



INITIAL INVALID 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

County of Invalid transfer operations: _____

OWNERSHIP TYPE: For-Profit Non-Profit

- Single Proprietor
- Local Government
- Limited Partnership

- State Government
- Association
- Corporation

Other (Specify)

MANAGEMENT ORGANIZATION:

- Government
- Civil Defense
- Industry

- Hospital
- Fire Department
- Proprietor

Other (Specify)

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: INVALID SERVICE LICENSURE.

PERSONNEL

The invalid service license application must include a list of personnel and vehicle operators initially employed by the operation. Complete the required information on the enclosed form titled: **New Service-Initial 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.

VEHICLE MARKINGS

All invalid vehicles operated by a service must meet the specifications as outlined in 1200-12-01-.09 (3) and receive approval prior to permitting. Submit a color photo or color drawing reflecting the color and marking scheme of the vehicle to be approved. The photos/drawings must include both sides, rear, front and top of the vehicle.

VEHICLE PERMITS

All Ambulances or Invalid Vehicles operated by the service must have a permit. Apply for permits by providing a listing of all vehicles with the information requested on the enclosed form titled: **New Service-Vehicle Permit Information.**

MECHANICAL SAFETY INSPECTION

A Mechanical Safety Inspection form (PH-2405) for each vehicle requesting to be permitted must be submitted with the application.

FEES

Initial license fee for new Ground Ambulance **\$ 5,000.00**

Vehicle(s) to be permitted _____ x **\$250.00 each** \$ _____

TOTAL FEES TO BE SUBMITTED \$ _____

ENCLOSE A CHECK OR MONEY ORDER FOR TOTAL FEES MADE PAYABLE TO: **TDH-EMS**

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 INVALID 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.				()



DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES

**NEW INVALID SERVICE
INITIAL PERSONNEL AND VEHICLE OPERATORS LISTING**

	Name	Date of Birth	Driver 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.								



DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES

**NEW INVALID 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.								