

Current Expiration Date: 1	<input type="checkbox"/> Ambulance Service <input type="checkbox"/> ALS First Responder Service (non-transporting) 2		
Name of Service 3	Federal Employer ID No. 4	NYS EMS Agency Code ⁵	
Physical Address of principal business location (street and no.) 6	Mailing Address (PO Box) 7		
City, Town, Village 8	State	Zip Code	County
Business Phone Number 9	Emergency Dispatch Phone No. 10		
Agency Email Address: 11	Fax Number 12		
Organizational Structure (check only one) 13			
<input type="checkbox"/> Commercial <input type="checkbox"/> Hospital Based <input type="checkbox"/> Independent <input type="checkbox"/> Industrial <input type="checkbox"/> Fire Department <input type="checkbox"/> Municipal/Government <input type="checkbox"/> College (State or Private Campus/University)			
Type of Ownership (check only one) 14			
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation (For Profit or Not for Profit) <input type="checkbox"/> Municipal (Fire or Ambulance District) <input type="checkbox"/> Partnership <input type="checkbox"/> Municipal (Village, City, Town or County) <input type="checkbox"/> Government (State or Federal)			
Name of Individual Owner, Partners or Government/Municipal entity 15			
If a corporation, give official corporate name. Also indicate all DBAs on file with NYS Department of State. Attach separate list if more than one DBA on file. (Initial applications must provide certified copies of all DOS filings both corporation and DBA) 16 Corporation Name _____			
For Profit and Not for Profit Corporations must provide names/addresses of current corporation officers			
President _____	Home Address _____	Home Phone _____	
Vice President _____	Home Address _____	Home Phone _____	
Secretary _____	Home Address _____	Home Phone _____	
Treasurer _____	Home Address _____	Home Phone _____	
Chief Operating Officer (Captain, Operations Manager)	Title	Day Phone No.	Night Phone No. 17
Tax District: Is this organization funded by a tax district? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of District _____ 18			
Name of Operator (if different from owner) _____		Business Phone No. _____ 19	
Address _____	City _____	State _____	Zip Code _____
Highest Level of Care Currently Authorized by REMAC (Check Only ONE) 20			
<input type="checkbox"/> BLS (EMT) <input type="checkbox"/> EMT-Defibrillation <input type="checkbox"/> EMT-Intermediate <input type="checkbox"/> EMT-Critical Care <input type="checkbox"/> EMT-Paramedic			
Please provide the following statistical information for the last calendar year (January 1st thru December 31st) 21			
Total Number of EMS Calls responded (dispatched) to: _____ Total Number of Calls Medical Care given (not including RMAs, Standbys, call cancelled, etc): _____ Total EMS Budget (non-commercial services only) in dollars for the last full fiscal year: _____			

Service Medical Director: _____ Phone No. _____ 22
 Address _____
 NYS MD License Number: _____

List the address of each location where any certified EMS response vehicle is garaged if not the same as your principal business location. Provide list if more than 3. 23 Location 1: _____ Location 2: _____ Location 3: _____	Number of Vehicles 24 First Response _____ Ambulance _____ EASV _____
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Your operating territory is: _____ 25

Total Number of Employees/Members: _____ Number Volunteer _____ Number Paid (on payroll) _____ 26

Provide number of individuals currently certified at each level: 27
 CFR/CFR-D _____ EMT/EMT-D _____ AEMT-I _____ AEMT-CC _____ AEMT-P _____

Communication/Dispatch Information 28

Principal Dispatch Method: Two-way Cellular Phone Pager Other: _____

Frequency on which you are dispatched _____ mhz

Agency that dispatches your service _____ Local 911/PSAP Self

Identify radio systems for hospital calling/medical direction : VHF UHF Other

UHF MED 1-8 capacity: Yes No Do your vehicles have Cellular Phones? Yes No

155.340 capability: Yes No If your service has a FCC License give call sign _____

Attachments Required: 29

- Affirmation of Compliance (DOH-1881, Affirmation, Side 1) **MUST BE NOTARIZED**
- List of all vehicles operated by the service (use DOH-1881, Affirmation, Side 2)
- List of all agency personnel - Use DOH 2828
- List of all owners with 10% or more share of ownership

Agency Certification: I have received, read and understand the content of the following documents and will comply with all requirements: 30

- Article 30/30A, NYS Public Health Law
- Part 800, 10NYCRR, State EMS Code
- NYSDOH Memorandum, DNR Law Changes

In addition, I certify that all the information contained in this application is true and correct, and that neither the corporation nor any of the owners, principals, or stockholders have been convicted of Medicaid or Medicare fraud, and I understand that under Section 3012(a) or PHL Article 30 that the ambulance service or ALS FR service certificate for this agency may be revoked, suspended, limited or annulled if this application includes willful misrepresentation.

_____ Name of Owner, CEO or COO Title _____ Signature Date _____ Notary Public affirmation and acknowledgement	FOR DOH USE ONLY Date Application Received _____ New Expiration Date _____ NYS EMT Rep. review and approval _____ Date _____
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Submit application and all required attachments in duplicate to the appropriate DOH Area Office. Incomplete applications will be returned.