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WHITE PAPER

Medical Direction Is Not Enough

Why Pre-Hospital Care for Family Offices, Corporations, and Private Security Firms Requires an EMS Agency — Not Just a Physician's Pen

A structural analysis of how emergency medical services are lawfully organized and overseen — and why **medical control alone** is a necessary but insufficient foundation for delivering professional, defensible pre-hospital care in private and protective environments.

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Executive Summary

Private family offices, corporations, and executive-protection firms are, correctly, adding medical capability to their security programs. The instinct is sound: in a protective environment, medicine cannot be an afterthought. But a common assumption travels with it. An organization retains a physician to provide "medical oversight," places emergency medical services (EMS) personnel on its details, and reasonably believes the medical question is answered.

It is not. In most U.S. states, EMS clinicians — Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced EMTs (AEMT), and Paramedics — are not authorized to practice pre-hospital medicine by virtue of their certification alone, nor by the signature of a physician alone. They practice under the authority of a licensed EMS agency: the organizational infrastructure a state EMS office holds accountable for medical direction, clinical quality, infection control, training, credentialing, protocols, controlled substances, and records. The physician is one required element of that infrastructure. The physician is not a substitute for it.

This paper makes four arguments. **First**, pre-hospital care is regulated at the level of the agency, not the individual credential and not the individual physician. **Second**, an EMS agency delivers a set of functions — a designated infection control officer, a quality assurance and improvement program, a training officer, credentialing to protocol, controlled-substance custody, and active clinical practice — that a medical director's signature, standing alone, does not. **Third**, the leading medical models in the protective-services market today — physician overwatch, elite credentialed operators, and assistance or staffing networks — each deliver genuine value and each pairs naturally with a licensed EMS agency practice that supplies clinical authorization, oversight, and quality assurance. **Fourth**, protective medicine is not medical control bolted onto a security detail; it is the deliberate fusion of a licensed protective-security practice with a licensed EMS practice.

> *A credential is not a practice. A physician's pen is not a practice. Protective Medicine is the fusion of a licensed protective-security agency and a licensed EMS agency — not medical direction stapled to a security contract.*

For the private client who demands genuine professionalism, the difference is not academic. It is the difference between a program that can withstand scrutiny — clinical, legal, and reputational — and one that can be strengthened to. EMERGILITY is positioned not only to deliver this model but to help others build it — offering consulting, advisory, and direct EMS program support with clinical oversight to family offices, corporations, and protective-services and medical-assistance firms alike. This paper closes with a due-diligence checklist any principal, family office, general counsel, or security director can use to understand whether a medical capability is a full practice or a foundation ready to be completed.

1. The Problem: A Credential Is Not a Practice

Consider how the arrangement typically forms. A principal or a security director recognizes a gap: on a detail, at a residence, at an event, or in transit, professional medical care may be needed before a 9-1-1 system can arrive — or in places a public system does not reach at all. So the organization hires a paramedic, or assigns a team member who holds an EMT card, and — aware that medicine requires physician involvement — retains a doctor to serve as "medical director." The box is checked. Everyone feels covered.

The gap that remains is invisible until it matters. A certification card verifies that, on the day of the exam, an individual met an entry standard. It does not authorize that person to carry and administer medications, to perform invasive procedures, or to practice to a defined scope in a given jurisdiction. That authority flows from somewhere else entirely: from a licensed EMS agency operating under state EMS regulation, with a medical director accountable for that agency's clinicians, protocols, and outcomes.

The distinction EMERGILITY draws is deliberate. There is a difference between an *EMS technician* — someone who holds a credential — and an *EMS clinician* — someone who actively practices medicine, under a physician, within an accountable practice. The card is the beginning of that story. It is not the whole of it.

Why "the physician's pen" is not the answer

Retaining a medical director is necessary. But a medical director who signs protocols for many unrelated clients, who never reviews a chart, never runs a case, never verifies a competency, and never interacts with the providers operating under his or her name is not providing meaningful medical oversight. That physician is lending a signature. In the absence of an agency — a structure where senior EMS clinicians help manage, run, and lead the practice — the oversight exists on paper and nowhere else.

> *Medical oversight that never touches the provider is not oversight. It is authorship of a document. The private client is paying for a practice, and should insist on getting one.*

The purpose of this paper is not to diminish the physicians, the paramedics, or the security professionals doing serious work in this space. It is to identify a structural gap that even excellent people fall into when the underlying model is wrong — and to describe the model that closes it.

2. How Pre-Hospital Care Is Actually Regulated

EMS is a regulated practice of medicine delivered in the field. Its defining feature is delegation: pre-hospital clinicians perform medical acts under the authority of a physician, within a system a state government licenses and supervises. The unit of that licensure, in most states, is the EMS agency.

In Virginia — where EMERGILITY is licensed — EMS is governed by the **Virginia EMS Regulations (12VAC5-31)**, administered by the Virginia Department of Health, Office of Emergency Medical Services (VDH OEMS). Under that framework, an organization must hold an **EMS agency license** to operate, and each licensed agency must have an **Operational Medical Director (OMD)** — a physician who is responsible for the clinical practice of the agency's personnel. Certification of the individual and licensure of the agency are two separate things, and both are required. EMERGILITY holds VA OEMS Agency license 50537.

The structure is not a Virginia peculiarity. Across the country, EMS is organized this way for a reason: pre-hospital medicine is high-acuity, low-frequency, and unsupervised in the moment. The system compensates by holding an accountable organization — not just a person — responsible for the medicine before, during, and after the call. That is why, in most states, a paramedic cannot simply be hired and turned loose to practice; the paramedic must be affiliated with, and credentialed by, a licensed EMS agency that operates under a physician's medical direction.

