

PH-3987 (Rev 3-2019)

# INITIAL AMBULANCE SERVICE LICENSE APPLICATION

Name of Service:					
Name of Owner(s):					
Mailing Address:			Street		
	City		State	Zip	
Physical Address of Pr	rincipal Place of	Business if dif	ferent from abov	/e:	
		Street			=
Cit	ty	State		Zip	_
Office Telephone: (	)		Fax: (	)	
Emergency Telephone	:: ()_				
Email Address:					
Name of Director (if d	ifferent from O	wner):			
FOR MULTIPLE ST Additional Station Lo		ASE COMPLE	TE ENCLOSE	D FORM TITLED: New S	Service
Is this Service a prim	ary provider o	f Emergency N	<b>Iedical Services</b>	s as defined in Rule 1200-12	2-114?
Describe the principal	nature of Ambu	llance or Invalid	l transfer operati	ions:	
			D. C.		
OWNERSHIP TYPE  Single Proprietor  Local Government  Limited Partnership	_	Profit No State Gover Association Corporation		Other (Specify)	

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### MANAGEMENT ORGANIZATION Government Hospital Other (Specify) Civil Defense Fire Department Industry Proprietor **INSURANCE** Please provide the following information concerning Insurance Agent and/or Company providing Vehicle and Professional Insurance: **Vehicle Liability Insurance:** Agent and/or Company Name: Mailing Address: \_\_\_\_\_\_Street City Telephone: (\_\_\_\_\_) Fax: (\_\_\_\_\_) **Professional Liability Insurance:** Agent and/or Company Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_\_Street Telephone: (\_\_\_\_\_) Fax: (\_\_\_\_\_)

AN ORIGINAL CERTIFICATE OF INSURANCE MUST BE SUBMITTED DEMONSTRATING COMPLIANCE WITH RULE 1200-12-1-.07 INSURANCE COVERAGE. THIS MUST BE FORWARDED BY YOUR INSURANCE AGENT OR COMPANY TO THIS OFFICE MARKED ATTENTION: AMBULANCE SERVICE LICENSURE.

#### **EMS PERSONNEL**

The ambulance service license application must include a list of emergency medical personnel and vehicle operators initially employed by the operation. Complete the required information on the enclosed form titled: **New Service-Initial Emergency Medical Personnel and Vehicle Operators Listing.** 

A Class D Drivers License with (F) for-hire endorsement is required unless the operator holds a commercial Drivers License (Class A, B, or C). After filing the listing with the initial license application, the listing should be updated as personnel change. The EMS Consultant will review this information on the service audit/survey.

#### **RADIO COMMUNICATIONS**

Applicants must demonstrate compliance with Tennessee EMS Telecommunications Rule 1200-12-01-.08. Attach a copy of the current FCC Radio Station License identifying the call sign, station location, appropriate EMS radio frequencies and license expiration date **or** provide:

- 1. A copy of your application for the FCC License (Form 601) identifying appropriate EMS frequencies; **and**
- 2. A letter of Cooperative Communications with a licensed EMS Base Station in Tennessee <u>or</u> a letter of Mobile Unit Authorization and Assignment under an existing EMS radio fleet.

If the dispatch facilities	es are not located at the Ambulance	Service address, please	e provide the following:	
Street	City	Sta	te Zip	
Non-Emergency Telep	phone: ()		_	
MEDICAL DIRECT	COR			
the application. Rule	essee licensed physician accepting of 1200-12-114 explains the functions vice's Medical Director and provide	of the Medical Directo	or. In addition to the letter,	
Name of Medical Dire	ector:			
Mailing Address:				
		Street		
<del></del>	City	State	Zip	
Office Telephone: (		Fax: ()		
Email Address:		rofession License Nur	nber:	
VEHICLE MARKIN	NGS			
1200-12-0102 (3) an	ted by a service must meet the design receive approval prior to permittind marking scheme to be approved. The vehicle.	ng. Submit a color pho	to or color drawing	
VEHICLE PERMIT	S			
-	ated by the service must have a peri- information requested on the enclo	11 1	• •	
MECHANICAL SAI	FETY INSPECTION			
A Mechanical Safety submitted with the app	Inspection form (PH-2405) for eaplication.	ch vehicle requesting	to be permitted must be	
FEES				
ACTION	INITIAL AMBULANCE SERVICE	INITIAL VOLUNTEI	ER AMBULANCE SERVICE	
License Fee	\$5,000.00	\$2,000.00		
Vehicle Permit Fee	\$250.00 Per Vehicle No. of Vehicles	S100.00 Per Vehicle No. of Vehicles		

ENCLOSE A CHECK OR MONEY ORDER FOR TOTAL FEES MADE PAYABLE TO: TDH-EMS

TOTAL FEES TO BE SUBMITTED

\$

The applicant hereby certifies that they have read and prepared this application and understands the contents thereof; that the statements are true and correct, and that the applicant has obtained and reviewe copies of the Statutes and Rules regulating the provision of Emergency Medical and Ambulance Services in the State of Tennessee.						
Applicant's Signature	Date					
Print Name	Title or Position					



### DIVISION OF HEALTH LICENSURE AND REGULATION OFFICE OF EMERGENCY MEDICAL SERVICES

# NEW AMBULANCE SERVICE ADDITIONAL STATION LOCATIONS

	Street Address	City	State	Telephone Number
1.				( )
2.				( )
3.				( )
4.				( )
5.				( )
6.				( )
7.				( )
8.				( )
9.				( )
10.				( )
11.				( )
12.				( )
13.				( )
14.				( )
15.				( )



## DIVISION OF HEALTH LICENSURE AND REGULATION OFFICE OF EMERGENCY MEDICAL SERVICES

## NEW AMBULANCE SERVICE INITIAL EMERGENCY MEDICAL PERSONNEL AND VEHICLE OPERATORS LISTING

	Name	Date of Birth	Driver's License Number	State	Driver's License Endorse- ment(s)	TN EMS Personnel License Number	TN EMS Personnel License Level	TN EMS Personnel License Expiration Date
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								



## DIVISION OF HEALTH LICENSURE AND REGULATION OFFICE OF EMERGENCY MEDICAL SERVICES

## NEW AMBULANCE SERVICE VEHICLE PERMIT INFORMATION

#### A MECHANICAL SAFETY INSPECTION (PH-2405) MUST BE FURNISHED FOR EACH VEHICLE

	Vehicle Identification Number	Manufacturer	Year	Type / Model	Mileage	License Tag Number	Unit Call Number	Use
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								