***** Submit This Page With Application *****

Rhode Island Department of Health
Center for Emergency Medical Services

3 Capitol Hill, Room 105
Providence, RI 02908-5097

Instructions and Application To Operate an

Ambulance Service

Please select the type of Ambulance Service you are applying for:

- ☐ Class A — ALS only (A-1 and/or C-1 vehicles)
- ☐ Class B — BLS only (A-2 and/or C-2 vehicles)
- ☐ Class C — EMR (Emergency Medical Responder)

Service Name

FOR DEPARTMENT OF HEALTH USE ONLY

Fee Exempt ☐ ☐ Approved ☐ Denied Date: _____

By: _____

Phone: (401) 222-2401 **Fax: (401) 222-6683** **TTY/TDD: (800) 745-5555**

Revised 03/06/2019 jcp

***Detach Page - Do Not Submit With Application ***

GENERAL INFORMATION

1. Requirements for licensure are established by the Rules and Regulations Rules and Regulations 216-RICR-20-10.2, available through the Center for EMS website at http://www.health.ri.gov/licenses

2. EMS licensure can be denied pursuant to the provisions of the Regulations Rules and Regulations 216-RICR-20-10.2. Statements or documents may be considered sufficient cause to deny or revoke a license as an Ambulance Service in Rhode Island and may result in additional penalties as deter mined by law.

3. Should you have any questions regarding the license requirements or completion of the application form, contact the Center for Emergency Medical Services at (401) 222-2401.

This application form (dated 01/29/2019) supplants all previous versions. Prior versions of the application will not be accepted or processed after this date. All applications are considered valid one year from the day they are received at RIDOH. If you do not complete the application process and obtain a license within one year a new application must be sumbitted. This is a continuing application and any subsequent changes require notification to the Center for Emergency Medical Services.

APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark “NA” on questions that are Not Applicable. Please type this application using the fillable form online then print the completed application.

2. Do not detach any full pages from this application packet.

3. Sign the application and return it with the required payment, if applicable, payable to the General Treasurer, State of Rhode Island.

4. Do not submit the application without all applicable information, documentation and fee(s).

5. Mail the completed application to:

Rhode Island Department of Health
Center for Emergency Medical Services
Room 104, 3 Capitol Hill
Providence, RI 02908-5097

REQUIRED DOCUMENTATION

- Completed, signed, notarized application for an Ambulance Service
- EMT Roster/Schedule - Listing all persons authorized to act as an attendent on any ambulance owned or operated by the licensee.
- Copy of the Ambulance Service’s policies and procedures
- Application fee(s) payable to General Treasurer, State of Rhode Island in the form of a cashier’s check or money order, if applicable, payable to the General Treasurer, State of Rhode Island.
- Bureau of Criminal Identification (BCI) report supported by fingerprints. You must apply to the Department of Attorney General’s Office. For information on this process please visit: http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php, if applicable.
- Financial Capacity - According to the Rules and Regulations 216-RICR-20-10.2. all Private Am bulance Service Providers are required to provide proof of the following types of insurance: Gener al Liability, Automobile liability, Professional liability and Workers compensation. Please see the regulations for the limit requirements. These insurances must be in effect at all times while licensed with the Department.

Once all required material is received, reviewed and approved by the Department, an inspection will be conducted. Licenses will not be renewed until an inspection has taken place and all deficiencies corrected.

State of Rhode Island
Division of Emergency Medical Services
Application for Ambulance Service License

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name of Service:

Name of Service

2. Contact Person:

Provide the name of the person to contact regarding this service.

First Name | Middle Name | Surname, (Last Name)

3. FEIN/SSN:

Provide the FEIN (Federal Employee Identification Number for this Service. If you are a sole proprietor this number may be your Social Security Number.

Federal Employer Identification Number (FEIN)

OR

U.S. Social Security Number (SSN)

Owner Date of Birth

NOTE: If you are the sole proprietor of a facility or business, then you must supply your Social Security Number (SSN) and date of birth. If you are an individual representing a facility or a business that is seeking licensure, then you must supply the Federal Employer Identification Number (FEIN) for the facility or the business.

THIS INFORMATION IS MANDATORY

4. Mailing Information:

Please provide the mailing information for all communication regarding this license. It is your responsibility to notify the Center of all address changes.