> *Certification licenses the person. Agency licensure authorizes the practice. A private program that has the first without the second has a credentialed individual, not an EMS capability.*

This is not merely EMERGILITY's reading. It is the reason EMERGILITY's own EMS practice states plainly that, in most states, pre-hospital providers must *affiliate with an authorized EMS agency* in order to deliver care — and it is precisely the gap that family offices, private businesses, and security firms encounter the moment they try to field a medical capability of their own.

Nor is the agency model only a state-by-state rule; it is the settled architecture of the profession at the interstate level as well. The **United States EMS Compact (REPLICA)** — which extends an EMS clinician's license across its member states, much as a driver's license is honored across state lines — is explicit that it *does not create independent practice*. To exercise the Compact's privilege, a clinician must remain affiliated with a licensed EMS agency and practice under a physician medical director. The two requirements this paper identifies as essential are, quite literally, the requirements the profession has written into its national framework.

A note on nuance: EMS regulation is a state matter, and the details vary. A minority of states and specific non-transport or occupational-health contexts are structured differently, and some medical acts can be delivered under other licensure pathways. The general rule, and the safe assumption for any organization building a program, is the one above: pre-hospital EMS is practiced under a licensed agency and its medical director, not under a certification card and not under a stand-alone physician engagement.

Legal disclaimer. *The state-by-state discussion that follows is not legal advice. It reflects EMERGILITY's good-faith interpretation of publicly available legal and regulatory guidance from each jurisdiction — statutes, administrative codes, and the published materials of each state's EMS and health authorities — as of publication. EMS law changes and varies by jurisdiction and by the specific facts of a given arrangement, and nothing here creates an attorney-client relationship or should be relied upon as a legal conclusion about any particular person or program. Organizations should consult qualified healthcare counsel and the relevant state EMS authority before acting on anything in this section.*

A closer look: how key states regulate this

Because private clients often ask how this works in the states they actually touch, the table below examines several — from the largest markets to the jurisdictions closest to home. The routes differ, but the destination is the same: each requires a licensed EMS agency operating under a physician medical director. It is a useful comparison precisely because it shows that the agency requirement is not a Virginia idiosyncrasy but a national norm — which also means a program built correctly in one place is, in its essentials, built correctly almost everywhere. (The right-hand column notes whether each is a member of the EMS Compact, which is a separate question from whether an agency is required — every jurisdiction requires the agency, member or not.)

State	What it takes to operate as a field EMS provider	EMS Compact member?
Texas	A DSHS EMS Provider License is required to operate an ambulance/EMS service (Health & Safety Code ch. 773; 25 TAC §157.11), with an employed physician medical director and protocols the director signs. Texas is also the notable state with a statutory "delegated-practice" scheme — but ALS must still be under a physician's control, and the clinician practices for a licensed provider.	Yes
Florida	An ALS or BLS ambulance service license is required before providing EMS to the public (§401.25, F.S.; Rule 64J-1), together with a county Certificate of Public Convenience and Necessity and a Florida-licensed physician medical director (with DEA registration for ALS).	No
New York	Ambulance and ALS First-Response services must be certified through a Certificate of Need (Public Health Law Article 30, §3005; 10 NYCRR Part 800). Clinicians are credentialed and supervised under a Regional Emergency Medical Advisory Committee (REMAC) and online/offline medical control; only Article-30 services may carry controlled substances.	No
California	ALS care is delivered by an approved provider under a Local EMS Agency (LEMSA). A state paramedic license is not enough to practice: the paramedic must also hold local LEMSA accreditation, which is available only to paramedics employed by an approved ALS provider and is revoked when that employment ends (Health & Safety Code Div. 2.5; 22 CCR).	No
Maryland	Commercial ambulance services and EMS operational programs must be licensed or approved through MIEMSS and retain a Maryland-licensed physician medical director; all medical direction follows the statewide Maryland Medical Protocols (COMAR Title 30).	No
District of	No entity may operate an EMS agency without a license from the District, and	No

State	What it takes to operate as a field EMS provider	EMS Compact member?
Columbia	the agency must have a DC-licensed physician medical director responsible for medical oversight of all agency operations (DC Code § 7-2341.03).	
Virginia (for reference)	An EMS Agency License is required, with a designated Operational Medical Director (Virginia EMS Regulations, 12VAC5-31). EMERGILITY holds VA OEMS Agency license 50537.	Yes

What the comparison shows

Two findings stand out. **First, in every one of these states, operating as a field EMS provider — responding, carrying and administering medications, and functioning within the pre-hospital system — requires a state-licensed or state-certified EMS agency (or service/provider) operating under a physician medical director.** The label differs (Texas "provider license," Florida "service license," New York "certificate," California "approved provider plus LEMSA accreditation," Maryland and the District of Columbia "agency license"), but the substance is the same.

Second, the popular idea that a paramedic can simply "practice under a physician's license" is narrower than it sounds. In most states, paramedics practice under their *own* license, with a physician medical director supervising — not literally under the physician's license; Texas is the notable exception with a formal delegated-practice statute. Where paramedics do work purely under physician supervision outside an EMS agency, it is generally a facility-based role — in a hospital, clinic, urgent-care, or event-medicine setting, governed by that facility's credentialing rather than by EMS-agency licensure. That is a legitimate way to employ a paramedic's clinical skills, but it is not the same as being an EMS provider.

