OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

License Renewal Application Checklist

Your service license will expire on . Please review the preprinted enclosed renewal application for accuracy and complete the areas that are blank. *Make any corrections by drawing a line through the incorrect information and placing the correct information above.*

Use this checklist to make sure the application is complete before mailing.

Only completed applications will be accepted. All required information must be received prior to expiration date or license shall expire and service will have to re-apply for licensure.

APPLICATION:

- ☐ Filled out completely with correct information, signed and dated.
- ☐ **Federal Tax ID Number or E.I.N.**

ATTACHMENTS:

- ☐ List of all Ambulette drivers and their date of hire ***(Ambulette Only).***
- ☐ Copy of blank trip/run report. ***Required with initial application or with renewal application, if changes were made to the report.***
- ☐ Color photograph of vehicle logo. ***Required with initial application or with renewal application, if changes were made to the logo or lettering on the vehicle.***

CERTIFICATE OF INSURANCE: (* Does not include Air Medical Service)

- ☐ General Liability (Minimum $500,000 each occurrence and General Aggregate*)
- ☐ Vehicle Liability (Minimum $350,000 combined single limit each occurrence or Minimum $100,000 bodily injury / per person, $300,000 per accident, $50,000 property damage per accident*)
- ☐ Same organization name shown on insurance as on application.
- ☐ **State Board of Emergency Medical, Fire, and Transportation Services** listed as certificate holder on insurance documents.

FEES: **License Fee: $100.00 (All Service)** License Fee + (Permit Fee x Number of Vehicles)

Vehicle Permit Fee:	**Ambulance / MoICU:**	**$200.00 per vehicle**
	Non-Transport Vehicle:	**$200.00 per vehicle**
	Aircraft:	**$200.00 per vehicle**
	Ambulette:	**$100.00 per vehicle**

Made payable to: Ohio Treasurer of State

Please mail the **completed** application packet by .

Mail to: Division of EMS 1970 W. Broad St. Columbus Ohio 43223 1 (800) 233-0785

OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR AIR MEDICAL LICENSE

Incomplete application **WILL NOT** be processed.
Required fields, as indicated by asterisk (*), must be completed

TYPE OR PRINT CLEARLY

Service Code:				TYPE OF APPLICATION: **RENEWAL**
NAME OF SERVICE*	DBA's AND/OR TRADE NAME (Attach additional sheet as required)			
MTO HEADQUARTERS STREET ADDRESS*	CITY*	STATE*	ZIP CODE*	COUNTY*
MTO MAILING STREET ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	
TAX ID NUMBER OR EIN*	BUSINESS PHONE NUMBER*	FAX NUMBER		
PRIMARY CONTACT PERSON*	EMAIL ADDRESS*	PHONE NUMBER*		
CONTACT PERSON	EMAIL ADDRESS	PHONE NUMBER		
CONTACT PERSON	EMAIL ADDRESS	PHONE NUMBER		
MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER			
HIGHEST LEVEL SERVICE TO BE PROVIDED* **AIR MEDICAL**				

LIST PRIMARY OHIO SERVICE AREA* (Attach additional sheet if required)

ALL OHIO COUNTIES ☐ YES	OHIO COUNTIES

CHECK TYPE OF ORGANIZATION* (Choose only one)

☐ Privately Owned ☐ Publicly Owned ☐ University ☐ Hospital ☐ Other

TOTAL NUMBER OF AIRCRAFT*

FIXED WING	ROTOR WING

TOTAL NUMBER OF TRANSPORTS LAST CALENDAR YEAR*

FIXED WING	ROTOR WING

TYPE OF TRANSPORTS* (Choose only one)

- ☐ Scheduled Non-emergent Transports ONLY
- ☐ Emergent Transports ONLY (includes 911, interfacility and nursing home)
- ☐ Both Emergent and Scheduled Transports

LIST NAMES OF OWNER(S) OR CHIEFS / CORPORATE OFFICERS AND / OR DIRECTORS* (Attach additional sheet if required)

NAME	TITLE	EMAIL ADDRESS	PHONE NUMBER
NAME	TITLE	EMAIL ADDRESS	PHONE NUMBER
NAME	TITLE	EMAIL ADDRESS	PHONE NUMBER

MEDICAL DIRECTOR*

NAME	OHIO PHYSICIAN LICENSE NUMBER	
ADDRESS	EMAIL ADDRESS	PHONE NUMBER

LIST THE ADDRESS OF EACH SATELLITE SERVICE LOCATION (Attach additional sheet if required)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
		Massachusetts			
CONTACT PERSON	EMAIL ADDRESS			PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
		Maine			
CONTACT PERSON	EMAIL ADDRESS			PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	# VEHICLES
		Ohio			
CONTACT PERSON	EMAIL ADDRESS			PHONE NUMBER	

REQUIRED INFORMATION*

- ☐ Minimum Insurance in the amounts required by Ohio Revised Code (R.C.) 4766.06

Attach a copy of the current Certificate of Insurance, including the notice of cancellation.

- ☐ **General Liability Coverage**
- ☐ **Vehicle Liability Coverage**
- ☐ **Attach a color photograph of side of vehicle showing color scheme and logo.**
- ☐ **Attach blank trip report**

COMMUNICATION EQUIPMENT INFORMATION*

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 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	DATE
X	

SEND THIS APPLICATION AND ALL ATTACHMENTS TO:

Ohio Department of Public Safety
Division of Emergency Medical Services
1970 W. Broad St.
Columbus, OH 43223
Phone (800) 233-0785 or (614) 466-9447
Fax (614) 466-9461

Ohio Administrative Code (O.A.C.) 4766-5-2
Listing of all aircraft to be inspected and permitted*
Indicate Type: **Fixed Wing** or **Rotor Wing**

(A computer printout in this format may be substituted for this page.)

NOTE: IF SUBMITTING A COMPUTER PRINTOUT, YOU MUST ATTACH THIS PAGE WITH THE VEHICLE COMPLIANCE STATEMENT COMPLETED.

EMS PERMIT#*	YEAR*	MAKE*	MODEL*	AIRCRAFT TAIL#*	HOURS ON AIRCRAFT*	AIRCRAFT TYPE*

VEHICLE COMPLIANCE STATEMENT*

I, _____, Owner / Operator / Chief / Executive Officer (circle as appropriate), of the organization named in this application, certify that the aircraft listed on this application meets the minimum Ohio and federal standard.

SIGNATURE OF OWNER / OPERATOR / CHIEF / EXECUTIVE OFFICER	DATE
X	