NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Application for EMS Operating Certificate

Submit application and all required attachments in duplicate, to the appropriate DOH Area Office. Incomplete applications will be returned.

☐ INITIAL ☐ RENEWAL Current expiration date_____

Check only one ☐ Ambulance Service ☐ ALS First Responder Service (non-transporting)

Name of Service

Federal Employer ID No.

NYS EMS Agency Code

Physical Address of prinicpal business location (street and no.)

Mailing Address (PO Box)

City, Town, Village State Zip Code County

Business Phone No.

Emergency Dispatch Phone No.

Organizational Structure (check only one)

☐ Proprietary ☐ Hospital Based ☐ Vol. Independent ☐ Industrial

☐ Vol. Fire Department ☐ Municipal/Government ☐ Other_____

Type of Ownership (check only one)

☐ Individual ☐ Partnership ☐ Government ☐ Corporation

Name of Individual Owner, Partners or Government entity

If a corporation, give official corporate name
(Initial applications must include a certificate of incorporation and any DBA registration)

Corporation Name_____

AND list names and addresses of corporate officers:

President_____ Address_____ Phone_____

Vice-President_____ Address_____ Phone_____

Secretary_____ Address_____ Phone_____

Treasurer_____ Address_____ Phone_____

Attach a list of any/all owner(s) of 10% or more stock

Chief Operating Officer (Captain, Operations Manager) Title Work Phone No. Home Phone No.

Tax District Is this organization funded by a tax distict? ☐ Yes ☐ No Name of District_____

Name of Operator (if different from owner)

Business Phone No.

Address City State Zip Code

Level of service (highest level approved by REMAC)

☐ BLS (CFR/EMT) ☐ CFR-Defibrillation ☐ EMT-Defibrillation ☐ EMT-Intermediate ☐ EMT-Critical Care ☐ EMT-Paramedic

Medical Control Provided by

Phone No.

System Medical Director Address City State Zip Code Phone No.

Service Medical Director Address City State Zip Code Phone No.

List the address of each location where any EMS response vehicle is garaged.

_____

_____

_____

VEHICLES

No. First Response:

No. Ambulance:

List specific Primary Operating Territory. Describe using municipal or political subdivision boundaries. Territory will be verified as that served in 1975 for ambulance services, or 1993 for ALS first responder services, including any subsequent Regional EMS Council Certificate of Need decisions. Initial applications need to include a map. Statements such as "surrounding or vicinity" are not acceptable.

Employees/Members

_____ No. of Volunteer (no monetary compensation) _____ No. of Paid (receive a paycheck)

Provide number of individuals currently certified at each level

_____ CFR / CFR-D _____ EMT / EMT-D _____ AEMT-I _____ AEMT-CC _____ AEMT-P

Communication/Dispatch Information

NOTE: specify all frequency information in megacycles (eg. 46.040 155.715 or 453.450), NOT channel selector positions such as F1, F2.

Primary Method of Communication: ☐ Two-way or Trunked ☐ Cellular phone ☐ Other_____

Dispatch frequency_____ mhz CTCSS/DCS Tone_____ FCC call sign_____ FCC license expire date_____

Agency that dispatches your ambulances_____

List EMS/Local Gov frequencies available _____, _____, _____, _____, _____, _____, _____

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

List other radio systems available ☐ VHF Cmcl ☐ UHF Cmcl ☐ Cmcl Trunked ☐ Public Safety Trunked

ATTACHMENTS REQUIRED

- List of all vehicles operated by the service (use DOH-1881, Affirmation, side 2)
- List of all agency personnel (initial certifications only)
- List of all owners of more than 10%
- Affirmation of Compliance (DOH-1881, Affirmation, side 1) MUST BE NOTARIZED

- **Initial Applications must also include:**
  Certificate of Incorporation and any DBA registration, and
  Primary Operating Territory Map
  Personnel Roster (use DOH-2828 or equivelant)
- **ALS First Responder Service must also include the required Operations Plans with all initial applications.**

Agency Certification

I have received, read and understand the content of the following documents supplied with the application, and will comply with all requirements.

- 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) of 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 or CEO Title

_____

Signature Date

_____

Notary Public affirmation and acknowledgement

FOR EMS OFFICE USE ONLY

Date application received_____

New expiration date_____

NYS EMS Rep. review and approval

_____ Date _____