NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Application for New EMS Service,Expansion of Primary Operating Territory or Transfer of Ownership

Application for: (check one)

- ☐ New Service (Sections A, B, C, D, F)
- ☐ Expansion of Primary Operating Territory for existing service (Sections A, B, D, F)
- ☐ Transfer of existing service operating authority (Sections A, D, E, F)

Type of Service: (check one)

- ☐ Ambulance
- ☐ ALS First Responder

Section A Organizational Structure

For a corporation, attach a copy of certificate of incorporation, any DBAs and a listing of all owners, stockholders or principals.

Name of Service	DOH Agency Code	Federal Employer Identification No.

Address	City	State	Zip	County

Contact Person	Business Phone No.	Home Phone No.

Title

Current Organizational Sponsor Type

- ☐ Proprietary
- ☐ Vol. Fire Department
- ☐ Hospital Based
- ☐ Municipal/Government
- ☐ Vol. Independent
- ☐ Other _____
- ☐ Industrial

Type of Ownership ☐ Individual ☐ Partnership ☐ Government ☐ Corportation

Name of Individual Owner, Partners, Corporate or Government Entity (Attach a listing of any/all owners or 10% or more stock)

Section B Primary Operating Territory

Specify exactly the geographic area being requested, using municipal, political or other identifiable boundaries. Attach a detailed map of the primary service area. Statements such as "surrounding, adjacent, vicinity, proximity, contiguous, adjoining, " etc. are not acceptable when defining a primary operating territory.

Proposed new or expanded primary operating territory

For expansion, list existing primary operating territory

Section C Financial Responsibility

Applicant is required to attach detailed fiscal and budgetary information, as specified in the DOH Policy Statement. An initial start-up budget and sufficient financial information, as well as the source of such, must be provided to insure the fiscal responsibility and stability of the ownership.

Insurance Carrier

Agent	Business Phone No.

Types and limits of coverage: Liability Malpractice Other_____

Section D Description of Proposed Services

Level of Service (check only one)

☐ BLS (CFR, EMT) ☐ Defibrillation (CFR, EMT) ☐ Intermediate ☐ Critical Care ☐ Paramedic

Agency Medical Director	Address	City	State	Phone No.

Agency Providing Medical Control	Phone No.

System Medical Director	Address	City	State	Phone No.

Size of Population to be Served	Days of Operations	Hours of Operation

Projected call volume Total_____ Emergency_____ Non Emergency_____

Source of Statistics for call volume

Total No. Ambulances_____ Total No. Emergency Ambulance Service Vehicles (EASVs)_____ Total No. ALS First Response Vehicles_____

Section E Proposed Organizational Structure

For a corporation, attach a copy of certificate of incorporation, any DBAs and a listing of all owners, stockholders or principals.

Proposed Name of Service			Federal Employer Identification No.

Address	City	State	Zip

Contact Person	Business Phone No.	Home Phone No.

Title

Proposed Organizational Sponsor Type

☐ Proprietary ☐ Hospital Based ☐ Vol. Independent ☐ Industrial
☐ Vol. Fire Dept. ☐ Municipal/Gov't ☐ Other _____

Proposed Type of Ownership ☐ Individual ☐ Partnership ☐ Government ☐ Corportation

Name of Proposed Individual Owner, Partners or Government Entity

Section F Certification of Accuracy and Ownership Competency

As owner of the ambulance service described herein, I attest to the accuracy of the information contained within this application and its attachments, and to having received and read the Public Health Law Article 30 and the State EMS Code Part 800. I also state that neither the corporation nor any of the owners, principals or stockholders in the corporation have been convicted of Medicare or Medicaid fraud. I understand that under Section 3012(a) of the PHL, Article 30, that the ambulance service or ALS FR service certificate for this agency may be revoked, suspended, limited or annulled if this application includes willful misrepresentation.

Attachments Required

- Detailed narrative to support need, or statement of purpose and intent for transfer
- Affirmation of Fitness and Competance (DOH 3778)
- Certificate of Incorporation, DBAs, and ownership and/or shareholders listing (not required for expansion of territory)
- Financial information, including funding, budget and insurance (not required for expansion of territory)
- Primary operating territory map

Name of Owner or CEO _____ Title _____

Signature _____ Date _____

Notary Public affirmation and acknowledgement

FOR REGIONAL EMS COUNCIL USE ONLY

Date complete application received_____

Date of Council Decision_____

Approved ☐ Denied ☐

Council Chair Signature_____