AIR AMBULANCE SERVICE LICENSE APPLICATION INSTRUCTIONS

The items listed below are required for a complete application. Please use this list of instructions to ensure the application is complete before mailing. A complete application will greatly reduce processing time. Your application must be received in this office 30 days before you wish to start a new service or renew your current license.

Type of Application: Mark all the appropriate lines.

Number One: The name of the service you put on line 1 must be the same as the name on your Certificate of Public Convenience and Necessity (COPCN). If you are not required to have a COPCN, then the name should be the same as the one registered with the Florida Department of State, Division of Corporations. Complete all remaining lines appropriately. Include your internet e-mail address if you have one. The manager's name should be the person who is designated to receive all correspondence from this office. Under the Type of Ownership, check **ALL** the items that apply to your service.

Number Two: All the blanks must be completed. If you have more than one medical director include the same information for each on a separate sheet of paper and submit with application.

Number Three: Fill in as requested or if it does not apply place N/A.

Number Four: List the locations of each aircraft permitted in the State of Florida.

Number Five: List all counties in which you have a COPCN, or mutual aid agreement. This applies to prehospital services only.

Number Six: List the type of communication between your aircraft and the receiving medical facility. Med 8 is required for pre-hospital services.

Number Seven:

_____Attachment 1: A COPCN is required for each county in which you operate, if you are a prehospital service. If you are a fixed wing service this does not apply.

_____Attachment 2: One permit application, DH Form 1576, needs to be completed and signed for each aircraft you wish permitted. Attach a copy of FAA Part 135 Certificate, including all of parts A and D of the operations specifications listing the aircraft you wish permitted. If the name of the certificate holder is not the applicant, or the company which owns the aircraft, include a letter of agreement or contract between all involved parties.

_____Attachment 3: Include medical malpractice/professional liability insurance for all air medical crew members and medical directors. The policy must show limits of liability and list the applicant as the insured. Minimum limits - $100,000/$300,000 for privately owned services. Total amount for all coverage for government owned services is $200,000.

_____Attachment 4: Aircraft liability insurance coverage. The policy must include the name of the licensed service, limits of coverage, expiration date, and FAA tail number of each aircraft or state all aircraft owned and operated by the insurer.

_____Attachment 5: A copy of a fully executed contract between a Florida licensed physician and the applicant or a letter of agreement signed by the physician and the other party must be included. Include a copy of the medical directors Florida medical license issued by the department and a copy of the U.S. Department of Justice, Drug Enforcement Administration Certificate issued to the physician. The DEA form must list the address where the controlled substances are stored.

_____Attachment 6: Trauma transport protocols (**pre-hospital only**) must be signed by the current medical director and dated.

_____Attachment 7: Provide a copy of each pilot's commercial license and current medical certificate.

_____Attachment 8: A copy of the air worthiness certificate for **each** aircraft permit you are applying for.

Number Eight: A company check or money order made payable to Emergency Medical Services, 4052 Bald Cypress Way, Bin C-30, Tallahassee, Florida, 32399-1738 must be included in the package. **ALL FEES ARE NONREFUNDABLE.** (401.34, F.S.)

Air Ambulance Service License	$1375.00
Aircraft Permit	$25.00 each

Number Nine: If you are a helicopter service that will be available 24/7 place an x in that box. If you are a fixed wing service, even if you are available 24/7 you need to mark the box that states interfacility transport only. Sign the application and have it notarized.

IF YOU ARE NOT CURRENTLY LICENSED IN THIS STATE, A LICENSE MUST BE ISSUED BEFORE YOU MAY OPERATE IN THIS STATE. (SECTION 401.251, F.S.) YOUR APPLICATION MUST BE IN THIS OFFICE 30 DAYS BEFORE YOU WISH TO START A NEW SERVICE OR RENEW YOUR CURRENT LICENSE.

