



**DEPARTMENT OF HUMAN SERVICES  
EMS AND TRAUMA SYSTEMS SECTION  
PO BOX 14450  
PORTLAND OR 97293-0450**



**APPLICATION FOR AIR AMBULANCE LICENSE**

Mail the completed application with the appropriate **NONREFUNDABLE FEE** to: Department of Human Services, Business Services, P.O. Box 14260, Portland, OR 97293-0260. Make the check in the following amount payable to the **Department of Human Services, EMS & Trauma Systems Section.**

- \$45** per ambulance - This service has a maximum of four full-time paid positions.  
 **\$80** per ambulance - This service has five or more full-time paid positions.

All ambulance licenses expire on June 30 of each year, except for a license that is issued between April 1 and June 30, then the license shall expire on June 30 of the following year.

**AMBULANCE SERVICE INFORMATION**

Registered Owner's Name: \_\_\_\_\_  
Last First M.I.

Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street or PO Box Number

\_\_\_\_\_

City	County	State	Zip Code
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Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of person making application: \_\_\_\_\_

**AIR AMBULANCE DESCRIPTION**

**Aircraft Type:**     Fixed Wing                       Rotar-Wing

**Number of engines:**    One                       Two

**IFR Equipped:**                       Yes                       No

Aircraft Make: \_\_\_\_\_ Aircraft Model: \_\_\_\_\_ Model Year \_\_\_\_\_

FAA Registration Number: \_\_\_\_\_

- Major repairs and alterations have been made to this aircraft and there is FAA Form(s) 337 on file in our business office
  
- No major repairs or alterations have been made to this aircraft and no FAA Form(s) 337 are required.

Colors of: Aircraft Fuselage \_\_\_\_\_ Stripe \_\_\_\_\_ Lettering \_\_\_\_\_

Insigne name, monogram or other distinguishing characteristics: \_\_\_\_\_

**STATEMENT OF TRUTH OF APPLICATION**

I, \_\_\_\_\_, certify that I am an authorized agent of the entity that owns or leases and operates the ground ambulance described in this application.

I certify that to the best of my knowledge, that this ground ambulance meets all federal, state, county and city requirements to operate as an ambulance in Oregon. 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 and all statements made 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 ground ambulance license or my ambulance service license to operate in the State of Oregon.

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**(Signature of the authorized agent owning or leasing this ambulance)**

**Date**