The distinction matters because a paramedic working only under physician delegation, without agency affiliation, does *not* carry the privileges that agency affiliation confers: the EMS Compact *Privilege to Practice* (which by its own terms requires affiliation with a licensed or authorized EMS agency and a physician medical director), the use of permitted emergency vehicles and emergency-vehicle operation, lawful custody of controlled substances, and recognition to function as an EMS provider within the pre-hospital system at all. In short, the private client's instinct — that a physician alone is not enough — is confirmed by the structure of EMS law in the nation's largest states.

One more wrinkle compounds the difficulty: states do not even use the same word for an EMS clinician's credential. Virginia *certifies* its EMTs and paramedics; California *licenses* its paramedics; the national credential is itself a *registration* (the National Registry's "Nationally Registered" designation, which most states build upon); and some states cannot keep the terms straight within their own walls — Florida's Department of Health describes its Division of Medical Quality Assurance as "certifying paramedics," on the very page, headed "Licensing Requirements," that promises "your license will be issued" on passing the exam. The *agency*, in turn, is separately licensed, certified, or permitted. Certified, licensed, registered — the labels differ, the scopes differ, and the reciprocity rules differ. That disparity is precisely what makes delivering EMS across state lines complicated, even for the most seasoned professional, and precisely why the EMS Compact was created to knit these disparate systems together for its member states.

Sources: *U.S. EMS Compact / REPLICA (emscompact.gov), incl. Privilege-to-Practice and Employer/Agency guidance; Texas Health & Safety Code ch. 773 and 25 TAC §157.11 (DSHS); Florida Statutes §401.25 and Fla. Admin. Code ch. 64J-1 (FL DOH), and the Florida Department of Health EMT/Paramedic licensing page; New York Public Health Law Article 30 (§3005) and 10 NYCRR Part 800 (NYSDOH-BEMS); California Health & Safety Code Div. 2.5 and 22 CCR (California EMSA / LEMSAs); Virginia EMS Regulations, 12VAC5-31 (VDH OEMS); District of Columbia EMS Act, DC Code § 7-2341.03 (DC Health); Maryland COMAR Title 30 (MIEMSS), incl. Commercial Ambulance Services (30.09) and EMS Operational Programs (30.03); Federation of State Medical Boards (FSMB) telemedicine policy and AMA licensure guidance on the practice of medicine occurring where the patient is located. Regulatory details change; organizations should confirm current requirements with the relevant state EMS authority and counsel.*

"But can't a paramedic just work under a physician?" The structure question

A fair objection follows: if some clinicians operate without an EMS agency by saying they are simply "linked to a physician's license," does that work for private, non-public patients — the executive, the family, the protectee? The honest answer is that it depends entirely on what is being delivered and how it is structured, and the structure options are narrower than they first appear.

Can you be licensed without owning an ambulance? Yes — but it is still an agency. Most states license *non-transport* or first-response EMS entities, not just ambulance services. New York certifies Advanced Life Support First-Response services; Texas licenses First Responder Organizations that provide on-scene care under a medical director but do not transport; many states permit non-transport agencies for industrial, event, and similar settings. This is well suited to protective medicine, where the goal is capable on-scene care rather than routine transport. But note what it is: a **licensed EMS agency without an ambulance** — still permitted by the state EMS office, still under a medical director, still carrying the agency infrastructure. It is not a way around the agency; it is the agency without the truck.

Can a paramedic instead treat private patients purely as a physician's extender, with no EMS agency at all? Only in a different lane, and at a cost. A physician may delegate medical acts to a paramedic who works as clinical staff within the physician's *own medical practice* — in an office, clinic, or event-medicine setting governed by that practice's credentialing. That is a legitimate and valuable role. It simply is not "EMS," and it does not carry the privileges that agency affiliation confers: the EMS Compact Privilege to Practice, permitted emergency vehicles and emergency-vehicle operation, EMS controlled-substance custody, and standing to function as an EMS provider in the field. A physician extender in a clinic is practicing as part of a medical practice — a different role, not a lesser one, than an EMS clinician in the field.

And can a paramedic and a physician simply "partner" and practice outside both an EMS agency and a professional medical entity (a PC or PLLC)? Generally, no clean path exists. In the largest states, the **corporate practice of medicine** doctrine (strong in California, Texas, and New York; far weaker in Florida) requires that the practice of medicine be delivered through a physician-owned professional entity, and it restricts how non-physicians may share in or control medical services. Practically, that leaves two lawful vehicles for delivering this care: a *licensed EMS agency* under a medical director, or the *physician's own professional practice* with the paramedic as delegated staff. A bare paramedic-and-physician "partnership" sitting outside both structures runs into corporate-practice, fee-splitting, billing, credentialing, and insurance complications that are difficult to resolve.

Insurance is where this becomes concrete. EMS liability coverage is underwritten around transport operations, and EMS reimbursement has historically required transport — "treat and release" or treat-no-transport care is largely unreimbursed and sits outside the standard EMS insurance model. Yet treat-in-place, no-transport care is exactly the high-stakes, private, VIP, and executive scenario in which a protective clinician most often operates. An arrangement that cannot be cleanly insured or placed within a recognized structure is not a program a serious private client should rely on. A licensed EMS agency — including a non-transport one — is the structure that makes this care lawful, insurable, and defensible.

A subtler version deserves a mention, because it comes up often and looks fine at first glance. Imagine a physician who lives in one state — say, California — but also holds a medical license where the paramedics are working — say, Florida — and signs on to provide their "medical control," without practicing in Florida and without any EMS agency in the picture. The licensing box looks checked. On its own, though, it still is not the same as EMS medical direction, for the same familiar reason: in Florida, as in the other states here, EMS medical direction exists only as a function of a licensed EMS agency — the medical director is the medical director *of an agency*.