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

Barbara Hyde (850) 245-4440 x 2723
E-Mail: Barbara_Hyde@doh.state.fl.us

COMMUNICATION INFORMATION

Chapter 401, Florida Statutes, Part 1, is administered by the State Technology Office which requires the following related to communications:

____Obtain copies of the Emergency Medical Services Communications Plan-**-Volume 1** for administration and **Volume II** for each vehicle and dispatch center.

____Obtain final approval from the State Technology Office to purchase your communication system (vehicular and dispatch) - an up to 30 day process.

Federal radio system requirements are as follows:

____Obtain a Federal Communication Commission (FCC) license authorizing your radio communication system operation - an up to 60 day process.

Please direct all questions related to communications to:

EMS Communications Engineer
State Technology Office
4030 Esplanade Way
Tallahassee, Florida 32399-0950
Phone: (850) 922-7424
SUNCOM: (850) 292-7424
Fax: (850) 414-8324

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES
AIR AMBULANCE SERVICE LICENSE APPLICATION

TYPE OF APPLICATION: _____ Prehospital _____ Interfacility
(check all that apply) _____ Fixed Wing _____ Rotor Wing

New___ Renewal_____ Change of Name_____ Change of Address____

1. Name of Service _____ Date _____
Provider ID# _____
Mailing Address _____
City _____ State _____ Zip Code _____
Physical Address of Records Location _____
City _____ State _____ Zip Code _____
Phone Number (_____)_____ Fax Number (_____)_____
24 Hour Number (_____)_____ Internet E-mail Address_____

Manager's Name _____ Title _____

Type of Ownership (check **all** that apply):
Private _____ City _____ County _____ Other Government _____
Volunteer ____ Fire Department _____ Hospital Based _____
Corporation _____ Special Tax District _____
Other (Describe) _____
For Profit _____ Not For Profit _____

2. Medical Director _____
Mailing Address _____
City _____ State _____ Zip Code _____
Phone Number (_____)_____ Fax Number (_____)_____
(Attach separate sheet if more than one Medical Director. Also attach copy of Florida medical license and D.E.A. certificate for each)

3. Provide name of owner(s) or list all officers, directors and share holders (if a corporation) **(attach separate sheet if necessary)**

Name	Address	Position

4. List the address and/or describe the location of your base station and all substations **(attach separate sheet if necessary)**

5. Identify the counties to be served by your service **(prehospital only)**

6. Excluding air traffic control radio, you must have communication capability between medical attendant and ground medical facilities. List means of communication:

From Aircraft	From Base Station

7. Attach the following:

Attachment #1	Copy of Certificate of Public Convenience and Necessity for each county in which the service will operate **(prehospital only)**.
Attachment #2	Application for air ambulance permit(s) **(DH Form 1576)**.
Attachment #3	Medical Malpractice/professional liability insurance for all air medical crew members and medical director.
Attachment #4	Insurance verification - copy of insurance policy, certificate of insurance or certificate of self-insurance showing limits of coverage, policy expiration date and FAA number of each aircraft.
Attachment #5	Verification of medical director employment. Include a copy of the Florida medical license and the D.E.A. certificate.
Attachment #6	Trauma transport protocols **(prehospital only)** signed by current medical director and dated (see attached information).
Attachment #7	Pilot licensure ~ Copy of each pilot's commercial license and current medical certificate.
Attachment #8	Copy of the air worthiness certificate for each aircraft permit you are applying for.

8. Fees are established by § 401.34, Fla. Stat. Check or money order should be made payable to Emergency Medical Services. All fees are nonrefundable.

9. Check the box that applies

☐ *I hereby certify that this service will be available to provide continuous service on a 24-hour, 7-day week basis with all the medical supplies, equipment and personnel required to conduct, at a maximum, ____ air ambulance transports simultaneously.*

☐ *I hereby certify that this service will provide interfacility transport only and may not be available 24 hours a day 7 days a week.*

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

Signature

NOTARY SEAL

Notary Public

Name (Please Print)

My commission Expires Date

Position

Date

FALSE OFFICIAL STATEMENTS: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree. §837.06 Fla. Stat.