



_____ New
_____ Renewal
_____ License #
_____ Receipt #

APPLICATION FOR AMBULANCE SERVICE LICENSE

General Information:

Full Name of Business _____

DBA (trade name) _____

Address of Business _____ Business Phone _____

Contact Person (Authorized Representative) _____

The information requested below must be provided by the applicant and every person who, directly or indirectly, has any right to participate in the management or control of the business to be conducted at the premises of the proposed establishment. Such information should be provided on separate sheets and attached to this application.

Name of Owner _____

Mailing Address of Owner _____

Daytime Phone _____ Email Address _____

State the type of business entity which will be operating the proposed service (e.g., sole proprietorship, partnership, corporation, etc.) _____

If this is a corporation or partnership, the following must be completed.

Corporation Name _____

NAME OF PARTNERS (general and limited)
OR OFFICERS OF CORPORATION

TITLE

RESIDENCE

A. _____

B. _____

C. _____

Location of area from which the ambulance service intends to operate:

Describe training and experience in the transportation and care of patients:

Does your service hold a valid certificate of ambulance service authorization issued by the Iowa Department of Public Health to operate at the paramedic specialist level in the City of Cedar Rapids as set forth in Section 67.06 of the Cedar Rapids Municipal Code? **(Please attach a copy)**

YES NO

Does your service have at least one non-transporting supervisory vehicle, equipped at the advanced life support level, staffed by at least one paramedic specialist supervisor available for operation within the City of Cedar Rapids 24 hours per day, 7 days per week?

YES NO

Does your service have a minimum of 3 advanced life support ambulances each staffed by at least one paramedic specialist and one additional EMS provider available for operation within the City of Cedar Rapids 24 hours per day, 7 days per week?

YES NO

What is your multiple-patient response capability within the limits of the City of Cedar Rapids?

Describe your capability to continuously operate an ambulance dispatch center equipped with a geographically referenced computer aided dispatch system covering the entire service area of the ambulance service. Please provide the manner by which the ambulance dispatch center is equipped with telephone equipment capable of receiving and passing a computer aided dispatch system location both wire line and wireless request for service and the manner by which the dispatch center is capable of communicating with the City of Cedar Rapids 800MHz public safety radio system, the Linn County/Marion VHF radio system and the State of Iowa regional and statewide medical communications frequency. (Section 67.06, Cedar Rapids Municipal Code)

Provide a description of the system for providing medical direction:

Service Program Medical Director:

Medical Director _____

Mailing Address _____

Daytime Phone _____ Alternate Phone _____

Iowa License Number: M.D. _____ D.O. _____

Advanced cardiac life support (ACLS) expiration: _____

****Please include a copy of the Medical Director's ACLS certification.**

Section 67.09 of the Municipal Code allows the responsibilities of the Medical Director to be delegated by the Medical Director to a qualified individual of equivalent or higher training than the service being offered by the ambulance service.

Will the Medical Director be delegating responsibilities? YES NO

If yes, please complete the following in reference to the qualified individual:

Name _____

Mailing Address _____

Daytime Phone _____ Alternate Phone _____

Iowa Certification or License Number _____ Level of Training _____

BCLS Certification (or higher) Expiration _____

Vehicles:

How many primary response units will be staffed 24 hours per day, 7 days per week, at the advanced life support level? _____

How many backup vehicles will you provide? _____

****An application for each ambulance vehicle must accompany this application for an Ambulance Service License. The vehicle application must include a description of each ambulance, including the make, model, year of manufacture, motor and chassis number; current state license number; the length of time the ambulance has been in service; and the color, scheme, insignia, name, monogram or other distinguishing characteristics to be used to designate the applicant's ambulance.**

Insurance:

Please attach a certificate of insurance showing compliance with Section 67.10 of the Cedar Rapids Ambulance Services ordinance. Please note that the certificate(s) must include the City of Cedar Rapids as an additional insured.

Staff:

Please attach a list of all ambulance drivers, their certification level and a current schedule.

Do you fully understand that any falsifications made hereinbefore will constitute grounds for revocation of your license?

YES NO

The undersigned states that representation made herein on oath are true and correct, that the Applicant acknowledges and agrees to continuously meet all eligibility criteria as set forth in Section 67.06 of the Cedar Rapids Municipal Code, to follow the standards for licensed ambulance services as set forth in Section 67.07 of the Cedar Rapids Municipal Code and to follow all requirements for ambulances, equipment, and supplies as set forth in Section 67.08 of the Cedar Rapids Municipal Code during the period covered by this license.

Signature of applicant or authorized representative

Signature of applicant or authorized representative

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public in and for Linn County, Iowa