



OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR AMBULETTE 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		
MEDICAID PROVIDER NUMBER					
HIGHEST LEVEL SERVICE TO BE PROVIDED AMBULETTE					

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

<input type="checkbox"/> Mark this box if ALL Ohio counties.	OHIO COUNTY
OHIO COUNTY	OHIO COUNTY

CHECK TYPE OF ORGANIZATION* (Choose only one)

<input type="checkbox"/> Privately Owned	<input type="checkbox"/> Publicly Owned	<input type="checkbox"/> University	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other
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TOTAL NUMBER OF AMBULETTES*

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TOTAL NUMBER OF TRANSPORTS LAST CALENDAR YEAR*

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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
NAME	TITLE	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 list of drivers and dates of hire.

☐ Attach blank trip report.

COMMUNICATION EQUIPMENT INFORMATION*

Two-Way Communication (Dispatch)

☐ 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 West Broad Street
Columbus, OH 43223
Phone (800) 233-0785 or (614) 466-9447
Fax (614) 466-9461

Ohio Administrative Code (O.A.C.) 4766-3-02
Listing of all vehicles to be inspected and permitted

(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*
EXAMPLE	1993	FORD	E-350	1	F	D	J	S	3	4	M	X	R	H	B	8	9	0	1	2	59583	AMBULETTE

VEHICLE COMPLIANCE STATEMENT*

I, _____, Owner / Operator / Chief / Executive Officer (circle as appropriate), of the organization named in this application, certify that the Ambulettes listed on this application meet or exceed the minimum criteria for roadworthiness and equipment as defined by R.C. 4766 and O.A.C. 4766-3.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER

X

DATE