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Mailing Address Phone | Extension | Mailing Address Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

5. Service Location Information:

Please provide the physical location information for this service. It is your responsibility to notify the Center of all address changes.

This information will appear on the HEALTH website.

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Mailing Address Phone | Extension | Mailing Address Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Applicant: Print your complete service name >

6. Type of Ownership

Please Check ONE

- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Partner
- ☐ Sole Proprietorship — Complete Section 8 Below
- ☐ Limited Partnership
- ☐ Partnership
- ☐ Governmental Entity
- ☐ Other (Describe):

7. Ownership Information for "privately held" organizations:

Provide the name address and telephone number(s) of the facility/business owner in the spaces provided.

Name of Owner

D.B.A. (Doing Business As)

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Phone | Extension | Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

8. Sole proprietor Information:

If you are the sole proprietor of this service please complete this section. Attach additional 8 1/2 x 11 sheets **as needed.**

If you are a sole-proprietor you must include a BCI supported by fingerprints with this application.

Has the sole proprietor ever been convicted of any violation of federal or state law (Felony or Misdemeanor)? (If yes, explain)

☐ Yes ☐ No

Sole proprietor's Experience in EMS

Applicant: Print your complete service name > .

9. Key Personnel:

Provide the name, phone number and email address for the specified personnel at your service.

EMS Service Chief:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Coordinator:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

Physician Medical Director:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Training Coordinator:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Data Manager:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Quality Improvement Coordinator:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Pediatric Emergency Care Coordinator:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Inspection Contact:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com) | Phone

EMS Communications Coordinator:

First Name | Middle Name | Surname, (Last Name)

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

Phone | Fax

Payment of Fees:

Fees should be in the form of a check or money order, payable to: General Treasurer, State of Rhode Island

Required fees must accompany the application.

PLEASE NOTE: ALL FEES ARE NON REFUNDABLE

Service Application Fee $490.00

Vehicle Application Fee(s) . . . . . .$250.00 per Vehicle

Vehicle Inspection Fee(s) . . . . . .$170.00 per Vehicle

Service Application @ $490.00 **$490.00**

Enter the number of vehicles you are applying for @ $250.00 each [ ] **x $250.00 =**

Enter the number of vehicles you are applying for @ $170.00 each for inspection [ ] **x $170.00 =** **+** _____

Total Enclosed:

☐ **I am exempt from application/examination fees**

Per RI General Law and 216-RICR-20-10.2, the following categories of Rhode Island Licensed EMS Providers are considered "Exempt":

- **City or town services, vehicles and their employees.**
- **Volunteer or not-for-profit services, vehicles and individuals providing services therein.**
- **Fire district service, vehicles and individuals providing services therein.**

10. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made 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 denial, suspension or revocation of my license in the State of Rhode Island.

I understand that in order to conduct a business or occupation in the state of Rhode Island I am required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76). In order to verify that the state is not owed taxed, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify status prior to the issuance of a license.

I further attest that I am in compliance with the minimum insurance coverage types and limits referred to in Section 9.13 of the Rules and Regulations and I understand that all of the coverage types and limit requirements must be in effect at all times while licensed with the Department

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Division of Emergency Medical Services of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

_____ _____

Name of Notary (Print, Type or Stamp) Signature of Notary

_____ _____

Notary No/Commission No. Commission Expiration Date (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Notary Seal

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Application

- ☐ I have read and understand the Application Instructions.
- ☐ I have completed the Rhode Island application as instructed (pages 3-7).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 10, **Affidavit of Applicant**, and had the form notarized by a notary public.
- ☐ I have a **cashier's check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"General Treasurer, State of Rhode Island"*** and attached it to the upper right-hand corner of the first (Top) page of the application.
  Or I have checked off that I am exempt from application/examination fees pursuant to RIGL and 216-RICR-20-10.2

- ☐ I am a sole proprietor and have requested a BCI supported by fingerprints
- ☐ I have attached a copy of the EMS practitioner roster and schedule
- ☐ I have attached a copy of the Ambulance Service's policies and procedures
- ☐ (For Private Ambulance Service Providers)
  I have attached proof of the insurances required by RIGL and 216-RICR-20-10.2

EMS Practitioner Roster:

List names and license numbers of all personnel employed at this service.

Make copies of this page and attach if necessary.

Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time
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Name	License Number	Level	☐ Full Time	☐ Part Time
Name	License Number	Level	☐ Full Time	☐ Part Time