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.

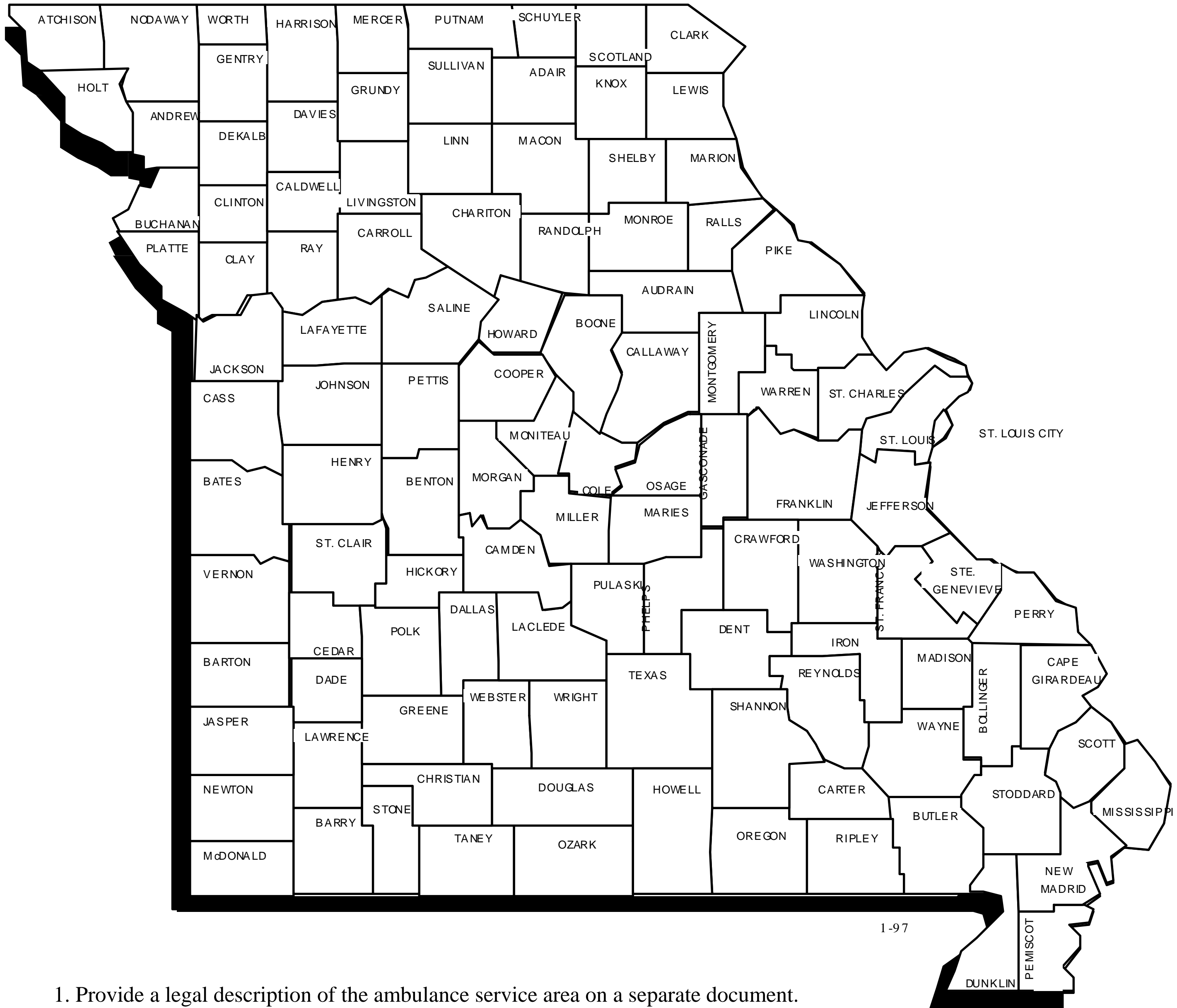
I have attached all Ambulance Service licensure and related administrative licensure actions taken against this ambulance service or owner by any state agency in any state.

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

MAP OF AMBULANCE SERVICE AREA **(Shade in your service area on the map below)**



1. Provide a legal description of the ambulance service area on a separate document.
2. Is this a change in your service area since your last licensure period?
   ________ Yes ________ No
3. List name or names of emergency medical response agencies (BLS or ALS) in your service area.

   1.____

   2.____
4. Do you have a memorandum of understanding with each of the EMRA's listed above?
   _________ Yes _________ No

MANAGER SIGNATURE	DATE

SERVICE APPLICATION ADDENDUM

INSTRUCTION

Dear Applicant:

In an effort to assemble information that would be needed in the event of a disaster or mass causality event, the Bureau of EMS has included an addendum to the service application form.

This addendum is included with the application on this website link. Please complete the information requested regarding any and all satellite locations your service may operate in addition to your primary service.

If your service does not operate any satellite locations, please indicate "NONE" on the form.

Please submit the completed addendum with your application for licensure.

Thank You for Your Assistance.

BEMS
Missouri Bureau of Emergency Medical Services

SERVICE LICENSE APPLICATION ADDENDUM

SATELLITE SERVICE INFORMATION

PRIMARY SERVICE NAME	LIC. #

SATELLITE NAME	ADDRESS	# OF STAFFED VEHCILES IN OPERATION