The takeaway is less a warning than a clarification. A medical license lets its holder practice medicine; it is not a credential that can be handed to others so they may practice EMS on their own. Even a perfect license does not, by itself, supply the agency — which simply restates the paper's theme one more way: medical control is necessary, and an agency practice is what completes it. (Where the physician is not licensed in the patient's state at all, the same conclusion arrives sooner, since medicine is practiced where the patient is located.)

The same answer across the region — and beyond

This is not a Florida peculiarity or a matter of one state's drafting. The jurisdictions a Washington-area principal is most likely to touch — Virginia, the District of Columbia, and Maryland — reach the identical result, as do Texas and New York. In each, EMS medical direction is a creature of the licensed EMS agency: the medical director is required by, and accountable for, that agency, and clinicians practice under that agency's medical direction, not under a physician's freestanding license.

Jurisdiction	How EMS medical direction is structured	Agency-based medical direction required?
Virginia	EMS agency license required, with a designated Operational Medical Director — a Virginia-licensed physician (Virginia EMS Regulations, 12VAC5-31).	Yes
District of Columbia	No entity may operate an EMS agency without a license; the agency must have a DC-licensed physician medical director responsible for medical oversight of all agency operations, and personnel perform under the authority of the agency's medical director (DC Code § 7-2341.03).	Yes
Maryland	Commercial ambulance services and EMS operational programs are licensed/approved through MIEMSS and must retain a Maryland-licensed physician medical director; all medical direction follows the statewide Maryland Medical Protocols (COMAR Title 30).	Yes
Texas	A DSHS EMS provider license is required to operate, with an employed Texas-licensed medical director and director-signed protocols (Health & Safety Code ch. 773; 25 TAC §157.11).	Yes
New York	Ambulance and ALS first-response services must be certified via a Certificate of Need, and clinicians are credentialed and supervised under a Regional Emergency Medical Advisory Committee (REMAC) (Public Health Law Article 30, §3005).	Yes
Florida	An ALS/BLS ambulance service must be licensed, with a Florida-licensed physician medical director of that licensed service (§401.25, F.S.; Rule 64J-1).	Yes

The right-hand column reads the same all the way down, and that consistency is the reassuring part: every jurisdiction is building on the same foundation. A physician's individual license authorizes the physician to practice medicine; the licensed agency and its medical direction are what authorize EMS. From Richmond to Annapolis to Austin to Albany, the structure — not a signature alone — is what the system is built around, which is exactly why a program grounded in an agency travels so well from one state to the next.

If some of this describes a capability you already have, that is not a verdict to be defensive about — it is a gap that is entirely fixable, and closing it is a good deal of what EMERGILITY does. Many excellent clinicians and firms begin right here: a capable physician, capable people, and real commitment, but without the agency structure beneath them. The aim of this section is not to fault anyone; it is to make the framework legible, so principals can choose with confidence and professionals can build on solid ground. Where the structure is missing, EMERGILITY can supply it — through affiliation, program management, or partnership — and turn a well-intentioned arrangement into a defensible practice.

3. What an EMS Agency Provides That a Physician Alone Cannot

If a medical director's signature were the whole of medical oversight, the agency requirement would be pointless. It is not pointless, because the agency is where oversight becomes real. Below are the core functions a licensed EMS agency maintains — the functions that convert a physician relationship into a defensible clinical practice. A retained medical director, absent an agency, delivers few of them.

Agency function	What it does — and why the private client should care
Operational Medical Director (OMD), tied to the agency	A physician accountable for this agency's clinicians, protocols, and outcomes — not a signature shared across unrelated clients. Oversight is continuous and relational, not transactional.
Designated Infection Control Officer (DICO)	A named individual responsible for exposure control, bloodborne-pathogen compliance, notification, and post-exposure management. A protective detail that draws blood or manages wounds without this has an unmanaged liability, not a program.
Quality Assurance / Continuous Quality Improvement (QA/CQI)	Structured chart review, case review, and performance monitoring that catch drift before it becomes harm. This is where oversight is exercised, documented, and improved — the opposite of a box checked once.
Training Officer & continuing education	Ongoing competency verification, skills maintenance, and protocol training. A card earned years ago is not evidence of current competence; the training function is.
Credentialing & privileging to protocol	The agency verifies each clinician's certification, scope, and readiness and privileges them to a defined set of protocols. Authority is granted deliberately, not assumed from a card.
Protocols & formulary	A written, physician-approved scope of practice and medication formulary that tells every clinician exactly what they may do and carry — and creates the record that they did so appropriately.
Controlled-substance custody & diversion prevention	Secure storage, tamper-evident chain-of-custody, inventory, and record retention for scheduled medications. Without an agency framework, controlled substances in a protective setting are a regulatory exposure of the first order.
Medication & medical-supply integrity	Every medication in date, stored within its required temperature range, tracked by lot, and screened against recalls; every consumable sterile, sealed, and within its shelf life. A drug that has cooked in a vehicle or expired on a shelf is not medicine — it is a hazard. The agency is what keeps the bag trustworthy.
Rx-only devices, legend drugs & prescriptive supplies	Lawful acquisition, custody, and use of prescription-only medications and devices — those that may be possessed and administered only under medical direction and appropriate licensure. Absent an agency and its medical director, carrying and using these is not authorized; with one, it is accountable.
Emergency vehicles & fleet management	Response and transport vehicles maintained, inspected, insured, and mission-ready — with scheduled servicing, equipment checks, and readiness logs. A medical program is only as reliable as the vehicle that carries it, and readiness is a managed function, not an assumption.

