ADVANCED/BASIC LIFE SUPPORT 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 the 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 that is placed on line 1 must be identical to the name listed on your Certificate of Public Convenience and Necessity (COPCN). All the rest of the lines need to be filled out appropriately. Include your internet e-mail address if you have one. The manager's name should be the person who would receive all correspondence from this office. Under the Type of Ownership, check **ALL** of the items that apply to your service.

Number Two: All the blanks need to be filled in. If you have more than one medical director include the same information for each one on a separate sheet of paper.

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

Number Four: List the address of your base station (headquarters) and all substations, including the substation identifier (e.g. station 2).

Number Five: List all counties in which you have a COPCN, or mutual aid agreement.

Number Six: List the type of communication between your vehicle and the hospital. Med 8 is required pursuant to the EMS communications plan established in Chapter 401 part 1, Florida Statutes.

Number Seven:

_____Attachment 1: A COPCN is required for each county in which you operate. If you change a county throughout the year, the changes must be submitted to the department pursuant to Chapter 401.25, F.S.

_____Attachment 2: The permit application, DH Form 1510, needs to be filled out and signed. If you have a computer generated list of vehicles, you may just put "see attached" on Form 1510, sign the form and attach your list. Permit applications must be received by the department 30 days prior to change, as required on DH Form 1510, which is incorporated in Chapter 64E-2.007(1), Florida Administrative Code.

_____Attachment 3: Insurance verification: A copy of an insurance policy, a self insurance policy or certificate of insurance is acceptable. Documentation must include a schedule of vehicles covered, if the policy is not blanket coverage or self-insurance. Limits of vehicle liability and property damage coverage and expiration date must be shown. Minimum limits – Bodily injury $100,000/$300,000 and property damage $50,000 for non-government owned services. Bodily injury and property damage for government services is $200,000 total.

_____Attachment 4: Trauma Transport Protocols expire at the same time as your license. If there have been no changes, a signed statement from your medical director to that effect is acceptable. If they are uniform for the entire county a signed statement from your medical

director to that effect is acceptable. Otherwise there are directions and forms included in this package.

_____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,

_____Attachment 6: The medical director must be a Florida license physician. A copy of his/her current license from the department must be included.

_____Attachment 7: ALS providers must also include a copy of the U.S. Department of Justice, Drug Enforcement Administration Certificate issued to the physician or hospital pharmacy (if hospital based) listing the address at which the applicant stores controlled substances.

If you are permitting aircraft under an ALS license application, please attach the following information:

_____Attachment 8: A separate air permit application, DH Form 1576 must be filled out for each aircraft you wish to permit. Each application must be signed and include a FAA Part 135 Certificate and complete parts A & D of the operations specifications listing for each of the aircraft you wish permitted. If the 135 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 9: Medical malpractice/professional liability insurance for each air medical crew member and medical director. Form must show limits of liability and list the applicant as the insured. Minimum limits - $100,000/$300,000 for privately owned services. Minimum limit for government owned services is $200,000 for all coverage combined.

_____Attachment 10: Aircraft liability insurance coverage. Policy must include the name of the licensed service, limits of coverage, expiration date, and FAA tail number of each aircraft or include all aircraft owned and operated by the insurer.

_____Attachment 11: Provide a copy of each pilot's commercial license and current medical certificate. Only legible copies will be accepted.

_____Attachment 12: A copy of the air worthiness certificate for **each** aircraft permit you are applying for.

Number Nine: A company or county 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. Only volunteer providers identified as such by the EMS office are exempt from licensure fees. **ALL FEES ARE NONREFUNDABLE**. (401.34, F.S.)

Advanced Life Support Service License	$1375.00
Basic Life Support Service License	$660.00
Vehicle or Aircraft Permit	$25.00 each

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

Number Ten: Check the box that applies to your service according to the COPCN issued to you by the county.

Number Eleven: 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 401.25, 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

BUREAU OF EMERGENCY MEDICAL SERVICES
GROUND AMBULANCE SERVICE PROVIDER LICENSE APPLICATION

Type of application (Check all that apply):
New _____ Renewal _____
ALS _____ BLS Transport _____

Change of Name _____ Change of Address _____

1. Name of Service _____ Provider ID# _____
Mailing address _____ City _____ State _____
Physical address of records _____ City _____ State _____
County _____ 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 _____	Not for Profit _____
Volunteer _____	County _____	Special Tax District _____
Fire Department _____	Hospital Based _____	Other (Describe) _____
Corporation _____	For Profit _____	_____

2. Medical Director _____
Mailing Address _____
City _____ State _____ Zip Code _____
Phone Number (___) _____ Fax Number (___) _____
Florida License Number _____ Exp. Date _____
D.E.A. Certificate Number _____ Exp. Date _____
(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.

_____
_____

_____

6. You must have communication capability between your ambulance and hospital. List means of communication:

_____

_____

7. Attach the following:

Attachment #1 Certificate of Public Convenience and Necessity (for each county in which you operate).

Attachment #2 Application for ambulance permit(s) DH Form 1510 (multiple vehicle permit application).

Attachment #3 Insurance verification - copy of insurance policy, certificate of insurance or certificate of self-insurance showing limits of auto liability coverage and expiration date. Must also list schedule of vehicles covered if not blanket coverage or self insured.

Attachment #4 Trauma Transport Protocols signed by the current Medical Director.

Attachment #5 Verification of Medical Director employment, (i.e. fully executed contract, letter of agreement, etc.)

Attachment #6 Copy of the Medical Director's Florida medical license.

Attachment #7 Copy of the Medical Director's D.E.A. certificate if ALS

8. If you are permitting aircraft under an ALS license application, please attach the following information:

Attachment #8 Application(s) for air ambulance permit(s) - for each aircraft requested. Must be completed and signed.

Attachment #9 Medical Malpractice/professional liability insurance for all air medical crew members and medical director.

Attachment #10 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
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Attachment #11 Pilot licensure - Copy of each pilot's commercial license and current medical certificate.

Attachment #12 Air worthiness certificate- Copy of the air worthiness certificate for each aircraft permit you are applying for.

9. Fees are established by §401.34, Florida Statutes. Check or money order should be made payable to Emergency Medical Services. All fees are nonrefundable.

10. Check the box that applies

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

☐ 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 this licensee meets all requirements for operation of an ambulance service in the state as provided in Chapters 395 and 401, Florida Statutes, and Chapter 64E-2, Florida Administrative Code. I further acknowledge any violations or discrepancies discovered will subject this service and it's authorized representatives to actions and penalties provided by law.

To the best of my knowledge, all statements on this application are true and correct.

NOTARY SEAL

Signature

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, Florida Statutes.