and continuing education, and will be supported with tiered compensation. Recognition of higher certification levels must be integrated into both operational deployment and professional advancement frameworks.

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ARTICLE THIRTEEN

MARRIAGE, MATERNITY, & PATERNITY LEAVE

We seek a maternity policy that allows a mother to take light-duty positions three months prior to pregnancy, sick leave a month before the due date, and then activate a combined FMLA/Employer subsidized paid bank for 24 weeks, half employer, half state. Once that sick leave is used up, the mother can use any vacation days and then take up to 365 days of unpaid leave.

Twenty-four weeks (6 months) at 100 percent salary for both parents, both will have a mandatory eight weeks (2 months) off for childbirth and bonding. Up to 1 year fully paid when combined with existing leave balances.

Employers will grant 14 consecutive PTO days for a new marriage of two employees.

ARTICLE FOURTEEN **DEATH AND DISABILITY INSURANCE**

Death and disability benefit parity should be matched to comparable plans offered by regional law enforcement and fire services.

Employers and unions where involved will be mandated to provide a subsidized On-or-Off-Job injury insurance plan and an accidental death and long-term disability plan. It will be in several tiers to cover varying lengths of disability.

All agencies will treat area EMS Deaths within a specific system as if they were their own member and facilitate the attendance of the funeral as long as it does not result in a complete shutdown of all operations. Agencies will allow their members to use mental health days, unplanned time off, or PTO to attend the funerals of their EMS colleagues.

Adoption and caregiver leave must be recognized as essential components of every benefits package. Many EMS clinicians are faced with the challenges of caring for older family members. EMS clinicians who have chosen to adopt children face unique obstacles that fall outside of what was typically considered traditional benefits before, and they should be allowed to leave to bond and care for newly adopted family members. These benefits should align with federal FMLA standards and state equivalents.

ARTICLE FIFTEEN **Functional and Engaging CISM and Peer Support**

ALL OVER AMERICA, WE HAVE AN UNWELL WORKFORCE WITH HIGH, PERSISTENT LEVELS OF SUICIDE AND SELF-HARM. Employers must establish essential programs to protect Members from cumulative and post-traumatic stress. The State will mandate a separate balance of PTO days for mental health recuperation after serious calls. A multi-tier program of confidential support for members and their families must be set up by each agency. Free counseling, peer-to-peer networks, and subsidized physical fitness.

Critical Stress debriefing services must be triggered after any call with major trauma, pediatrics, or mass casualty. Participation will be mandatory but can result in additional PTO/AL days post-incident when appropriate.

Mental Health Resilience Infrastructure: Each EMS organization must appoint one or more Mental Health Resilience Officers responsible for building and overseeing wellness programs. Peer-support counseling teams will be mandatory. All EMS clinicians must receive entry-level mental health protection training with continuing education updates annually to reinforce resilience, stress management, and protective coping strategies.

We must encourage the legislator to enact legislation or regulatory standards requiring all EMS providers, regardless of service delivery model (public, private, nonprofit, or volunteer), to establish a formal Mental Health Resilience Infrastructure. This mandate shall include the appointment of at least one designated Mental Health Resilience Officer (MHRO) per agency, responsible for developing and overseeing comprehensive wellness and mental health support programs.

All EMS agencies must implement peer-support counseling teams composed of trained clinicians to provide confidential, internal support. Additionally, every EMS clinician must receive initial mental health protection and resilience training as part of onboarding, with mandatory annual continuing education focused on stress management, trauma recovery, and coping strategies to mitigate burnout and psychological injury. This requirement shall be overseen by the state EMS authority to ensure uniform implementation and accountability across all EMS systems. Suicide prevention training, mandatory annual mental wellness assessments, and improving the availability of debriefings are essential to protecting our workforce.

ARTICLE SIXTEEN

MAKE EMS A “UNIFORMED SERVICE”

POLITICAL WILL MUST SUPPORT THE AMBULANCE SERVICE.
UNIFORMED MEANS WE WILL BARGAIN INDEPENDENT OF CIVILIAN TITLES.

Any EMS clinician, regardless of organizational affiliation, private, non-profit, hospital, municipal, state, federal, private, or any other non-governmental entity, shall have the same responsibilities, powers, and authorities as any other governmental EMS clinician. Non-governmental EMS clinicians are entitled to equal protection and legal standing and must be recognized as having the same professional scope and authority as their municipal or state-employed counterparts.

