INSTRUCTIONS FOR THE COMPLETION OF OKLAHOMA’S GROUND AMBULANCE SERVICE INITIAL AND AMENDMENT APPLICATION FORMS
APPLICATION: Please type or print all information, except where a signature is required.

<table>
<thead>
<tr>
<th>Type of Fee</th>
<th>Reg</th>
<th>Fee for Initial License</th>
<th>Initial Vehicles</th>
<th>Substation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for license</td>
<td>O.A.C. 310:641-3-10 (g) (13)</td>
<td>$600.00 (non-refundable)</td>
<td>$20.00 for each unit after two units for transport (non-refundable)</td>
<td>$150.00 each (Non-refundable)</td>
</tr>
<tr>
<td>Renewal of license</td>
<td>310:641-3-12 (a) (2)</td>
<td>$100.00</td>
<td>$20.00 for each unit after two units</td>
<td>$50.00</td>
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<tr>
<td>Amendment</td>
<td>310:641-3-14 (b)</td>
<td>$100.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 1 – Type of Application
- Enter the date of the application.
- Enter the application purpose.
- Enter the agency license number if submitting an application amendment.

When amending the current license, complete section one, then complete the sections that will be changing within the application.

An amendment to the license is not required when changing protocols. When changing protocols, review and complete the protocol packet.

Section 2 – Business Information
- Enter the name of your agency.
- Enter the mailing address of your agency including city, state and zip code.
- Enter the physical address of your agency including city, state and zip code.
- Enter the records retention address (address of where the agency records will be kept) including city, state and zip code.
- Enter the business telephone number and an emergency telephone number.
- Enter the name of the person who will be a point of contact for the Department.
- Enter an email that the point of contact will be able to access to receive correspondence for the Department.
- Enter the days and times of the agencies operations. Please include the days and times that records will be available for an unannounced inspection review.
- Additional points of contact may be included with the application

Section 3 – Level of Care (310:641-3-11 (b) (1) to (4))
Select the level of care that will be provided.
- Basic life support
- Intermediate life support
- Advanced life support
- Paramedic life support
Section 4 – Type of Owner
Enter the type of ownership for the agency. Essentially, what type of organization will own the license?

- Will an Ambulance Service District (522 District or a Title 19) District own the license?
- Will a Fire Protection District (Title 18 or Title 19 District) own the license?
- Will a different type of board or trust own the license?

Section 5 – Type of Operation
Enter the type of operation for the agency. For Section 5 and 6 – These are examples of type of owner and type of operation combinations:

- A city (or county) owns the license, and the service is based in the city fire department, then governmental city (or county) and fire-based would be marked.
- A city (or county) owns the license, and the service is based in the police department (or county sheriff’s office), then governmental city (or county) and law enforcement would be marked.
- A city (or county) owns a hospital, and the service is based in the hospital, then governmental city (or county) and hospital would be marked.
- A city or county owns a hospital, and then appoints a board for the hospital. The city still owns the hospital.
- If a board owns the hospital, then it will be a board or trust that is marked with hospital.
- If the license will be owned by an Ambulance Service District (522 District or Title 19) or a Fire District (Title 18 or Title 19), then mark either Fire Based or other type of operation.
- Third service means the agency is not fire or law enforcement based but is governmental owned.

Section 6 – Communication Policy (310:641-3-10 (g) (10) (A) – (B))
Agency Dispatch
- Enter the agency phone number to be used by dispatch to contact by phone.
- Enter who will receive the call (i.e. crew members, agency dispatcher).

Other Dispatch
- Enter the agency that is providing dispatch to the agency.
- Enter the phone number of the agency providing dispatch for the agency.

Radio System
- Enter the type of two-way radio communication maintained by the agency (UHF/VHF/800 MHz)
- Enter the frequency being used for dispatch if applicable.

(NOtE: The agency must maintain a communication policy that addresses how it receives and dispatches both emergency and non-emergency calls. The communication plan must be compliant with Local, State and Federal communication plans. The agency must complete and submit a statement stating the agency has a communication policy as part of this application.)
Section 7 – Quality Assurance Plan (310:641-3-10 (g) (7))
The applicant must develop and submit a quality assurance plan. The plan must show how the medical director will be involved with the review of patient care as outlined in the plan. The plan must include: 1) patient care refusals, 2) airway management interventions, (3) time sensitive medical, (4) time sensitive trauma, (5) cardiac arrests, and (6) a random review of a portion of all remaining patient care reports.

