EMS & TRAUMA SYSTEMS
Portland State Office Building | 800 NE Oregon Street, Suite 465 | Portland, OR 97232-2162
Oregon Health Authority

APPLICATION FOR AMBULANCE SERVICE LICENSE

In order to receive a new ambulance service license, please complete this application. Completion of the application shall consist of providing the information requested in OAR 333-250-0020 and submitting a NON-REFUNDABLE licensing fee. Type or print the appropriate response in blue or black ink only. Upon completing the application, have the person with the power of attorney sign it.

PAYMENT DUE:

- ☐ **$75.00** with a maximum of four full time paid positions
- ☐ **$250.00** with five or more full time paid positions

Make check payable to:

OHA, EMS/TS,
DHS, Business Services,
P. O. Box 14260,
Portland, OR 97293-0260.

Please print legibly

Name of Service	
Mailing address	
Telephone Number:	
FAX Number:	
E-Mail Address:	
Owner:	
Principal Contact Person:	
Power of Attorney given to the following persons for signing applications:	
Medical Director	
Medical Director Email	

Type of Ownership:	
Type of Agency:	
Type of Service Provided:	
Ambulance Locations:	

Ambulance Vehicle Roster: Please attach a separate vehicle roster for all State licensed ambulances. Please double check to make sure the correct number of vehicles has been included in your agency renewal fee listed above. Please include the following information in the vehicle roster.

Plate	**VIN**	**Vehicle Manufacturer**	**Vehicle Year**	**Ambulance Type** Ground Type 1, 2, or 3, Fixed Wing, or Rotor Wing

Level of personnel used: (*Check all that apply*)

☐ EMR	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ EMT	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Advanced EMT	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ EMT-Intermediates	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Paramedics	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Registered Nurses	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Physician Assistants	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Physicians	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Non-EMT Drivers	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Pilots	☐ Paid full-time	☐ Paid part-time	☐ Volunteer

Level of care provided: (*Check all that apply*)

☐ Basic level of care -Personnel and equipment provided 24 hours-a-day
☐ Basic level of care -Personnel and equipment provided only part of a 24 hours-a-day
☐ Intermediate level of care -Personnel and equipment provided 24 hours-a-day
☐ Intermediate level of care -Personnel and equipment provided only part of a 24 hours-a-day
☐ Advanced level of care -Personnel and equipment provided 24 hours-a-day
☐ Advanced level of care -Personnel and equipment provided only part of a 24 hours-a-day

Training Director's Name:_____
Training Director, Email:_____

Medical Director Information:

Medical Director License #_____
Medical Director's Name:_____
Medical Director Email:_____

Signed Standing Orders: (*Standing orders must have been signed within the past twelve months.***)**

- ☐ Signed standing orders for EMR . Date signed:
- ☐ Signed standing orders for EMT . Date signed:
- ☐ Signed standing orders for Advanced EMT . Date signed:
- ☐ Signed standing orders for EMT-Intermediates. Date signed:
- ☐ Signed standing orders for Paramedics. Date signed:

☐ Our medical director has authorized the purchase and use of controlled substances.
If checked, you must have a DEA license containing the name of your medical director and the name and address of your ambulance service. A separate DEA license is required for each location where controlled substances are stored. (Stored does not mean the controlled substances that are kept on an ambulance.)

Our DEA license has an expiration date of:

☐ Our medical director has authorized the use of blood glucose monitoring devices to determine blood glucose levels. If checked, you must have a CLIA Laboratory Certificate of Waiver.

CLIA Number: Expiration Date:

Proof of financial responsibility as prescribed in ORS 682.105. If certificate is expired, attach a copy of current certificate of insurance. (*NOTE - Government owned services do not need to submit a certificate of insurance.*)

Ground Ambulance Liability:
Name of Insurance Company:
Expiration Date:

Air Ambulance Liability:
Name of Insurance Company:
Expiration Date:

Personnel Liability:
Name of Insurance Company:
Expiration Date:

Medicare/Medicaid Provider Numbers:
Medicare Number:
Medicaid Number:

STATEMENT OF TRUTH OF APPLICATION

I, _____, being of first duly sworn, deposed and that I am an authorized agent of the entity that owns and operates the ambulance service described in this application.

I certify that there have been no attempt to knowingly and willfully falsify, conceal, or omit a material fact, or make any false, fictitious, incomplete or fraudulent statements or representations, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry for the purpose of obtaining or attempting to obtain an ambulance service license to operate in the State of Oregon. Where I have relied upon documents submitted by employees or agents, I have made a reasonable effort to verify the validity of those documents.

I certify that to the best of my knowledge, that any ambulances operated _____ meets all federal, state, county and city requirements to operate as an ambulance in Oregon. I have carefully read and completed the application without reservations of any kind, and I declare under penalty of perjury that the information provided by me herein is true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of this ambulance license or my ambulance service license to operate in the state of Oregon.

I authorize any persons or entities, including but not limited to hospitals, institutions, organizations, or governmental entities to release to OPH, EMS & Trauma Systems Section (Section) any information, files, or records requested by the Section in connection with the processing of this application. I further authorize the Section to release to any person or entities information which is pertinent to my application.

Upon receiving an ambulance service license from the Section, I authorize disclosure of information by insurance companies, physicians, health care facilities, including but not limited to hospitals, nursing homes or free standing medical centers, to the Section relating to service provide by the ambulance service to those facilities or to patients being taken from or to those facilities.

I have carefully read the application and answered the appropriate questions completely and without reservations of any kind, and I declare under penalty of perjury that my answers, all statements made and documents provided by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of this ambulance service license to operate in the State of Oregon.

_____

(Authorized Agent to sign in presence of Notary Public)

Subscribed and sworn to before me this _____day of _____, 20___ Notary Public

Notary Public for _____My Commission Expires ___/____/___ Seal

_____

(Notary Signature)

Attach a vehicle roster, personnel roster, agency renewal fee, and double check all information before signing and returning this application.

Mail the completed application with a non-refundable licensing fee and all requested documents to the:

Department of Human Services
Business Services
P. O. Box 14260
Portland, OR 97293-0260

(For EMS & Trauma Systems Section Use Only)

Date application Received:

☐ License Approved Date: _____/_____/_____

License Number Issued: _____ Expiration Date: ____/___/___

☐ License Denied Date: _____/_____/_____

Reason for denial: _____

_____

(Signature of Ambulance Licensing Program Representative)