



AMBULANCE PROVIDER PRINTOUT



Oklahoma State
Department of Health

STATE OF OKLAHOMA

Service Name _____

Region: _____

License #: _____

Business Information:

Name: _____

Mailing Address: _____

Physical Address: _____

City: _____

State: _____

Zip Code: _____

County: _____

Business Phone: (____) _____

Emergency Phone: (____) _____

Fax #: (____) _____

Director: _____

Email for Director: _____

Secondary Point of Contact: _____

Email for Secondary Point of Contact: _____

Secondary Phone #: _____

Status of Operation:

Level of Care Licensed: _____

Individual Protocols: Yes or No

Highest Level of Care Provided: Intermediate or Paramedic

Type of Owner: _____

Type of Operation: _____

Funding Methods: _____

2011 Charges, Collections, Budget:

Operating Budget: _____

Amount of Subsidy: _____

Base Rate Emergency: _____

Base Rate Transfer: _____

Mileage Charge per Mile: _____

Coverage Area: _____

Response Time: _____

2011 Annual Runs:

Transported: _____ Treat, No Transport: _____

Care Transfer: _____ False Call: _____

Cancelled: _____ No Patient Found: _____

Refused: _____ DOA: _____

Communication Information:

Type of Dispatch: _____ Dispatch Frequency: _____, _____

Medical Frequency: _____, _____



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Personnel:

Emergency Medical Responder: _____

EMT Intermediate: _____

EMT Basic: _____

EMT Paramedic: _____

Medical Director:

Physician's Name: _____ MD / DO (circle one)

Address: _____

City, State, Zip Code: _____, _____

Telephone #: (_____) _____

Email: _____

Physician's State License #: _____

Physician's OBND #: _____

Vehicles:

Type 1: _____

Stretcher Aid Van: _____

Type 2: _____

Aircraft: _____

Type 3: _____

General Information:

Sole Source Agreement or Ordinance: Yes or No

If yes, please attach copy.

Subscription Program: Yes or No

If yes, please provide copies of the membership agreement, application, and surety bond.

I hereby certify that all information is complete and that all information is true and correct to the best of my knowledge.

Print Name: _____

Title: _____

Signature: _____

Date: _____

Sign before me on the _____ day of _____ 20__.

Notary Public _____

My Commission Expires: _____

Send to:
Oklahoma State Department of Health – EMS Division
1000 N.E. 10th Street
Oklahoma City, OK 73117-1299