

EMS & TRAUMA SYSTEMS

Portland State Office Building | 800 NE Oregon Street, Suite 465 | Portland, OR 97232-2162



APPLICATION FOR AMBULANCE SERVICE LICENSE

In order to receive an ambulance service license, please complete this application. Completion of the application shall consist of providing the information requested in OAR 333-250-0020 and submitting a non-refundable licensing fee. Please check, type or print the appropriate response in blue or black ink only. Upon completing the application, have the person with the power of attorney sign it.

- PAYMENT DUE:** **\$75.00** with a maximum of four full time paid positions (QC 498)
- \$250.00** with five or more full time paid positions (QC 499)

PLEASE NOTE: Make check payable to: *Oregon Health Authority EMS and Trauma Systems*, and mail to:

**Oregon Health Authority
EMS & Trauma Systems
PO Box 14450
Portland, OR 97293-0450**

Name of Service:	
Mailing Address:	
Telephone Number:	
FAX Number:	
E-Mail Address:	
Owner:	
Principal Contact Person:	
Power of Attorney given to the following persons for signing applications:	

Type of Ownership:	
Type of Agency:	
Type of Service Provided:	
Ambulance Locations:	

Level of personnel used: *(Check all that apply)*

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> EMT | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> EMT- Advanced | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> EMT- Intermediate | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Paramedic | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Registered Nurses | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Physician Assistants | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Non-EMT Drivers | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Pilots | <input type="checkbox"/> Paid full-time | <input type="checkbox"/> Paid part-time | <input type="checkbox"/> Volunteer |

Level of care provided: *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Basic level of care | -Personnel and equipment provided 24 hours-a-day |
| <input type="checkbox"/> Basic level of care | -Personnel and equipment provided only part of a 24 hour-day |
| <input type="checkbox"/> Intermediate level of care | -Personnel and equipment provided 24 hours-a-day |
| <input type="checkbox"/> Intermediate level of care | -Personnel and equipment provided only part of a 24 hour-day |
| <input type="checkbox"/> Advanced level of care | -Personnel and equipment provided 24 hours-a-day |
| <input type="checkbox"/> Advanced level of care | -Personnel and equipment provided only part of a 24 hour-day |

Training Director's Name:

Medical Director Information:

Medical Director's Name:

Medical Directors address:

Medical Directors Contact Numbers:

Signed Standing Orders: *(Standing orders must have been signed within the past twelve months.)*

- Signed standing orders for Emergency Medical Technicians. Date signed:
- Signed standing orders for EMT-Intermediates/ Advanced. Date signed:
- Signed standing orders for Paramedics. Date signed:

- Our medical director has authorized the purchase and use of controlled substances.
If checked, you must have a DEA license containing the name of your medical director and the name and address of your ambulance service. A separate DEA license is required for each location where controlled substances are stored. (Stored does not mean the controlled substances that are kept on an ambulance.)

Our DEA license has an expiration date of:

- Our medical director has authorized the use of blood glucose monitoring devices to determine blood glucose levels. If checked, you must have a CLIA Laboratory Certificate of Waiver.

CLIA Number:

Expiration Date:

Proof of financial responsibility as prescribed in ORS 682.105. If certificate is expired, attach a copy of current certificate of insurance. (*NOTE - Government owned services do not need to submit a certificate of insurance.*)

Ground Ambulance Liability:

Name of Insurance Company:

Expiration Date:

Air Ambulance Liability:

Name of Insurance Company:

Expiration Date:

Personnel Liability:

Name of Insurance Company:

Expiration Date:

Medicare/Medicaid Provider Numbers:

Medicare Number:

Medicaid Number:

Advertising in the telephone book yellow pages:

- I am not advertising in the telephone book yellow pages.
- I am advertising in the telephone book yellow pages. This advertising meets the requirement of OAR 333-250-0100. Attached are copies of the advertisement.

