



Spring 2026

Siren

A PUBLICATION OF THE CALIFORNIA AMBULANCE ASSOCIATION

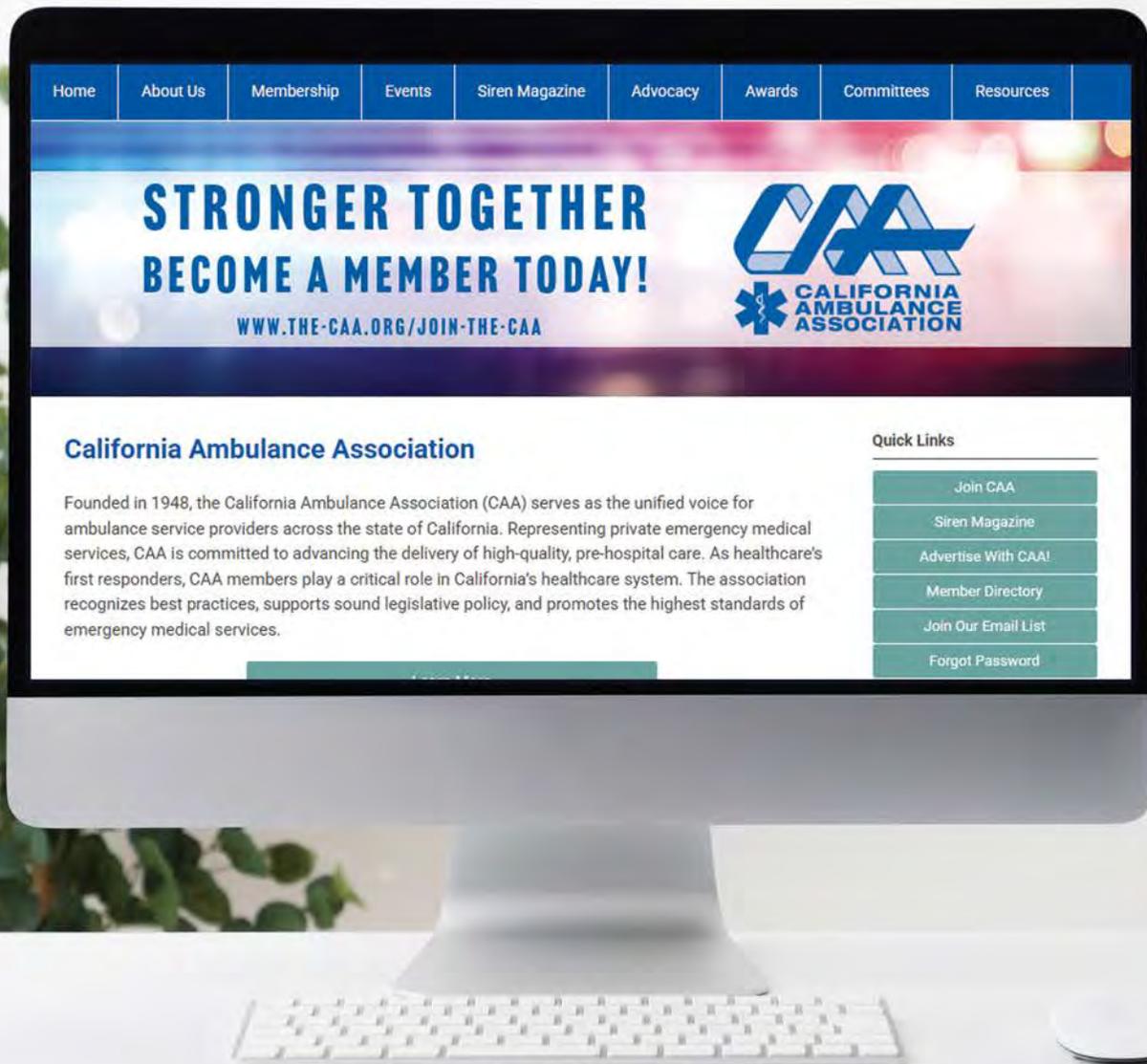




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CAA Vision

To champion the leadership, advocacy, education, and tools that empower California’s private ambulance and mobile healthcare services to provide people-centered EMS systems and standards. The CAAs overarching role is to provide support for those who care for their communities.

CAA Mission

Be a recognized voice, advocate, and authority of best practices for ambulance providers throughout California.

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- Executive Administrator:**
Christy Sinclair – christy@caladmanagement.com
- Accountant:**
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- Meeting Planner:**
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- Publications Director:**
John Berkowitz – john@caladmanagement.com

Table of Contents

- President’s Message** _____ 2
— *Steve Grau*
- Executive Director’s Report** _____ 3
— *Rob Lawrence*
- What If Success Looked Like People Loving Their Jobs?
A Conversation with Our COO, Danielle Thomas** _____ 5
— *Jacob Sarasohn*
- Where Refusals Meet Responsibility –
A Closer Look at *Murphy v. City of Petaluma*** _____ 9
— *JohnRey Hassan, Esq., RN, EMT-P*
- Education Isn’t Where Careers End. It’s Where They Take Off** _____ 13
— *Danielle Thomas*
- Anaheim 2026: Where California EMS Comes
to Connect, Challenge, and Lead** _____ 15
— *Danielle Thomas*
- CARLY’S CORNER: Time Management in EMS
Isn’t Aout the Clock – It’s About Survival** _____ 17
— *Carly Strong*
- PAYER ISSUES: Medicare Advantage and Ambulance Services:
A Strategic Contracting Decision** _____ 19
— *Doug Wolfberg*
- Operations Committee** _____ 20
— *Rob Lawrence*
- Welcome to the 2026 Board** _____ 21

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California Ambulance Association
 2520 Venture Oaks Way, Suite 150
 Sacramento, CA 95833
 (877) 276-1410 (toll free)
 (916) 924-7323 (fax)
www.the-caa.org



PRESIDENT'S MESSAGE

Stewardship, Legacy, and the Future of California EMS

Steve Grau
President
California Ambulance Association

It is an extraordinary privilege to serve as President of the California Ambulance Association at a moment like this.

Across our membership, I see leaders who care deeply not only about their organizations, but about their people, their communities, and the future of EMS in California. What unites us is more than the work itself. It is a calling rooted in service, responsibility, and impact.

CAA exists to represent the ambulance service organizations that employ **thousands of EMTs, paramedics, dispatchers, clinicians, and support professionals** who show up every day for **millions of patients across this state**. The decisions we make as an association ripple far beyond boardrooms and committee meetings. They shape careers, workforce stability, systems of care, and the trust placed in EMS as a critical component of California's healthcare infrastructure.