Section 8 – Protocols (310:641-3-10 (g) (7))
- Enter the type of protocol that will be used by the applicant.
- If your organization desires to use the state protocols, please provide a separate letter stating your intent of using the protocols as is. The letter must be signed by the applicant director and applicant medical director.
- If your organization desires to use the state protocols with changes, please provide a separate letter stating your intent of using the protocols with changes. The letter must be signed by the applicant director and applicant medical director.
  - Any removal or addition must be indicated in the letter
  - Any additions must be submitted with supporting evidence based documents.
- If you desire to use an agency or applicant specific protocol, please submit the entire protocol to the Department for approval. If your agency specific protocols differ from the State protocols you must submit the supporting evidence based documents with you protocol(s).
  - The agency specific protocol must include a letter signed by the agency director and agency medical director.
  - In addition to any type of protocol intent letter, you must also complete and submit an Authorized Procedure List (APL).

Section 9 – Additional Documentation
- These additional documents that are to be submitted with the application.
- Applications without these documents are incomplete.
- Contracts for equipment and services are to be submitted, if applicable.
- For each unit the applicant owns, complete a vehicle checklist and submit with the application

Section 10 – Documents of Support and Licensed Service Area
(O.A.C 310:641-1-7 and 3-10 (g) (9) (A) – (C)
"Licensed Service Area" means the contiguous geographical area identified in an initial ambulance service application or in an amendment to an existing license. The geographic area is identified by the application and supported with documents provided by the local governmental jurisdictions. For ground ambulance services, this is the geographic area the ambulance service has a duty to act within.

The application will need to include:
- Documents that support agency licensure from the governmental authority(ies) having jurisdiction over the proposed emergency response area. If multiple jurisdictions are proposed, then documents from each are required. The documents are to be consistent with the County EMS Plan;
Section 11 – Type of Owner (310:641-3-10 (g) (1) (A) - (C))
- Enter the name of the agency owner (You must also complete and submit the ownership supplementary form)
- A business plan is also required. The plan must include a financial disclosure statement showing evidence of the ability to sustain the operation for at least one (1) year.

Section 12 – Indirect Ownership (310:641-3-10 (g) (1) (A) - (C))
List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

Section 13 – Mortgage (310:641-3-10 (g) (1) (A) - (C))
List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

Section 14 – Corporation Officers / Directors (310:641-3-10 (g) (1) (A) - (C))
If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

Section 15 – Felony Statement (310:641-3-13 (a) (1))
Has any owner, principal, officer, or director been convicted of a felony? If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the felony conviction.

Section 16 - EMS District Board (310:641-3-10 (g) (1) (A) - (C))
If the disclosing entity is a ‘522’ District Board, or received money from a ‘522’ District Board, list the names, titles and addresses of the officers and directors.
Section 17 – Other Ownership or Controlling Interests (310:641-3-10 (g) (1) (A) - (C))
If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board ("522 or "Title 19"), a city, a county, a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Section 18 – Owner Signature (310:641-3-10 (e))
• Print the license owner's name in the space provided.
• Print the license owner’s title in the space provided.
• Enter the date in the space provided.
• The license owner must sign in the space provided.
• The signature must be verified by a notary public.

Additional Forms
• Personnel Roster – List all personnel for your agency who provide patient care.

• Inspection Forms – This form is used by the Department for inspections. Complete the form to provide us with your ambulance’s information as well as an equipment checklist. Complete this form for each of your agency’s ambulances. The Record Review checklist detail records to be maintained at the agency.

• Medical Director – See the attached Medical Director Checklist to ensure you are sending all of the required information.

• Approved Procedures List – Check each box to indicate the procedures used at your agency—including procedures at scopes of practice above your agency’s level of care. Include a signed letter from the medical director and agency director stating acceptance of the Oklahoma State Protocols either "as-is" or "with changes", to include or attach an outline of the changes.