Agency function	What it does — and why the private client should care
Equipment readiness, storage & transport	Devices calibrated and functioning, batteries charged, oxygen and consumables stocked, and everything stored and transported to standard so it works at the moment of need. The difference between a kit and a capability is the system that keeps it ready.
Patient care records, privacy & retention	Documentation of every patient encounter, retained and protected consistent with health-information rules. The record is the client's protection as much as the patient's.
Active clinical practice between assignments	Because agency clinicians practice EMS as a matter of routine — not only when a detail happens to need them — their skills stay current. A provider who practices only when a principal is present is not practicing; they are waiting.

Read that list as a single question: who does these things, for your program, when you retain a physician and hire a paramedic but do not stand up an agency? In most private arrangements, the honest answer is no one. The medical director signs a protocol. The paramedic carries a bag. And the infection control officer, the QA program, the training function, the credentialing, the controlled-substance custody, and the routine clinical practice that keeps skills sharp — simply do not exist.

> *The agency is not bureaucracy. It is the machinery of oversight. Remove it and "medical direction" becomes a name on a page, unaccompanied by any of the functions that make direction mean something.*

4. The Market Today: A Spectrum of Capable Models

The protective-services market has responded to the demand for medical capability with real sophistication, and the firms below do serious, valuable work. The point of this section is not to critique them — it is to distinguish among models, so that a buyer can understand what each is designed to deliver and how a licensed EMS agency practice fits alongside it. These models are complementary to an agency practice, not in competition with it. In fact, EMERGILITY works with, and is positioned to support, providers of every type described here. The examples reflect how each firm publicly positions itself and are used to illustrate an archetype, not to characterize any company's internal arrangements, which its marketing may not fully describe.

Model 1 — Physician Overwatch

The pitch: a board-certified physician oversees the protective medical program, embedding medical planning into the security architecture. Raven Medical Support Group is a clear example, marketing "physician-led medical overwatch for high-risk principals" and contrasting its board-certified physician model against "EMT or paramedic staffing" that it characterizes as reactive and clinically limited. **What it does well:** it puts a physician and genuine medical planning at the center, which is more than many programs do. **Where an agency practice fits:** physician overwatch and a licensed EMS agency are natural partners. Overwatch brings the clinical planning and judgment; an agency supplies the operational scaffolding beneath it — the DICO, QA/CQI, training officer, credentialing, and controlled-substance framework that turn oversight into a fully operational practice. A physician-led program and an EMS agency are complementary instruments, and EMERGILITY can provide the agency layer that lets a physician-led model operate at full capacity.

Model 2 — Elite Credentialed Operators

The pitch: exceptional individuals — often from military special-operations backgrounds — who hold advanced medical credentials and deliver care in austere, tactical, or unreachable settings. XPJ Global exemplifies this, staffing former U.S. Air Force Pararescuemen whose operators hold NREMT-Paramedic certification with TCCC and TECC

credentials, providing trauma care "where conventional EMS cannot reach." **What it does well:** the individual capability is extraordinary, and for certain high-threat, remote, or expeditionary missions it is exactly right. **Where an agency practice fits:** elite operators bring capability few can match; an agency brings the civilian-EMS authorization and oversight structure that lets that capability be deployed on a compliant footing on U.S. soil — medical direction, infection control, quality, training, and controlled-substance accountability. The two pair naturally, and EMERGILITY can serve as the licensed EMS agency and medical-control home that complements a world-class operator model.

Model 3 — Assistance, Coordination & Staffing Networks

The pitch: a global platform that coordinates medical support — telemedicine with board-certified physicians, medical evacuation, event medical support, embedded chief medical officers, and medical or paramedical staffing. Global Guardian markets 24/7 tele-medical consultation, medical evacuation, and event medical support with "dedicated physicians for smaller gatherings." Crisis24 (a GardaWorld company) offers duty-of-care consulting, medical and paramedical staffing and training, event medical support planning, an embedded chief medical officer, and medical evacuation. **What it does well:** reach, coordination, referral, evacuation logistics, and the ability to place credentialed people quickly, worldwide. **A different, complementary model:** these platforms are built for global reach and coordination, drawing on broad networks to place capable people quickly, almost anywhere. An employed clinical practice is simply a different instrument — a smaller, standing team under unified medical direction and continuous quality assurance. Neither replaces the other; the reach of a network and the continuity of a practice complement each other well. EMERGILITY can provide that practice layer — direct EMS program support and clinical oversight — alongside a coordination or staffing platform, so the two together give a client both reach and a resident, quality-assured clinical practice.

Model 4 — Turnkey Security-and-Medical Logistics

The pitch: integrated security, medical, and response logistics delivered at scale, often for government and large commercial programs, using a deployable community of licensed professionals. GardaWorld Federal presents "turnkey security, medical, and response logistics" backed by "experienced, licensed professionals." **What it does well:** scale, program delivery, oversight frameworks, and the capacity to sustain complex multi-site operations. **Where an agency practice fits:** at program scale, a licensed EMS agency and its clinical-oversight infrastructure slot in as a defined component within the larger integrated model — the piece that authorizes the pre-hospital scope and carries the medical direction and quality functions. EMERGILITY can supply exactly that component, partnering within large integrated programs as the EMS agency and clinical-oversight layer.

> *Each of these models answers "who provides the medicine?" A licensed EMS agency practice answers the companion question — "under what practice is that medicine authorized, overseen, and quality-assured?" The two belong together, and EMERGILITY is built to provide that second layer, whether directly or in partnership with the providers above.*

5. Protective Medicine Is a Fusion — Not a Bolt-On

There is a deeper point beneath the agency question. **Protective security (PSS) and emergency medical services (EMS) are two different professions**, each with its own licensure, culture, competencies, and regulator. One protects an asset against a broad range of threats. The other delivers a physician-directed practice of medicine in the field. Excellence in one does not confer authority in the other.