MAKE EMS LEGALLY A “UNIFORMED STATUS.”

EMS must be given official recognition as “uniformed” for municipal and state bargaining. Classify EMS legally as a unique and uniformed field, with the same protections of Law Enforcement, Firefighters, and Sanitation.

Public or private sector EMS must enjoy a privileged status for bargaining. We should not be lumped with other fields; we must have our own bargaining units.

Classify EMS legally in each system as a separate bargaining unit from civilian pattern bargaining contracts. Mandate that municipal EMS bargain separately from larger municipal civilian conglomerations.

Political engagement needs to occur with legislation passed at the state level that empowers EMTs and paramedics, regardless of the service delivery model. These are the action items for any proposed legislation:

Equal Legal Standing as Public Safety Personnel

- Legislation should define EMTs and paramedics as *essential public safety professionals*, on par with law enforcement, firefighters, and nurses, under all state and federal statutes.
- EMS professionals respond to life-threatening emergencies, disasters, and violent incidents. Recognition as public safety officers ensures access to comparable rights, protections, and benefits.
- Applies uniformly across all agencies, whether public or private, unionized or not. (this has been done for Humane Officers in PA and CA to enforce laws and make arrests, even though they work for private entities).

Occupational Safety and Violence Prevention Protections

- This legislation needs to mandate that all EMS providers are covered under workplace violence prevention laws (similar to those applied to healthcare, fire service, and law enforcement), including:
 - Enhanced criminal penalties for assaulting EMS personnel.
 - The right to withdraw from unsafe scenes without punitive consequences.
 - Access to employer-paid body armor and violence de-escalation, escape/evade, and self-defense training.
- EMTs and paramedics face increasing rates of workplace assault and need legal protection to ensure safe working environments.

Due Process and Whistleblower Protections

- EMTs and paramedics should have legislated due process rights, including:
 - Protection against retaliation for clinical advocacy or patient safety reporting.
 - A formal grievance process for clinical or disciplinary disputes.
 - Shielding from termination without just cause.
- Providers who advocate for patient safety or ethical concerns are often vulnerable, especially in at-will or private-sector employment. These protections are afforded to governmental employees, but are afforded to non-governmental employees on a limited basis.

Legal Immunity and Liability Protection

- Legislation must include the ability to extend qualified immunity protections to *all* EMTs and paramedics operating in an EMS system of care and under medical direction or local/state protocol.
- Fear of litigation can inhibit clinical decision-making, especially in high-stakes environments. EMTs and paramedics for the FDNY are afforded certain protections that are not available to voluntary hospital EMS units. This protects providers acting in good faith.

EMS must be given official recognition as “uniformed” for the purpose of municipal and state bargaining. When we are not given such status, we will bargain with the weakness of civilian, private sector employees.

ARTICLE SIXTEEN

MAKE EMS AN “ESSENTIAL SERVICE”

“ESSENTIAL” MEANS WE ARE INTEGRAL TO THE BUDGET AS SOMETHING THAT MUST BE PROVIDED TO THE ESSENTIAL RUNNING OF SOCIETY.

MAKE EMS “LEGALLY ESSENTIAL.”

Ambulance Services are an *expected entitlement* by the taxpayer. They must be funded as a necessity of public safety. EMS should be demonitized. We should funded it like other first responders because it's expected in a modern society to have 911 ambulances.

“ESSENTIAL” MEANS YOU ARE INTEGRAL TO THE BUDGET AS SOMETHING THAT MUST BE PROVIDED TO THE ESSENTIAL RUNNING OF SOCIETY.

We should be budgeted as an essential part of all municipal and state budgets, a vital service not left to the private sector or volunteerism.

We should be budgeted as an “essential” part of all municipal and state budgets, a vital service not left to the private sector or volunteerism.

ARTICLE EIGHTEEN

FEDERAL EMS CORPS.

SUPPORT AN EMS CORPS

An EMS Corps must be established at the Federal level to deploy EMS personnel in a similar manner as service in the military. We should use this paramilitary models to end the shortage of EMTs and Paramedics across the nation. Young people who serve in the 3-4 year EMS Corps will get military healthcare and educational opportunities similar to regular service.

