DATE APPLICATION RECEIVED AT COUNTY:_____
DATE LICENSE EXPIRES:_____

MULTI-COUNTY AMBULANCE LICENSE APPLICATION

PLEASE PRINT. ORIGINAL DOCUMENTS REQUIRED. APPLICATION MUST BE NOTARIZED IN 2 PLACES.

New Application _____ Renewal Application _____ Date _____

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

Adams: ☐ **Arapahoe:** ☐ **Boulder:** ☐ **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 _____ Other _____

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 Name _____

service: 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 (any amount)
- Drug list approved by the Medical Director/sponsor for use in the field (signed and dated by Medical Director)
- Copies of waivers granted by CDPHE for specific skill(s) and/or medication(s)
- 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 numbers and respective expiration dates, ONLY ambulance drivers Driver's License with the 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 and accurate to the best of my knowledge and beliefs, meets the new 6 CCR 1015-3 Rule, 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 _____

Facility Address _____ City _____ State _____ Zip code _____

Telephone number _____ Fax number _____ E-Mail _____

☐ I have been granted a waiver from CDPHE for specific skill(s) or medication(s). I will provide a copy of all waivers with the application.

The following are licensing requirements of a medical director:

1) Meet the requirements established by the Rules Pertaining to EMS Practice and Medical Director Oversight 6 CCR 1015-3, Chapter 2
2) Registered and Accepted as a Colorado Medical Director as defined in the 6 CCR 1015-3, Chapter 2
3) Provision of a medical continuous quality improvement (CQI) program that meets the newest standards of CCR (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]