APPLICATION FOR AMBULANCE SERVICE AREA FRANCHISE

PLEASE CHECK, TYPE OR. PRINT THE APPROPRIATE RESPONSES.

Be sure to complete all items. Mail or hand deliver the completed application to: Marion County Health Department, 3180 Center St NE, Salem, OR 97301, Attn. Marion County ASA Administrator.

Application must be received by September 5, 2023 @ 5:00 PM**.**

I. Ambulance Service Area You Are Applying to Serve:

II. Ambulance Service Information

Ambulance Service Name: _____

Other Business Names: _____

Parent Company / Owner _____

Mailing Address: _____

_____

Type of Agency (Check one): ☐ Fire Dept/Dist. ☐ Municipal ☐ Hospital ☐ Private ☐ Other

Type of Ownership (Check one): ☐ Government ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Special District ☐ Other

Type of Service Provided (Check all that apply): ☐ Ground ☐ Marine ☐ Air

Medicare Provider Number:

Medicaid Provider Number:

III. Contact Information for Official Communications with Marion County

Name:

Address (If different form above):

Non-Emergency Phone and Fax

Email:

IV. Staffing

Type of Personnel Used (Check all that apply):

☐ EMR	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ EMT	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Advanced EMT	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Oregon Intermediate	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Paramedic	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Registered Nurse	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Physician Assistant	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Physician	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Non-EMT Driver	☐ Paid full-time	☐ Paid part-time	☐ Volunteer
☐ Pilot	☐ Paid full-time	☐ Paid part-time	☐ Volunteer

Level of Service Provided (Check all that apply):

☐ Basic Level of Care: -Personnel and equipment provided 24 hours-a-day.

☐ Basic Level of Care: -Personnel and equipment provided only part of a 24 hour day.

☐ Intermediate Level of Care: -Personnel and equipment provided 24 hours-a-day,

☐ Intermediate Level of Care: -Personnel and equipment provided only part of a 24 hour day.

☐ Advanced Level of Care: -Personnel and equipment provided 24 hours-a-day.

☐ Advanced Level of Care: -Personnel and equipment provided only part of a 24 hour day.

EMS Training Director's Name:

EMS Training Director's Email:

V. Medical

Medical Director Information:

Medical Director's Name:

Medical Director's Email:

Signed Standing Orders: (Standing orders must have been signed within the past twelve months.)

☐ Signed standing orders for EMRs . Date signed:

☐ Signed standing orders for EMTs Date signed:

☐ Signed standing orders for Advanced EMTs. Date signed:

☐ Signed standing orders for Oregon Intermediates Date signed:

☐ Signed standing orders for Paramedics Date signed:

☐ Our medical director has authorized the purchase and use of controlled substances.
If checked, you must have a DEA license containing the name of your medical director and the name and address if your ambulance service.

Our DEA license has an expiration date of:

☐ Our medical director has authorized the use of blood glucose monitoring devised to determine blood glucose levels. If checked, you must have a CLIA Laboratory Certificate of Waiver.

CLIA Number:

Expiration Date:

VI. Proof of financial responsibility

Proof of general liability/umbrella insurance in the amount of not less than $1,500,000 per occurrence and Auto insurance in the amount of not less than $1,500,000 per accident and in the form of a certificate of insurance or letter from the carrier. Applicants may be self-insured. Attach a copy of current certificate of insurance or self insurance.

Ground Ambulance Liability:

Name of Insurance Company

Expiration Date:

Air Ambulance Liability:

Name of Insurance Company

Expiration Date:

Personnel Liability:

Name of Insurance Company:

Expiration Date:

VII. Briefly describe how you will provide /ensure 24/7 ALS ambulance service for your Ambulance Service Area. List and explain any subcontracts you have or anticipate having as part of your services. Describe your general approach to deployment and location of personnel and equipment as well as plans for surge capacity. (Use additional sheets if needed.)

VIII. Attach a staff roster including names, EMT level, certificate number, and expiration date.

IX. Attach a vehicle roster for all state ambulances. Include ambulance type and year.

STATEMENT OF TRUTH OF APPLICATION

_____, being first duly sworn, depose and that I am an authorized agent of the entity that owns and operates the ambulance service described in this application

I certify that there has been no attempt to knowingly and willfully falsify, conceal, or omit a material fact, or make any false, fictitious, incomplete or fraudulent statements or representations, or make or use any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry for the purpose of obtaining or attempting to obtain an ambulance service area franchise in the State of Oregon. Where I have relied upon documents submitted by employees/volunteers, 1 have made a reasonable effort to verify the validity of those documents.

Upon receiving an ambulance service area franchise from Marion County, I authorize disclosure of information by health care facilities, including but not limited to hospitals, nursing homes, or free standing medical centers, to the County relating to service provided by the ambulance service to those facilities or to patients being taken from or to those facilities.

I have carefully read the application and answered the appropriate questions completely and without reservations, of any kind, and I declare under penalty of perjury that my answers, all statements made and documents provided by me herein are true and correct. Should I furnish any false information in this application. I hereby agree that such act shall constitute cause for the denial, suspension or revocation of this ambulance service area franchise to operate in the State of Oregon.

_____

(Authorized Agent to sign in presence of Notary Public)

Subscribed and sworn to before me this_____ day of , 20 Notary Public

Notary Public for My Commission Expires

Seal

(Notary Signature)

Mail or hand deliver the completed application and all requested documents to the:

Attn: Marion County ASA Administrator

Marion County Health Department 3180
Center St. NE Salem OR 97301