The American EMS Corps would serve as a federally supported, civilian medical reserve force designed to address the nation’s chronic shortage of emergency medical personnel while creating a respected career pathway for public service. Modeled after the structure and benefits of the armed forces, the Corps would recruit and train EMTs and paramedics to deploy across diverse EMS systems—urban, rural, tribal, and disaster-affected zones. Members would serve under contracts ranging from two to six years, rotating through assignments based on regional needs, much like National Guard units or military medical branches. The goal would be to create a professionalized and mobile EMS workforce that is both responsive to crises and embedded in community-based care.

In exchange for their service, members of the EMS Corps would receive robust benefits on par with those offered by the military: comprehensive health insurance, a living wage with hazard pay options, housing stipends, tuition-free advanced training or college education, and a

structured pension or loan forgiveness program. These benefits would not only reward those willing to serve on the medical frontlines, but also help standardize EMS pay and working conditions nationwide—long overdue for a field often excluded from the broader healthcare system and lacking the protections afforded to police, fire, or military personnel.

The Corps would also emphasize continual professional development, offering structured promotion tracks, specialization in areas like wilderness medicine, tactical EMS, disaster response, and public health education. Just as the Peace Corps builds soft-power diplomacy and the military builds logistical readiness, the EMS Corps would strengthen our national resilience in the face of climate disasters, pandemics, and infrastructure failures. The program could draw from and contribute to local EMS agencies, acting as both a relief valve and a training ground, improving retention across the board.

ARTICLE NINETEEN

EXPANSION OF COMMUNITY PARAMEDICINE

INCREASE SCOPE AND DEVELOPMENT OF COMMUNITY PARAMEDICINE

Community Paramedicine (CP) has developed all over the nation, driven by insurance companies seeking to cut the costs of in-hospital care/ in-hospital admissions, which are massive. Some laws prohibit rebilling when patients are admitted repeatedly within a certain window, usually a month.

Community Paramedicine and wellness checks on legitimate medical emergencies will be fully billable calls or broadly subsidized by insurance companies, and there will be more financial incentives to deliver more care in the home/field. Community Paramedic wellness checks must be widely expanded and utilized to prevent recurrent use of the ED for primary care.

There is a wide variety of current CP models for deployment across the nation, but the large and successful ones combine four elements:

- (1) check-ups and surveillance; i.e., a visiting nurse service using paramedics, usually administering medications to vulnerable patient populations with high ER usage.
- (2) using digital telemetry to have a patient check in with an advanced care provider on a screen in their home (usually an NP, PA, or MD) while the paramedic aids in the physical exam tests and administers medication under orders/ takes various labs/tests.
- (3) Social workers and a care team (usually RNs/PAs) follow up by phone or video by phone telemetry and help make referrals and appointments.
- (4) Logistics of care, such as paying for cabs to appointments, increasing the number of home health aid hours, and providing counselors/therapists, are often coupled with having the insurance company pay for more medical equipment that is going to prevent repeated hospitalizations.

It is widely believed that 85% of procedures done in the ED can be done in the field less expensively, at greater comfort for the patient, but this requires not only highly accountable paramedics, but it also requires oversight and follow-up visits.

New Laws are going to allow an increasing number of agencies to bill for treatment and release. State-level billing compensation must begin for all treat-and-release and treat-in-place type calls. As well as diversions to alternative destinations. Dispatchers and 911 units should have the ability to downgrade a call type to a private transport agency.

There should be an Expansion of Community Paramedicine and an increase in in-hospital utilization of EMTs and Paramedics.

ARTICLE TWENTY

EMERGENCY SERVICE WORKER PARITY

A large number of EMS in America are deployed from Fire Departments, and a lesser amount from Police agencies. We must equalize pay and benefits for all EMS that are fire department-based/ law enforcement-based within the services deploying them.

FireFighter/Dual Resource EMS is a widespread model of coverage across the U.S. Major cities like L.A. and Chicago utilize paramedic firefighters. There should be a reverse promotion **from FF into more specialized, more clinical EMS**, not the other way around. Where dual-resource Fire Dept-based EMS exists, becoming an EMT should be a prerequisite for then becoming a Firefighter, thus beginning to eliminate awkward division in the services that utilize a dual response. Becoming a paramedic is a 1-2 year program, which is a completely different skill set than that of a firefighter.

