New York State Department of Health
Bureau of Emergency Medical Services

Affirmation of Fitness and Competency

By completing this form, you are aware that the NYS Department of Health will be conducting a detailed background review in order to determine fitness and competency in accordance with Article 30 of the NYS Public Health Law.

Name of EMS Service	NYS EMS Agency Code
Full Name Corporate Entity requiring F&C review as a new owner/operator	
Full Name of Individual	Title
Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator	
Social Security Number (this is not releasable under the provisions of FOIL)	Date of Birth

As the proposed new owner/operator of an EMS service, I hereby certify that I am or have been a director, sponsor, principle, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES	NO	
☐	☐	Emergency Medical Service certified by the NYS Department of Health, or equivalent in any other state.
☐	☐	Hospital, long term care facility or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state.
☐	☐	Invalid coach (Ambulette) Service authorized by the NYS Department of Transportation or equivalent in any other state.
☐	☐	Home or residence licensed by NYS or equivalent in any other state.
☐	☐	Halfway house, hostel or residential facility or institution licensed by, or subject to the rules of the NYS Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD), or equivalent in any other state.

If **YES** has been marked for any of the above, on an attached page, please provide the following information for each:

- Name of agency or facility
- Mailing address of facility or agency
- Name of Certifying or Licensing authority
- If applicable, a copy of license, certificate or identification number
- Individual position(s) held with start and end dates

If **NO** has been marked for all of the above, it indicates that there is no history of operating an entity identified in NYS Public Health Law; signing this affirmation is informational only and a testimony to the accuracy of the information provided.

REQUIRED ATTACHMENTS TO THIS AFFIRMATION

- **Current resume or curriculum vitae**
- **Copies of any related licenses and certifications**
- **Listing of address of residence, or if less than 2 years, addresses of prior residences.**

Certification of Competency

By completing and signing this affirmation, I certify that I have operated all of the agencies indicated in compliance with all applicable statutes, rules, regulations and policies, specifically 10 NYCRR800 and 10 NYCRR660.2.

Further, I certify that there have been no administrative orders issued by any Federal, State or local agency for matters that are or were recurrent or uncorrected, or dealt with patient harm or neglect in accordance with NYS Public Health Law during my tenure as a director, sponsor, principle, stock holder, operator or operations manager.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Full Name	
Signature	Date

Certification of Fitness

By completing and signing this affirmation, I certify that I have not been convicted of any crime at any time involving murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs, nor have I pleaded nolo contendere to a felony charge relating to any of these offenses.

Further, I certify that I am not, or was not subject to a state or federal administrative order relating to fraud, embezzlement or patient harm, including, but not limited to actions involving Medicare and/or Medicaid.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of fitness.

Full Name	
Signature	Date

Notary Public Affirmation and Acknowledgement

Notary Public Name	
Signature	Date

Please affix Notary Public Stamp or equivalent.