

# AMBULANCE SERVICE LICENSE

## MULTI-COUNTY APPLICATION

PLEASE PRINT. APPLICATION MUST BE NOTARIZED.

New Application \_\_\_\_\_ Renewal Application \_\_\_\_\_ Date \_\_\_\_\_

Indicate the county the ambulance company is based in & number of units you wish to license and inspect:

Adams: \_\_\_\_\_ Arapahoe: \_\_\_\_\_ Broomfield: \_\_\_\_\_ Denver: \_\_\_\_\_ Douglas: \_\_\_\_\_ Elbert: \_\_\_\_\_ Jefferson: \_\_\_\_\_

**Please attach a check to the application(s).**

**Telephone numbers and fees for each county are listed on the Pre-Inspection Checklist.**

**Note: Denver County requires any ambulance company that transports within the City & County of Denver to license their company, whether or not the ambulance company is based in Denver.**

### Company name (Owner/parent Company)

Check one: Sole Proprietor \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

**Doing Business As (AKA)** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

**Manager or individual responsible for operation of service:** Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

### Dispatch Center

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

**Insurance Company** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Insurance Agent** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

### Attachments required to complete the application:

- Name and address of each stockholder or partner owning 10% or more of the outstanding stock of the company, or having more than 10% ownership interest (if applicable).
- Certificate of Insurance showing: Bodily Injury (Each person \$1,000,000, Each accident \$2,000,000)
  - Property Damage (Each accident \$1,000,000)
  - Professional Liability (Each person \$1,000,000, Each accident \$2,000,000)
  - Workman's Compensation
- Drug list approved by the Medical Director/sponsor for use in the field (signed and dated by Medical Director)
- Geographic of the service area
- Motor Vehicle Condition form completed for each vehicle
- List of locations (central and sub-station), where ambulances will be located. Attach zoning authorization if appropriate
- List of current personnel providing service (list all levels of state certified EMT's and respective expiration dates)

- List of current ambulances (include the year, make, type, maximum capacity for each vehicle)
- Please attach at check to each application

*I hereby certify that the information provided in this application is true to the best of my knowledge and belief and contains no willful misrepresentations or falsification.*

*Determination that an ambulance service license has been issued based on false information constitutes grounds for license revocation and possible criminal prosecution.*

**Applicant's Signature** \_\_\_\_\_ Date Signed \_\_\_\_\_

Please **print** the applicant's name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 2008, IN THE COUNTY OF \_\_\_\_\_ STATE OF COLORADO.*

*Signature of Notary \_\_\_\_\_ My Commission Expires \_\_\_\_\_*

[SEAL]

**TO BE COMPLETED BY THE MEDICAL DIRECTOR**

**Medical Director** \_\_\_\_\_ Medical License Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

**Facility Affiliation** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_ E-Mail \_\_\_\_\_

The following are licensing requirements of a medical director:

- 1) Meet the requirements established by Colorado Board of Medical Examiners (CBME) as defined in CBME 3CCR713-6, Rule 500
- 2) Provision of Medical Oversight for the ambulance service and personnel
- 3) Provision of a medical continuous quality improvement program (must be available to County upon request)
- 4) Ensure that the ambulance service complete a patient care report for each patient that is assessed
- 5) Ensure that the ambulance service completes and submits an agency profile
- 6) Investigate and provide written documentation of the investigation and resolution process of each complaint received from the County (Non-compliance with any of these requirements may result in suspension or revocation of ambulance service license).

**I understand and accept the responsibilities of a Medical Director for \_\_\_\_\_ service. I understand that non-compliance with any of these requirements may result in suspension or revocation of ambulance license.**

**Medical Director's Signature** \_\_\_\_\_ Date Signed \_\_\_\_\_

Please **print** Medical Director's name \_\_\_\_\_ Telephone # \_\_\_\_\_

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 2008, IN THE COUNTY OF \_\_\_\_\_ STATE OF COLORADO.*

*Signature of Notary \_\_\_\_\_ My Commission Expires \_\_\_\_\_*

[SEAL]