MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
GROUND AMBULANCE SERVICE LICENSE APPLICATION

FOR DOH OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ **INITIAL LICENSURE**	**AMBULANCE SERVICE LIC. #**	**DATE PASSED INSPECTION**
☐ **RELICENSURE**	**DATE APPLICATION RECEIVED**	**DATE LICENSED**
INSPECTOR ASSIGNED	**DATE INSPECTOR ASSIGNED**	**EXPIRATION DATE**
______________________	**DATE OF FIRST INSPECTION**	

APPLICANT MUST COMPLETE INFORMATION BELOW ***TYPE OR PRINT***

1. TRADE NAME OF AMBULANCE SERVICE ***(Name on vehicle)***	**NUMBER OF VEHICLES**
LOCATION OF AMBULANCES *(STREET, ROUTE, CITY, STATE, ZIP)*	☐ BLS ☐ ALS

2. OPERATOR OF AMBULANCE SERVICE

NAME OF OPERATOR	NAME OF MANAGER (LAST, FIRST, MI)		TELEPHONE NUMBER-BUSINESS ( )
OPERATOR MAILING ADDRESS *(STREET, ROUTE, ETC.)*			TELEPHONE NUMBER-EMERGENCY ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

3. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)*			☐ MD ☐ DO
MAILING ADDRESS *(STREET, ROUTE, ETC.)*			OFFICE TELEPHONE NUMBER ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

☐ BOARD CERTIFICATION ☐ ACLS ☐ ATLS ☐ PALS ☐ LETTER OF AGREEMENT

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance service medical director (*190.103 RSMo Supp. 1998 & 19 CSR 30-40.303*) and I agree to serve as medical director.

SIGNATURE OF AMBULANCE SERVICE MEDICAL DIRECTOR	DATE

4. CONSULTANT MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)*	☐ MD ☐ DO
MAILING ADDRESS *(CITY, STATE, ZIP CODE)*	OFFICE TELEPHONE NUMBER ( )

☐ BOARD CERTIFICATION ☐ ACLS ☐ ATLS ☐ PALS ☐ LETTER OF AGREEMENT

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an ambulance service medical director (*190.103 RSMo Supp. 1998 & 19 CSR 30-40.303*) and I agree to serve as consultant medical director.

SIGNATURE OF AMBULANCE SERVICE CONSULTANT MEDICAL DIRECTOR	DATE

5. AMBULANCE SERVICE LICENSEE

NAME OF POLITICAL SUBDIVISION OR CORPORATION	NAME OF CEO		TELEPHONE NUMBER-BUSINESS ( )
BUSINESS MAILING ADDRESS *(STREET, ROUTE, ETC.)*			TELEPHONE NUMBER-EMERGENCY ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Ambulance Service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 1998.

I have attached all Ambulance Service licensure and related administrative licensure actions taken against this ambulance service or owner by any state agency in any state.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF AMBULANCE SERVICE LICENSEE	DATE

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri Statutes 575.060.

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102