Protective Medicine — what EMERGILITY defines as **PSS-EMS** — is the emerging specialty at the intersection of the two. It is not a security detail that happens to have a medic. It is not a physician's letter appended to a protection contract. It is the deliberate, licensed fusion of a protective-security practice and an EMS practice, so that the protectee receives protection and medicine as one integrated capability, each delivered lawfully under its own authority.

This is why medical control alone is not protective medicine. A medical director can direct EMS clinicians. A medical director cannot, by signature, transform a security company into an EMS agency, supply the infection-control and quality infrastructure, or make a protective detail into a licensed clinical practice. The fusion has to be built, licensed, and run — on both sides.

> *Medical control alone is not Protective Medicine. The professional fusion of a licensed PSS agency and a licensed EMS agency is.*

EMERGILITY is built as that fusion. It is licensed by the Virginia Department of Criminal Justice Services as a private security business **(DCJS 11-18032 and 88-10763)** and licensed by the Virginia Office of EMS as an EMS agency **(OEMS 50537)**. Its clinicians are EMS clinicians who practice under an agency — not technicians carrying a card onto a detail. That dual licensure is the point, not a footnote.

Matching the clinician to the mission

The fusion also answers a question the market rarely names: not only what structure a clinician practices under, but which kind of clinician a given client actually needs. The two are not the same, and the honest answer depends on the mission.

For the extreme edge of protective work — off-grid expeditions, extreme-sport pursuits, hostile or austere environments, the rare high-threat mission — a rescue-capable tactical medic is the right partner, and an exceptional one. A former **68W** combat medic, **18D** Special Forces medical sergeant, or Air Force Pararescueman **(PJ)** brings trauma capability forged in exactly those conditions. When a principal is base-jumping, operating in a conflict zone, or venturing where no help can reach, that warfighter at their side is precisely the right call.

But those missions are the exception, not the rule. Most protective work unfolds in ordinary environments, protecting principals and their families across the whole range of human medicine — children and grandparents, chronic disease and acute illness, cardiac, respiratory, and metabolic emergencies — not penetrating trauma in a fit young operator. For that reality, the superior everyday choice is an **advanced-practice paramedic who is dually trained in protective security** — the PSS-EMS clinician — able to care for patients of every age and condition, and to do so under a licensed agency practice. This is Protective Medicine embodied not just in an organization but in a person.

The point is not that one clinician is better than the other; it is that they are optimized for different missions. The tactical medic is built for the austere extreme. The advanced-practice protective paramedic is built for the breadth of real life. A serious program matches the clinician to the mission — and for the vast majority of principals and families, that clinician is the protective advanced-practice paramedic.

A different aim: treat in place, transport when needed

Protective and concierge paramedicine also differ from conventional EMS in a way that has nothing to do with the caliber of the provider and everything to do with the aim of the work. The traditional EMS enterprise — 9-1-1 response, interfacility transport, aeromedical — is built, appropriately, around a single objective: move the patient from where they are (home, work, or on the road) to definitive care as quickly and safely as possible. Treatment happens along the way; the destination is the point. That model is exactly right for the mission it serves.

Protective and concierge paramedicine — the capability home offices increasingly ask for — changes the default. Transport to an emergency department or specialty center is **never delayed when it is genuinely needed**. But the priority, when it is clinically indicated and feasible, is to treat, temporize, or manage the illness or injury **on-site rather than in an emergency department**. This is not that a traditional EMS provider could not do such work; it is that the traditional EMS business is not aimed at it. Treating in place is a genuinely different practice of medicine, and it asks more of the clinician, not less.

Practicing this way demands an active, fully integrated infrastructure that neither a lone medic nor a lone physician's signature can supply: an advanced-practice EMS provider able to assess and treat across the full range of illness and

injury, an Operational Medical Director engaged in real time, and access to specialty-care physicians for navigation and escalation. The skill required is not only clinical — it is judgment. It is intelligent healthcare navigation: knowing when and how to treat in place, and knowing when transport is the right first move.

> *Protective medicine is not about treatment-and-transport. It is about proper treatment, sound navigation, and the judgment to choose the right course — which is exactly why it must be practiced within an EMS agency and its integrated medical direction, not improvised at the edge of a security detail.*

6. The Duty-of-Care and Risk-Management Case

Private clients — principals, families, family offices, corporations — demand the utmost professionalism precisely because the stakes are personal and the tolerance for failure is low. In that context, the EMS agency is not red tape. It is the risk-management substrate on which a defensible program stands.

Consider the exposures that an agency practice manages and a stand-alone arrangement does not:

- **Authority to practice.** The agency and its medical direction are what authorize the clinician's scope. Without them, even a skilled provider may be operating without the structure the system is built around — a gap that tends to surface at the hardest possible moment.
- **Duty of care.** Once an organization undertakes to provide medical care, it assumes a duty to provide it competently. The agency's credentialing, training, and QA functions are how that duty is met and, critically, how it is documented.
- **Continuity and currency.** A clinician who practices only when a principal is present has skills that decay between engagements. An agency clinician practices routinely — in the community, at the workplace, on other assignments — and stays sharp. The private client is buying that currency whether they realize it or not.
- **Controlled substances.** Scheduled medications in a protective setting demand secure custody, chain-of-custody records, and diversion controls. These are agency functions; improvised, they are a liability.
- **Defensibility.** If an outcome is ever questioned — in litigation, by a regulator, by an insurer, or in the press — the program's defense is its structure: licensed agency, named medical director, documented protocols, credentialed clinicians, QA records. A box checked with a physician's signature is not a defense. A practice is.