Honoring the Foundation We Stand On

This association did not emerge by accident. It was built by pioneers who fought for professional recognition, meaningful standards, and a credible voice in shaping California EMS. They understood that strong patient care depends on strong organizations and a supported workforce.

Every era of CAA has been defined by people willing to step forward when the moment demanded leadership.

Today, that responsibility belongs to us.

A Time of Transformation

California EMS is entering a period of profound change. Healthcare delivery is evolving. Workforce pressures are intensifying. Policy, regulatory, and reimbursement challenges are becoming more complex and more interconnected.

For the organizations we represent, these pressures are not abstract. They show up in recruitment and retention challenges, in strained margins, in increasing expectations for quality and accountability, and in the responsibility to deliver exceptional care in an increasingly constrained environment.

Incremental solutions are no longer enough. This moment calls for collaboration over fragmentation, clarity over complacency, and leadership grounded in trust.

CAA's role is not simply to respond to change, but to help shape what comes next.

Becoming the Association the Future Requires

Leadership in this era requires leaning into hard conversations, challenging one another respectfully, and setting goals that stretch us beyond what feels familiar.

It also requires acknowledging a fundamental truth: the health of California

EMS is inseparable from the health of the organizations that employ and support the workforce. Sustainable EMS systems require sustainable business models, thoughtful regulation, and policies that reflect the real operational realities our members face every day.

The true measure of our work will not be found only in outcomes, but in who we become through the process. How we collaborate. How we listen. How we prepare the next generation of EMS leaders to lead organizations, not just respond to calls.

Our vision for the future of California EMS rests on three pillars:

Advocacy and Influence

Strengthening our collective voice in Sacramento by advancing reimbursement reform, regulatory clarity, and practical, solution-oriented policy leadership that reflects the realities of delivering care across diverse communities.

Workforce and Leadership

Investing in the growth, wellbeing, and leadership development of the EMTs, paramedics, dispatchers, and professionals who are the heartbeat of EMS, and the organizations that recruit, train, and support them.

continued on page 23

EXECUTIVE DIRECTOR'S REPORT



Rob Lawrence
Executive Director
California Ambulance Association

Welcome to the first *Siren* of the year and welcome to our first major event of the year. This edition of the *Siren* is scheduled to be published at the 2026 CAA Stars of Life event in Sacramento. This is a great time to reflect on and celebrate our amazing providers, communicators, nurses, pilots, and those people who support us in every way and who all contribute to the mission star we follow: to provide care for those in their moment of need.

I would also like to welcome the 2026 CAA Board, our new President, and President-Elect. It has been a pleasure to be part of the CAA in my capacity over the last six years - or, in association-management speak, four Presidents. I have relished watching the bench strength of the Association grow through those presidential tenures, and the vibrancy of our committee structure develop and strengthen. I am fortunate, through my other professional interests across the country, to know that the structure, governance, and energy of the CAA in its current form are admired from afar by many. Speaking of professional interests, I am delighted to share that I have been able to adjust my own workload to dedicate more time – double the hours, in fact – to the Association as Executive Director.

Looking ahead, we have another strong year lined up to legislate for the profession, advocate for our members, and, in turn, support our amazing teams and their patients. The legislative agenda for 2026 is already

taking shape. Revised committee structures, particularly around events and education, are growing in both membership and output. Our newly formed regulatory subgroup has also met to monitor and comment on the wide range of California rules and regulations that are in a constant state of change.

As mentioned, this edition of the *Siren* coincides with Stars of Life and runs alongside our annual advocacy event, **CAA@Capitol**, where we spend focused time meeting with elected officials, committee members, and chairs to discuss and explain key issues. We also take the opportunity to distribute copies of the *Siren* to the offices we visit. To those who represent us in Sacramento: thank you for all that you do, and thank you for listening to and supporting the issues of the day. This support matters deeply to our members and

directly translates into our ability to provide mobile healthcare to our patients and your constituents.

As we gather to honor excellence at Stars of Life and engage in meaningful advocacy at the Capitol, this *Siren* reflects who we are as an Association: grounded in service, focused on patients, and united in purpose. The work ahead – legislative, regulatory, and educational – will require continued collaboration, clear voices, and steady leadership, but the foundation is strong. Together, with engaged members, resolute volunteers, and supportive partners, the CAA will continue to advance mobile healthcare across California, ensuring our professionals are supported, our systems are sustainable, and our patients receive the care they deserve when they need it most. *







What If Success Looked Like People Loving Their Jobs? A Conversation with Our COO, Danielle Thomas

Jacob Sarasohn
Director of Marketing and Communications
Royal Ambulance

[Originally Post On: www.RoyalAmbulance.com/blog]

B

efore we ever spoke, Danielle Thomas mentioned something almost in passing over email.

“I just want to make sure my uniform’s coming.”

It wasn’t framed as a value statement or a metaphor. It was practical. But over time, it began to feel like a small window into how she approaches leadership, not as something separate from the work, but as something that stays close to it. The uniform mattered because the work mattered, and because she wanted to show up the same way the rest of the team did.

Danielle recently joined Royal Ambulance as Chief Operating Officer. She’s new to the organization, but not to healthcare or operational leadership. What stood out in our conversation wasn’t a desire to announce change or introduce a new philosophy. It was her curiosity. She spoke less about what she planned to do and more about what she wanted to understand first.

“I’m still learning,” she said plainly. “And that’s intentional.”

When I asked how she thinks about success, she didn’t hesitate.

“Success is looking around and seeing people love their jobs,” she said. “Not tolerate them. Love them.”

She didn’t offer it as an aspiration. She offered it as a test, one she applies continuously, including to herself.

In healthcare, success is often measured in dashboards and scorecards. Those matter. Danielle isn’t dismissive of metrics, but she’s clear about what they don’t capture. “If people are just getting through the day,”

continued on page 6

she said, “something’s off.” For her, the data only means something if it reflects a team that feels supported, clear on expectations, and trusted to do their work well.

That belief shows up in how she talks about her role. She avoids sweeping language and instead comes back to clarity. “In the first six months, my job is to execute on what this organization already believes,” she said. “That means making expectations clear so people can do their jobs without unnecessary friction.” She’s focused on alignment across service lines, not overhaul. Strengthening what already works. Removing noise that slows people down. “When people know what’s expected,” she said, “a lot of the stress disappears.”

Danielle prefers the word enhance over rebuild or reinvent, and she’s quick to credit what’s already in place. “There are strong programs here,” she said. “The Culture, Critical Care, FTO Program, New Hire Academy, and most importantly how Royal cares for people.” Her role, as she sees it, is to connect those programs more directly to the day-to-day experience of the people doing the work.

That emphasis is personal. Danielle describes EMS as her second career, one she entered later than many of her peers. She’s open about the humility that came with that transition. “I didn’t come in knowing everything,” she said. “I still don’t.” What she did know



was where she could contribute most. “Education became my lane,” she said. “If I could help people grow, they could go on to help others in ways I never could on my own.”