FF-CFRs should be utilized for crisis staffing alone. Not routinely sent on medical calls without justification. This is a highly wasteful model of deployment, and there is a hard limit to what FF-CFRs are trained to do. They should not be able to be released without the direct authorization of the EMS unit on scene. All FF-CFR or FF-EMS should be taking **at least one set of vitals and beginning the process of extrication** via a carrying device for any EMS delay to the scene.

It will be prohibited for any Fire Department to provide separate and unequal facilities to its non-FF EMS personnel. EMS employed/ deployed from firehouses must receive equal pay as firefighters and be integrated into the departments they work for.

There should be **no second-class first responders**, especially those serving in the same agencies/organizations.

ARTICLE TWENTY-ONE

VOLUNTEER AMBULANCE CORPS

We must audit, merge, and consolidate volunteer ambulance corps systems, and provide \$2500 tax credits for those that are actual viable operations. All economically stable VACs should seek to use paid employees.

We must decrease the reliance on the Volunteer Ambulance Corps.

This is a service model of inefficiency and desperation based on there being no ability to provide paid professional EMS. All Volunteer Agencies with valid documentation of ongoing demonstrated service will be allotted a fixed subsidy by City and State Officials to sustain operations. Those unable to meet 24/7 coverage will be merged or shut down completely. VACs will be given specific units and cross-street designations and be deployed into the 911 system as a regular voluntary unit. Greater availability of grants and stronger integration of the VAC units into the 911 system will not improve function.

There will be an increase in tax incentives for Volunteer groups operating professionally and efficiently with a regular degree of consistency. We support a major increase in programs to incentivize VAC involvement with a \$2,500 available annual tax credit and scholarship opportunities for EMTs and Paramedics active with a VAC.

VAC that employs EMTs or Paramedics will register them with the nearest adjacent municipal service and establish their pay/benefit parity on equitable regional lines.

ARTICLE TWENTY TWO

EMS TRAINING AND CONTINUING MEDICAL EDUCATION

There must be a complete revitalization of EMS training and certification methods in the United States to meet the complex demands of modern emergency care and ensure both workforce readiness and long-term retention. The current fragmented system—marked by inconsistent state standards, variable course quality, and insufficient clinical exposure—produces uneven skill levels and poor professional continuity. A national overhaul should establish competency-based, standardized curricula that integrate simulation training, early hands-on experience, and up-to-date clinical science. The goal is not just to produce test-passing graduates, but to shape capable, adaptable clinicians ready for the realities of prehospital care in high-stress environments.

Equally urgent is the need to modernize Continuing Medical Education (CME), transforming it from a perfunctory requirement into a dynamic, career-building process. Too often, EMS professionals are subjected to redundant or outdated modules that neither enhance clinical skills nor reflect current public health needs. Modern CME should be flexible in format—offered online, in-person, and hybrid—and grounded in real-world scenarios, covering areas like trauma-informed care, mental health crises, disaster response, and community paramedicine. When tied to clear pathways for promotion and specialization, high-quality CME becomes a tool not just for professional development, but for retention and respect. Together, these reforms would establish EMS as a lifelong profession and a vital pillar of the nation's emergency response and public health infrastructure.

ARTICLE TWENTY THREE

DEMONETIZE ACTUAL EMERGENCY EMS

We must take the money out of EMS, where and when EMS is utilized, as its training and purpose are warranted; not when it is used as a medical taxi, a means to shift civic liability, or frankly, a means by which the Middle and Upper classes dispose of the homeless.

Rather than bask in moral failure or cynicism about human nature, we must have a frank conversation about what is a real emergency, where a human is in extremis, where they might die without a medical intervention. Thus, we know and realize the vast majority of our calls are NOT emergencies; the vast majority are system abuse and activations motivated by the threat of litigation, not humanitarian purposes.

Emergency Medical Services (EMS) should be fully demonetized—removed from the fee-for-service healthcare model—and treated as an essential public safety function on par with police and fire departments. Just like law enforcement and firefighting, EMS responds to urgent, life-threatening emergencies regardless of a person's ability to pay. Yet unlike those counterparts, EMS is too often forced to operate within the constraints of a healthcare billing system, where ambulance transports and interventions are tied to insurance reimbursements or out-of-pocket costs. This model creates dangerous delays, disincentivizes necessary care, and places patients and providers in a morally compromised position where lifesaving help is treated as a commodity rather than a guaranteed public right.

