DEPARTMENT OF HUMAN SERVICES
OREGON HEALTH DIVISION
EMERGENCY MEDICAL SERVICES AND SYSTEMS
PO BOX 14450
PORTLAND OR 97293-0450
Telephone No. (503) 731-4011 Extension 633

SIGNATURE AUTHORIZATION

Agency Number: _____

Ambulance Service Name: _____

Chief Officer/Owner: _____
(Name) (Title)

Signature: _____

DESIGNATION OF AUTHORIZED SIGNATORY

9 I do NOT wish to authorize any other person to sign ambulance service and ambulance licensing documents on behalf of this agency.

9 In addition to myself, I hereby authorize the individual whose name, title, and signature appear below to sign any and all documents related to ambulance service and ambulance licensing.

Authorized Signatory: _____
(Name) (Title)

Signature: _____

_____
(Signature of Chief Officer/Owner) (Date)

Please return the completed form to the address printed at the top of this form.