One idea she returns to often is something she calls the trust battery.

“I don’t make people earn my trust,” she said. “I give it to them.”

Everyone starts full. When something happens and trust drops, she wants it addressed directly. “No guessing. No side conversations. If there’s a problem, we talk about it.” For her, that isn’t about avoiding conflict. It’s about protecting energy. “Drama pulls focus away from what matters,” she said. “And the work matters too much.”

That same thinking shapes how she approaches presence. Not micromanagement. Not distance. Proximity.

“When you start somewhere new, you have to go on a listening tour,” she said. “Teach me. You’re the expert.”

That’s how she spent her first month, listening, learning, asking questions, often more than she spoke. Now she’s beginning to translate what she’s heard into action. “It’s about aligning those insights with our objectives,” she said, “measuring what matters, and communicating clearly.”

Healthcare doesn’t allow for abstraction, she pointed out. “This is an in-person industry. We treat and transport patients. If the people doing the work are present, leadership needs to be present too.”

She describes her leadership philosophy as an upside-down pyramid.

“I work for the people doing the work,” she said. “My job is to remove barriers and help them do better tomorrow than they did today.”

When I asked what she hopes people feel when they talk about working with her, she paused. Not because she didn’t know, but because she was careful.

“I want it to feel fair,” she said. “Equitable. Truthful.” She laughed softly and added, “I don’t need to be the smartest person in the room.”

It always came back to the same measure. If people love their jobs, they show up differently. They stay longer. They take better care of each other. And in healthcare, that difference reaches patients whether we name it or not.

“Success,” Danielle said again, “is looking around and seeing people love their jobs.” Not tolerate them. Love them. ✨

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Where Refusals Meet Responsibility – A Closer Look at *Murphy v. City of Petaluma*

JohnRey Hassan, Esq., RN, EMT-P
CAO & In-House Counsel, Royal Ambulance



Nothing contained in this article is legal advice and no attorney-client relationship is being created. Please consult with a licensed attorney about your specific situation.

Last November, the California Court of Appeals decided the case of *Murphy v. City of Petaluma* (2024 Cal. App. 1st Dist., Div. 1, No. A168012). This case provided additional insights and helps clarify how we look at situations where patient care and/or transport to a hospital is offered, refused, and the specific issue of when a legal duty begins for pre-hospital providers in California.

Case Background

In February 2020, the Plaintiff, Marites Murphy was involved in a head-on vehicle accident in Petaluma. The Petaluma Fire Department, including two Paramedics, Engineer Paramedic Shay Burke and Captain Paramedic Jude Prokop, responded and assessed Murphy. Murphy was ambulatory on-scene and walking around her vehicle along with the other occupant.

Murphy appeared cognitively intact and the paramedics believed that she had decision making capacity. The paramedics attempted to encourage Murphy to go to the hospital, explaining that she could have serious injuries. Murphy repeatedly stated that she was not hurt and that she did not want nor need medical assistance. Engineer Paramedic Burke was insistent on speaking with Murphy, asking her further questions, and attempted multiple times to convince her to go to the hospital. Burke did not observe any signs that she was injured, in pain, or not fully cognitively intact.

Ultimately, Murphy left the scene after calling her boyfriend to pick her up. Her boyfriend took her home where she went to sleep and eventually became unarousable leading to the boyfriend to call 911. Murphy was taken to the hospital

and subsequently diagnosed with a traumatic stroke. The stroke left Murphy with permanent brain damage, speech and language impairment right sided paralysis and left her with no recollection of the events that day.

In February of 2021 Murphy filed a professional negligence action against the City claiming that the paramedics were grossly negligent by failing to conduct a reasonable medical assessment, failing to examine/record biomarkers (i.e. vital signs), and failing to transport her to the hospital.

The City moved to dismiss the case via a motion for summary judgement on the basis that the paramedics owed no legal duty to Murphy. In California, public entities and emergency rescue personnel

continued on page 10

generally owe no duty to provide services absent a statutory basis, and EMS personnel owe no duty to provide care unless they undertake to do so or otherwise assume a duty. *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175,1185; *Golick v. State* (2022) 82 Cal.App.5th 1144.)

Understanding Negligence in California EMS

Under California law, professional negligence, also referred to as medical malpractice, occurs when a licensed health-care provider fails to use the level of skill, knowledge, and care that a reasonably careful provider in the same field would have used under similar circumstances (See. Judicial Council of California Civil Jury Instruction “CACI” No. 501; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992). To prevail in a civil professional negligence suit, a plaintiff must prove by a preponderance of the evidence that the defendant owed a duty of care, breached that duty by falling below the applicable standard of care, and that this breach was both a cause in fact (actual causation) and a proximate (foreseeable) cause of the plaintiff’s harm, and that the plaintiff suffered compensable damages. (see CACI Nos. 400-401; *Ladd v. County of San Mateo* (1996) 12 Cal.4th 913, 917).

Importantly, in cases involving pre-hospital emergency medical care, California law provides statutory liability protections for certain emergency medical personnel and for public entities. Health & Safety Code §1799.106 grants limited immunity to EMTs-I, EMTs-II, paramedics, registered nurse in the pre-hospital setting, amongst others when they render emergency medical services at the scene of an emergency or during an emergency transfer, limiting liability to conduct amounting to gross negligence or bad faith. Separately, Health & Safety Code § 1799.107 provides qualified immunity to public entities and their employees designated as “emergency rescue personnel,” again limiting liability to acts or omissions performed in bad faith or in a grossly negligent manner while providing emergency services. These statutes do not automatically cover all

licensed health-care providers; rather, they apply only to the categories expressly identified in the statutes and only when acting within the scope of emergency services.

The California Supreme Court confirmed this framework in *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1184–1185, clarifying that these statutes narrow liability and require plaintiffs to prove gross negligence or bad faith whenever emergency rescue personnel act within the scope of their emergency functions.



The Importance of Duty

Duty is the first fundamental principle required to sustain a negligence action – that is, one party must actually owe a legal duty to another party before liability can attach – usually by nature of action. However, once a person undertakes an action to provide aid, they assume a duty to do so with reasonable care. The failure to do so can give rise to the “negligent undertaking doctrine.” As the court held, “this requires more than a voluntary undertaking to provide aid to establish a duty under the negligent undertaking doctrine. A plaintiff must also show the defendant’s conduct increased the harm,

or the risk of the harm, inflicted by the third party. *Golick* at 1146–1147; *Greyhound Lines, Inc. v. Department of California Highway Patrol* (2013) 213 Cal.App.4th at p. 1136.