> *Risk management is not what you say about your program. It is what your program is made of. The agency is the material.*

The reputational dimension matters as much as the legal one. A principal who has invested in genuine protection does not want a medical capability that looks impressive until it is examined. The agency practice is what allows a program to be examined — by counsel, by an insurer, by a discerning security director — and to hold.

7. The EMERGILITY® Model: Practice, Not Paperwork

EMERGILITY exists to close exactly the gap this paper describes. It is a Northern Virginia–based private practice that integrates Protective Security, Protective Intelligence, and Protective Medicine under one dual-licensed operation — a licensed private-security business and a licensed EMS agency in one house.

A practice, not a staffing firm

One distinction sits beneath all the others. **EMERGILITY is a practice, not a staffing firm.** Our clinicians, personnel, and protective agents are our own team members — employed within our practice, credentialed under our agency, and accountable to our medical direction and quality program. We do not assemble a capability, per engagement, from an extended network of external contractors summoned when a client calls. The people who deliver our care are the people who belong to our practice.

This is not a branding preference; it is what makes the oversight described in this paper real rather than nominal. Continuous quality improvement, competency verification, infection control, credentialing, and controlled-substance accountability are exercised over a known, employed team that practices together — not over a roster of strangers gathered for a night and dispersed. An agency can only truly oversee the clinicians it actually holds. We hold ours.

> *A staffing firm sends you people. A practice brings you its team — the same clinicians, under the same medical direction, accountable to the same quality program, every time.*

An advanced-practice model — a genuine practice of medicine

EMERGILITY EMS is not a pre-hospital technician pool with a medical director's name on file; it is a practice of medicine. It integrates the **advanced-practice provider** — the registered nurse, the nurse practitioner, and the physician assistant — alongside the advanced-practice paramedic and under physician direction, so that the clinical ceiling of the program is set by real medical depth, not by the limits of a single certification. A registered nurse practicing in an expanded pre-hospital role, a family nurse practitioner whose scope spans the full lifespan from pediatric to geriatric, a physician assistant, an advanced-practice paramedic, and a physician — working as one team — can assess and treat far more than a lone medic ever could.

This is what distinguishes a private EMS practice from a private security detail that happens to carry a medic. The breadth of provider types is what lets EMERGILITY care for real people — children, adults, and elders; the acutely injured and the chronically ill — rather than only the young and fit. It is also what makes the next capability possible.

For the organization that wants an EMS capability but has not stood up an agency

Most family offices, private businesses, and security firms do not want to become EMS agencies. They want the capability without the burden of building and maintaining the entire regulated infrastructure themselves. **EMERGILITY EMS provides EMS Program Management and EMS agency affiliation for exactly this purpose.** Rather than every solo paramedic or protective team standing up an agency of its own, EMERGILITY serves as the affiliation home — the EMS agency infrastructure — under which credentialed clinicians can lawfully practice. This is a distinct support service: here, an organization's *own* personnel are brought under EMERGILITY's agency, medical direction, and quality program — gaining the oversight structure they lack, without EMERGILITY becoming a staffing pool. The division of responsibility is clean and deliberate: the client **retains their employee under the client's own operational management and direction**, while EMERGILITY provides **operational medical control only**. We do not employ or operationally manage the client's personnel; we hold the medicine. It is the mirror image of the market's problem: instead of credentialed people with no practice behind them, it is credentialed people given a real practice to stand on.

Through that model, EMERGILITY EMS brings the systems-level functions a compliant program requires:

- **Medical direction** under a named Operational Medical Director tied to the agency;
- **Protocol and formulary access** defining a clear, physician-approved scope;
- **Credentialing and provider oversight** of affiliated clinicians;
- **Quality assurance, credential tracking, and performance review** — the CQI backbone;
- **Infection control, controlled-substance custody, and records** managed to agency standard;
- **EMS training and education** — from EMR and EMT coursework to specialized, tactical, and protective instruction — that keeps affiliated providers current and consistent.

The result is that a home office, a private business, or a private security company can field EMS-credentialed personnel who genuinely practice under an agency — with medical direction, quality assurance, and the full infrastructure behind them — rather than personnel who merely carry a card and operate under a distant signature.

For clients who want the fused capability directly

Where a principal wants Protective Medicine delivered rather than merely enabled, EMERGILITY provides it as the fusion it is: protective-security professionals and EMS clinicians operating together, each under proper licensure, coordinated as a single protective capability across the home front, the workplace, special events, travel, and protective details.

Direct access — security and medicine, delivered locally

EMERGILITY did something the market had not: it made both protective security and emergency medical services available through a **direct-access model** — not brokered through insurers, dispatchers, or third-party networks, but accessed directly and locally. That access extends to four communities it serves: **Protected Members** (individuals, families, executives, and protectees), the **Private Sector** (businesses, medical practices, communities, and HOAs), the **Public Sector**, and **First Responders**. Clients reach their own security and their own medicine directly — and can call on their own local protectors, who know them and can travel with them when life or work takes them elsewhere.

Care that can prevent the unnecessary trip to the ER

Because EMERGILITY pairs a private **Mobile Integrated Healthcare (MIH)** capability with a licensed private EMS agency, it can assess and treat, in the home or on-site, a wide range of injuries and illnesses that a 9-1-1 call or public EMS would otherwise be obligated to transport to a crowded emergency department. Direct-access primary care led by a family nurse practitioner, direct-access Paramedicine, point-of-care diagnostics and laboratory testing, and an EMS agency that can escalate when needed together mean that many problems can be resolved where the patient is — privately, promptly, and without the cost, exposure, and lost hours of an avoidable ER visit.

