DESOTO COUNTY
BOARD OF COUNTY COMMISSIONERS
DIVISION OF EMERGENCY MEDICAL SERVICES

APPLICATION
for

CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY (COPCN)

Type of Application: New_____Renewal_____

Type of Service: Basic Life Support Ambulance (BLS) ____
Advanced Life Support Ambulance (ALS) ____

Name of Service: _____

Mailing Address: _____

County_____State _____Zip Code _____

Business Phone Number ( )_____Fax ( ) _____

Type of Ownership (i.e., Private, City, County, Volunteer, etc.)_____

Date of Formation or Corporation _____

Manager's Name: _____

The area or areas which the applicant desires to serve._____

Attach the following information:

Attachment 1:	Provide name(s) of Owners(s), Officers, Directors and/or Shareholders and address.
Attachment 2:	Description of the staffing patterns to assure compliance with staffing requirements set forth in 64J, Florida Administrative Code. Submit a personnel roster of EMTs and Paramedics with a copy of certificates and/or licenses.
Attachment 3:	Insurance Verification (copy of Policy) - limits of coverage must be shown on policy. Must be current.
Attachment 4:	Copies of the last three (3) State Bureau inspections.
Attachment 5:	A statement of facts showing the demand or need for the proposed service.
Attachment 6:	A proposed schedule of rates, fares and charges.
Attachment 7:	The addresses of the applicant's present and proposed base station location and all sub-stations. If approved, must be able to show proof of residency in DeSoto County with the exception of air transport.

Attachment 8:	The year, model, type, Department of Health and Rehabilitative Services permit number, motor vehicle, or FAA license number and mileage of every ambulance, rescue vehicle, aircraft or other type of transporting or responding vehicle used by the applicant.
Attachment 9:	A copy of vehicle permit application.
Attachment 10:	A description of the applicant's communication system, including its assigned frequency, call numbers, mobiles, portables, range and hospital communications ability.
Attachment 11:	The name of the municipalities and description of the geographical area that the applicant currently authorized to serve in Florida or any area outside of the State of Florida.
Attachment 12:	Compilation Statement showing assets and liabilities prepared by Certified Public Accountant.
Attachment 13:	Proof that the applicant possesses all required Federal or State licenses and permits.
Attachment 14:	Proof that the applicant has employed or contracted with a medical director qualified in the manner required by Section 401.265, Florida Statutes (1983), and obligated to fulfill all requirements of that statue.
Attachment 15:	The condition of the vehicles and equipment provided by the service.
Attachment 16:	The adequacy of the management plan of the applicant upon the request of this service.
Attachment 17:	Verification of drug free workplace.

I, the undersigned representative of the above service, do hereby attest my service meets all of the requirements for operation of an ambulance service in the State as provided by Chapter 401, Part III, Florida Statues, and 64J, Florida Administrative Code. I further acknowledge any discrepancies discovered by inspection will subject this service and its authorized representatives to corrective action. I understand there maybe additional reasonable documentation required. To the best of my knowledge, all statements on this application are true and correct.

_____

Signature

_____

Position

Notary Seal

Notary Signature:_____Date_____