

**Stanislaus County Sheriff's Office
Emergency Services Division**



Jeff Dirkse

*Sheriff/
Director of OES*

Richard Murdock

*Chief of Emergency Services/
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Chad Braner

EMS Agency Director

*3705 Oakdale Rd, Modesto, CA 95357
Phone: 209.552.3600 Fax 209.552.2512*

**Stanislaus County
Emergency Medical Services Agency**

**General Application for the Provision of
Non-Emergency Interfacility Ambulance Service in Stanislaus County**

Applicants who wish to provide Non-Emergency ambulance services within Stanislaus County as administered by the Stanislaus County EMS Agency (hereafter referred to as the "EMS Agency") shall provide documentation in answer to the questions listed in this package. When answering the questions, please be as specific and complete as possible. An incomplete application may cause a delay in processing and may result in the denial of the application. An applicant who knowingly makes a false statement of fact in this application may be subject to denial of his/her application.

Once the application is completed, submit it to:

**Stanislaus County EMS Agency
EMS Director
3705 Oakdale Rd.
Modesto, CA 95357**

Upon receipt of the completed application, the EMS Agency, shall make, or cause to be made, an investigation to determine if the applicant meets all requirements as outlined in applicable laws, ordinances and regulations. Within ninety (90) days of receipt of the application the EMS Agency shall decide to issue, or decline to issue, an Ambulance Provider Agreement.



Stanislaus County

Emergency Medical Services Agency

Application for Non-Emergency Interfacility Ambulance Services Certificate of Operation

<input type="checkbox"/> Initial Application	<input type="checkbox"/> Renewal Application	<input type="checkbox"/> Information Update
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Applicant Name: _____

Company Name: _____

Company Address: _____
Street City State Zip Code

Phone: _____ Fax: _____ Email: _____

Service Level Requested:	<input type="checkbox"/> BLS	<input type="checkbox"/> ALS	<input type="checkbox"/> CCT
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Have you ever provided ambulance service *within* Stanislaus County EMS Agency and/or *within* Stanislaus County? Yes No

If yes, what type of service: BLS ALS CCT

Company Name: _____

Length of Time: _____

Do you provide ambulance service *out* of Stanislaus County EMS Agency? Yes No

List counties: _____

If yes, what type of service: BLS ALS CCT

Company Name: _____

Length of Time: _____

Provide a 24-hour availability phone number for supervisory or management contact

Phone Number: _____



Stanislaus County Emergency Medical Services Agency

General Application for the Provision of Non-Emergency Interfacility Ambulance Service Components

- ✓ Please assemble the application components listed below into a binder and/ or PDF
- ✓ Each section or attachment must be identified by a divider marked with the lettering outlined below

Initial Application

Renewal Application

Attachments	Completed	Notes
A. Name, Title, and Contact Information of Person(s) completing this application	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
B. Provide Name(s) under which the applicant has engaged, does, or proposes to engage in ambulance service	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
C. List the Names, Addresses, and Contact Information of the Applicant(s), Registered Owner(s), Partner(s), Officer(s), Director(s), and Controlling Shareholder(s)	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
D. Submit a statement that verifies that the applicant owns or has under their control, in good mechanical condition, required equipment (please see EMS Agency Policy 407.00 – Transporting Ambulance Equipment and Supply Inventory) to consistently provide quality ambulance service in the area for which the applicant is applying, and that the applicant owns or has the access to suitable facilities for maintaining equipment in a clean and sanitary condition	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
E. Certificate of Operation Application	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
F. Describe the ambulance response area and type of ambulance service(s) proposed by applicant	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
G. Submit a description of the applicant’s training and experience in the transportation and care of patients for applicable level of service(s) contracted to provide	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
H. A copy of the business license for the city(ies) in which the applicant will be doing business	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
I. A statement of the legal history of all applicants, including criminal, civil convictions, judgments, or liens	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
J. Submit a statement identifying any previous denial of authorization to provide ambulance service by an EMS Agency within the State of California, identifying the EMS Agency and reasons for denial of said authorization	<input type="checkbox"/> Y <input type="checkbox"/> N	_____



Stanislaus County Emergency Medical Services Agency

Attachment A

Additional Applicant Information

- ✓ Please list all other owner(s), partner(s), officer(s), director(s) and controlling shareholder(s)
- ✓ Please attach additional pages if necessary

No additional applicants

Applicant Name: _____

Business Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

Registered Owner Partner Officer Director Controlling Shareholder

Applicant Name: _____

Business Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

Registered Owner Partner Officer Director Controlling Shareholder

Applicant Name: _____

Business Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

Registered Owner Partner Officer Director Controlling Shareholder

Applicant Name: _____

Business Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

Registered Owner Partner Officer Director Controlling Shareholder



Stanislaus County

Emergency Medical Services Agency

Attachment C

Signed Declaration Statement

Please sign and date the following declaration statement:

I declare under penalty of perjury and the laws of the State of California, that the information contained in this application is accurate and true to the best of my knowledge. I am aware that should any of the information be found false, the affected County and/or Stanislaus County EMS Agency may pursue any remedy authorized by law, which shall include the right, at the option of the County and/or Stanislaus County EMS Agency, of declaring any agreement made as a result there of to be void.

Date

Printed Name

Signed Name

STANISLAUS
COUNTY