



OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR AIR MEDICAL LICENSE

TYPE OR PRINT CLEARLY

TYPE OF APPLICATION NEW
DATE OF APPLICATION

NAME OF SERVICE		DBA's AND / OR TRADE NAME	
MTO MAILING STREET ADDRESS OR P.O. BOX		CITY	STATE
MTO HEADQUARTERS STREET ADDRESS (IF DIFFERENT)		CITY	STATE
TYPE OF ENTITY <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> OTHER			
FAX #		EMAIL ADDRESS	
BUSINESS PHONE		CONTACT PERSON	
EMERGENCY PHONE		OWNER / CHIEF / CEO	
MEDICARE PROVIDER #		MEDICAID PROVIDER #	
HIGHEST LEVEL SERVICE TO BE PROVIDED AIR MEDICAL			

LIST PRIMARY SERVICE AREA (Attach additional sheet if required)

COUNTY	STATE	COUNTY	STATE
COUNTY	STATE	COUNTY	STATE

CHECK TYPE OF ORGANIZATION

<input type="checkbox"/> PRIVATE	<input type="checkbox"/> NON-PROFIT PRIVATE	<input type="checkbox"/> UNIVERSITY
<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> INDUSTRIAL	<input type="checkbox"/> PUBLIC SERVICE

TOTAL NUMBER OF AIRCRAFT

FIXED WING	ROTOR WING
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TOTAL NUMBER OF TRANSPORTS LAST CALENDAR YEAR

FIXED WING	ROTOR WING
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LIST THE NAMES OF CORPORATE OFFICERS AND / OR DIRECTORS (Attach additional sheet if required)

NAME	NAME
NAME	NAME

MEDICAL DIRECTOR

NAME	PHYSICIAN LICENSE #
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LIST THE ADDRESS OF EACH SATELLITE SERVICE LOCATION (Attach additional sheet if required)

STREET ADDRESS	CITY	STATE	ZIP CODE	# VEHICLES
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STREET ADDRESS	CITY	STATE	ZIP CODE	# VEHICLES

INSURANCE INFORMATION

Minimum Insurance in the amounts required by Ohio Revised Code (R.C.) 4766.06 YES NO

Attach a copy of the current Certificate of Insurance, including the notice of cancellation
Attach a color photograph of side of vehicle showing color scheme and logo

COMMUNICATION EQUIPMENT INFORMATION (F.C.C. 90.203)

Two-Way Communication (Dispatch) YES NO
 Two-Way Communication (Medical Control) YES NO
 Dispatch Center Manned 24 Hours Per Day YES NO

CERTIFICATION OF APPLICATION INFORMATION

As the Owner, Operator, Chief, and / or Executive Officer of the Air Medical Service organization named in this application, I do hereby certify that all information provided in this application is accurate and complete.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER X	DATE
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SEND THIS APPLICATION AND ALL ATTACHMENTS TO:

Ohio Department of Public Safety
 Division of Emergency Medical Services
 1970 W. Broad St.
 P.O. Box 182073
 Columbus, OH 43218-2073
 Phone (800) 233-0785 or (614) 466-9447
 Fax (614) 466-9461

FOR STATE USE ONLY

EMS Service Code _____	Field Inspector Assigned _____ NAME
Reviewed _____ DATE INITIALS	Field Inspector Notified _____ DATE INITIALS

