LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Initial License Application

☐ *INITIAL* ☐ *CHOW/CHOI* ☐ *OTHER* (Specify) _____

TOTAL FEE AMOUNT INCLUDED _____ *COMPANY CHECK / MONEY ORDER #* _____

☐ **check if any change has occurred since last application** **STATE ID #MT___ ___ ___ ___ ___ ___ ___**

I. ***FACILITY (DBA) NAME*** _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____ ***EMERGENCY PHONE NUMBER (____)*** _____

TELEPHONE NUMBER (____) _____ ***FAX NUMBER (____)*** _____ ***EMAIL ADDRESS*** _____

II. MAILING ADDRESS ***(IF DIFFERENT FROM ABOVE)*** _____

CITY / STATE / ZIP _____

III. DIRECTOR OF OPERATIONS _____ **MEDICAL DIRECTOR** _____

MEDICAL DIRECTOR'S:
ADDRESS _____ **PHONE NUMBER** _____

IV. TYPE OF FACILITY: ☐ ***GROUND EMS*** ☐ ***AIR EMS*** ***(*must complete separate application for each)***

V. DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST INFORMATION:

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *STATE*
☐ *CORPORATION*	☐ *CORPORATION*	☐ *PARISH*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *CITY/PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *LLC*	☐ *CITY*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify):* _____	☐ *HOSPITAL DISTRICT*
☐ *VOLUNTEER*		☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):* _____		☐ *OTHER (Specify)* _____

IF THE DISCLOSING ENTITY IS A CORPORATION, LIST NAMES, ADDRESSES, AND PHONE NUMBERS OF THE DIRECTORS:

DIRECTOR'S NAME	ADDRESS	TELEPHONE #

VI. ***ENTITY / CORPORATION NAME*** _____ ***EIN#:*** _____

ENTITY MAILING ADDRESS ***(IF DIFFERENT)*** _____

CITY / STATE / ZIP _____

ENTITY TELEPHONE NUMBER (____) _____ ***ENTITY FAX NUMBER (____)*** _____

(BEMS-IL revised 07/01/2019)

Bureau of EMS
7273 Florida Blvd., Baton Rouge, Louisiana 70806
Phone #: 225/925-4022 • Fax #: 225/925-7244 • *http://EMS.LDH.LA.GOV*

EMERGENCY MEDICAL SERVICES LICENSE APPLICATION

VII. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER	ADDRESS	TELEPHONE #

VIII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	*ADDRESS*	*TELEPHONE NUMBER*

IX. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ ***Yes*** ☐ ***No***
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.

NAME	*ADDRESS*	*PROVIDER NUMBER*

X. Has there been a change of ownership or control within the last year? ☐ ***Yes*** ☐ ***No*** ***If yes, give date:*** _____

XI. List the Parishes served: _____
_____

XII. ALL APPLICANTS MUST SUBMIT THE FOLLOWING ATTACHMENTS WITH THIS LICENSE APPLICATION:

1. *Service area description to include map.*
2. *List of all ambulance stations - include complete geographical address including zip code (attachment 1).*
3. *List of all drivers and certified or licensed personnel (EMT, RN/LPN), including registration or license number (attachment 2A and 2B).*
4. *A list of any first responder drivers to include their social security and drivers' license numbers (attachment 3).*
5. *List of all vehicles: Ambulances and Sprint Vehicles include VIN, make, year model, type, GVW, license plate number, unit (fender) number (attachments 4A and 4B).*
6. *Certificates of Insurance: Medical Malpractice, Automobile Liability, General Liability. We do <u>not</u> accept Louisiana Automobile Insurance Identification Cards.*
7. *A copy of their current medical protocols with the document signed by the medical director accompanied by a cover letter from the appropriate parish or component medical society or societies for use in their service area. An electron copy may be submitted.*
8. *A copy of the agency's current equipment and supply checklist.*
9. *A copy of their standard operating procedures. An electronic copy may be submitted.*
10. *Attach a copy of your current CLIA Waiver certificate, Louisiana CDS license, and United States Drug Enforcement Administration Controlled Substance registration.*
11. *Attach copies of all pertinent municipal and parish licenses and permits including Certificates of Need if they apply.*
12. *Attach a copy of the Articles of Incorporation.*
13. *Attach a copy of the Act of Sale or other Act of Transfer.*
14. *Payment of license fee of $150.00 plus $75.00 per vehicle (ambulance, sprint, or aircraft).*
15. *Copy of the applicant's criminal background check from the Louisiana State Police, and proof of United States or legal resident alien status from the United States Department of Homeland Security.*
16. *For air ambulance services only: FAA Part 135 Certificate, FAA Aircraft Certificate of Registration*, FAA Certificate of Airworthiness*, FAA pilot's license (for each pilot) (*denotes that one is required for each aircraft)*

XIII. Do you utilize 911 in your area for receiving calls? _____
List your authorized radio frequencies: _____

<u>ATTESTATION:</u> I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Louisiana Department of Health, Office of Public Health, Bureau of EMS in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health.

_____
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE ***DATE***