# MULTI-COUNTY AMBULANCE LICENSING INSPECTION
# PRE-INSPECTION CHECKLIST

Prior to inspection, the following items must be completed and returned to each county representative no less than 30 days before the date of license expiration. ***NOTE: Original Documentation is REQUIRED:***

_____ 1. **Application** for Ambulance Service License. Applicant and Medical Director signatures must be notarized.

_____2. **Name & address** of each stockholder or partner owning 10% or more of the outstanding stock of the company, or having more than 10% ownership interest (if applicable).

_____3. **Certificate of Motor Vehicle Condition Form** (completed for each vehicle and within 60 days of application submission)

**A.** In order to assure patient and crew safety, all ambulances must be manufactured by an organization registered with the National Highway Traffic Safety Administration (NHSTA) as a final stage manufacturer. 6CCR 1015-3 3.3.1H

_____4. **Certificate of Insurance** showing the required liability coverage:

**A. Statutory Worker's Compensation Insurance**
Any amount

**B. Public Liability, Property Damage, Bodily Injury**

| | |
|---|---|
| Each person | $ 1,000,000 |
| Each accident | $ 2,000,000 |

**C. Property Damage**

| | |
|---|---|
| Each accident | $ 1,000,000 |

**D. Professional Liability**

| | |
|---|---|
| Each person | $ 1,000,000 |
| Each accident | $ 2,000,000 |

(Do not send the Evidence of Insurance card that is normally kept in the glove box)

_____5. **Drug list** approved by the Medical Director/sponsor for use in the field (**signed and dated** by Medical Director)

_____6. **List of personnel** providing ambulance service (please list all levels of state certified EMT's, the respective expiration dates and for the personnel that are ONLY ambulance drivers, please provide the drivers name and license expiration date only. No driver's license numbers please.)

_____7. **List of current ambulances** including year, make, type, patient capacity for each vehicle

_____8. **List of locations** (central & sub-station), where ambulances will be located. Attach zoning authorization if appropriate.

_____9. **Map of service area**

_____ 10. **Check(s) or money order(s)** for the fees to the appropriate county.

When all of the paperwork and fees are received and approved by the appropriate counties, the Ambulance Inspector will be contacted. The Inspector will contact the ambulance company to schedule the inspection.

**PLEASE ALLOW 10 BUSINESS DAYS FOR APPLICATION REVIEW**

| Adams | Arapahoe | Boulder | Broomfield | Douglas | Elbert | Jefferson |
|---|---|---|---|---|---|---|
| 720.322.1401 | 720.874.3804 | 303.441.3637 | 720.887.2220 | 303.660.7589 | 303.805.6132 | 303.271.8398 |
| **Per unit cost** | **Per unit cost** | **Per unit cost** | **Per unit cost** | **Per unit cost** | **Per unit cost** | **Per unit cost** |
| **$125** | **$125** | **$125** | **$125** | **$125** | **$125** | **$125** |

**Failed, Follow-up or Re-Inspection Fee Per Unit Cost an additional $50**

**DATE APPLICATION RECEIVED AT COUNTY:**_____
**DATE LICENSE EXPIRES:**_____

# MULTI-COUNTY AMBULANCE LICENSE APPLICATION

**PLEASE PRINT**. ORIGINAL DOCUMENTS REQUIRED. APPLICATION MUST BE NOTARIZED IN 2 PLACES.

New Application _____ Renewal Application _____ Date _____

Indicate the **county that the ambulance company is based in & number of units** you wish to license and inspect:

**Adams:** ☐ **Arapahoe:** ☐ **Boulder:** ☐ **Broomfield:** ☐ **Douglas:** ☐ **Elbert:** ☐ **Jefferson:** ☐

**Please attach a check to the application(s).**
**Telephone numbers and fees for each county are listed on the Pre-Inspection Checklist.**

**Company name (Owner/parent Company)**

Check one: Sole Proprietor _____ Partnership _____ Corporation _____ Other _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

**Doing Business As (AKA)** _____

Address _____ City _____ State _____ Zip code _____

Telephone number _____ Fax number _____ E-Mail _____

**Manager or individual responsible for operation of** Name _____

**service:** Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

**Dispatch Center**

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

**Insurance Company** _____

Address _____ City _____ State _____ Zip Code _____

**Insurance Agent** _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

**Attachments required to complete the application:**

- Name and address of each stockholder or partner owning 10% or more of the outstanding stock of the company, or having more than 10% ownership interest (if applicable).
- Certificate of Insurance showing: Bodily Injury (Each person $1,000,000, Each accident $2,000,000)
  - Property Damage (Each accident $1,000,000)
  - Professional Liability (Each person $1,000,000, Each accident $2,000,000)
  - Workman's Compensation (any amount)
- Drug list approved by the Medical Director/sponsor for use in the field (signed and dated by Medical Director)
- Copies of waivers granted by CDPHE for specific skill(s) and/or medication(s)
- Geographic of the service area
- Motor Vehicle Condition form completed for each vehicle
- List of locations (central and sub-station), where ambulances will be located. Attach zoning authorization if appropriate
- List of current personnel providing service (list all levels of state certified EMT's numbers and respective expiration dates, ONLY ambulance drivers Driver's License with the respective expiration dates)
- List of current ambulances (include the year, make, type, maximum capacity for each vehicle)
- Please attach a check to each application