As the court ultimately stated here, “the distinctive feature of this case is that Murphy repeatedly told the paramedics she was not injured and did not want or need medical assistance, and she said so even after being warned she might have suffered a serious injury that was not yet symptomatic and being urged to accept transport to a hospital for examination by a physician. Accordingly, after concluding Murphy had the capacity to refuse medical treatment, the paramedics left the scene” (*Murphy v. City of Petaluma*, slip op, at 1)

Key Takeaways

1. Be Reasonable, Be Kind

I can’t stress this enough, be reasonable, and be kind. Behaving in a manner that a similar licensed professional under similar circumstances would can fundamentally serve to cut of the causal chain needed. As for being kind, while it isn’t an element of proving a negligence claim, those perceived as kind generally are involved in less litigation. Based on the record, the defendants, if nothing else, appeared to be both reasonable and kind.

2. Document clearly, consistently, and timely

Nothing in the record reflects that the paramedics completed an against medical advice form or fully documented their assessment in real-time. Documenting accurately and thoroughly as close as possible to the incident with as much detail as possible is essential. While good documentation later is better than no documentation at all, waiting to document only after you have knowledge of an outcome can impact the credibility of such documentation during later litigation. Additionally, having a set of vitals was not dispositive of this case, but would have clearly helped. Documentation for refusals should clearly state the specific and detailed concerns that the EMS provider

continued on page 11

had, why the patient wanted to refuse care, and what specific actions that the EMS provider took to address the patients reasons for wanting to refuse such care.

3. Clearly communicate the specific risk

The case reflects that the paramedics, multiple and repeated times, attempted to talk Murphy into going to the hospital. They explained risk and expressed genuine concern. While this did not change the court’s analysis around their lack of a duty to aid Murphy, it likely played well to show that the paramedics were operating in a reasonable fashion with good intentions.

4. Work collaboratively with defense counsel

When working with outside defense counsel (which often times maybe chose

exclusively by your insurance carrier, and not yourself) ensuring that they understand the nuances of California’s laws around EMS providers is essential. Considering should be given to choice of counsel provisions in your in insurance policies and building relationships with counsel beyond those managed by your carrier.

5. Consider MICRA and § 1799.106 interaction

As discussed, California has generally strong protections in place around EMS related professional negligence. When handling a matter involving medical negligence, especially in the EMS context, defense counsel should be reminded to consider the provisions of Health and Safety Code § 1799.106 (§ 1799.107 if a public entity) and that Medical Injury Compensation Reform Act (MICRA)

generally apply. While the court recently declined to extend MICRA protections to driving an ambulance, actions which are directly tied to an healthcare providers licensure can fall under the provision of professional negligence and therefore MICRA. Importantly, courts have not decided how § 1799.106 may apply to *interfacility* or non-emergency ambulance transport and the statutory language only expressly calls out emergency transports.

In summary, this case serves as a powerful reminder of the importance of documentation, capacity assessment, and clear refusal procedures. *Murphy v. City of Petaluma* provides clarity around when an EMS provider’s duty begins, especially in situations where a patient repeatedly refuses care despite risk communication and encouragement to seek evaluation. *

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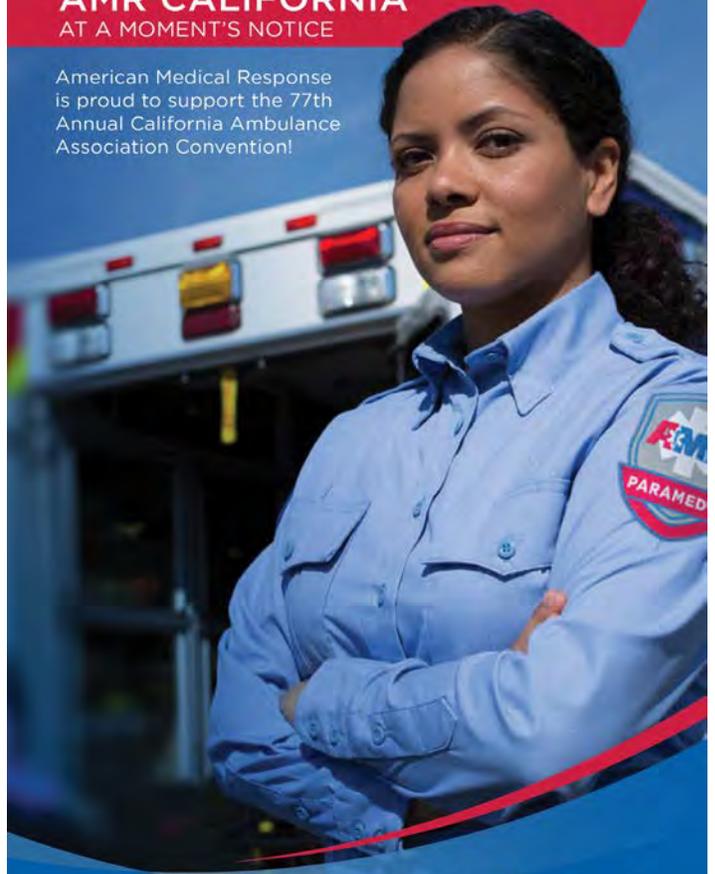
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Education Isn't Where Careers End. It's Where They Take Off

Danielle Thomas
Chief Operating Officer
Royal Ambulance



For decades, EMS education has carried an unfair label.

In quiet conversations and unspoken assumptions, teaching became something you did *after* the work. A softer landing. A lighter assignment. Sometimes even a place to park experience when the rig no longer fit.

It was rarely said out loud, but it was widely understood: education was viewed as adjacent to the real work, not central to it.

That story no longer holds.

EMS is evolving, and so are the people who choose it. The next generation of clinicians is not asking fewer questions. They are asking better ones. They want to know where they belong, how they will grow, and whether the organization they serve is invested in them as humans, not just as headcount.

When asked what matters most, younger EMS professionals consistently point to community, involvement, diversity,

purpose, and giving back. They are thinking beyond the next shift. They are thinking about identity and about a better way to travel their path toward Fire Service, Law Enforcement, Critical Care, Advanced Practice Medicine, Leadership, or roles we have yet to define.

And they are paying attention.

Over the last decade, EMS adapted to fewer “career junkies” and more “stone steppers.” We flipped the script and openly developed people to leave because that was often the only way to get them in the door. Patient contact hours needed for your application? Come join us. We accepted short tenure as the cost of entry.

Say it again for the people in the back: we developed people to leave.

Now, that model is no longer enough.

Today’s EMS candidates are watching how organizations onboard. How feedback is delivered. How mistakes are handled. How curiosity is treated. They notice whether

learning is encouraged or merely tolerated, whether questions are welcomed or quietly dismissed.

In other words, they are watching how we teach.

