 **DEPARTMENT OF HEALTH**

**BUREAU OF EMERGENCY MEDICAL OVERSIGHT**

**AIR/GROUND SERVICE PROVIDER LICENSE APPLICATION**

|  |  |
| --- | --- |
| Dept. Use Only | |
| \_\_\_\_\_  Type | \_\_\_\_\_  File # |

Type of Application: New \_\_\_ Renewal \_\_\_ Change of Name \_\_\_ Change of Address\_\_\_ Change of Ownership\_\_\_

Change of Medical Director\_\_\_

Primary Type of Provider: Ground ALS \_\_\_Ground BLS \_\_\_\_ Air Fixed Wing \_\_\_ Air Rotary Wing\_\_\_

**1.** Name of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMS ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code\_\_\_\_\_\_\_\_\_\_\_

Physical Location of Records Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code \_\_\_\_\_\_\_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ 24 Hour Number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_

Manager’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager’s Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Federal Employee Identification Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Organizational Tax Status:**

For Profit \_\_\_\_\_ Not for Profit \_\_\_\_\_ Other (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Organizational Type:**

Fire Department \_\_\_\_\_ Hospital Based \_\_\_\_\_ Private, Non-Hospital \_\_\_\_\_

Governmental, Non-Fire \_\_\_\_\_ Tribal \_\_\_\_\_

**Primary Type of Service Provided: (select only one type)**

911 Response (Scene) with Transport Capability\_\_\_\_\_ Inter-facility Ground \_\_\_\_\_

911 Response (Scene) without Transport Capability\_\_\_\_\_ Medical Transport (BLS transport not 911) \_\_\_\_\_

911 Air Medical Response (Scene) \_\_\_\_ Air Inter-facility\_\_\_

**Other Types of Services Provided: (select all that apply)**

911 Response (Scene) with Transport Capability\_\_\_\_\_ Inter-facility Ground \_\_\_\_\_

911 Response (Scene) without Transport Capability \_\_\_\_\_ Medical Transport (BLS transport not 911) \_\_\_\_\_

ALS Intercept \_\_\_\_\_ 911 Air Medical Response (Scene) \_\_\_\_\_ Air Inter-facility\_\_\_ Hazmat \_\_\_\_Rescue \_\_\_\_

Community Paramedicine \_\_\_\_\_

**2.** Is the EMS provider accredited by the Commission on Accreditation of Ambulance Services? \_\_\_ Yes \_\_\_\_ No

If yes, include a copy of accreditation certificate.

**3.** Medical Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Florida License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEA Certificate Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** Provide the name of the owner(s) or, if a corporation, list the names of all officers, directors and shareholders.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Position

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Position

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Position

**5.** List the name and address of the base station and all substations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address

**6.** Identify the counties in which you will operate (prehospital only).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** List means of communications between vehicle and hospital/dispatch center.

Vehicle Hospital/Dispatch Center

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Provide the contact information for the communications director.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9.** Indicate the method of compliance with Florida Administrative Code Rule 64J-1.014, regarding data submission to the

Department.

Emergency Medical Services Tracking and Reporting System (EMSTARS)

EMS Aggregate Prehospital Report and Provider Profile Information

**10**. Attach the following:

Attachment 1 Copy of the COPCN for each county you will be operating in (prehospital only).

Attachment 2 Completed permit application(s), DH Form 1510, July 2017. **If AIR SERVICE PROVIDER:** Copy of each pilot’s current commercial license and current medical certificate. Copy of the air worthiness certificate for each aircraft you are permitting.

Attachment 3 Copy of insurance policy, certificate of insurance or certificate of self-insurance showing all of the following: limits of auto liability coverage, policy expiration date and list vehicles covered if not blanket coverage or self-insured. **If AIR SERVICE PROVIDER:** Copy of Medical Malpractice and professional liability insurance for all medical crew members and the medical director.

Attachment 4 Copy of the Trauma Transport Protocols, signed and dated by the current medical director.

Attachment 5 Copy of a fully executed contract between medical director and service.

Attachment 6 Copy of the medical director’s Florida medical license and DEA certificate.

Attachment 7 If applicable, a copy of the written agreement between the county health departments located in each county where the agency’s paramedics administer immunizations.