• Substations – Check “yes” if your agency will maintain substations. Complete and submit the Ambulance Substation form with your application.

Department Application Procedures
After submitting your application, it will be reviewed by Department staff for completeness, accuracy and legibility. You will be contacted if the package is incomplete or additional information is required. Once the application is complete, an EMS Administrator will be assigned to conduct an initial inspection of your files, equipment and facility. Upon receipt of the EMS Administrator’s inspection report, your EMS Agency Certificate will be mailed to the address on record. Information regarding your Ground Ambulance application package may be obtained by calling (405) 271-4027.
Date application received: __________________  Date complete application received: ________________

Reason for package: Initial_____ Amended_____ Update_____ Other ____________________________

Agency Name: ____________________________

Level of Care: Paramedic __________________ Specialty Care: ____________________________

(Complete Specialty Care Application)

Scheduled for Inspection: ________________ Date: ________________ (or attach Aspen Report)

Please check each item:

<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
<th>Regulation (O.A.C)</th>
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<td>Type of Operation</td>
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<td>(10) (A and B)</td>
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<td>Quality Assurance Plan</td>
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<td>310:641-3-15</td>
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<td>Response Plan</td>
<td>310:641-3-10 (g)</td>
<td>(11)</td>
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<td>Medical Director</td>
<td>310:641-3-10 (g)</td>
<td>(5) and 3-24</td>
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<td>Vehicle Inspection checklist</td>
<td>310:641-3-20 and 3-22</td>
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<td>Support and Licensed Service Area</td>
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<td>310:641-1-7 &amp; 3-10 (g)</td>
<td>(8) (9) (A) - (C)</td>
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<td>(1) (A) – (C)</td>
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<td>310:641-3-10 (g)</td>
<td>(1) (A) – (C)</td>
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<td>310:641-3-10 (g)</td>
<td>(1) (A) – (C)</td>
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<td>Felony Statement</td>
<td>310:641-3-13 (a)</td>
<td>(1)</td>
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<td>310:641-3-10 (g)</td>
<td>(1) (A) – (C)</td>
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<td>Other Ownership</td>
<td>310:641-3-10 (g)</td>
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<td>Substation list</td>
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<td>Separate form</td>
<td>Medical Director Checklist</td>
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<tr>
<td>Separate form</td>
<td>Authorized Procedure List and protocols</td>
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<tr>
<td>Separate form</td>
<td>Substations</td>
<td></td>
<td></td>
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</tbody>
</table>
Medical Director Checklist

Agency Name: __________________________

Medical Director __________________________

Please provide these items or copies of these items:
If you change your Medical Director, a new Medical Director Checklist will be needed.

- Letter from the physician agreeing to be your Medical Director
- Copy of Medical Director’s State Medical License
- Copy of Medical Director’s OBNDD or DEA certificate
- Medical Director’s Curriculum Vitae
- Medical Director’s Primary Practice Address
- Medical Director’s Email Address
- Name of Hospital where Medical Director is On Staff
- Medical Director’s Specialty
- Medical Director’s Approval of Protocols – include whether you are accepting the State protocols “as-is” or “with changes”, including a list of any proposed changes. This letter should be signed by the EMS director and Medical Director.
- Provide documentation showing what steps will be taken in the event of a Lapse in Medical Direction – such as a back-up or reserve Medical Director.
- Completed Authorized Procedure List (included), signed by the EMS director and Medical Director
Ground Ambulance Service Application

License fees

<table>
<thead>
<tr>
<th>Type of Fee</th>
<th>Reg</th>
<th>Fee for Initial License</th>
<th>Initial Vehicles</th>
<th>Substation</th>
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<tr>
<td>Fee for license</td>
<td>O.A.C. 310:641-13-2 (b)</td>
<td>$600.00 (non-refundable)</td>
<td>$20.00 for each</td>
<td>$150.00 each (Non-refundable)</td>
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<td>unit after two</td>
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<td>units for transport</td>
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<td>Renewal of license</td>
<td>310:64113-4</td>
<td>$100.00</td>
<td>$20.00 for each</td>
<td>$50.00</td>
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<tr>
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<td>after two units</td>
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<tr>
<td>Amendment</td>
<td>310:641-13-7</td>
<td>$100.00</td>
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<td>$100.00</td>
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</tbody>
</table>

