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|  | **Massachusetts Department of Public Health**Office of Emergency Medical ServicesPart E: Vehicle Certification |  |

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).

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| 1) Service Number  | | | | |  | | 2) Service Expiration Date | | | | | | 3) Is this vehicle a(n)  \_\_\_\_\_Addition \_\_\_\_\_Replacement \_\_\_\_\_Renewal | | | | | |
| **4) SERVICE INFORMATION** | | | | | | | | | | | | | | | |
| Service Name | | | | | | | | | | | | | | | |
| Service Address | | | | | | | | | | | | | | | |
| Service City | | | | | | | | Service State | | | | | Service Zip | | |
| Business Phone Number  ( ) | | | | | | | | Business Fax Number  ( ) | | | | | | | |
| Vehicle Location Address (**if not Garaged at Service Address**) | | | | | | | | | | | | | | | |
| Vehicle Location City | | | | | | | | Vehicle Location State | | | | | Vehicle Location Zip | | |
| **4) Has this vehicle been previously certified to another service in Massachusetts?** YES NO | | | | | | | | | | | | | | | |
| **6) Vehicle Identification Number**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | |
| **7) License Plate Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vehicle Garaged at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **8) Vehicle Unit ID unique to your serviced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Replacement for Vehicle # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **9) Chassis Make (Manufacturer)** | | | | | | | | **Model** | | | | **Year** | | | |
| **10) Has this chassis been replaced?** YES NO | | | | | | | | | | | | | | | |
| **11) Ambulance Manufacturer** | | | | | | | | **Model** | | | | **Year** | | | |
| **12) Current total mileage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **13) Class for which Ambulance is to be certified:** (check one class and one type) | | | | | | | | | | | | | | | |
| Class I  Class II | \_\_\_Type I  \_\_\_Type I | | | | \_\_\_Type II  \_\_\_Type II | | \_\_\_Type III  \_\_\_Type III | Class IV  Class V | | | \_\_\_Fixed Wing  \_\_\_Type I \_\_\_Type II | | | | \_\_\_Rotary Wing  \_\_\_Type III |
| **14A) Have waivers been issued for this?** YES NO  If yes, please detail. Add extra sheets if necessary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **14B) This vehicle conforms to all applicable standards?** YES NO | | | | | | | | | | | | | | | |
| **15) Has this vehicle been involved in a reportable accident since last inspection?** YES NO  If yes, has the report(s) been filed with OEMS? If no, please attach report(s)  YES NO | | | | | | | | | | | | | | | |
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| **Weight Verfication Form**  **To be completed with adding or replacing a new vehicle certfication**  **NOTE: WEIGHT VERIFICATION IS REQUIRED ONLY FOR REPLACEMENT AND ADDITIONAL AMBULANCES. When requesting certification for multiple vehicles that have the same year of manufacture, design and construction specifications, a service need only take weight verification information on one sample vehicle from the group once during the chassis-manufacturing year and copy that information onto Part E, number 18 for the other identical vehicles in the group. For example, if a service is to purchase two or more identical ambulances manufactured in 2014, verify weight of one and put that information onto Part E, number 18 for other identifical 2014 vehicles. Please do not complete this part for vehicles previously certified under your license.**  **Complete the following checklist to verify the weight of stocked ambulance:**  1. Stock ambulance with required medical and vehicle equipment and supplies. ( )  2. Stock ambulance with optional medical and vehicle equipment and supplies. ( )  2. Count the number of seats that include seat belts and the cot. # of seats & Cot \_\_\_\_\_\_\_\_\_ ( )  3. Stock ambulance as an in-service vehicle, with standard equipment required  by the service for day-to-day operations. ( )  4. Fill fuel tank(s) to full level. ( )  5. Weigh stocked ambulance empty of personnel. ( )  6. Record weight of ambulance Wt =\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )    7. Record gross vehicle weight (GVWR). GVW R=\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )    8. **Attach vehicle weight bill to this form**. ( )  Note: If an ambulance is found to exceed its identified GVW rating, the service must take measures to reduce the weight in order to conform to the vehicle’s posted GVW rating. Certification of an ambulance will be contingent on the licensee’s ability to demonstrate compliance with the ambulance’s GVWR. | | | | | | | | | | | | | | | | |
| Authorized Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| **FEE INFORMATION:**  The fee for certification is $200.00 per vehicle.  Make check(s) payable to the **Commonwealth of Massachusetts**.  Return completed **Part E Form**, **Vehicle Weight Bill**, and **Certification Fee** to: Office of Emergency Medical Services **67 Forest Street**  **Marlborough, MA 01752** | | | | | | | | | | | | | | | | |
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| **OEMS use only** | | | Fee Received | | | Amount | | | Certificate Number  | | | | | | | | Temp Certificate issued:  | | | | |
| Wt\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_+ # of Seats &Cot = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X 175lbs Wt Exceeds GVW Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_  OEMS Review by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |