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 EMS service authorization issued by the Iowa Department of Public Health to operate at the paramedic 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 ambulance or non-transporting supervisory vehicle, equipped at the advanced life support level, staffed by at least one paramedic supervisor available for operation within the City of Cedar Rapids 24 hours per day, 7 days per week?

YES NO

An ambulance service must have available for operation within the city of Cedar Rapids at all times an adequate number of ambulances and qualified personnel to provide 24-hour per day, 7-day per week ambulance service, including a minimum of three advanced life support ambulances each to be staffed by at least one paramedic, plus one other EMS provider. Does your service have this capability?

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 (CAD) 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 to the CAD system location both wire-line and wireless requests 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 inspection report for each ambulance vehicle must accompany this application for an Ambulance Service License. The report must be completed by an Automotive Service Excellence (ASE) certified mechanic or a mechanic certified by the manufacturer of the ambulance inspected or similar certification organization.**

Insurance:

Please attach a certificate of insurance showing compliance with Section 67.10 of the Cedar Rapids Ambulance Services ordinance.

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

Indemnification

The undersigned agrees to defend, indemnify and hold harmless the City of Cedar Rapids, its agents, officers and employees from and against all claims for injury or damages to persons or property arising out of or caused by the use of such property.

The undersigned further agrees, upon receipt of notice from the City of Cedar Rapids, to defend at its own expense the City of Cedar Rapids from any action or proceeding against the City of Cedar Rapids arising out of or caused by the use of such property. The City of Cedar Rapids may maintain an action against the undersigned to recover the amount of the judgment together with all the expenses incurred by the City in the action.

Certification

I certify that all information in this application and the required documents is true and correct to the best of my knowledge, and upon submittal becomes public record.

I understand that any missing documentation may delay license approval.

I further understand that should I commit a violation of the terms and conditions of this license, my license may be revoked.

I agree that I will obtain any other permits necessary and will follow the guidelines and requirements set forth in Chapter 67 of the Cedar Rapids Municipal Code.

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Signature of applicant or authorized representative