

EMS Agency Name: \_\_\_\_\_

Agency No. \_\_\_\_\_

Date of Inspection: \_\_\_\_\_

Approved  Yes  No

Follow-up  Yes  No

Rep Sign: \_\_\_\_\_



109 Governor St., Suite UB-55  
Richmond, VA 23219  
(800) 523-6019

## **APPLICATION FOR EMS AGENCY LICENSE**

PLEASE COMPLETE APPLICATION FORM IN ITS ENTIRETY  
PRIOR TO TIME OF INSPECTION. IF YOU HAVE QUESTIONS,  
PLEASE CONTACT YOUR OEMS PROGRAM REPRESENTATIVE.

**PLEASE COMPLETE ENTIRE APPLICATION: Print or Type**

Agency name: \_\_\_\_\_ FIN # \_\_\_\_\_  
 Agency no.: \_\_\_\_\_ NPS # \_\_\_\_\_  
 Physical location of agency and directions from major route: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Number of stations: \_\_\_\_\_ (Please attach a list of each station number, name, complete address and phone number)  
 Mailing Address: \_\_\_\_\_

Street Address

City

State

Zip Code

Shipping Address: \_\_\_\_\_

Street Address

City

State

Zip Code

Agency telephone no.: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency e-mail address: \_\_\_\_\_

Agency FIPS no. \_\_\_\_\_ Agency Web site: \_\_\_\_\_

Type of application:  Initial  Recertification  Change of classification

Please check the **Organizational Status** and **Type**, all **Classifications**, and **Description** of Agency

**ORG. STATUS**

- Volunteer  
 Career  
 Mixed Vol/Career

**ORG. TYPE**

- Community, Non-profit  
 Governmental, Non-fire  
 Private, Non-hospital  
 Fire Department  
 Hospital  
 Tribal

**CLASSIFICATION**

- Non-Transport - BLS  
 Non-Transport - ALS  
 Emergency Ground Transport - BLS  
 Emergency Ground Transport - ALS  
 Neonatal Ambulance  
 Air Ambulance

**DESCRIPTION**

- Fire Department  
 1st Response - Only  
 Rescue Squad - EMS  
 Hospital  
 Police  
 Other: \_\_\_\_\_

Does agency utilize career EMS personnel?  Yes  No

If so, who are they employed by:

Agency  Local government  Other

Types and no. of personnel: \_\_\_\_\_ First Responder \_\_\_\_\_ EMT-Paramedic  
 \_\_\_\_\_ EMT-Basic \_\_\_\_\_ Driver Only (EVOC)  
 \_\_\_\_\_ EMT-Enhanced \_\_\_\_\_ Support Personnel  
 \_\_\_\_\_ EMT-Intermediate \_\_\_\_\_ MD \_\_\_\_\_ RN

Hours of operation:  24 hours  Other: \_\_\_\_\_

Month/year agency established: \_\_\_\_\_

Month/year agency began EMS operations: \_\_\_\_\_

Is agency a member of:  Virginia Association of Volunteer Rescue Squads  
 Virginia Ambulance Association  
 Virginia Governmental EMS Administrators

**EMS TRANSPORTS:**

Total no. of 911 calls/calendar year: \_\_\_\_\_ EMS dispatch volume/calendar year: \_\_\_\_\_

EMS transport volume/calendar year: \_\_\_\_\_ EMS contact volume/calendar year: \_\_\_\_\_

Total service area (sq. mi): \_\_\_\_\_ Total service area population \_\_\_\_\_

Are agency vehicles used by any other licensed agency?  Yes  No

If yes, total no. of calls other agencies utilize vehicles permitted to your EMS agency? \_\_\_\_\_

Vehicle insurer: \_\_\_\_\_  
 Underwriter Policy No. Expiration Date

No. of defibrillators: \_\_\_\_\_ Manual \_\_\_\_\_ Automated \_\_\_\_\_ Combination

**Representative/Owner #1:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Representative/Owner #2:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Agency Designated Infection Control Officer:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Training Officer:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street Address

\_\_\_\_\_ City State Zip Code

Daytime Phone No. \_\_\_\_\_ Evening Phone No. \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Operational Medical Directors:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**COMMUNICATIONS:**

Dispatch facilities:  Agency  Central Dispatch (specify): \_\_\_\_\_  
 Other (specify): \_\_\_\_\_  
Dispatch business telephone no. : \_\_\_\_\_

**Frequencies:**

Dispatch frequencies: 1) TX \_\_\_\_\_ PL \_\_\_\_\_ RC \_\_\_\_\_ PL \_\_\_\_\_  
Other frequencies: 1) TX \_\_\_\_\_ PL \_\_\_\_\_ RC \_\_\_\_\_ PL \_\_\_\_\_  
2) TX \_\_\_\_\_ PL \_\_\_\_\_ RC \_\_\_\_\_ PL \_\_\_\_\_  
3) TX \_\_\_\_\_ PL \_\_\_\_\_ RC \_\_\_\_\_ PL \_\_\_\_\_

Agency notified by:  Radio (voice)  Radio (paging)  Telephone  
Number of radios: \_\_\_\_\_ Mobile \_\_\_\_\_ Portables \_\_\_\_\_ Paging  
Emergency telephone no.:  911  Other: \_\_\_\_\_  
Emergency telephone no. listed for public:  Yes  No  
Does dispatch prioritize or provide pre-arrival instructions?:  Yes  No

FCC license holder:  Agency  Local Government  Other: \_\_\_\_\_  
If local government or other, written permission for use?  Yes  No  
FCC license expiration date: \_\_\_\_\_

**EXTRICATION EQUIPMENT:**

Is required equipment supplied by applicant Agency?  Yes  No  
If no, who is supplying the required equipment? \_\_\_\_\_

**OTHER EQUIPMENT:** (check all that apply)

- Rescue/Crash Truck
- Water Rescue Capability
- Haz Mat Response Vehicle/Trailer
- Command/Communications Vehicle
- Technical Rescue Vehicle/Trailer
- Disaster/Mass Casualty Trailer
- Emergency Back-up Generator (on location)

**AGENCY BILLING:**

Does agency bill for services?  Yes  No  
If yes, what year did agency begin billing? \_\_\_\_\_  
Who is responsible for billing (vendor or agency)? \_\_\_\_\_  
Does agency have a billing Subscription Service?  Yes  No

**AGENCY REPRESENTATIVE/OWNER SIGNATURE:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Please print name

I hereby affirm that the information on this application is true and correct and I realize that any fraudulent entry may be considered sufficient cause for rejection of agency application, and/or enforcement action.

\_\_\_\_\_ Date: \_\_\_\_\_  
Please sign name