EMS Agency Name: _____ Agency No. _____

Date of Inspection: _____ Approved Yes No

Follow Up Yes No

Rep Sign: _____

Virginia

OFFICE OF EMERGENCY MEDICAL SERVICES

Virginia Department of Health

www.vdh.virginia.gov/oems

1041 Technology Park Drive
Glen Allen, VA 23059-4500
(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 PROGRAM REPRESENTATIVE.

PLEASE COMPLETE ENTIRE APPLICATION

Agency Name: _____ FIN # _____

Agency Number: _____ NPI # _____

Physical location of agency and directions from major route:

Number of stations: _____ (Please use station list page at the end of this application)

Mailing Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Shipping Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Business Phone: _____ Fax: _____

Agency FIPS #: _____ Agency Web Site: _____

Type of Application: _____

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

Organizational Status: _____ Description: _____

Organizational Type: _____ If Other describe: _____

Classification:

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

Does agency utilize career EMS Personnel?

If so, who are they employed by:

Types and # of personnel:

_____ First Responder/Medical Responder		_____ Paramedic	
_____ EMT		_____ Driver Only (EVOC)	
_____ A-EMT/EMT–Enhanced		_____ Support Personnel	
_____ Intermediate		_____ MD	_____ RN

Hours of Operation: 24 Hours Other _____

Month/Year Agency Established: _____ _____

Month/Year Agency Began EMS Operations: _____ _____

Agency is a member of:

- Virginia Association of Volunteer Rescue Squads
- Virginia Ambulance Association
- Virginia Governmental EMS Administrators
- Other _____

EMS TRANSPORTS:

Total # of 911 calls/calendar year: _____ EMS dispatch volume/calendar year: _____

EMS Transport volume/calendar year: _____ EMS contact volume/calendar year: _____

Total service area (square miles): _____ Total service area population: _____

Are agency vehicles used by any other licensed agency? _____

If yes, total number of calls other agencies utilize vehicles permitted to you EMS agency? _____

EXTRICATION EQUIPMENT:

Is required equipment supplied by applicant agency? _____

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)

VEHICLE INSURER:

_____ _____ _____

(Underwriter) (Policy Number) (Expiration Date)

# of defibrillators: _____ Manual _____ Automated _____ Combination

AGENCY OFFICIAL REPRESENTATIVE(S) OR OWNER(S)

Chief Executive Officer:

Name: _____ _____ _____ Title: _____

(Last Name) (First Name) (Middle Name)

Mailing Address: _____

(Street Address)

_____

(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____ SSN: _____

EMS Certification # (if applicable):_____

Chief Operations Officer:

Name: _____ _____ _____ Title: _____

(Last Name) (First Name) (Middle Name)

Mailing Address: _____

(Street Address)

_____

(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____ SSN: _____

EMS Certification # (if applicable):_____

AGENCY PORTAL SUPERUSER:

Name: _____ _____ _____ Title: _____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____ EMS Certification #:_____

AGENCY DESIGNATED INFECTION CONTROL OFFICER:

Name: _____ _____ _____ Title: _____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____ EMS Certification #:_____

TRAINING OFFICER:

Name: _____ _____ _____ Title: _____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____ EMS Certification #:_____

OPERATIONAL MEDICAL DIRECTORS:

	NAME	PRIMARY/SECONDARY
1.	_____	_____
2.	_____	_____
3.	_____	_____

COMMUNICATIONS:

Dispatch facilities: Agency Central Dispatch (Specify) _____
Other (Specify) _____

Dispatch business telephone number: _____

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: _____

Number of radios: Mobile _____ Portable _____ Paging _____

Emergency telephone number: 911 Other _____

Emergency telephone number listed for public: _____

Does dispatch prioritize or provide pre-arrival instructions? _____

FCC license holder: Agency Local Government Other _____

If local government or other, written permission for use?: _____
FCC license expiration date: _____ Call Sign: _____ Narrowband Compliant: _____
Permission for Office of EMS to operate on frequencies: _____

AGENCY BILLING:

Does agency bill for service? _____
If yes, what year did agency begin billing? _____
Who is responsible for billing? _____ Specify Vendor: _____
Does agency have a billing Subscription Service? _____

VACCINE ADMINISTRATION PROGRAM: (Only if EMS Personnel administer vaccines)

Do you have a vaccination program? _____ If Yes: _____
List Virginia Immunization Information System (VIIS) number: _____

PROGRAM ADMINISTRATION:

Authorized Prescriber: _____

Name: _____ _____ _____ Title: _____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Daytime Phone Number: _____ Evening Phone Number: _____

E-mail Address: _____

AGENCY REPRESENTATIVE/OWNER SIGNATURE:

Name:_____ Date: _____

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)

AGENCY OPERATIONAL MEDICAL DIRECTOR SIGNATURE:

Name:_____ Date: _____

I hereby affirm that I am the primary Operational Medical Director for the above listed agency and have signed a current list of authorized provider form/roster as outlined in §12VAC5-31-1040.

_____ Date: _____
(Please sign name)

(DERA ONLY) LOCAL GOVERNMENT SIGNATURE: (County Administrator or City Manager)

Name:_____ Date: _____

I acknowledge the above listed agency is compliant with the local emergency response plan

_____ Date: _____
(Please sign name)

Agency Station List

Include station number, physical address, telephone number