



Expiration Date: _____

Check #/Amount: _____

**MAINE EMS SERVICE LICENSE
APPLICATION FOR RENEWAL**

Section I – Service Information

- A. Service Name: _____ Service #: _____
Mailing Address: _____ Shipping Address: _____
(Must be a physical address, not a PO Box)
City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____
- B. Business Telephone #: _____ Fax #: _____
- C. Federal Tax ID# (EIN): _____ E-Mail Address: _____
- D. Physical address of ambulances licensed under this service
 - 1. Street: _____ City: _____ State: ____ Zip: _____
Telephone #: _____ Fax #: _____
 - 2. Street: _____ City: _____ State: ____ Zip: _____
Telephone #: _____ Fax #: _____
 - 3. Street: _____ City: _____ State: ____ Zip: _____
Telephone #: _____ Fax #: _____
 - 4. Street: _____ City: _____ State: ____ Zip: _____
Telephone #: _____ Fax #: _____
- E. Organizational Type: ____ Community, Non-Profit ____ Fire Department ____ Governmental, Non-Fire ____ Hospital
____ Private, Non Hospital ____ Tribal

Section II – Authorized Service Representatives (ASR) and Designated Infection Control Officers (DICO)

List the names and telephone numbers of the Director/Chief, Assistant Director/Chief, other authorized service representatives, and the DICO and Alternate DICO for the service (Note: this list will supersede all previous lists).

- 1. Director/Chief: _____ Telephone # - (Day): _____ (Night): _____
- 2. Ass't Director/Chief: _____ Telephone# - (Day): _____ (Night): _____
- 3. Alternate ASR: _____ Telephone# - (Day): _____ (Night): _____
- 4. Alternate ASR: _____ Telephone# - (Day): _____ (Night): _____
- 5. DICO: _____ Telephone# - (Day): _____ (Night): _____
- 6. Alt. DICO: _____ Telephone# - (Day): _____ (Night): _____

Section III – License Level – Please indicate the service’s current license level.

____ First Responder ____ EMT-Basic ____ EMT-Intermediate* ____ EMT-Critical Care* ____ Paramedic*

Section IV – Service Permit Level – Please indicate the service’s current permit level.

____ EMT-Basic ____ EMT-Intermediate* ____ EMT-Critical Care* ____ Paramedic*

** If there have been **changes** to your agreement with a hospital pharmacy (or other Maine EMS approved pharmacy), please attach a copy of the agreement to this application. If your service is licensed or permitted at the EMT-I level and this is the first time a renewal application has been submitted since the service first began carrying Intermediate level drugs, please attach a copy of your service’s agreement with a hospital pharmacy (or other Maine EMS approved pharmacy).*

Section V - Quality Assurance/Quality Improvement Committee – Please list the names of your QA/QI Committee.
If your QA/QI program has changed, attach a copy of your service’s updated program.

Section VI – Communications – Please list the following agencies and their telephone numbers:

Public Safety Answering Point (9-1-1 Center): _____ PSAP Business Tel #: _____
 Dispatch Agency: _____ Dispatch Business Tel #: _____

Section VII – Vehicle Information

A. List, below, the vehicle(s) for which the service requests ambulance vehicle licensure (attach extra sheets as necessary):

Year	Chassis Mfg	Amb Mfg	VIN# (Last 5 numbers/letters)	Type	Radio Call Sign	DMV Registration #	Maine EMS#

B. List, below, the Emergency Medical Services Vehicle(s) (EMSV) for which the service has received Maine EMS authorization.
Do not list vehicles in this section that are licensed as ambulances or fire service vehicles.

Year	Chassis Mfg	VIN #(Last 5 numbers/letters)	Radio Call Sign	DMV Registration #	Maine EMS #

Section VIII – Endorsements

A. Transporting Service Endorsement for Non Transporting Services

I certify that the below named ambulance service has a letter of understanding or other written agreement in effect with the applicant which provides for the simultaneous dispatch, and transport of patients, as required in Chapter 3 § 4.1.C.5 of the Maine EMS Rules.

Name of Transporting Service: _____ Service #: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

B. Service Representative Endorsement

I hereby certify: that the foregoing statements are correct and true to the best of my knowledge ; that the service is eligible for licensure/authorization in accordance with the Maine EMS Rules and EMS Law (32 M.R.S.A. § 81 *et seq*); the service possesses the required equipment as set forth in the Maine EMS Rules; and, that the personnel providing medical care on behalf of the service possess current and valid Maine EMS licenses. The service requesting licensure understands that the Maine EMS systems Quality Assurance /Quality Improvement (QA/QI) process is an integral part of being a licensed Maine EMS service and agrees to participate in the Maine EMS QA/QI system in accordance with criteria approved and published by the Board, and further agrees that QA/QI information pertaining to the service may be shared amongst recognized participants within the Maine EMS QA/QI system. I request that the Maine EMS Board approve any changes indicated regarding the Service’s Quality Assurance/Quality Improvement Committee (in accordance with 32 M.R.S.A. § 92-A *et seq*). I understand that making a false statement that I do not believe to be true on this application or knowingly creating or attempting to create a false impression by omitting information necessary to prevent this application from being misleading constitutes a criminal offense, and may be prosecuted as, among other offenses, unsworn falsification pursuant to 17-A M.R.S.A. § 453 (Class D) and may also result in disciplinary action against the service’s license by Maine EMS.

Print Name: _____ Signature: _____ Date: _____

FEE SCHEDULE

Service Fee - \$100.00 per Licensed Base per year
Ambulance and EMS Vehicle Fee - \$60.00 per vehicle per year
Make checks payable to: Treasurer of State

Mail the completed application and fees to Maine EMS 152 State House Station Augusta, Maine 04333.
Please call Maine EMS at 207-626-3860 if you have questions.