The following must be submitted with this application to obtain an ambulance service license:
Service operating air, ground or marine ambulance:

- Proof of financial responsibility for operation of ambulances. Minimum amounts are: \$100,000 because of bodily injury to or death of one person in any one accident; subject to that limit for one person, \$300,000 because of bodily injury to or death of two or more persons in any one accident; and \$20,000 because of injury to or destruction of the property of others in any one accident. Attach a copy of the certificate of insurance.
- Proof of financial responsibility because of injury arising from the negligent provision of prehospital care to any one individual in the amount of \$500,000. Attach a copy of the certificate of insurance.
- If business address is in another state, attach a copy of the current ambulance license for that state.
- Power of attorney for all persons, if any, signing the application on behalf of an owner, general partner, corporate officer, or authorized person.
- All radio licenses issued by the Federal Communications Commission or written authorization from FCC license holder. Attach copies of licenses or authorization letter.
- A list of all radio frequencies included in mobile radios. This includes frequency name, transmit frequency, receiving frequency, and CTCSS tone. This information is contained on the printout from the CPU of a programmable radio.
- Medicare/Medicaid provider/vendor numbers issued by the Oregon Medical Assistance Program and Health Care Financing Administration or its designee. Attach a list of all medicare/medicaid numbers.
- If advertising in the telephone book yellow pages, attach copies of all pages where the advertisement appears.
- Prehospital care report form. Department of Human Services Prehospital Care Report Form or using own prehospital care report form.

Service operating ground ambulance:

- Medical personnel roster must include: full name; certification or license number; type of certificate/license and expiration date. Operating personnel roster must include: full name; operator's driver license number and expiration date. Indicate if person is paid full-time, paid part-time or volunteer.

Service operating air ambulance:

- Air Carrier Operating Certificate. Attach a copy of the certificate.
- FAA 337 form. Do not send copy. Maintain copy in ambulance service business office for each modification made to aircraft.

- Medical personnel roster must include: full name; certification or license number; type of certificate/license and expiration date; date completed the initial US Department of Transportation's Air Medical Crew National Standard Curriculum or equivalent. If more than one year has lapsed since completing the initial course, then list the date that an annual review was completed, the length of which is established by the medical director. Operating personnel roster must include: full name of the pilot; pilot's license number and expiration date. Indicate if person is paid full-time, paid part-time or volunteer

STATEMENT OF TRUTH OF APPLICATION

I, _____, being of first duly sworn, depose and that I am an authorized agent of the entity that owns and operates the ambulance service described in this application.

I certify that there have been no attempt to knowingly and willfully falsify, conceal, or omit a material fact, or make any false, fictitious, incomplete or fraudulent statements or representations, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry for the purpose of obtaining or attempting to obtain an ambulance service license to operate in the State of Oregon. Where I have relied upon documents submitted by employees or agents, I have made a reasonable effort to verify the validity of those documents.

I authorize any persons or entities, including but not limited to hospitals, institutions, organizations, or governmental entities to release to Oregon Health Authority EMS and Trauma Systems (Authority) any information, files, or records requested by the Authority in connection with the processing of this application. I further authorize the Authority to release to any person or entities information which is pertinent to my application.

Upon receiving an ambulance service license from the Authority, I authorize disclosure of information by insurance companies, physicians, health care facilities, including but not limited to hospitals, nursing homes or free standing medical centers, to the Authority relating to service provide by the ambulance service to those facilities or to patients being taken from or to those facilities.

I have carefully read the application and answered the appropriate questions completely and without reservations of any kind, and I declare under penalty of perjury that my answers, all statements made and documents provided by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of this ambulance service license to operate in the State of Oregon.

(Authorized Agent to sign in presence of Notary Public)

Subscribed and sworn to before me this ____ day of _____, 20____ Notary Public

Notary Public for _____ My Commission Expires ___/___/___ Seal

(Notary Signature)

Mail the completed application with a non-refundable licensing fee and all requested documents to:

Oregon Health Authority
EMS & Trauma Systems
PO Box 14450
Portland, OR 97293-0450

(For EMS & Trauma Systems Authority Use Only)

Date application Received License Denied Date: ____/____/____

Reason for denial: _____

License Approved Date: ____/____/____

License Number Issued: _____ Expiration Date: ____/____/____

(Signature of Ambulance Licensing Program Representative)

This document has 6 pages.
