NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Application for EMS Operating Certificate

Current Expiration Date ____/____/____ ☐ Ambulance Service ☐ ALS First Response Service (non-transporting)

Name of Service | Federal Employer ID No. | NYS EMS Agency Code

Physical Address of Principal Business Location Street and Number

City, Town, Village | State | Zip Code | County

Mailing Address (PO Box)

Business Phone Number ( ) - | Fax Number ( ) - | 911 Center 10 Digit Phone Number ( ) -

Agency E-mail Address | Agency Website

Organizational Structure (check only one)

☐ Commercial ☐ Hospital Based ☐ Independent ☐ Industrial
☐ Fire Department ☐ Municipal/Government ☐ College (State or Private Campus/University)

Type of Ownership

☐ Individual ☐ Corporation (☐ for profit ☐ not for profit) ☐ Municipal Fire ☐ Ambulance District
☐ Partnership ☐ Municipal (☐ village ☐ town ☐ city ☐ county) ☐ Government (☐ State ☐ Federal)

Name of Individual Owner, Partners or Government/Municipal entity

If a corporation, give official corporate name. Also indicate all DBAs on file with NYS Department of State. Attach separate list if more than one DBA on file. (initial applications must provide certified copies of all DOS filings both corporation and DBA)

Corporation Name

DBA/Assumed Name

For Profit and Not for Profit Corporations must provide names/addresses of current corporation officers

	Name	Home Address	Home Phone
President			( ) -
Vice President			( ) -
Secretary			( ) -
Treasurer			( ) -

Chief Operating Officer (Captain, Operations Manager)

Name | Title | Day Phone ( ) - | Night Phone ( ) -

Tax District

Is this organization funded by a tax district? ☐ Yes ☐ No Name of District

Name of Operator (if different from owner) | Business Phone ( ) -

Address | City | State | Zip

Highest Level of Care Currently Authorized by REMAC (check only one) ☐ EMT ☐ AEMT ☐ Critical Care ☐ Paramedic

Agency Participates in CME Program ☐ Yes ☐ No

Billing for Service ☐ Yes ☐ No

If yes , Name of Service Bureau | Service Bureau Number (if not agency) | Medicaid Number

Service Physician Medical Director (please list all others on separate sheet)

Address | Phone ( ) - | NYS Physician License Number

List the address of each location where any certified EMS response vehicle is garaged if not the same as your principal location.
Provide list if more than 3

Location 1 | Number of vehicles assigned

Location 2 | Number of vehicles assigned

Location 3 | Number of vehicles assigned

Total Number of Vehicles operated by certificate holder

Ambulances _____ EASV's (ambulance service only)_____ First Response (ALSFR) _____

Description of operating territory boundaries etc.:

Total Employees/Members: _____ Number Volunteer _____ Number Paid (on payroll) _____

Provide number of individuals currently certified at each level

CFR _____ EMT _____ AEMT _____ Critical Care _____ Paramedic _____

Communications/Dispatch Information

Principal Dispatch Method: ☐ Two-way ☐ Cellular Phone ☐ Pager ☐ Other

Frequency on which you are dispatched _____ MHz

Agency that dispatches your service _____ ☐ Local 911/PSAP ☐ Self

Identify radio systems for hospital calling/medical direction ☐ VHF ☐ UHF ☐ Cellular ☐ Other _____

UHF MED 1-8 capacity ☐ Yes ☐ No Do your vehicles have Cellular Phones ☐ Yes ☐ No

155.340 capability ☐ Yes ☐ No Call sign if service has FCC License _____

Attachments Required

- Affirmation of Compliance (DOH-1881, Affirmation Side 1 MUST BE NOTARIZED)
- List of all vehicle operated by the service (DOH-1881 Affirmation side 2)
- List of all agency personnel –Use DOH-2828
- List of all owners with 10% of more share of ownership
- Map of current operating territory

Agency Certification

I have received and read and understand the contents of the following documents and will comply with all requirements:

- Article 30/30A, NYS Public Health Law
- Part 800, 10NYCRR, State EMS Code
- Applicable DOH EMS Policy Statements and SEMAC Advisories

In addition, I certify that all the information contained in this application is true and correct, and that neither the corporation nor any of the owners, principals, or stockholders have been convicted of Medicaid or Medicare fraud, and I understand that under Section 3012(a) or PHL Article 30 that the ambulance service or ALSFR service certificate for this agency may be revoked, suspended, limited or annulled if this application includes willful misrepresentation.

Name of Owner, CEO or COO | Title

Signature | Date

Notary Public affirmation and acknowledgement

For DOH Use Only

Date Application Received _____

New Expiration Date _____

BEMS review and approval

_____

Date _____

ADDENDUM TO DOH-206 FORM

Please use this form to list additional Corporate Officers not listed on DOH-206 Form.
See General Instructions for Renewal Form Completion.

Officer Title and Name	Home Address	Home Phone Number