MAINE EMS
SERVICE LICENSE APPLICATION

For what license are you applying (check all that apply)?

☐ 1. New Service License (Complete all sections of this application)
☐ 2. Upgrade in License Level (Complete sections I, II, III, IV, VII, X, XI)
☐ 3. Downgrade in License Level (Complete sections I, II, III, IV, VII, X, XI)
☐ 4. Change in Permit Level (Complete sections I, II, III, IV, V, VII, X, XI)
☐ 5. Change in Primary Service Area (Complete sections I, III, IV, V, VI, XI)
☐ 6. Change in Secondary Service Area (Complete sections I, III, IV, V, VI, XI)
☐ 7. Change in Service Name (Complete sections I, III, IV, V, XI)
☐ 8. Change in Base Location (Complete sections I, III, IV, V, VI, VIII, XI)

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

Note: If you checked boxes a or e above, you must attach 4 character references in accordance with Chapter 3 §5.1.C.4.

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 - Service Type - For what type of service license are you applying?

_____ 9-1-1 Response (Scene) with Transport Capability   _____ 9-1-1 Response (Scene) without Transport Capability

_____ Scene Response Air Ambulance   _____ Transfer Air Ambulance Service   _____ Restricted Response Air Ambulance Service (RRAAS)

Section IV - License Level

Please indicate the license level at which the service can provide at least one EMS provider, licensed at the level of the service, on all emergency medical calls. This is the license level you may advertise.
(Note: Transporting Ambulance Services may not license at the first responder level).

_____ First Responder   _____ EMT-Basic   _____ EMT-Intermediate   _____ EMT-Critical Care   _____ Paramedic

Note: If applying for licensure at the EMT-Critical Care or Paramedic level, a copy of the service's agreement with a hospital pharmacy (or other Maine EMS approved pharmacy) must be attached to this application. A pharmacy agreement must also be attached if the application is for EMT-Intermediate and the service will be using EMT-Intermediate medications.

Section V - Service Permit Level

Please indicate the level of care to which the service requests authorization to provide on a part time basis. This is the permit level of the service, and may not be advertised to the public.

_____ EMT-Basic   _____ EMT-Intermediate   _____ EMT-Critical Care   _____ Paramedic

Note: If applying for permit at the EMT-Intermediate, EMT-Critical Care or Paramedic level, a copy of the service's agreement with a hospital pharmacy for the dispensation of drugs must be attached to this application. A pharmacy agreement must also be attached if the application is for EMT-Intermediate and the service will be using EMT-Intermediate medications.

Section VI - Service Area

A. Primary Response Area - List, by city or town, the service's Primary Response Area. A Primary Response Area is defined as the area(s) to which a service is made routinely available when called by the public to respond to medical emergencies.

______________________   ____________________________   ________________________

______________________   ____________________________   ________________________

B. Secondary Response Area - List, by city or town, the service's Secondary Response Area. A Secondary Response Area is defined as the area(s) to which the service is routinely made available when called by other Maine EMS licensed services or health care facilities, as a specialty or mutual aid responder for medical emergencies.

______________________   ____________________________   ________________________

______________________   ____________________________   ________________________

Section VII - Quality Assurance/Quality Improvement Committee

List, name and position (e.g. Service Director, Paramedic, EMT), the members of your service's Quality Assurance/Quality Improvement Committee, and attach a copy of your services quality improvement program

______________________   ____________________________   ________________________

______________________   ____________________________   ________________________

Section VIII - Communications

A. Describe the method for public access to the service; the name of the dispatch center; explanation of the dispatch method and procedures; type and quantity of communications equipment to be utilized; and a list of radio frequencies utilized by the service (use additional sheets as necessary): ______________________________

____
____
____
____

B. 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 IX - 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	DMV Registration #	Maine EMS# (Office Use)

B. List, below, the vehicle(s), other than the service's licensed ambulances, for which the service requests Emergency Medical Services Vehicle (EMSV) authorization. EMSV must be owned or leased, and operated, by the Service named in this application.

Year	Chassis Mfg	VIN #(Last 5 numbers/letters)	DMV Registration #	Maine EMS # (Office Use)

Section X - Personnel

Please attach a current list of Maine EMS licensed personnel for your service.
(If the application is for a request to permit only, list only those personnel who are licensed at the proposed permit level.)

Section XI - 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 §5.1.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 and belief; 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); that 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. Further, I request that the Maine EMS Board approve the Service's Quality Assurance/Quality Improvement Committee in accordance with 32 M.R.S.A. §92-A et seq.

Print Name: ________________________________ Signature: ___________________________________ Date: ___________

Fee Schedule

Service Fee....................................$100.00 per year
Ambulance Vehicle Fee................$60.00 per year
EMS Vehicle Fee...........................$60.00 per year

Payment must be enclosed with the application
Make check payable to: **Treasurer of State**

Have You:

Completed the Application?
Attached All Required Documentation?
Obtained Required Signatures?
Enclosed the Correct Payment?

Mail your application package to:
Maine EMS, 152 State House Station, Augusta, ME 04333-0152
207-626-3860