SECTION 1 – TYPE OF APPLICATION (Print or Type)

Date of Application: ____________________________  Purpose: Initial ___ Amended ___ Update ___  License No: ____________________________

SECTION 2 – BUSINESS INFORMATION

Service Name: ____________________________________________

Mailing Address: _________________________________________

Physical Address: ___________________________ City State Zip Code

Record Retention Address: ___________________________ City State Zip Code

Business Telephone: ___________________________  Emergency Telephone: ___________________________

Director / Administrator / Coordinator / CEO Name: ____________________________________________

(Additional points of contact may be included with the application)

Email Address: ____________________________________________

Hours of Business Operation (Include days and times): ____________________________________________

SECTION 3 – LEVEL OF CARE

Basic Life Support ___
Intermediate Life Support ___
Advanced (EMT) Life Support ___
Paramedic Life Support ___

SECTION 4 – TYPE OF OWNER

Governmental City ___
Governmental County ___
Governmental Federal ___
Governmental Tribal ___
Private (Not For Profit) ___
Private (For Profit) ___
Board or Trust (Other) ___
522, Title 18 or 19 Board ___

SECTION 5 – TYPE OF OPERATION

Fire Based ___
Law Enforcement ___
Hospital ___
3rd Service (government owned) ___
Private ___
Other: ____________________________

SECTION 6 – Communication Policy (O.A.C. 310:641-3-10 (g) (10) (A and B))

Agency Dispatch

Agency phone number where calls are received: (____) ___ The call is received by: ____________________________

Other Dispatch

Agency providing dispatch: ____________________________ Phone number for agency providing dispatch: (____) ___

Radio System (How are you dispatched?)

Cell Phone? ___ VHF? ___ UHF? ___ 700Mhz _800Mhz __________________ What Freq? ____________________________

Does the agency applicant have a communication policy that addresses receiving and dispatching emergency and non-emergency calls that is State and Federal compliant?  Yes ___ No ___ (You must include a policy statement)
**SECTION 7 – QUALITY ASSURANCE PLAN (O.A.C. 310:641-3-10 (g) (7) (C)) See Protocol Application Packet**

**SECTION 8 – PROTOCOLS (O.A.C. 310:641-13-11 (f) (5) (F)) See Protocol Application Packet**

**SECTION 9 – Additional documentation (Return with Application)**
- Certificate of Vehicle Insurance ($1,000,000.00) (O.A.C. 310:641-3-10 (g) (2))
- Professional Liability Insurance ($1,000,000.00) (O.A.C. 310:641-3-10 (g) (3))
- Workers’ Compensation Program Verification (O.A.C. 310:641-3-10 (g) (4))
- Copies of Contacts for Equipment & Services (O.A.C. 310:641-3-10 (g) (6)) (if applicable)
- Confidentiality Policy (O.A.C. 310:641-3-10 (g) (12))
- Business plan and financial disclosure (O.A.C. 310:641-3-10 (g) (1) (C))
- Personnel Roster (form enclosed) (O.A.C. 310:641-3-15)
- Inspection checklists (form enclosed) (O.A.C. 310:641-3-20 and 22)
- Response plan (O.A.C. 310:641-3-10 (g) (11))
- Medical Director (O.A.C. 310:641-3-10 (g) (5) and 3-24) (See checklist)

**SECTION 10 – LICENSED SERVICE AREA:** See directions and explanation in application instructions and guidance.

**SECTION 11 – TYPE OF OWNERSHIP (310:641-3-10 (g) (1) (A)-(C))**
- Government Ownership (City, State or Federal) – Give Description:
- Sole Proprietorship. List name of owner:
- Partnership. List partners:
- Corporation. Name of corporation:
- Disclosing entity received money from, or contracts with, a ‘522’ District (Article X);
  - Give ‘522’ district name:
- Disclosing entity received money from or contracts with, an ‘Ambulance Service’ District (Title 19);
  - Give ‘Ambulance Service’ district name:
- Other (Specify):

**SECTION 12 – INDIRECT OWNERSHIP (310:641-3-10 (g) (1) (A)-(C)) (if applicable)**
List the names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the DISCLOSING ENTITY.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
</tr>
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</tbody>
</table>

**SECTION 13 – MORTGAGE (310:641-3-10 (g) (1) (A)-(C)) (if applicable)**
List the names and addresses of individual, organizations or other entities having an interest in the form of the mortgage, or other obligation, secured by disclosing entity (equal to at least 5% of the assets).

