

**AMBULANCE SERVICE LICENSE
MULTI-COUNTY APPLICATION**

PLEASE PRINT. APPLICATION MUST BE NOTARIZED IN 2 PLACES.

New Application _____ Renewal Application _____ Date _____

Indicate the county the ambulance company is based in & number of units you wish to license and inspect:

Adams: _____ Arapahoe: _____ Broomfield: _____ Douglas: _____ Elbert: _____ Jefferson: _____

**Please attach a check to the application(s).
Telephone numbers and fees for each county are listed on the Pre-Inspection Checklist.**

Company name (Owner/parent Company)

Check one: Sole Proprietor _____ Partnership _____ Corporation _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

Doing Business As (AKA) _____

Address _____ City _____ State _____ Zip code _____

Telephone number _____ Fax number _____ E-Mail _____

Manager or individual responsible for operation of service: Name _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

Dispatch Center

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

Insurance Company _____

Address _____ City _____ State _____ Zip Code _____

Insurance Agent _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

Attachments required to complete the application:

- Name and address of each stockholder or partner owning 10% or more of the outstanding stock of the company, or having more than 10% ownership interest (if applicable).
- Certificate of Insurance showing: Bodily Injury (Each person \$1,000,000, Each accident \$2,000,000)
 - Property Damage (Each accident \$1,000,000)
 - Professional Liability (Each person \$1,000,000, Each accident \$2,000,000)
 - Workman's Compensation
- **Drug list approved by the Medical Director/sponsor for use in the field (signed and dated by Medical Director)**
- Geographic of the service area
- Motor Vehicle Condition form completed for each vehicle
- List of locations (central and sub-station), where ambulances will be located. Attach zoning authorization if appropriate
- List of current personnel providing service (list all levels of state certified EMT's and respective expiration dates)
- List of current ambulances (include the year, make, type, maximum capacity for each vehicle)
- Please attach a check to each application

I hereby certify that the information provided in this application is true to the best of my knowledge and belief and contains no willful misrepresentations or falsification.

Determination that an ambulance service license has been issued based on false information constitutes grounds for license revocation and possible criminal prosecution.

Applicant's Signature _____ Date Signed _____

Please **print** the applicant's name _____ Telephone # _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE _____ DAY OF _____ 20____, IN THE
COUNTY OF _____ STATE OF COLORADO.*

Signature of Notary _____ My Commission Expires _____

[SEAL]

TO BE COMPLETED BY THE MEDICAL DIRECTOR

Medical Director _____ Medical License Number _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

Facility Affiliation _____

Address _____ City _____ State _____ Zip code _____

Telephone number _____ Fax number _____ E-Mail _____

The following are licensing requirements of a medical director:

- 1) Meet the requirements established by Colorado Board of Medical Examiners (CBME) as defined in CBME 3CCR713-6, Rule 500
- 2) Provision of Medical Oversight for the ambulance service and personnel
- 3) Provision of a medical continuous quality improvement program (must be available to County upon request)
- 4) Ensure that the ambulance service complete a patient care report for each patient that is assessed
- 5) Ensure that the ambulance service completes and submits an agency profile
- 6) Investigate and provide written documentation of the investigation and resolution process of each complaint received from the County (Non-compliance with any of these requirements may result in suspension or revocation of ambulance service license).

I understand and accept the responsibilities of a Medical Director for _____ service.

I understand that non-compliance with any of these requirements may result in suspension or revocation of ambulance license.

Medical Director's Signature _____ Date Signed _____

Please **print** Medical Director's name _____ Telephone # _____

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE _____ DAY OF _____ 20____, IN THE
COUNTY OF _____ STATE OF COLORADO.*

Signature of Notary _____ My Commission Expires _____

[SEAL]