TN Department of **Health**

INITIAL <u>AIR</u> AMBULANCE SERVICE LICENSE APPLICATION

Name of Service: _____

Name of Owner: _____

Mailing Address: _____
<div align="center">Street/P.O.Box</div>

_____

| City | State | Zip |

Physical Address of Principal Place of Business if different from above:

_____
<div align="center">Street</div>

_____

| City | State | Zip |

Office Telephone: (_____) _____ Fax: (_____) _____

Emergency Telephone: (_____) _____

Email Address: _____

Name of Director (if different from Owner): _____

FOR MULTIPLE STATIONS PLEASE COMPLETE THE ENCLOSED FORM TITLED: **New Air Service-Additional Station Locations.**

Describe principal nature of ambulance operations: _____

_____

_____

OWNERSHIP TYPE: ☐ For-Profit ☐ Non-Profit

☐ Single Proprietor ☐ Local Government
☐ Limited Partnership ☐ State Government
☐ Association ☐ Other (Specify) _____
☐ Corporation

MANAGEMENT ORGANIZATION:

☐ Government   ☐ Civil Defense   ☐ Industry   ☐ Other (Specify) _____

☐ Hospital   ☐ Fire Department   ☐ Proprietor

AIRCRAFT INFORMATION

All Air Ambulances operated by the service must complete the enclosed form titled: **New Air Ambulance Service-Aircraft Information.** Attach a copy of the operator's Part 135 Air Charter Certificate with a copy of the FAA approved Air Ambulance Operations Specifications. For Air Ambulance aircraft modifications, document supplement type certification (STC) or field approval of installed liter systems and medical equipment.

INSURANCE

Please List the Insurance Agent and/or Company providing Air Charter and Professional Medical Liability Insurance.

Aircraft Liability Insurance:

Agent and/or Company Name: _____

Mailing Address: _____
                 Street   City   State   Zip

Telephone: (_____) _____ Fax: (_____) _____

Professional Liability Insurance:

Agent and/or Company Name: _____

Mailing Address: _____
                 Street   City   State   Zip

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 Air Ambulance Service license application must include a list of emergency medical personnel and air crewmen initially employed by the operation. Complete the required information on the enclosed form titled: **New Service-Initial Emergency Medical Personnel and Air Crewmen Operators Listing.**

For Air Charter Services: (Designate Pilots with appropriate FAA Commercial Air Transport endorsements for aircraft and total logged flight time as pilot in command.) EMS personnel licenses should indicate if the individual is licensed as an EMT, AEMT, EMT-P, or RN-EMT. 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

Helicopter Services 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 600) identifying appropriate EMS frequencies; **and**
2. A letter of Cooperative Communications with a licensed EMS Base Station in Tennessee **or** a letter of Mobile Unit Authorization and Assignment under an existing EMS radio fleet.

Fixed-Wing Air Ambulance Services must identify the FCC frequencies and current FAA Unicom frequencies at aircraft base locations and call sign or tail numbers of aircraft used for air ambulance service.

Appropriate radio frequencies for helicopter air ambulance operations in Tennessee include 155.205 and 155.340 MHz. If the dispatch facilities are not located at the Ambulance Service address, please provide the following:

_____
| Street   City   State   Zip

Non-Emergency Telephone: (_____) _____

MEDICAL DIRECTOR

A letter from a Tennessee licensed physician accepting off-line medical direction must be submitted with the application. Rule 1200-12-1-.14 explains the functions of the Medical Director. In addition to the letter, please identify the service's Medical Director and provide the following information:

Name of Medical Director: _____

Mailing Address: _____
                                              Street

_____
                  City   State   Zip

Office Telephone: (_____) _____ Fax: (_____) _____

Email Address: _____ Profession License Number: _____

FEES

Initial license fee for new Air Ambulance   **$10,000.00**
(Permit fees are not applicable to air ambulance applicants)

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

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 reviewed 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

NEW <u>AIR</u> 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.				( )

NEW <u>AIR</u> AMBULANCE SERVICE
INITIAL EMERGENCY MEDICAL PERSONNEL AND AIR CREWMEN OPERATORS LISTING

	Name	Date of Birth	Driver 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.								

NEW <u>AIR</u> AMBULANCE SERVICE
AIRCRAFT INFORMATION

	Tail Number	**Manufacturer**	**Year**	**Model**	**Type**	**Use**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						