**11**. Provide a company check, cashier’s check or money order made payable to Emergency Medical Services, 4052 Bald

Cypress Way, Bin A-22, Tallahassee, Florida 32399. **All fees are nonrefundable.**

**12.** Provide contact information for the individual responsible for coordinating the quality assurance committee with the

service’s medical director.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13**. Check the box that applies.

I hereby certify that this service will be available to provide continuous service on a 24-hour, 7-day a week basis.

I hereby certify that this service will provide inter-facility transport(s) only and may not be available 24 hours a day and 7 days a week.

**14.** Indicate the type of health and wellness programs provided by your agency. (check all that apply):

None/Not Applicable \_\_\_\_ Fall Prevention \_\_\_\_\_ Opioid Awareness \_\_\_\_\_ DOT Safety Program \_\_\_\_\_ Drowning Prevention \_\_\_\_\_ Safe to Sleep \_\_\_\_\_ Cardiovascular Health \_\_\_\_\_ HIV Prevention \_\_\_\_\_ Pediatric Avoidable Readmission Program \_\_\_\_\_ Adult Avoidable Readmission Program \_\_\_\_\_

High Frequency User Program \_\_\_\_\_\_ Mental Health \_\_\_\_\_\_\_\_

Employee Wellness (Smoking Cessation, Weight Management, Nutrition) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization Program \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I, the undersigned, a representative of the above service, do hereby affirm that my service meets all of the statutory and rule requirements for operation of an ambulance service in the state of Florida, including, but not limited to, those provided in Chapters 395 and 401, Florida Statutes and Florida Administrative Code Chapter 64J-1. I understand that my service must be fully operational within 30 days of licensure and that my service will be inspected by the Department of Health within 90 days of licensure. I further affirm that any violations will subject this service and its authorized representative to actions and penalties as provided by law.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

STATE OF FLORIDA

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_

Sworn to (or affirmed) and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_

by, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Notary Public Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personally Known \_\_\_\_\_\_\_\_\_or Produced Identification\_\_\_\_\_\_\_\_

Type of Identification Produced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEPARTMENT OF HEALTH**

**BUREAU OF EMERGENCY MEDICAL OVERSIGHT**

**AIR/GROUND SERVICE PROVIDER LICENSE APPLICATION INSTRUCTIONS**

Please use this list of instructions to ensure the application is complete before mailing. The items listed below are required for a complete application. If ALS/BLS, your application must be received in the Bureau of Emergency Medical Oversight no more than 90 days and no less 30 days before the date of permit(s) expiration. If AIR, your application must be received in the Bureau of Emergency Medical Oversight no more than 90 days and no less 60 days before the license expiration. If starting a new service, the application must be received 30 days before you wish to begin offering services.

**Type of Application:** Mark all that apply.

**Primary Type of Provider:** Please select only one.

**Number One:** Complete all lines that apply. The name of the service must be the same as the name on the Certificate of Public Convenience and Necessity (COPCN). If you are not required to have a COPCN, the name shall be the same as the name registered with the Florida Department of State, Division of Corporations. The manager’s name shall be the person designated to receive all correspondence from the Bureau of Emergency Medical Oversight. NOTE: The physical location is where the records should be stored. Please add your Federal Employer Identification Number.

**Number Two:** Answer yes or no.

**Number Three:** All information requested must be provided. If you have more than one medical director, provide the same requested information on a separate sheet of paper and submit with the application.

**Number Four:** Complete all information requested or mark “N/A” if this does not apply to your service. Attach a separate sheet of paper if additional room is needed.

**Number Five:** List the name and address of the base station and all substations (e.g., “Station 2”). Attach a separate sheet of paper if additional room is needed.

**Number Six:** If providing prehospital services, list all counties in which you have obtained a current COPCN or mutual aid agreement. Attach a separate sheet of paper if additional room is needed. If this does not apply to your service, please mark “N/A.”

**Number Seven:**  List the type(s) of communication between your vehicle and the receiving medical facility. If providing prehospital services, Med 8 is required. If more space is needed provide a separate sheet of paper.

