|  |  |  |
| --- | --- | --- |
|  | **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:

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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)