Treasurer's Stamp

CITY OF SPRINGFIELD
AMBULANCE OPERATOR PERMIT APPLICATION

PLEASE NOTE: THIS PERMIT MUST BE APPLIED FOR BY DECEMBER 15th THE YEAR PRIOR

Section I: Applicant Information ***Treasurer's Code: AOP***

Name of Ambulance Company: _____

Owner of Ambulance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Illinois Department of Public Health Agency License Number: _____ Expiration Date: _____

Location(s) of Ambulance Operations: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Location(s) of Ambulance Operations: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Section II: Ambulance Operator Information

DBA or Company Name: _____ EMS Resource Hospital: _____

Number of BLS Transport Ambulances: _____ Number of ALS Transport Ambulances: _____

Number of Non-Transport Units and Care Level: _____

Section III: Required Attachments

- ☐ **Ambulance Operator Licenses:** provide copies of all licenses/certifications required by the state of Illinois to operate an ambulance service.
- ☐ **Employee Licenses:** provide records showing employees are properly licensed by the state of Illinois.
- ☐ **Proof of Insurance:** provide proof of insurance with the City of Springfield named as an additional insured.
- ☐ **Ambulance Description:** provide a listing of each transport and non-transport unit to include: Make; Model; Year of Manufacture; Motor and Chassis Number; Current IDOT License Number; Length of Time Ambulance has been in service; Color Scheme; Insignia; Name, Monogram, or Other Distinguishing Features.
- ☐ **Employee Certifications:** provide certificates for all personnel of required NIMS and HazMat Awareness Training.
- ☐ **Ambulance Transport Rates:** provide current rates and fees for all services provided.

Section VI: Legal Affidavit

The undersigned certifies that there are no willful misrepresentations, omissions or false statements made by me in this application and all of my answers are true and correct to the best of my knowledge. I understand that this application is to provide transport ambulance services to the city of Springfield and that the above ambulance transport company is in compliance with applicable OSHA rules and regulations. I understand that knowingly providing false statements, misrepresentations or omissions will result in denial of the application for a permit.

The undersigned, being duly sworn, hereby attest, under the penalty of perjury that I have paid all taxes or other debts owed to the City of Springfield. I understand that the Springfield Fire Department shall refuse to issue the underlying license or shall deny approval of this background check until such time as all taxes and outstanding debts are paid. The Springfield Fire Department shall be authorized to suspend or revoke any license if I fail to pay any tax or other debt owed to the City of Springfield to date.

Applicant Signature: _____ Date: _____

Section V: Notary Signature

Subscribed and sworn before me on this: _____ Day of, _____ _____

(date) (month) (year)

(seal) _____

(Notary Signature)

For Springfield Fire Department Division of Fire Operations Use Only

Approve ☐ Deny ☐

If Denied: _____

_____

_____

Permit Inspection Date: _____ Inspection Done By: _____

Final Review Date: _____ Review Done By: _____

Notes: _____

_____

_____

_____

Fire Chief: _____

For City of Springfield Use

Fee: $1500.00

Treasurer's Code:

Treasurer's Office

Approve ☐ Deny ☐ If Denied: _____

Approved by: _____ Date: _____

Permit Issued by the Clerk? Yes ☐ No ☐

City Clerk: _____ Date: _____