Recently, two fire department chiefs reached out seeking guidance on how associations and committees can create real value for their members. Those conversations were telling. The definition of value is shifting. Compensation still matters. Schedules still matter. But meaning, development, and inclusion now sit firmly at the table.

Education has become one of the most powerful signals an organization sends about who it is.

This is where EMS must finally confront a lingering myth: “those who can’t do, teach.”

In truth, teaching in EMS is not the absence of skill. It is the demonstration of mastery.

continued on page 14

The strongest educators are often the most credible clinicians, the most operationally fluent leaders, the CQI professionals who see patterns before they become incidents, and the managers who understand that clarity reduces risk faster than discipline ever could. Often, educators are not strong, they have been voluntold.

Education is not separate from operations. It is one of its most critical tools.

Every protocol explanation, every coaching moment, every after-action review, every onboarding conversation teaches something. The only question is whether that teaching is intentional, consistent, and aligned with the system we are trying to build.

This is why education has quietly become one of the largest recruitment and retention levers in EMS.

Yes, it is an investment. It requires time, content, personnel, and commitment. But that investment is now a differentiator. Increasingly, EMS professionals are choosing where to work not only based on pay or call volume, but on where they believe they will grow, be supported, and be seen.

Organizations that treat education as strategic infrastructure, not a side function, are winning that choice.

It is within this context that the California Ambulance Association Education Collaborative was created. Not as another committee. Not as a box to check. But as a deliberate effort to reframe education as a leadership discipline and a shared responsibility.

The Collaborative brings together experienced educators and those new to the pathway, operators, clinical experts, CQI professionals, data scientists, and emerging leaders. It recognizes that education does not live solely in classrooms. It lives in systems, culture, and decision-making.

Each monthly session includes approximately 35 minutes of expert-driven education, followed by meaningful discussion. The Collaborative meets the third Friday of each month at 11:00 a.m. via Zoom, creating accessible, high-value engagement across for members of the CAA. Sessions feature nationally respected voices exploring education, simulation, leadership, and the powerful intersection of data, CQI, and performance improvement.

The goal is not just better classes. The goal is better systems.

Because when education is done well, morale improves. Attrition decreases. Confidence grows. Risk shrinks. Leaders emerge. And patients feel the difference, even if they never know why. Education is no longer where careers end. It is where confidence builds. Where leaders are shaped. Where people decide to stay.

It is where careers take off. And the future of EMS depends on how seriously we choose to treat it. ❄️



*Wishing you a
safe and happy
holiday season.*

As we celebrate the season of gratitude, Medic Ambulance extends heartfelt thanks to our EMS partners, healthcare professionals, and the communities we proudly serve. Your dedication inspires us every day.

From all of us at Medic Ambulance — Happy Holidays and a healthy New Year!



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Anaheim 2026: Where California EMS Comes to Connect, Challenge, and Lead

Danielle Thomas
Chief Operating Officer, Royal Ambulance

For many years, EMS conferences followed a familiar formula. A schedule full of CE. A handful of recognizable speakers. A few days away from work before returning to the same pressures and problems.

That model no longer reflects what the profession needs.

The California Ambulance Association Annual Conference, taking place September 23–24, 2026, in Anaheim, has grown into something fundamentally different. What began as a strong state association meeting has evolved into a national destination for EMS leadership, innovation, and connection.

This is not an accident.

As EMS faces increasing operational complexity, workforce challenges, and rising expectations from patients and partners, the need for meaningful convening has never been greater. Leaders are no longer looking for passive learning. They are looking for insight, connection, and conversations that matter.

That is exactly what Anaheim 2026 is designed to deliver.

Over the past several years, CAA has intentionally expanded the scope, caliber, and relevance of its Annual Conference. Today, it attracts some of the most respected names in EMS from across the country, along with operators, educators, clinicians, and innovators who are shaping the future of the profession in real time.

Attendees can expect more than continuing education hours. Anaheim 2026 will offer:

- * Nationally recognized speakers tackling revenue cycle, workforce, leadership, education, operations, and innovation

- * Practical sessions designed for immediate application, not theory
- * Space for honest conversation about what is working and what is not
- * Opportunities to connect with peers who understand the realities of EMS leadership

Equally important is what happens between the sessions.

The Annual Conference has become a place where relationships are built, partnerships are formed, and ideas are pressure-tested. It is where emerging leaders find mentors, experienced executives compare notes, and organizations discover new ways to think about old problems.

For newer generations of EMS professionals, conferences are no longer just about credentials. They are about belonging, purpose, and access. Anaheim 2026 recognizes this shift by creating an environment that values engagement, inclusion, and real dialogue.

CAA is not just hosting a conference.

It is hosting a national conversation.

Whether you are a seasoned executive, an operator navigating daily challenges, an educator shaping future clinicians, or an emerging leader looking for direction, Anaheim 2026 offers something increasingly rare in EMS: a space to step back, think bigger, and reconnect with why this work matters.

Mark your calendars for September 23–24, 2026.

The conversation is happening in Anaheim. *



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CARLY'S CORNER

Time Management in EMS Isn't About the Clock – It's About Survival

Carly Strong
Chief Operating Officer
Lifeline EMS

Time management in EMS isn't about color-coded planners or perfectly timed shift routines. It's about survival.

Long hours, unpredictable calls, skipped meals, and a constantly shifting tempo can wear down even the most enthusiastic new provider. Early in your career, you'll hear people say, "pace yourself," but rarely will anyone explain what that actually means when your radio never stops and the day keeps getting longer.

The truth is this: in EMS, you don't really manage time, you manage your energy, your mindset, and your recovery. And learning how to do that is what determines whether you simply make it through your shifts or build a career that lasts.

Start With Mindset: Know What You're Signing Up For

Long shifts and unpredictable call volume are simply part of EMS. They're largely out of our control and they're often part of what drew us here in the first place.

Working nights when the rest of the world sleeps. Running call after call. Twelve- and twenty-four-hour shifts. EMS is its own special little club. The intensity, the pace, the shared exhaustion; it's part of the intrigue, part of the romance of the job. And the bonds and friendships that form during long, tough shifts are priceless. For many of us, they're some of what makes life worth living.

So go into this career with your eyes open and your expectations grounded. Don't set yourself up for failure by believing it will be easy. It won't be. You will get held over. You will be tired. You will have to push yourself.

But you will also do work that matters. You will meet some of the most incredible people on the planet. You will learn what trust, teamwork, and true friendship really mean.

Research consistently shows that mindset directly affects performance and resilience. Individuals with a growth mindset are significantly more likely to persist through challenges and improve over time. In EMS, that matters, because your mindset often determines whether stress consumes you or strengthens you.

Manage Energy, Not Minutes

One of the most important lessons in EMS is learning the difference between running on adrenaline and running on focus; and recognizing when you're simply out of gas.

