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|  | Massachusetts Department of Public HealthOffice of Emergency Medical ServicesPart A: Ambulance ServiceLicense Application |  |

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| 1) Service Number  | | | | | |  | 2) Service Expiration Date | | | | | | | | |  | 3) Is this application  \_\_\_\_\_\_Initial \_\_\_\_\_\_Renewal \_\_\_\_\_\_\_Modification  Modification of License to:  \_\_\_\_Advanced \_\_\_\_Paramedic \_\_\_\_ Critical Care Transport | | | | | | | | | | | | | | | | | |
| **4) SERVICE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address P.O. Box | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | State | | | | | | | | | | | | | | Zip | | | | | | | | | |
| Business Phone Number | | | | | ( ) | | | | | | | | | | | Fax Number | | | | | | ( ) | | | | | | | | | |
| Manager Name | | | | | | | | | Contact Person | | | | | | | | | | | | | | E-mail address | | | | | | | | |
| **7) LICENSEE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | State | | | | | | | | | | | | | | Zip | | | | | | | | | |
| Business Phone Number | | ( ) | | | | | | | | 24 Hour Access Number, Non 911 | | | | | | | | | | | | ( ) | | | | | | | | | |
| E-mail address | |  | | | | | | | | 24 Hour Access Fax Number | | | | | | | | | | | | ( ) | | | | | | | | | |
| **8) PARENT or ASSOCIATED COMPANIES OF OWNER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City | | | | | | | | State | | | | | | | | | | | | | | Zip | | | | | | | | | |
| **9) Service Ownership Type?** | | | | | | | | Sole Proprietor  Government | | | | | | | | Partnership Corporation LLC | | | | | | | | | Limited Partnership  Other: | | | | | | |
| **10) Is this service hold other valid licenses in the Commonwealth of Massachusetts?**  YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **11) Level of License applying**  BLS Advanced Paramedic Critical Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **12) With which hospital(s) do you have an affiliation agreement or memorandum of understanding or medication exchange?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital Name | | | | | | | | | | | | | | | | | | ALS | | | | | | Glucose Monitoring | | | | | Alb/Narcan | | EPI/Aspirin |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **13) Total number of vehicles**  Class I | | | | | | | | | | | Class II | | | | | Class IV | | | | | Class V | | | | | | | | EFR | | |
| **14) Total number of EMS personnel**  **EMTs:**  Basic: | | | | | | | Intermediate: Advanced: | | | | | | | | | | Paramedic: | | | | | | | | | | Services uses Paramedic/ Basic Minimum Staffing **YES NO** | | | | |
| **15) Does the ambulance service respond ONLY to calls from a unique population?** | | | | | | | | | | | | | | | | | | | | YES | | | | | | NO | | | | | |
| If yes, identify population(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **16) Indicate the number of runs performed by this service in the last calendar/fiscal year** | | | | | | | | | | | | \_\_\_/\_\_\_/\_\_\_\_\_  Date From | | | | | \_\_\_/\_\_\_/\_\_\_\_\_  Date To | | | | | **Yes** / **No**  Are numbers estimated? | | | | | | Total Number of Responses (incl cxl,refusal): | | | |
| Emergency Transports BLS: | | | | | | Emergency Transports ALS: | | | | | | Routine Transports  BLS: | | | | | | | Routine Transports  ALS : | | | | | | | | | Total Transports: | | | |
| **17) Do you currently have any Waivers?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check | Waiver Type | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Extension Requested | |
|  | Vehicle Waivers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES NO | |
|  | Service Operation Waivers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES NO | |
|  | Special Project Waiver | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES NO | |
|  | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES NO | |
| OEMS use only | | Fee Received | | | | | Amount | | | | | | | | OEMS Form 500-1 (08/2015) | | | | | | | | | | | | | | | | |

**Part A: Ambulance Service License Application**

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| STATEMENT OF NON-DISCRIMINATION Pursuant to 105 CMR 170.335 of the Emergency Medical Services System Regulations, Regulating Ambulances and Ambulance Services, “no person shall discriminate on the grounds of race, color, religion, national origin, sex, sexual orientation, age, ancestry or disability in any aspect of its provision of ambulance or EMS first response service or in employment practices. This section requires compliance with M.G.L. c. 151B, as amended, which is a statute prohibiting unlawful discrimination.”  This ambulance service is and will continue to be in conformance with these requirements. |

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| TAX CERTIFICATION STATEMENT I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.  This license will not be issued unless this certification clause is signed by the applicant.  Your tax identification number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or are delinquent WILL BE SUBJECT TO LICENSE SUSPENSION OR REVOCATION. This request is made under the authority of M.G.L. c. 62C s. 49A. |

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| 18) License social security or federal identification number: |  |
| 19) Does this service have any outstanding assessments levied by the Commonwealth of Massachusetts? | YES NO |
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## I understand that additional information may be required by the Massachusetts Department of Public Health to complete the application process, and agree to provide such information as requested. I, the undersigned, attest that I am duly authorized to complete and sign this application, that I have read this application in its entirety and that the information contained herein is complete, accurate and true. Signed under the pains and penalties of perjury.

## Authorized Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| FEE INFORMATION Fee must accompany application or a letter of explanation must be submitted.  Applications will not be submitted to Public Health Council until fee has been received.  **FEES ARE AS FOLLOWS:**  **BLS only: $400 ambulance service license, plus $200 per vehicle for Certificates of Inspection, OR**  **ALS (and BLS): $600 ambulance service license, plus $200 per vehicle for Certificates of Inspection.**  **ALS Upgrade: $600 ambulance service license upgrade (no Certificate of Inspection fee required if the upgrade is not at time of relicensure)**  Make check(s) payable to Commonwealth of Massachusetts. |

**Return completed application packet, fee and proof of insurance to:**

#### Office of Emergency Medical Services

**67 Forest Street**

**Marlborough, MA 01752**

OEMS Form 500-1 (06/2019)