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 email 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, Florida Statutes.

_____ 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 Rule 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 (TTPs) approvals expire at the same time as your license. You must submit a copy of your TTPs signed by the medical director even if there have been no changes since the last approval. If the TTPs are uniform for the entire county a signed statement from your medical director to that effect and a copy of TTPs must be submitted.
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 Eight: A company or county check or money order made payable to Emergency Medical Services, 4052 Bald Cypress Way, Bin A-22, 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 per section 401.34, Florida Statutes.

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

Number Ten: 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@flhealth.gov

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 I 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) 922-7426  
Fax: (850) 414-8324
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 [ ] Not for Profit
[ ] Volunteer [ ] 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:

______________________________________________________________
______________________________________________________________
______________________________________________________________

DH 631 04/09 Incorporated by reference, Rule 64J-1.002, Florida Administrative Code 4
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

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 section 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.

11. 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 Rule 64J-1, Florida Administrative Code. I further acknowledge any violations or discrepancies discovered will subject this service and its authorized representatives to actions and penalties provided by law.

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

______________________________
Signature

______________________________
Notary Public

__________  ___________
My commission Expires  Date

______________________________
Name (Please Print)

______________________________
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, section 837.06, Florida Statutes.