Tying EMS funding to transport billing has distorted the mission and scope of prehospital care. In many systems, agencies are financially rewarded for taking patients to the hospital—whether or not it's clinically necessary—while receiving little or nothing for treating someone on scene or preventing an unnecessary ER visit. This not only burdens hospitals but also leads to wasteful spending and burnout among EMS providers. It undermines community paramedicine and innovative models of care that could better serve people with chronic illness, mental health crises, or housing instability. By demonetizing EMS, we would allow providers to treat based on need, not reimbursement codes, and free the system to evolve into a proactive, mobile branch of public health.

Furthermore, the current monetized system erodes public trust. People often hesitate to call an ambulance out of fear of the cost—especially in underinsured or undocumented communities. No one should have to weigh financial ruin against the possibility of surviving a heart attack, overdose, or stroke. The fact that EMS is dispatched by 911 but funded like a hospital service creates a two-tiered system of emergency care: one where access and outcomes are shaped by socioeconomic status. Public safety services must be universally accessible and equitably funded through public dollars—not through charging sick people in crisis.

Demonetizing EMS would align the system with the ethical standards of other emergency services and lay the foundation for a more resilient, efficient, and just model of care. It would allow EMS professionals to focus on stabilizing patients, preventing escalation, and collaborating with health and social services without the pressures of billing quotas or transport incentives. Funding EMS as a fully public service—through municipal, state, or federal budgets—would not only improve outcomes and reduce costs downstream, but also restore the integrity and dignity of a profession that stands at the front lines of life and death every single day.

ARTICLE TWENTY FOUR

THIRD-SERVICE EMS

EMS MUST BE A STANDALONE, EMERGENCY RESOURCE

In every single place where EMS is based in Fire or PD, its members are second-class first responders. EMS needs to be deployed out of municipally funded/state-funded Departments of EMS. Getting an ambulance in an actual emergency should be an essential right, not a billable commodity.

All other configurations will result in mismanagement and inefficiency. We should move to abolish volunteer and private agencies from being involved in providing essential 911 services. Police uphold the law, Firefighters protect property, and EMS preserve human life. They are not the same, and EMS should not be in the shadow of the other two.

EMS Must Be Recognized as an Essential Service: EMS is already acknowledged as a mandatory benefit under Medicare and Medicaid. As such, EMS must be officially recognized and protected as an essential public service across all jurisdictions and levels of government. This designation shall ensure commitment at the community level, sustainable funding, integration into emergency response infrastructure, and prioritization in health and public safety policies.

To ensure reliable access to life-saving emergency medical care, we must pass legislation that formally designates EMS as an essential public safety service, equivalent to police and fire. This action would require every jurisdiction, regardless of whether EMS is delivered by a public, private, nonprofit, or volunteer agency, to provide consistent EMS coverage, backed by stable and equitable funding. By establishing EMS as essential, the law would also enable statewide minimum standards for clinical care, staffing, and response times, while protecting the workforce through wage floors, mental health resources, and workplace safety measures. This designation is a critical first step toward fixing the fragmentation, underfunding, and attrition crisis that threatens the stability of EMS systems nationwide.

ARTICLE TWENTY FIVE

ONE NATIONAL EMS UNION

ALL EMS SHOULD BE IN ONE LABOR ORGANIZATION.

It is time to organize ourselves nationwide. Form EMSPAC chapters. Join and revitalize existing unions and associations, knowing there should only be one union for the industry. Demand real representation. Demand dignity at work. Run for office on EMSCOs, run for office in our towns and cities. Propose solution-oriented processes. Refuse defection and defeat. From coast to coast, the future of EMS will be won by those willing to fight for it, together in a coordinated manner.

We must work to consolidate our unions into one.

We have a unique and difficult field, and we must combine our might as EMS workers to make real change in this field, and change in the lives of our struggling members. To that end, we

pursue the goal of a national EMT and Paramedic-only union and will openly raid and dissipate any opponent that profits off the status quo.

We support the creation of a singular, EMS-only labor organization that will combine over 500,000-4 million active duty/retired EMS into a powerful trade union dependent on no other labor federation. We will make every active and appropriate inroad to combine the locals of existing EMS into such a union. Thus, so far, no fully coherent or powerful unity is even close to emerging. Each union is dominated largely by non-EMS workers and takes care of only its bottom line. As of 2025, 90% of all EMS are non-union. There are under 100,000 EMS spread between IAFF, CSEA, IAEP, IBOTU, AFSCME, and SEIU.