The clock won't slow down. But how you manage your energy can keep you from burning out before your shift even ends.

Build small, intentional rituals that help you reset:

- * Eat a real meal when you can, not just a granola bar between calls

- * Stretch before sitting back in the cab
- * Take ten quiet minutes before logging available after a difficult call

These moments may seem small, but they add up. They keep you present. They help you recover just enough to keep going safely.

Prepare For the Shift You Know Is Coming

Since we can't control call volume, we prepare ourselves instead.

Plan for the season. Bring layers to stay warm or cool. Being physically uncomfortable adds stress that can often be avoided. Bring extra socks – because wet boots for hours can ruin even the strongest mindset.

Hydration and food matter more than we like to admit. One of the only guarantees in EMS is that you're *not* guaranteed time to stop and eat. Bring food with you. Bring food you actually like. Fun snacks or small treats give you something to look forward to during a long shift and those little boosts matter.

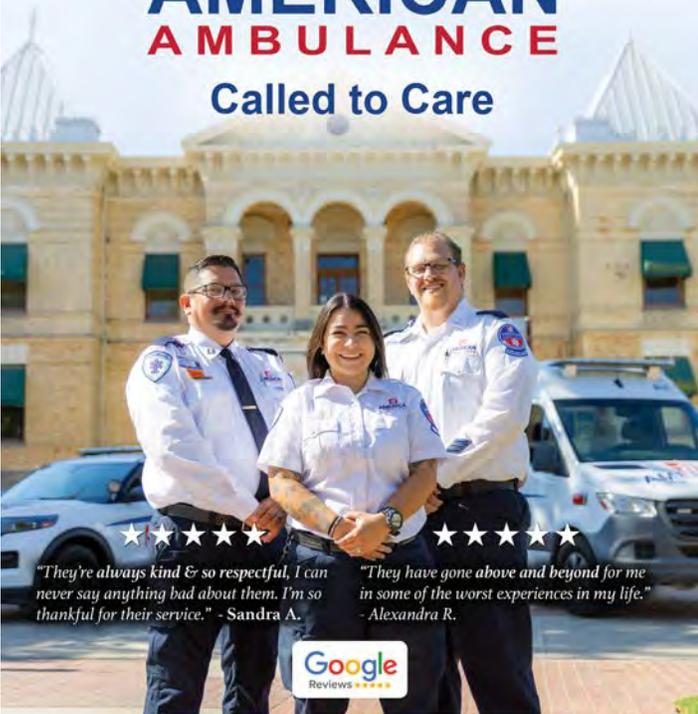
And when you *do* have the chance to stop for coffee or hit your favorite taco truck with your partner? Take it. Those moments build connection, boost morale, and remind you that this job can still be enjoyable.

continued on page 23



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PAYER ISSUES: Medicare Advantage and Ambulance Services: A Strategic Contracting Decision

Doug Wolfberg
PWW Advisory Group
CAA Medicare Consultants

For many CAA members, your ambulance service reimbursement strategy revolved around traditional, fee-for-service Medicare Part B. That world has changed. Medicare Advantage (MA) plans under Medicare Part C now enroll more than half of all Medicare beneficiaries, and their influence over ambulance reimbursement, utilization management, and cash flow continues to grow. For ambulance service leaders and RCM professionals, this shift forces an unavoidable strategic question: Should your company seek participating provider contracts with Medicare Advantage plans, or remain non-contracted and operate “out of network?”

The right answer depends heavily on the nature of your operations – particularly whether you provide primarily (or exclusively) 911 emergency services, or whether your company also furnishes non-emergency ambulance transports (as most CAA members do).

MA plans are required to provide Medicare-covered benefits, but they operate very differently from traditional Medicare. MA plans are private insurers paid a capitated amount by the federal government and given broad authority to manage costs through networks, contracts, prior authorization, and utilization controls. This distinction is critical for ambulance companies. While traditional Medicare pays according to a national fee schedule with

limited variation, MA plans for contracted providers negotiate payment terms, impose documentation requirements, and increasingly use network participation as a cost-control lever.

For 911 and other emergency ambulance services, MA plans, by federal law, must pay for medically necessary emergency care regardless of whether the ambulance provider is in-network or out-of-network. This protection exists to ensure beneficiaries can access emergency services without delay. As a result, ambulance services that mainly (or exclusively) provide 911-based ambulance services may have less need to seek to contract with an MA plan as a participating provider. Remaining non-contracted means you will be paid Medicare Part B fee schedule rates for emergency services, though beneficiary cost-sharing can vary by plan under the MA program.

However, “must pay” does not mean “must pay quickly or easily.” Even for emergency services, MA plans frequently dispute medical necessity, downcode services, or delay payment. Without a contract, providers may face appeals, arbitration, or write-offs – creating administrative burden and cash-flow volatility.

The calculus is different for providers that furnish non-emergency ambulance transports, such as dialysis, hospital

discharges, or non-emergency interfacility transfers (IFTs).

Unlike emergency services, MA plans are permitted to limit coverage of non-emergency ambulance transports to participating network providers. If your company is not contracted, the plan may simply deny payment - leaving the provider with little recourse and the patient unable to pay.

For ambulance companies that provide a mix of 911 emergency + non-emergency services, this creates operational risk. A company that remains out-of-network may be fully reimbursed (at Medicare fee schedule rates, anyway) for emergency calls but see growing denial rates for scheduled transports as MA enrollment expands in its service area.

Entering into MA participating provider agreements is not without downside. Contracts often include:

- * Rates lower than billed charges, sometimes below Medicare fee schedule rates
- * Authorization requirements (for non-emergency transports; MA plans are not permitted to require prior authorization for emergency services)

continued on page 20

PAYMENT ISSUES

– continued from page 19

- * Short payment windows with strict technical compliance rules

Yet contracting also brings important advantages:

- 1. Payment Certainty** – contracted rates establish clear expectations for reimbursement, reducing disputes and revenue unpredictability.
- 2. Lower Bad Debt** – when payment responsibility rests with the MA plan rather than the patient, collection rates improve and write-offs decline.
- 3. Administrative Efficiency** – while contracts come with rules, they can reduce the endless appeals and denials common in out-of-network billing.

There is no one-size-fits-all approach. A rural 911-only provider may reasonably conclude that contracting offers little upside. A suburban or urban provider with significant non-emergency volume may find that not contracting is no longer financially viable.

Some ambulance companies now pursue hybrid strategies – contracting selectively with the MA plans that are dominant in their service area, while remaining out-of-network with others, or negotiating contracts that carve out emergency services while addressing non-emergency transports.

