

APPLICATION FOR AMBULANCE PROVIDERS

1. Expiration Date or Effective Date (if new business): _____
2. Full Name of Service: _____
3. Street Address: _____
4. City: _____ County: _____ State: _____ Zip Code: _____
5. Mailing Address (if different): _____
6. Phone #: _____ FAX#: _____
7. Email address: _____ Web address www. _____
8. Name of Contact Person: _____ Title: _____
Phone # for Contact Person: _____
9. Type of Organization:
 Individual Partnership LLC Corporation- FEIN# _____
10. Is your service? For Profit Not for Profit
11. Date your service legally established: _____
*** If less than 3 years we will need resume for all owners/managers**

Number of years in this type of business: _____
Number of year's current ownership: _____
Number of year's current management in place: _____
12. Have you ever operated under a different name? Yes No
If yes, what name: _____
13. Is your service a subsidiary or division of another company? Yes No
If yes, please explain: _____
14. Is your service involved in any of the following? Yes No (If yes, please check)
 Air Ambulance Water Rescue Activities or operations other than EMS
 Special Event EMS Offshore EMS Mock Disaster participant

If checked yes to any of the above, please explain: _____

15. Total Estimated number of annual ambulance calls: _____
 _____% of total ambulance calls are BLS Non-Emergency
 _____% of total ambulance calls are ALS Emergency
 _____% of total ambulance calls are 911 Emergency
16. Total Estimated number of annual paratransit calls: _____
 _____% of total paratransit calls are Wheelchair
 _____% of total paratransit calls are Gurney/Stretcher
 _____% of total paratransit calls are Passenger Van
17. Does your service perform any of the following? Yes No (If yes, please check)
 Mast Trousers EOA IV Therapy including IV monitoring
 Defibrillation Intubation
A lack of entry for the above categories indicates only Basic Life Support skills are provided
18. Does your service have a Medical Director? Yes No
 If yes, please provide name: _____
19. How many of your employees, who provide patient care, are certified as the following:
 (Part time, Full time, paid or volunteer) Count each individual once.
 _____ EMT Basic _____ Paramedic
 _____ EMT Intermediate/Advanced _____ CPR Only
 _____ State Certified First Responder _____ All Other
 _____ Total number of above
20. Who dispatches your calls?
 911 In-House by own employees
 Outside Sources (please explain) _____
21. If dispatched in-house is previous experience required? Yes No
 If yes, please describe in-house training for dispatchers including length of time:

22. Does your service screen calls to determine whether or not an ambulance will be
 dispatched? Yes No If yes, please attach a copy of written procedures.
23. Is a call report completed on each call, and each time an ambulance is requested?
Yes No If no, please explain: _____
24. How often are your call reports reviewed for completeness, legibility and professional
 content? Daily Weekly By Shift Other _____
 Who reviews these reports? _____
Name Title
25. Number of hours worked per shift _____ Number of hours off between shifts _____

38. What is your minimum driver age? _____
39. Number of currently employed drivers: _____ Full Time _____ Part Time
40. What was the percentage of your driver turnover in the past 12 months? _____%.
41. Does your service review drivers motor vehicle reports? Yes No
How often? Annually Every 2-3 years More than 3 years
42. What does your service consider as an acceptable driver motor vehicle report? _____

43. Does your service provide an Ambulance Drivers Training Program? Yes No
If yes, which program(s) are drivers required to attend?
 Defensive Drivers Course: Film Hands-on Training
 Emergency Vehicle Operators Course (EVOC)
 Highway Patrol Training Fail Safe Drivers Training
 Road Safety Drive Cam GPS
 Other: _____
44. Please explain your Driver Training Program:

45. When adding new drivers, does your service require previous ambulance driving experience?
Yes No If yes, how much experience do you require? _____
46. Are disciplinary measures utilized when accidents are determined to be your driver's fault?
Yes No If yes, what are they? _____
47. What is the total replacement value of your Portable Equipment? \$ _____
48. Does your service carry Workers Compensation and Employer's Liability Coverage?
Yes No If yes, please complete the following:
Name of Workers Compensation carrier: _____
Policy #: _____ Policy Period: _____
Employers Liability Limits:
Bodily Injury by Accident \$ _____, Each Accident
Bodily Injury by Disease \$ _____, Policy Limit
Bodily Injury by Disease \$ _____, Each Employee

Location Information

***Please complete for each location**

Location# _____ Building # _____

Building occupied as? Office Crew Quarters Garage Other _____

Location Street Address: _____

City: _____ State _____ Zip _____ Building Age: _____

Are you a owner, tenant or lessee? Total square footage of building: _____

Total square ft you occupy: _____ # of stories: _____ Basement? yes no

Building Construction: frame stucco brick block steel other: _____

Any other businesses in the building? yes no What Kind? _____

Do you have a burglar alarm? yes no What Kind?: _____

Does this location have sprinklers? yes no

Do you have fire extinguishers and smoke detectors? yes no

Is Property Coverage needed? Yes No If yes, please complete below:

Building value: \$ _____ (Complete value if you own the building)

Contents, Furniture, Fixtures & Equipment (inside) Value: \$ _____

Computer Hardware Value: \$ _____ Computer Software Value: \$ _____

Deductible: \$250 \$500 \$1,000

Certificate Holder: _____

Address: _____

Attn: _____ Phone#: _____ FAX#: _____

Additional Insured

Mortgagee

Loss Payee

