



SERVICE / VEHICLE RELICENSURE APPLICATION

Service Name: _____ / _____
(Legal Name) (Also Known As)

Address: _____ EMS Agency/License #: _____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

EMS Representative: _____ Phone: _____

E-Mail Address: _____ FAX: _____

NOTE: This application may NOT be used to upgrade or change your agency's type of service license. Please contact our office for the appropriate forms needed to apply for a service type other than what you currently hold.

TYPE OF SERVICE (choose one only): Ambulance (Transport) Aid Service (Non Transport)

IF YOUR RESPONSE AREA AND/OR RESPONSE TIMES HAVE CHANGED SINCE YOUR LAST APPLICATION, PLEASE ATTACH A WRITTEN EXPLANATION TO THIS APPLICATION.

WOULD YOU LIKE TO CONTINUE YOUR VERIFIED STATUS? *Yes No N/A

***IF 'Yes', WHAT IS THE HIGHEST LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS?** BLS ILS ALS

ORGANIZATION TYPE: (check the one that *best* applies to your organization)

- | | | | | | |
|-------------------------------|--------------------------|-----------------------|--------------------------|---------------------------------------|--------------------------|
| Private for profit | <input type="checkbox"/> | Fire District | <input type="checkbox"/> | Law Enforcement | <input type="checkbox"/> |
| Private non-profit | <input type="checkbox"/> | City Fire Dept. | <input type="checkbox"/> | Municipal (city/county) | <input type="checkbox"/> |
| Private volunteer association | <input type="checkbox"/> | Industrial Fire Dept. | <input type="checkbox"/> | Search & Rescue | <input type="checkbox"/> |
| Hospital District | <input type="checkbox"/> | City/Fire Dist. Comb | <input type="checkbox"/> | Other (<i>please specify below</i>) | <input type="checkbox"/> |
| EMS District | <input type="checkbox"/> | Federal Fire Dept. | <input type="checkbox"/> | _____ | |

VEHICLES: Please provide the **number** of each type vehicle you are licensing (from Page 2):

Ground Ambulance Aid Vehicle (Non-Transport)

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year:

Primary Responses Transports Primary/Secondary
Secondary Responses Interfacility Transports *Only*

PERSONNEL STATUS: Are your EMS personnel primarily: (*check one*) Paid Volunteer

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**SERVICE / VEHICLE RELICENSURE APPLICATION
EMERGENCY MEDICAL VEHICLES**

Please provide the following information for all vehicles to be licensed. Vehicle location is the **address** in which the vehicle is **physically located**. Indicate the *type* of vehicle(s): AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030). Upon licensure, each vehicle will be issued a separate vehicle credential (license).

Please review WAC 246-976-260 through 340 to ensure your vehicles meet all requirements. WAC 246-976-300 requires all licensed vehicles to carry extrication equipment. A variance from this requirement may be requested, and if approved, the extrication equipment must be available within 10 minutes. To request a variance, indicate the **name** of the agency(s) providing extrication equipment below and check (X) the Variance Extrication Equipment Request (**VEER**) box next to the appropriate vehicles.

Name of agency providing extrication equipment: _____

YEAR	MAKE AND MODEL	LICENSE PLATE NUMBER	ACTUAL ADDRESS OF VEHICLE <i>(If Different From Page 1)</i>	Choose One (✓)		Vehicle Identification Number (VIN)	VEER
				AMB	AID		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Attach additional sheets as necessary, including all the required information.

NOTE: When *adding, removing, or changing* the location of licensed vehicles, it is always necessary to notify the Department of Health of the change(s). A **“VEHICLE CHANGES APPLICATION”** may be obtained from our web site provided on the following page or you may request one by contacting the licensing office, at the address or telephone number below.

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OEMSTS / L&C, PO BOX 47853, OLYMPIA, WASHINGTON 98504-7853 / (360) 236-2845 / 1-800-458-5281, Ext. #1

SERVICE / VEHICLE RELICENSURE APPLICATION GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. *(Please find this information on our website at www.doh.wa.gov/hsqa/emstrauma click on "Licensure Processes." If you require hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. Dispatch plan

2. Response plan

3. Response area

4. Type of transport (emergency and/or interfacility), if any

5. Tiered response and rendezvous, if any

6. Back-up plan to respond (may not apply to agencies doing interfacility transports only)

NOTE: Other services involved in your response plan must be informed by you that they are participants and identified in number 6 above. These agencies must agree to that participation. Attach extra sheets as necessary.

"I hereby affirm and declare that the information provided on this application is true and correct, and that:

- 1. We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures;*
- 2. The vehicles identified on the attached page meet the minimum equipment requirements for the type of licensure and/or verification requested by our service;*
- 3. We meet the minimum staffing requirements for licensure and/or verification as identified on the attached page;*
- 4. Our EMS Personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
- 5. We maintain current liability insurance coverage."*

Person Completing Application

(Please Print)

Date

Owner/Operator

(Signature & Title)

Date

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