



OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

**APPLICATION FOR AMBULANCE OR
MOBILE INTENSIVE CARE LICENSE**

Incomplete applications **WILL NOT** be processed.
Required fields, as indicated by an asterisk (*), must be completed.

TYPE OR PRINT CLEARLY

TYPE OF APPLICATION NEW
DATE OF APPLICATION*

NAME OF SERVICE*		DBA's AND / OR TRADE NAME*		
MTO MAILING STREET ADDRESS OR P.O. BOX*		CITY*	STATE*	ZIP CODE*
MTO HEADQUARTERS STREET ADDRESS (IF DIFFERENT)*		CITY*	STATE*	ZIP CODE*
TYPE OF ENTITY* <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other			TAX ID NUMBER OR EIN*	
FAX NUMBER		E-MAIL ADDRESS*		
BUSINESS PHONE*		CONTACT PERSON*		
EMERGENCY PHONE*		OWNER / CHIEF / CEO*		
MEDICARE PROVIDER NUMBER*		MEDICAID PROVIDER NUMBER*		
HIGHEST LEVEL SERVICE TO BE PROVIDED*				
<input type="checkbox"/> BLS <input type="checkbox"/> Intermediate <input type="checkbox"/> ALS <input type="checkbox"/> MoICU				

LIST PRIMARY SERVICE AREA* (Attach additional sheet if required)

COUNTY	STATE	COUNTY	STATE
COUNTY	STATE	COUNTY	STATE

CHECK TYPE OF ORGANIZATION*

<input type="checkbox"/> Private Ambulance	<input type="checkbox"/> Non-Profit Private	<input type="checkbox"/> University
<input type="checkbox"/> Funeral Home Ambulance	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Hospital ALS
<input type="checkbox"/> Corporation Public Service (Paid / Volunteer)	<input type="checkbox"/> Industrial	<input type="checkbox"/> Hospital MoICU

TOTAL NUMBER OF AMBULANCES*

BLS	ALS	MoICU	NON-TRANSPORT
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TOTAL NUMBER OF TRANSPORTS LAST CALENDAR YEAR

BLS	ALS	MoICU
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LIST THE NAMES OF CORPORATE OFFICERS AND / OR DIRECTORS* (Attach additional sheet if required)

NAME	NAME
NAME	NAME

MEDICAL DIRECTOR

NAME*	PHYSICIAN LICENSE NUMBER*
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LIST THE ADDRESS OF EACH SATELLITE SERVICE LOCATION* (Attach additional sheet if required)

STREET ADDRESS	CITY	STATE	ZIP CODE	# VEHICLES

INSURANCE INFORMATION*

Minimum Insurance in the amounts required by Ohio Revised Code (R.C.) 4766.06 YES NO

Attach a copy of the current Certificate of Insurance, including the notice of cancellation.*

General Liability Coverage* YES NO

Vehicle Liability Coverage* YES NO

Attach a color photograph of side of vehicle showing color scheme and logo.*

List all other names the service will be operating under using the same tax ID or EIN and include a copy of the trade name registration or the fictitious name registration on file with the Ohio secretary of state.

TRADE NAME / FICTITIOUS NAME	VERIFY REGISTRATION ATTACHED* <input type="checkbox"/> YES
TRADE NAME / FICTITIOUS NAME	VERIFY REGISTRATION ATTACHED* <input type="checkbox"/> YES

COMMUNICATION EQUIPMENT INFORMATION (F.C.C. 90.203)*

Two-Way Communication (Dispatch) YES NO

Two-Way Communication (Medical Control) YES NO

Dispatch Center Manned 24 Hours Per Day YES NO

CERTIFICATION OF APPLICATION INFORMATION*

As the Owner, Operator, Chief, and / or Executive Officer of the Emergency Medical Service organization named in this application, I do hereby certify that all information provided in this application is accurate and complete.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER X	DATE
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SEND THIS APPLICATION AND ALL ATTACHMENTS TO:

Ohio Department of Public Safety
Division of Emergency Medical Services
1970 W. Broad St.
P.O. Box 182073
Columbus, OH 43218-2073
Phone (800) 233-0785 or (614) 466-9447
Fax (614) 466-9461

FOR STATE USE ONLY

EMS Service Code _____

Field Inspector Assigned _____
NAME

Reviewed _____
DATE INITIALS

Field Inspector Notified _____
DATE INITIALS