**Number Eight:** Please provide the contact information for your communications director.

**Number Nine:** Indicate, by checking the applicable box, the method of data submission to the Department.

**Number Ten:**

\_\_\_\_\_ Attachment 1: Provide a copy of a valid COPCN or mutual aid agreement for each county you plan to operate in. Pursuant to section 401.251(4)(b), Florida Statutes. If you are an air ambulance provider using rotary-winged aircraft in conjunction with another EMS provider, you are required to have a COPCN for each county in which you operate. If changes occur regarding any COPCN during your licensure period, the changes must be submitted to the Department. If fixed-wing, this is not applicable.

\_\_\_\_\_ Attachment 2: Permit application must be made on DH Form 1510, July 2017. If you have more vehicles than the space allowed on the permit application, you may attach a separate sheet of paper using the same table format to list the additional vehicles. **For each aircraft being permitted**, attach a copy of FAA Part 135 Certificate (Parts A and D only), and the FAA tail number for each aircraft. If the certificate holder is not the applicant, or the company which owns the aircraft(s), include a signed letter of agreement or contract between all involved parties. Also include a copy of each pilot’s current commercial license and current medical certificate and a copy of the air worthiness certificate for each aircraft you are permitting.

\_\_\_\_\_ Attachment 3: Provide a copy of the insurance policy, a self -insurance policy or certificate of insurance. The policy must show the applicant as the insured party, a list of vehicles covered if the policy is not blanket coverage or self-insurance, the limits of vehicle liability and property damage coverage and the expiration date, and the FAA tail number for each aircraft insured. Minimum limits for bodily injury are $100,000/ $300,000 and $50,000 in property damage for non-government owned services. If the service is government owned, bodily injury and property damage coverage is $200,000 total. Provide a copy of the medical malpractice and professional liability insurance for all medical crew members and the medical director.

\_\_\_\_\_ Attachment 4: Provide a copy of the Trauma Transport Protocols, signed and dated by the current medical director.

\_\_\_\_\_ Attachment 5: Provide a copy of a fully executed contract whereby the service procures the services of a physician, qualified pursuant to this section, to be its medical director.

\_\_\_\_\_ Attachment 6: Provide a copy of the medical director’s Florida medical license issued by the Department. If ALS, provide a copy of the United States Department of Justice, Drug Enforcement Administration (DEA) certificate issued to the physician or hospital pharmacy. The DEA certificate must list the address of where the controlled substances will be stored (either the physician address or the hospital pharmacy address). BLS is not required to submit a DEA certificate.

\_\_\_\_\_ Attachment 7: If applicable, provide a copy of the written agreement between the county health departments located in each county where the agency’s paramedics administer immunizations.

**Number Eleven:**

Fees are established by section 401.34, Florida Statutes. Provide a company check, cashier’s check or money order made payable to Emergency Medical Services, 4052 Bald Cypress Way, Bin A-22, Tallahassee, Florida 32399. **All fees are nonrefundable.**

**Advanced Life Support Service License Fee** - **$1375.00**

**Basic Life Support Service License Fee** - **$660.00**

**Aircraft/Ground Vehicle Permit Fee - $25.00** (per aircraft/ground vehicle)

Applicants wishing to provide both ALS and BLS services must pay only the ALS license and permit fees.

**All licensed agencies are subject to random inspections to ensure compliance with all requirements. Licensure questions are to be directed to:**

Bureau of Emergency Medical Oversight

Emergency Medical Services Section

EMS Licensure/Investigation Unit

(850) 245-4440

**COMMUNICATIONS INFORMATION**

**Please ONLY direct questions related to communications to:**

EMS Communications

DMS Division of Telecommunications

4030 Esplanade Way

Tallahassee, Florida 32399-0950

Phone: (850) 922-7435

Fax: (850) 922-5313

Chapter 401, Florida Statutes, Part 1, is administered by the Department of Management Services (DMS), which requires the following related to communications:

\_\_\_\_\_ Obtain copies of the Emergency Medical Services Communications Plan – Volume I. for administration and Volume II for each ground vehicle/aircraft and dispatch center.

\_\_\_\_\_ Obtain final approval from DMS to expand or establish your communications system (vehicular and dispatch).

\_\_\_\_\_ Obtain a Federal Communications Commission license authorizing your radio communications system operation.