The Bottom Line

The migration from fee-for-service Medicare to Medicare Advantage is not a temporary trend – it is the new normal. Ambulance service leaders must treat MA contracting decisions as core strategic planning, not a billing afterthought. Understanding your call mix, payer penetration, and local MA dominance is essential.

In a Medicare Advantage world, the question is no longer *whether* MA will shape your revenue cycle, but how you choose to engage with it. *

Operations Committee

Brian Meader
Medic Ambulance
CAA Operations Committee Co-Chair

The Operations Committee meets on the second Tuesday of each month at 10:00 AM and is co-chaired by Max Laufer and Brian Meader. We host this Committee to bring agencies together around the real operational challenges faced every day in EMS.

Our goal is to make these meetings useful, practical, and worth your time. This is where agencies share what is working, talk honestly about what is not, and learn from each other's experiences. The focus is on operations in all forms, from staffing and deployment to equipment, technology, and compliance.

Recent meetings have included discussions on safety initiatives and the use of metrics to track operational performance. We have also taken a hard look at emerging technologies, including electronic wearables and AI-enabled glasses, to evaluate their risks, limitations, and real-world impact. These conversations are about helping agencies avoid costly mistakes and make informed operational decisions.

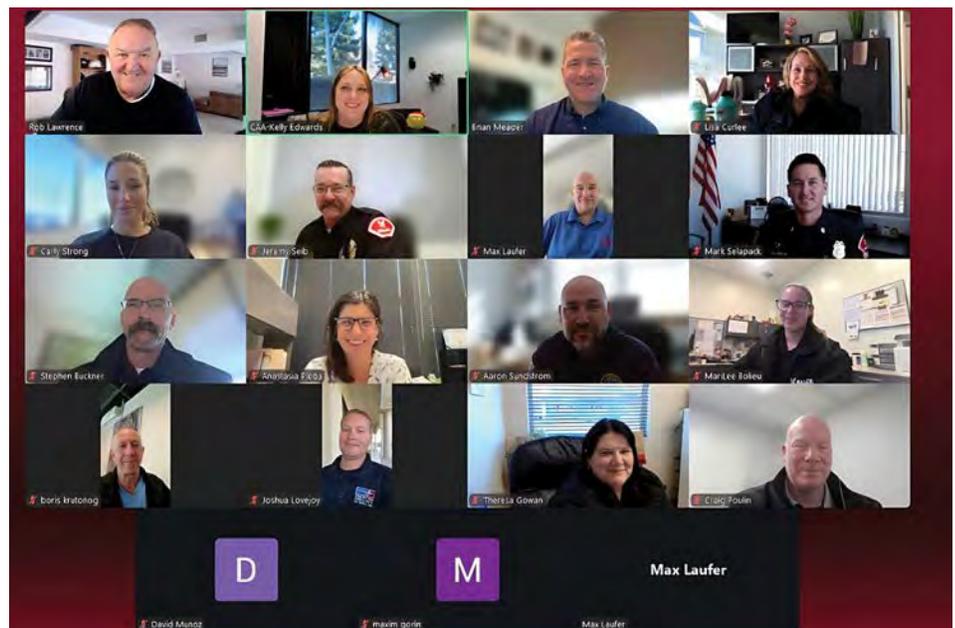
We strongly encourage organizations to send additional representatives to

participate. This Committee is not limited to executive leadership. Operations managers, supervisors, fleet personnel, training staff, and anyone responsible for day-to-day operations will benefit from being part of the conversation. The more perspectives in the room, the more valuable the discussion becomes for everyone.

To keep the conversation going between meetings, we have created a listserv at ops@tghe-cao.org. This allows agencies to share resources, ask questions, and collaborate on operational issues outside of the meeting itself.

Looking ahead, we will be addressing topics such as medication storage and security, temperature control, and other operational challenges identified by participating agencies.

These meetings are designed to deliver takeaways you can actually use. If your agency is facing operational challenges or wants to stay ahead of emerging issues, this is where you should be. We encourage you to attend and be part of the discussion. *



Welcome to the 2026 Board



The 2026 Board for the CAA is as follows

President (26/27)

Steve Grau

President-Elect (26/27)

Sean Sullivan

Immediate Past President (26/27)

Jaison Chand

Secretary

Melissa Harris (26)

Board Members

Ron Sandler (26/27)

James Pierson (26/27)

Carly Strong (26)

Bob Campbell (26)

New Members

Our former president and Immediate Past President, James Pierson returns to a Board seat and Board member, Sean Sullivan is elected into the President-Elect post. Joining us in 2026 are Bob Campbell and Ron Sandler. Their Bios are provided below.

Bob Campbell

Bob is elected to the board for 2026 and is filling the final year of the seat vacated by President Elect Sean Sullivan. Bob's seat will therefore open in the board election to seat our 2027 Board,

With a career rooted in the front lines of California's emergency services, Bob



Bob Campbell

Campbell serves as the Director of Government Affairs for Falck USA. He began his journey in 2002 as an EMT and Field Training Officer for Care Ambulance – prior to its acquisition by Falck – and as a Reserve Firefighter. That early experience forged a lasting passion that continues to drive him today: a commitment to helping the next generation of EMS professionals build successful careers and advocating for the competitive wages they deserve.

A graduate of Cal State Long Beach with a degree in Business Administration, Bob brings a diverse background to his role. His first job was at the Disneyland Resort, carrying on a unique family legacy – his

great-uncle was a plumber by trade, who was asked by his friend, Walt Disney, to help build the original park. Bob has also worked for Marriott and had the honor of traveling the world while helping manage a close friend's band.

Since dedicating his career to healthcare, Bob has served in several key capacities within the Falck organization, including Business Development and Hospital Territory Account Management, giving him a comprehensive understanding of the ambulance industry's operational and strategic landscape. As a lifelong resident of Orange County, where he lives with his wife, their three young children, Bob is deeply invested in his community. He is grateful for the opportunity to work with the current California Ambulance Association Board to advance the future of EMS in the state.

Ron Sandler

Ron is elected to the Board for calendar years 2026 and 2027.

Ron Sandler is a lifelong EMS professional whose career spans more than four decades of frontline care, organizational leadership, and community service in Northern California. Since 1985, Ron has served as President, CEO, and Paramedic of Del Norte Ambulance, leading the agency through decades of operational growth while continuing to practice as a working paramedic. His career reflects a

continued on page 22

rare blend of clinical credibility, executive stewardship, and deep local commitment.