***I hereby certify that the information provided in this application is true and accurate to the best of my knowledge and beliefs, meets the new 6 CCR 1015-3 Rule, and contains no willful misrepresentations or falsification.***

***Determination that an ambulance service license has been issued based on false information constitutes grounds for license revocation and possible criminal prosecution.***

**Applicant's Signature** _____ Date Signed _____

Please **print** the applicant's name _____ Telephone # _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE* _____ *DAY OF* _____ *20___, IN THE COUNTY OF* _____ *STATE OF COLORADO.*

*Signature of Notary* _____ *My Commission Expires* _____

**[SEAL]**

## TO BE COMPLETED BY THE MEDICAL DIRECTOR

**Medical Director** _____ Medical License Number _____

Address _____ City _____ State _____ Zip Code _____

Telephone number _____ Fax number _____ E-Mail _____

**Facility Affiliation** _____

Facility Address _____ City _____ State _____ Zip code _____

Telephone number _____ Fax number _____ E-Mail _____

☐ I have been granted a waiver from CDPHE for specific skill(s) or medication(s). I will provide a copy of all waivers with the application.

The following are licensing requirements of a medical director:

1) Meet the requirements established by the Rules Pertaining to EMS Practice and Medical Director Oversight 6 CCR 1015-3, Chapter 2
2) Registered and Accepted as a Colorado Medical Director as defined in the 6 CCR 1015-3, Chapter 2
3) Provision of a medical continuous quality improvement (CQI) program that meets the newest standards of CCR (must be available to County upon request)
4) Ensure that the ambulance service complete a patient care report for each patient that is assessed
5) Ensure that the ambulance service completes and submits an agency profile
6) Investigate and provide written documentation of the investigation and resolution process of each complaint received from the County (Non-compliance with any of these requirements may result in suspension or revocation of ambulance service license).

**I understand and accept the responsibilities of a Medical Director for** _____ **service.**
**I understand that non-compliance with any of these requirements may result in suspension or revocation of ambulance license.**

**Medical Director's Signature** _____ Date Signed _____

Please **print** Medical Director's name _____ Telephone # _____

*SUBSCRIBED AND AFFIRMED BEFORE ME THIS THE* _____ *DAY OF* _____ *20___, IN THE COUNTY OF* _____ *STATE OF COLORADO.*

*Signature of Notary* _____ *My Commission Expires* _____

**[SEAL]**

# Multi County
# Ambulance Inspection Checklist
# Certificate of Motor Vehicle Condition

**Date of Certification:** _____ **Agency's Fleet Number:** _____

**VIN:** _____ **Vehicle Owner:** _____

**Make:** _____ **Model:** _____ **Year:** _____

**License Plate Number:** _____ **Expiration Date:** _____

## Mechanical Evaluation Check List

| Item | Acceptable | Not Acceptable | Comments |
|---|---|---|---|
| Alignment | | | |
| Back-Up Alarm | | | |
| Body & sheet metal | | | |
| Belts and Hoses | | | |
| Brakes | | | |
| Electrical system | | | |
| Emergency Lights | | | |
| Engine Cooling System | | | |
| Exhaust system | | | |
| Fire Extinguishers (ABC 5-10lbs) (1 exterior/1 interior) secured and up to date | | | |
| Fuel System | | | |
| Glass | | | |
| Hand/Foot Brake | | | |
| Lights | | | |
| Opticom | | | |
| Running Lights | | | |
| Siren | | | |
| Spare Tire | | | |
| Steering | | | |
| Suspension | | | |
| Transmission | | | |
| Vehicle and patient compartment heater and cooling system | | | |
| Wheels & tires | | | |
| Wipers | | | |

**The undersigned, professing to be a motor vehicle mechanic, has of this date evaluated the mechanical condition of the identified ambulance, determined that this vehicle is in safe operating condition, and that the ambulance was manufactured by a National Highway Traffic Safety Administration (NHSTA) registered organization. Said evaluation does NOT warrantee future status of the ambulance due to conditions beyond mechanic's control.**

| Mechanic's Signature | Title | Date |
|---|---|---|
| Company Name | Address | Telephone |