



INITIAL AMBULANCE SERVICE LICENSE APPLICATION

Name of Service: _____

Name of Owner(s): _____

Mailing Address: _____
Street
City State Zip

Physical Address of Principal Place of Business if different from above:

Street
City State Zip

Office Telephone: () Fax: ()

Emergency Telephone: ()

Email Address: _____

Name of Director (if different from Owner): _____

FOR MULTIPLE STATIONS PLEASE COMPLETE ENCLOSED FORM TITLED: New Service-Additional Station Locations

Is this Service a primary provider of Emergency Medical Services as defined in Rule 1200-12-1-.14?

Yes No

Describe the principal nature of Ambulance or Invalid transfer operations: _____

OWNERSHIP TYPE: For-Profit Non-Profit
Single Proprietor State Government Other (Specify)
Local Government Association
Limited Partnership Corporation

MANAGEMENT ORGANIZATION

<input type="checkbox"/> Government	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Civil Defense	<input type="checkbox"/> Fire Department	_____
<input type="checkbox"/> Industry	<input type="checkbox"/> Proprietor	

INSURANCE

Please provide the following information concerning Insurance Agent and/or Company providing Vehicle and Professional Insurance:

Vehicle Liability Insurance:

Agent and/or Company Name: _____

Mailing Address: _____
Street City State Zip

Telephone: (_____) Fax: (_____)

Professional Liability Insurance:

Agent and/or Company Name: _____

Mailing Address: _____
Street City State Zip

Telephone: (_____) Fax: (_____)

AN ORIGINAL CERTIFICATE OF INSURANCE MUST BE SUBMITTED DEMONSTRATING COMPLIANCE WITH RULE 1200-12-1-.07 INSURANCE COVERAGE. THIS MUST BE FORWARDED BY YOUR INSURANCE AGENT OR COMPANY TO THIS OFFICE MARKED **ATTENTION: AMBULANCE SERVICE LICENSURE.**

EMS PERSONNEL

The ambulance service license application must include a list of emergency medical personnel and vehicle operators initially employed by the operation. Complete the required information on the enclosed form titled: **New Service-Initial Emergency Medical Personnel and Vehicle Operators Listing.**

A Class D Drivers License with (F) for-hire endorsement is required unless the operator holds a commercial Drivers License (Class A, B, or C). After filing the listing with the initial license application, the listing should be updated as personnel change. The EMS Consultant will review this information on the service audit/survey.

RADIO COMMUNICATIONS

Applicants must demonstrate compliance with Tennessee EMS Telecommunications Rule 1200-12-01-.08. Attach a copy of the current FCC Radio Station License identifying the call sign, station location, appropriate EMS radio frequencies and license expiration date **or** provide:

1. A copy of your application for the FCC License (Form 601) identifying appropriate EMS frequencies; **and**
2. A letter of Cooperative Communications with a licensed EMS Base Station in Tennessee **or** a letter of Mobile Unit Authorization and Assignment under an existing EMS radio fleet.

The applicant hereby certifies that they have read and prepared this application and understands the contents thereof; that the statements are true and correct, and that the applicant has obtained and reviewed copies of the Statutes and Rules regulating the provision of Emergency Medical and Ambulance Services in the State of Tennessee.

Applicant's Signature

Date

Print Name

Title or Position



DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES

**NEW AMBULANCE SERVICE
ADDITIONAL STATION LOCATIONS**

	Street Address	City	State	Telephone Number
1.				()
2.				()
3.				()
4.				()
5.				()
6.				()
7.				()
8.				()
9.				()
10.				()
11.				()
12.				()
13.				()
14.				()
15.				()

**NEW AMBULANCE SERVICE
INITIAL EMERGENCY MEDICAL PERSONNEL AND VEHICLE OPERATORS LISTING**

	Name	Date of Birth	Driver's License Number	State	Driver's License Endorsement(s)	TN EMS Personnel License Number	TN EMS Personnel License Level	TN EMS Personnel License Expiration Date
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

**NEW AMBULANCE SERVICE
VEHICLE PERMIT INFORMATION**

A MECHANICAL SAFETY INSPECTION (PH-2405) MUST BE FURNISHED FOR EACH VEHICLE

	Vehicle Identification Number	Manufacturer	Year	Type / Model	Mileage	License Tag Number	Unit Call Number	Use
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								