For private families and individuals, executives and protectees who demand more — who want a medical capability that can keep them out of the emergency department whenever it is safe to do so — **EMERGILITY is, to our knowledge, the only private EMS capability positioned to deliver this in Northern Virginia and the National Capital Region.**

Licensed in a compact state — reach beyond Virginia

There is one more advantage that follows directly from being a licensed EMS agency in the right state. Virginia is a member of the **United States EMS Compact (REPLICA)** — one of more than two dozen member states in which an EMS clinician licensed by any member state holds a recognized **Privilege to Practice**. Much like a driver's license honored across state lines, that privilege lets a member-state EMT, advanced EMT, or paramedic *originate and terminate* care in any other member state — at all times, not only during declared emergencies, and with no separate application or fee.

The reach extends further still. Beyond the Compact, a licensed EMS agency carries its own interstate authority: EMERGILITY's clinicians can travel with a client through any state or territory — compact or not — so long as the episode of care originates or terminates in Virginia. In practice, that means the same clinician who protects a principal at home can accompany them across the country and, on the return, bring them home under EMERGILITY's agency authority. For the family, executive, or protectee who moves, the medical capability moves with them.

This matters for the protective client who travels. Because EMERGILITY's clinicians are licensed in a compact state and practice under a physician medical director within a licensed EMS agency, their capability is portable in a way a certification card alone never is — subject, as always, to the Compact's conditions and the rules of the state where care is delivered. The reach is real; it is also, tellingly, reserved for exactly the model this paper describes. The Compact extends a privilege only to clinicians who already have a medical director and a licensed agency behind them. National mobility is a benefit earned by building the practice first.

> *EMERGILITY EMS is the agency behind the badge and the bag — the practice that turns a credential into care that can be trusted, examined, and defended.*

A partner to the protective-services industry

EMERGILITY does not view the firms described in this paper as adversaries. They are respected participants in a shared mission, and their models and EMERGILITY's are complementary. Where a physician-led firm, an elite-operator team, a global assistance or staffing platform, or a large integrated program wants to add or strengthen a licensed EMS capability with genuine clinical oversight, EMERGILITY is positioned to help — through consulting and advisory work, through EMS program design and management, and through direct EMS program support that supplies medical direction, credentialing, quality assurance, and the full agency infrastructure. The same expertise that lets EMERGILITY deliver Protective Medicine to a principal lets it stand up, support, or elevate an EMS capability for another provider. The goal is not to replace what these firms do well; it is to complete it.

8. A Buyer's Due-Diligence Checklist

Whether you are a principal, a family-office executive, a general counsel, a risk manager, or a security director, you can test any medical capability — in-house or vendor-supplied — with the following questions. If the answers are not clear and documented, you have a credential and a signature, not a practice.

1. **Is there a licensed EMS agency?** Which agency, licensed by which state EMS authority, authorizes the pre-hospital scope your clinicians deliver?
2. **Is the medical director tied to that agency?** Or is the physician a stand-alone signature shared across unrelated clients, with no routine interaction with your providers?
3. **Who is the designated infection control officer?** Name the individual and the exposure-control program.
4. **Where is the QA/CQI program?** Who reviews charts and cases, how often, and where is that documented?
5. **Who is the training officer?** How is current competency — not a years-old card — verified and maintained?
6. **How are clinicians credentialed to protocol?** What is the written scope and medication formulary, and who approved it?
7. **How are controlled substances handled?** Storage, chain-of-custody, inventory, diversion prevention, retention.
8. **Do the clinicians actively practice between assignments?** Or do their skills sit idle until a principal needs them?
9. **Is protective security itself properly licensed?** And is the medical capability fused with it lawfully — or bolted on?
10. **Would the program survive scrutiny?** If an outcome were questioned by counsel, an insurer, or a regulator, what is the documented structure that defends it?

Conclusion

The demand is real and growing: family offices, corporations, and protective-services firms increasingly need professional medicine woven into their security. Meeting that demand with a retained physician and a hired paramedic feels responsible, and it is a step in the right direction. But it stops short of the standard the private client actually deserves.

Pre-hospital care is practiced under a licensed EMS agency, not under a certification card and not under a physician's pen alone. The agency is where oversight becomes real — through infection control, quality assurance, training, credentialing, controlled-substance custody, and the routine practice that keeps clinicians sharp. And protective medicine, done right, is the fusion of a licensed protective-security practice with a licensed EMS practice, not medical direction stapled to a security contract.

EMERGILITY was built as that fusion, and EMERGILITY EMS extends it to others — providing the EMS agency infrastructure, program management, oversight, and training that let family offices, private businesses, and security firms deliver EMS the way the private client demands: professionally, lawfully, and defensibly. **A physician's pen is necessary. A practice is the point.**

About EMERGILITY® — EMERGILITY® is a Northern Virginia–based private practice founded in 2015, integrating Protective Security, Protective Intelligence, and Protective Medicine under one dual-licensed operation. It is licensed by the Virginia Department of Criminal Justice Services (DCJS 11-18032 and 88-10763) as a private security business and by the Virginia Office of EMS (OEMS Agency 50537) as an EMS agency, and delivers Protective Medicine (PSS-EMS), Mobile Integrated Healthcare, direct-access Paramedicine (daP™), and EMS training and education.

Learn more: emergility.com/ems · emergility.com/protective-medicine

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