OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR AMBULANCE OR MOBILE INTENSIVE CARE LICENSE

Incomplete applications **WILL NOT** be processed.
Required fields, as indicated by an asterisk (*), must be completed.

TYPE OR PRINT CLEARLY

TYPE OF APPLICATION
NEW

NAME OF SERVICE*	DBA's AND / OR TRADE NAME (Attach additional sheets as required)			
MTO HEADQUARTERS STREET ADDRESS*	CITY*	STATE*	ZIP CODE*	COUNTY*
MTO MAILING ADDRESS (IF DIFFERENT)	CITY		STATE	ZIP CODE
TAX ID NUMBER OR EIN*	BUSINESS PHONE NUMBER*		FAX NUMBER	
PRIMARY CONTACT PERSON*	E-MAIL ADDRESS*		PHONE NUMBER*	
SECOND CONTACT PERSON	E-MAIL ADDRESS		PHONE NUMBER	
THIRD CONTACT PERSON	E-MAIL ADDRESS		PHONE NUMBER	
MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER			

HIGHEST LEVEL SERVICE TO BE PROVIDED*
☐ BLS ☐ Intermediate ☐ Paramedic ☐ MoICU

LIST PRIMARY OHIO SERVICE AREA* (Attach additional sheet if required)

☐ Mark this box if ALL Ohio counties.	OHIO COUNTY
OHIO COUNTY	OHIO COUNTY

CHECK TYPE OF ORGANIZATION* (Choose only one)

☐ Privately Owned ☐ Publicly Owned ☐ University ☐ Hospital ☐ Other

TOTAL NUMBER OF VEHICLES*

AMBULANCE	MoICU	NON-TRANSPORT

TOTAL NUMBER OF TRANSPORTS LAST CALENDAR YEAR*

BLS	ALS	MoICU

TYPE OF TRANSPORTS* (Choose only one)

☐ Scheduled Non-Emergent Transports Only
☐ Emergent Transports Only (Includes 911, Interfacility And Nursing Home)
☐ Both Emergent And Scheduled Transports

LIST NAMES OF OWNER(S) OR CHIEFS / CORPORATE OFFICERS AND / OR DIRECTORS* (Attach additional sheet if required)

NAME	TITLE	E-MAIL ADDRESS	PHONE NUMBER
NAME	TITLE	E-MAIL ADDRESS	PHONE NUMBER
NAME	TITLE	E-MAIL ADDRESS	PHONE NUMBER

MEDICAL DIRECTOR*

NAME	OHIO PHYSICIAN LICENSE NUMBER	
ADDRESS	E-MAIL ADDRESS	PHONE NUMBER

LIST THE ADDRESS OF EACH SATELLITE SERVICE LOCATION (Attach additional sheet if required)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
CONTACT PERSON		E-MAIL ADDRESS		PHONE NUMBER	

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
CONTACT PERSON		E-MAIL ADDRESS		PHONE NUMBER	

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
CONTACT PERSON		E-MAIL ADDRESS		PHONE NUMBER	

REQUIRED INFORMATION*

☐ Minimum Insurance in the amounts required by Ohio Revised Code (R.C.) 4766.06

Attach a copy of the current Certificate of Insurance, including the notice of cancellation.

- ☐ **General Liability Coverage**
- ☐ **Vehicle Liability Coverage**

☐ **Attach a color photograph of side of vehicle showing color scheme and logo.**

☐ **Attach blank trip report.**

COMMUNICATION EQUIPMENT INFORMATION*

Two-Way Communication (Dispatch)	☐ YES	☐ NO
Two-Way Communication (Medical Control)	☐ YES	☐ NO
Dispatch Center Manned 24 Hours Per Day	☐ YES	☐ NO

CERTIFICATION OF APPLICATION INFORMATION*

As the Owner, Operator, Chief, and / or Executive Officer of the organization named in this application, I do hereby certify that all information provided in this application is accurate and complete.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER	DATE
X	

SEND THIS APPLICATION AND ALL ATTACHMENTS TO:

Ohio Department of Public Safety
Division of Emergency Medical Services
1970 W. Broad St.
Columbus, OH 43223
Phone (800) 233-0785 or (614) 466-9447
Fax (614) 466-9461

Ohio Administrative Code (O.A.C.) 4766-2-02, 4766-4-02
Listing of all vehicles to be inspected and permitted
Indicate Type: **Ambulance (A)**, **Non-Transport (N)**, **MoICU (M)**

(A computer printout in this format may be substituted for this page.)

NOTE: IF SUBMITTING A COMPUTER PRINTOUT, YOU MUST ATTACH THIS PAGE WITH THE VEHICLE COMPLIANCE STATEMENT COMPLETED.

EMS PERMIT#	YEAR*	MAKE*	MODEL*	VEHICLE ID NUMBER VIN*																ODOMETER READING*	VEHICLE TYPE A-N-M*	DUAL VEHICLE CERTIFICATION YES OR NO*
EXAMPLE	1993	FORD	E-350	1	F	D	J	S	3	4	M	X	R	H	B	8	9	0	1	2	59583	M	YES

VEHICLE COMPLIANCE STATEMENT*

I, _____, Owner / Operator / Chief / Executive Officer (circle as appropriate), of the organization named in this application, certify that the vehicle(s) listed on this application meet or exceed the minimum national standard that was in effect on the date of manufacture of the vehicle. Upon request of the Emergency Medical Services, I agree to submit for review the Manufacturer's Certificate of Compliance in accordance with R.C. 4766.07(C).

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER	DATE
X	

Dual Certified Vehicle: An ambulance licensed at the Mobile Intensive Care Unit (MoICU) level that carries additional immobilization and extrication equipment in order to also operate at the paramedic, intermediate or BLS level.