Section of Emergency Medical Service
New Ambulance Service License Application

Section Use Only

Amount Paid &Method	_____	Service License Number	_____
Received in Office	_____	Type of Service	_____
Inspection Date	_____	Issue Date	_____
Computer Entry Date	_____	Expiration Date	_____

Service Name: County:

Service License Number (three digit number from wall certificate- not applicable to new registrants)

Service Location (Physical address, Not a P.O. BOX):

Mailing Address:

Business Telephone: Emergency Telephone (Not 911):

Fax Number: E-mail Address:

Health Alert Network (HAN) Fax: HAN Telephone:

Ryan White Act Contact Name: Telephone:

TYPE OF LICENSE: ☐ PARAMEDIC ☐ ADVANCED RESP. ☐ AIR- ROTOR

Check Only one ☐ AIR- FIXED ☐ AIR- ROTOR- Special Purpose

☐ Adv. EMT ☐ EMT

☐ SPECIAL PURPOSE ☐ STRETCHER

TYPE OF ORGANIZATION: ☐ PRIVATE- For Profit ☐ PRIVATE- Non-Profit

☐ HOSPITAL-For Profit ☐ HOSPITAL- Non-Profit

☐ HOSPITAL-Other Explain:

☐ FIRE-Volunteer ☐ FIRE- Paid ☐ POLICE/DPS

☐ MUNCIPAL ☐ VOLUNTEER ☐ INDUSTRIAL

☐ OTHER Explain:

NUMBER OF VEHICLES THAT WILL BE REGISTERED UNDER THIS SERVICE LICENSE

****************************ADDITIONAL INFORMATION*******************************

LIABILITY INSURANCE: {Copy of Proof of current insurance must be attached (see reverse)}.

Each licensed ambulance service shall have in force liability insurance coverage, issued by an insurance company licensed to do business in the State of Arkansas, for each vehicle owned and operated by or for the applicant or licensee.

ADDITIONAL INFORMATION:

Submit additional information outlined on the "Ambulance Service License Checklist." Attach all required documents to this application.

SUB-STATIONS:

TOTAL NUMBER OF SUB-STATIONS AFFILIATED WITH THIS LICENSE:

PLEASE LIST ALL SUB-STATIONS: (This does not include staging areas.)

Please complete the following information. If addition space is needed, please submit the information on ambulance service letterhead and attach to this application.

Sub-station #1 Name and Location: (Physical address, Not a P.O. BOX)		
City:	State:	Zip:
County:	Business Telephone:	

Sub-station #2 Name and Location: (Physical address, Not a P.O. BOX)		
City:	State:	Zip:
County:	Business Telephone:	

Sub-station #3 Name and Location: (Physical address, Not a P.O. BOX)		
City:	State:	Zip:
County:	Business Telephone:	

ALL INTERMEDIATE, AIR AMBULANCE, ADVANCED RESPONSE, AND PARAMEDIC SERVICE APPLICANTS MUST COMPLETE THE FOLLOWING SECTION:

Name of Medical Director and Profession:		
Address:		
City:	State:	Zip:
Phone Number:		
Email:		

Attach a copy of the following [please check the appropriate blank(s)]. Any changes should be reported immediately.

_____ TREATMENT PROTOCOLS (MANDATORY FOR EMT, PARA, INT, AIR AND ADVANCED RESPONSE)
New applicants must submit with initial application.
Not required for renewal applicants. Copy of Patient Encounter forms

_____ ACLS CERTIFICATION FOR MEDICAL DIRECTOR (MANDATORY FOR PARA, INT, AIR AND ADVANCED RESPONSE)
Required for all applicants (Must Be Current)

_____ DRUG POLICIES, PROCEDURES, AND INVENTORY (MANDATORY FOR PARA, AIR AND ADVANCED RESPONSE)
New applicants must submit with initial application.
Not required for renewal applicants.

_____ DEA REGISTRATION (MANDATORY FOR PARA, AIR)
Required for all applicants (Must Be Current)
AND ADVANCED RESPONSE)

FALSIFICATION OF ANY INFORMATION ON THIS OR ANY APPLICATION WILL RESULT IN DENIAL OR REVOCATION OF THE SERVICE LICENSE.

****PLEASE PUT THE PERSON THAT WILL BE CONTACTED IN REFERENCE TO SERVICE RENEWAL INFORMATION.**
****I CERTIFY THAT THE ABOVE AND ATTACHED INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

SERVICE DIRECTOR'S NAME:	EMAIL:
SIGNATURE:	DATE:
PRINT NAME:	TITLE:

DO NOT OPERATE OR ADVERTISE AS AN AMBULANCE SERVICE UNTIL APPROVED BY THIS OFFICE

INSTRUCTIONS:

LICENSE:

All Services that engage in the emergency transport of people within the State of Arkansas on a routine basis must apply for an Ambulance Service License as issued by the Arkansas Department of Health, Section of Emergency Medical Service and Trauma Systems. Please complete this form and forward a non-refundable fee of five hundred twenty-five ($525) dollars, company check or money order, (Special Purpose only, $25.00.) with the application form to:

DEPARTMENT OF HEALTH
Section of EMS
5800 West 10th St. Suite 800
LITTLE ROCK, AR 72204-1763

LIABILITY INSURANCE:

Each licensed ambulance service shall have in force liability insurance coverage, issued by an insurance company licensed to do business in the State of Arkansas, for each vehicle owned and operated by or for the applicant or licensee. **A copy of the certificate of liability must be attached.**

HEALTH ALERT NETWORK (HAN):

The HAN messaging system is the infrastructure for management of public health call down lists and alerting public health personnel and their first responder's counterparts during times of emergency or crisis. Your HAN contact numbers should be a FAX and telephone that are answered or can be accessed 24 hours per day.

VEHICLES:

All vehicles used for the emergency transport of people must be registered with the Arkansas Department of Health, Section of EMS and Trauma Systems in order to operate in the State of Arkansas. Vehicle registration is accomplished by, completing the Vehicle Registration Application and forwarding a non-refundable fee of one hundred five ($105.00) dollars for each vehicle to the above address. (Special Purpose only $5.00.)

SUB-STATIONS:

Please list all sub-stations affiliated with this licensure application. All sub-stations must be within the licensed ambulance service area of operation. **Service Area:** The primary area of operation within a county for a licensed ambulance service as defined by that service and on file with the Section of EMS and Trauma Systems. **Each licensed ambulance service, including air ambulance services, shall be required to obtain a separate service license in each county the ambulance service has an operational base.**