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|  | **Massachusetts Department of Public Health**Office of Emergency Medical ServicesPart D: Place of Business |  |

Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances (Make as many copies of this form as needed).

|  |  |  |
| --- | --- | --- |
| 1) Service Number | | | |  | 2) Ambulance Service Name |
| **3) PLACE OF BUSINESS** |
| Address |
| City | State | Zip |
| Business Phone Number [For this location]( ) | Emergency Phone Number (non 911)( ) |
| **4) Is this location your headquarters?** YES NO Fax Phone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5) Number of vehicles normally operated at this location |
| Class I | Class II | Class IV | Class V |  |

**6) Is service from this place of business provided 24 hours a day, 7 days a week?** YES NO

If no, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **7) What type of service(s) is being provided from this location?** **(Check all that apply)** |   Basic  ALS-Advanced  ALS-Paramedic  ALS-Critical Care  |
|  |
| **8) How many hours per day is ALS-Intermediate service available? (if applicable)** |
| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|  |
| **9) How many hours per day is ALS-Paramedic service available? (if applicable)** |
| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|  |
| **10) ALS Information**Mass Controlled Substance Registration #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital with which you have an Affiliation Agreement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

 OEMS Form 500-1 (06/2019)