



Application for

**Certificate of Public Convenience and Necessity
Advanced Life Support, Transport**

SECTION 1: TYPE OF APPLICATION

COPCN TYPE		DATE OF APPLICATION
<input type="checkbox"/> New	<input type="checkbox"/> Modification	

SECTION 2: APPLICANT INFORMATION

AGENCY NAME		
AGENCY TRADE NAME OR ALIAS		
ORGANIZATION TYPE		
PHYSICAL ADDRESS		
CITY	STATE	ZIP CODE
COUNTY	BUSINESS TELEPHONE	BUSINESS FAX
PRIMARY CONTACT FOR AGENCY BUSINESS		TITLE
TELEPHONE	E-MAIL	

SECTION 3: OFFICERS, DIRECTORS AND ELECTED MEMBERS

PROVIDE A LIST OF ALL OFFICERS, DIRECTORS, SHAREHOLDERS AND COUNCIL OR COMMISSION MEMBERS. INCLUDE EACH INDIVIDUAL'S ADDRESS AND POSITION.

1.
2.
3.
4.
5.
6.

Additional OFFICERS, DIRECTOR AND ELECTED MEMBERS information on **ATTACHMENT 1**

SECTION 4: OPERATIONAL FACILITIES

PHYSICAL ADDRESS (STREET ADDRESS AND CITY) OF PRIMARY ADMINISTRATIVE FACILITY.
ADDRESS (STREET ADDRESS AND CITY) FOR PUBLIC ACCESS DURING BUSINESS HOURS.

SECTION 4: OPERATIONAL FACILITIES, continued

PHYSICAL ADDRESS (STATION IDENTIFIER, STREET ADDRESS AND CITY) OF ALL SATELLITE OR SUBSTATIONS.

Additional *facility* information on **ATTACHMENT 2**

SECTION 5: SERVICE AREA

PROVIDE A DETAILED DESCRIPTION OF GEOGRAPHIC AREA TO BE COVERED BY YOUR SERVICE.

Additional *service area* information on **ATTACHMENT 3**

SECTION 6: OPERATIONS

PERSONNEL

Number of Emergency Medical Technicians (EMTs) under the requested COPCN.

Number of Paramedics under the requested COPCN.

ROLLING STOCK/VEHICLES AND EQUIPMENT.

Number of basic life support (BLS) vehicles under the requested COPCN.

Number of advanced life support (ALS) vehicles under the requested COPCN.

Attach inventory¹ of all vehicles as **ATTACHMENT 4.**

SECTION 7: EXPERIENCE

1. Number of emergency medical responses during the preceding twelve months.
2. Number of patients that received care during the preceding twelve months.
3. Number of patients that received advanced life support care during the preceding twelve months.
4. Average or fractile response times for all emergency medical responses within preceding twelve months.
5. Number of emergency medical responses outside of the applicant's primary jurisdiction at the request of another emergency medical service provider within preceding twelve months.
6. A written analysis and evaluation of the activity level of the proposed service, including an evaluation of the unit hour utilization (UHU) of ambulances to be operated under the terms of the certificate. ATTACHMENT 5

¹ Rolling stock inventory must include: make; model; year of manufacture; VIN; vehicle type; tag number; mileage and current Florida Department of Health permit number.

SECTION 8: REQUIRED ATTACHMENTS

1. Schedule of the applicants intended fees and the length of time they will remain in effect. ATTACHMENT 6
2. Copy of the Florida Department of Health Advanced Life Support license, if this application is being submitted as a renewal. ATTACHMENT 7
3. Notarized statement or copy of a contract indicating that the applicant will utilize emergency medical dispatch (EMD) services for the duration of the COPCN. ATTACHMENT 8
4. A proposed and detailed budget, if public funds will be needed for the operation. ATTACHMENT 9
5. Notarized statement that the applicant agrees to utilize the services of the Volusia County EMS Medical Director for the duration of the COPCN. ATTACHMENT 10
6. Notarized statement that the applicant is in compliance with all applicable federal, state and local requirements, protocols, policies and directives. ATTACHMENT 11
7. Evidence of adequate insurance coverage for claims arising out of injury to or death of persons and damage to the property of others resulting from any cause for which the owner of such business or service would be liable in such sums and under such terms as required by the Florida Department of Health, Bureau of EMS. In lieu of such insurance, the applicant may furnish a certificate of self-insurance evidencing that the applicant has established an adequate self-insurance plan to cover such risks and that the plan has been approved by the department of insurance. ATTACHMENT 12

I, the undersigned representative of the aforementioned service, do hereby certify that the proposed service meets all applicable federal, state and local requirements for the requested Advanced Life Support (ALS) transport certificate. I further certify that the proposed service is, or will be in compliance with all local requirements, protocols, policies and directives and that the proposed service will continue such compliance for the duration of the certificate.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE
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STATE OF FLORIDA
COUNTY OF VOLUSIA

Before me, the undersigned authority, _____,
NAME

personally appeared as _____, who is personally
TITLE

known to me, who, after being duly sworn, did thereupon say that the information and statements contained in the foregoing instrument are true and correct to the best of his/her knowledge, information and belief.

NOTARY PUBLIC STATE OF FLORIDA AT LARGE	MY COMMISSION EXPIRES (AFIX SEAL)
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