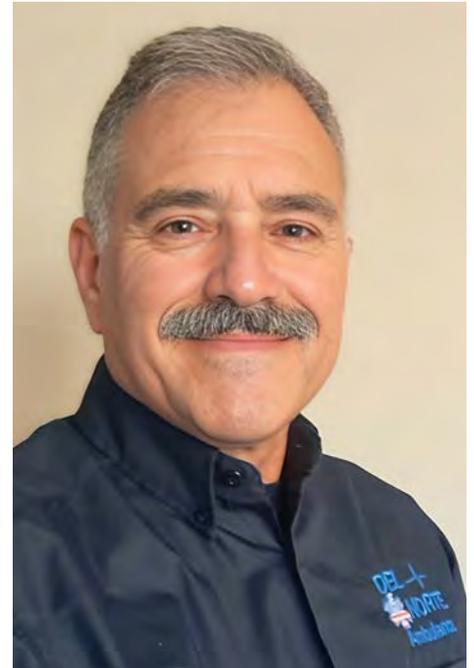
Ron began his EMS journey in Southern California in the early 1980s, serving with multiple ambulance services as an EMT and paramedic before relocating north. Over the years, he has built extensive experience not only in ground ambulance operations but also in wilderness and disaster medicine. He has served as a Line Medic and Medical Unit Leader (MEDL) with the U.S. Forest Service (Six Rivers National Forest), supported Southwest Team 3 as a MEDL, and continues part-time work with Wilderness Medics Inc., contributing to complex incident medical support and emergency preparedness.

A dedicated advocate for system quality and workforce development, Ron has long been active in professional associations and education. He is an instructor with the California Ambulance Association and serves as Director of the Del Norte Ambulance Training Center, delivering BLS, CPR, ACLS, PALS, EMR, First Aid, and

Instructor Development programs. His leadership background also includes service as a Paramedic-Firefighter and past EMS Chief, reinforcing his cross-disciplinary perspective on emergency response.

Ron's commitment to his community extends well beyond EMS operations. He has held numerous civic and healthcare leadership roles, including board and committee service with Sutter Coast Hospital, Del Norte County emergency and health advisory bodies, Rotary, fire protection districts, and multiple nonprofit organizations. His work has been recognized with numerous honors, including Business Leader of the Year, multiple EMS Star of Life awards, proclamations from the Del Norte County Board of Supervisors, and state and federal recognition for community service.

Born in Los Angeles, Ron is married to his wife Teri and is the proud father of two daughters, Amanda and Jaclyn, and grandfather to Theo and Nox. His career reflects a steadfast belief in service,



Ron Sandler

education, and local leadership – values that continue to shape EMS delivery and community resilience in Del Norte County and beyond. *



CAA Membership is a Business Essential

The business environment, the healthcare sector and the EMS industry are evolving at an ever-increasing pace. At the CAA we are dedicated to providing members with the essential tools, information, resources, and solutions to help your organization grow and prosper. And, the CAA's collective efforts on statewide legislative and regulatory issues are not possible without strong membership support and engagement.

Take your place in California's statewide ambulance leadership

Membership not only saves you money on CAA events and resources, but also keeps you up to date on trends, innovations, and regulatory changes through:

- Leadership on statewide legislative and regulatory issues
- Targeted conferences & educational programs
- Member-only updates and alerts
- Member-only discounts & access to expert resources
- Opportunities to exchange ideas with your colleagues statewide



Join the California Ambulance Association

Go to www.the-caa.org/join-the-caa for a membership application.

PRESIDENT'S MESSAGE

– continued from page 2

Collaboration and Innovation

Building bridges across healthcare, public agencies, and local systems to pilot new models of care that put patients first, while recognizing that technology, data, and AI increasingly shape outcomes, access, accountability, and how EMS organizations operate responsibly.

Together, these pillars point toward a clear North Star: a strong, respected, and unified EMS system that is sustainable, compassionate, and essential to California's healthcare infrastructure, with CAA serving as the voice, convener, and catalyst for what comes next.

A Shared Responsibility

The future of CAA will not be shaped by any single president, board, or committee. It will be shaped by participation. By member organizations that engage thoughtfully. By leaders who debate with respect. And by stakeholders who recognize private ambulance providers as a vital, professional link in California's healthcare system, connecting patients, providers, and communities every day.

If we remain grounded in service above self, committed to one another, and courageous in our leadership, we will leave this association stronger than we found it.

Not as the generation that finished the work, but as the one that made it worth continuing. ✨



CARLY'S CORNER – continued from page 17

Use Downtime Wisely – Even When It's Brief

Downtime in EMS rarely comes in long stretches. Learn to use the small windows.

Step away from stimulation when you can. Stretch. Walk briefly. Sit quietly. Listen to a song, a book, or a podcast. Something that isn't work-related and doesn't add stress.

Avoid doom scrolling or emotionally charged texts during these moments. They don't rest your brain. Feeding your mind positive or calming input triggers the brain's resilience chemicals and helps you recharge.

Rest doesn't always mean sleep, though sleep should always be taken when it's available. Sometimes rest is simply reducing stimulation. We're surrounded by sirens, radios, alarms, traffic, and noise all shift long. When you can, remove some of that input. Your nervous system needs it.

Your Time Off Is Both Recovery and Preparation

Your time off is precious. It's your recovery phase, and your preparation phase for the next round of shifts.

Protect it.

When you're off, disconnect from work. If you're not planning to pick up extra shifts, silence the notifications. If you're with coworkers socially, try not to talk only about work. Vent when you need to, but make a deal with yourself to share the top few things that matter, then let work stay at work.

Commit to doing at least one thing you enjoy on your time off. This isn't always easy when you're balancing school, family, kids, or second jobs, but it's essential. Budget time for it the same way you budget time for responsibilities.

Exercise matters, too. Staying physically fit reduces fatigue, improves resilience, and supports mental health. When possible, get outside. Being in nature lowers stress hormones and improves recovery.

Equally important: give yourself permission to do nothing sometimes. Don't fill every day off wall-to-wall. The mental overload of nonstop scheduling, at work and at home, fuels burnout faster than long shifts alone.

Speak Up When Something Isn't Right

Some stressors require more than rest. Bad calls. Loss of a coworker. Events that hit close to home.

These moments require honesty with yourself. If you don't feel right, say something. Speaking up isn't weakness, it's responsibility. To yourself, your patients, and your partners.

Think of it this way: you wouldn't take an ambulance out without checking that it's stocked and ready. You deserve the same care. Hydrated. Fed. Mentally prepared. Supported.

Find the Humanity – It Sustains You

Finally, find moments of happiness where you can.

Laugh with your coworkers. On difficult calls, notice the reminders of a patient's life beyond that moment. On less critical calls, connect - ask questions, listen, learn something about the person in front of you.

Human connection restores us. It reminds us why we do this work.

The Takeaway

In EMS, time management isn't about squeezing more into your day. It's about managing yourself.

Protect your mindset. Prepare intentionally. Guard your recovery. Invest in your relationships. Give yourself grace.

Because every minute you invest in balance is one you'll get back in longevity, and that's how careers, not just shifts, are survived. ✨



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