Job Code 38 **46211-31300-1786**

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

APPLICATION FOR AN AMBULANCE SERVICE OR AMBULANCE REPLACEMENT LICENSE

PLEASE USE A SEPARATE APPLICATION FORM FOR EACH REPLACEMENT LICENSE.

Mail the completed application with a **$10 NONREFUNDABLE FEE** to: Oregon Health Division, Business Services, P.O. Box 14260, Portland, OR 97293-0260. Make the check payable to the **"Oregon Health Division"**:

PLEASE CHECK, TYPE OR PRINT THE APPROPRIATE RESPONSE in blue or black ink only

AMBULANCE SERVICE INFORMATION

Registered Owner's Name: _____
Last First M.I.

Business Name: _____

Mailing Address: _____
Street or PO Box Number

_____
City County State Zip Code

Type of replacement license requested:

Information from previous license:

G **Ambulance Service** **Name of Service:** _____

G **Air Ambulance** **Registration Number:** _____
G **Internal Paper License**
G **3" X 6" Window License**
G **"01" Year Tag** **Year Tag Number, if known:** _____

G **Ground Ambulance** **License Plate Number:** _____
G **Internal Paper License**
G **3" X 6" Window License**
G **"01" Year Tag** **Year Tag Number, if known:** _____

G **Marine Ambulance** **Registration Number:** _____
G **Internal Paper License**
G **3" X 6" Window License**
G **"01" Year Tag** **Year Tag Number, if known:** _____

STATEMENT OF TRUTH OF APPLICATION

I, _____, certify that I am an authorized agent of the entity that owns and operates the ambulance service or owns or leases and operates the ambulance described in this application.

I certify that to the best of my knowledge, that this ambulance service or ambulance meets all federal, state, county and city requirements to operate in Oregon. I have carefully read the application and answered the appropriate questions completely and without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my ambulance service or ambulance license and the ability to operate in the State of Oregon.

_____

(Signature of the authorized agent owning or operating this ambulance service or owning, or leasing and operating this ambulance)

(HEALTH DIVISION USE ONLY)

Date Application Received:

G License Denied Date: ____/____/____

Reasons for denial: _____

_____

G License Approved Date: ____/____/____

Previous Fiscal Control Number: _____

New Fiscal Control Number: _____

Ambulance State I.D. Number: _____

Previous Year Tag Number Issued: _____

License Year Tag Number Issued: _____

License Number Issued: _____

License Expiration Date: ____/____/____

_____

(Signature of Ambulance Licensing Program Representative)