NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Affirmation of Fitness and Competency

Name of Service being Transferred	NYS EMS Agency Code
Name of Corporation/Entity/Individual requiring a F&C review as a new owner/operator	

As the proposed new owner/operator, I hereby certify that I am or have been an incorporator, director, sponsor, principle, stockholder or operator of one or more of the following in the past 10 years:

YES ☐ NO ☐ Ambulance Service certified by the NYS Department of Health, or equivalent in any other state

YES ☐ NO ☐ Hospital or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state

YES ☐ NO ☐ Invalid Coach (Ambulette) Service authorized by the NYS Department of Transportation, or equivalent in any other state

YES ☐ NO ☐ Home or residence licensed by the NYS Department of Social Services, or equivalent in any other state

YES ☐ NO ☐ Halfway house, hostel or residential facility, or institution licensed by, or subject to the rules of the NYS Office of Mental Health or Office or Mental Retardation and Developmental Disabilities, or equivalent in any other state

If YES to any of the above, provide the following for each (attach additional sheets if necessary).

Name of Agency/Facility			
Licensing Agency		Agency License or ID no.	
Address of Facility/Agency	City	State	Zip Code
Position		Position held from (start date)	to (end date)

Name of Agency/Facility			
Licensing Agency		Agency License or ID no.	
Address of Facility/Agency	City	State	Zip Code
Position		Position held from (start date)	to (end date)

Certification of Competency

By completing and signing this affirmation I certify that I have operated any of the agencies or facilities listed above, or attached, in compliance with all applicable statutes, rules and regulations, specifically 10NYCRR800 and 10NYCRR600.2; that no administrative orders have been issued by any Federal or State Agency for issues that are, or were, recurrent and uncorrected, or dealt with patient harm. *(If you are unable to sign in the affirmative, attach a copy of all background information, Department orders and or justification to assist in the review and determination of competency.)*

Name _____ Signature _____ Date _____

Certification of Fitness

By completing and signing this affirmaiton, I certify that I have not been convicted of any crime, nor am I currently under charge for, nor plead nolo contendere to any felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or the sale of drugs; or I have not, or am not, subject to a Federal or State administrative order relating to fraud or embezzlement. *(If you are unable to answer in the affirmative, attach any information to assist in the review and determination of fitness.)*

Name _____ Signature _____ Date _____

If there is no history of operating an entity identified in Article 30, signing this Affirmation is informational only and testimony to the accuracy of the information provided.

Notary Public affirmation and acknowledgement