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
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</tbody>
</table>
SECTION 14 – CORPORATION OFFICERS / DIRECTORS (310:641-3-10 (g) (1) (A)- (C)) (if applicable)

If the disclosing entity is a CORPORATION, list the names, titles and addresses of the officers and directors.

OFFICERS NAME

______________________________________________________________________________

TITLE

______________________________________________________________________________

ADDRESS

______________________________________________________________________________

______________________________________________________________________________

CORPORATION DIRECTORS

DIRECTORS NAME

______________________________________________________________________________

TITLE

______________________________________________________________________________

ADDRESS

______________________________________________________________________________

______________________________________________________________________________

SECTION 15 – FELONY STATEMENT (310:641-3-13 (a) (1) (if applicable)

Has any owner, principal, officer, or director been convicted of a felony? Yes _____ No ____.

If yes, please indicate details on a separate peace of paper. The applicant may also submit court documents detailing the felony conviction.

SECTION 16 – EMS DISTRICT BOARD (“522” or “Title 19” District) (310:641-3-10 (g) (1) (A)- (C)) (if applicable)

If the disclosing entity is a ‘522’ District Board, or received money from a ‘522’ District Board, list the names, titles and addresses of the officers and directors.

Name: __________________________________________ Position: __________________________
Address: __________________________________________ Contact Number: ________________

Name: __________________________________________ Position: __________________________
Address: __________________________________________ Contact Number: ________________

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contact or contracts to provide ambulance services with this form.

SECTION 17 – OTHER OWNERSHIP OR CONTROLLING INTERESTS (310:641-3-10 (g) (1) (A)- (C)) (if applicable)

If the disclosing entity is an Ambulance District Board established by Title 19, received money from an Ambulance District Board ("522 or "Title 19"), a city, a county, a council, or any entity list the names, titles, and addresses of the officer, directors, commissioners, council, etc. Give meeting dates, times and other pertinent information.

Name: __________________________________________ Position: __________________________ Ownership %: __________
Address: __________________________________________ Contact Number: ________________

Name: __________________________________________ Position: __________________________ Ownership %: __________
Address: __________________________________________ Contact Number: ________________

If the DISCLOSING ENTITY is not owned or operated by the District, then attach a contract(s) to provide ambulance service to this form.

SECTION 18 - OWNER SIGNATURE (310:641-3-10 (g) (1) (A)- (C))

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name __________________________ Title __________________________ Date ________________ Signature __________________________

Signed before this __________ day of __________ My Commission Expires: ________________ / __________ / ________________

Oklahoma State Department of Health
Protective Health Services / Emergency Systems

Form Ground Ambulance Application
March 2017
Page 3
**GROUND AMBULANCE AGENCY PERSONNEL ROSTER** (O.A.C. 310:641-3-15)

**Instructions:** List all certified and licensed personnel associated with the application/agency. Please list the names in alphabetical order. Please type or print only. 
*Volunteer means a person that does not receive compensation or is compensated at less than minimum wage.*

Agency Name: ___________________________ Date: ____/____/____

Person Providing the Information: ___________________________ Title: __________________

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<th>Name (Last, First and Middle Initial)</th>
<th>Level of License</th>
<th>SSN</th>
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<td>OK License Number and expiration date</td>
<td>Full/Part Time or Volunteer</td>
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Signature ___________________________  Date _____/_____/_____

Oklahoma State Department of Health
Protective Health Services / Emergency Systems
Ground Ambulance Service List of Substations

Do you have units positioned at locations other than the business office or main station? YES ___  NO ___

If yes, list the address and physical location, if different from the address of the units. Make additional copies of this page if necessary.

<table>
<thead>
<tr>
<th>Substation Name or Number</th>
<th>Address</th>
<th>City, Zip</th>
<th>Phone Number at Sub-station</th>
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