County of El Dorado Department of Health And Human Services Agency
Emergency Medical Services Agency
Application for Contract or Medical Transportation Provider Permit
READ ALL INSTRUCTIONS BEFORE COMPLETING APPLICATION

Full name of applicant: _____ Tel. No.: (___) _____

Full name of business: _____

Address of business: _____

Mailing address (if different): _____

If a corporation, exact corporate name: _____

Date of Incorporation: _____ Incorporation in the State of: _____

Name of Officers	Address	Title(s)

DESIGNATE WITH AN ASTERISK (*) THE ABOVE OFFICER(S) DULY AUTHORIZED TO ACCEPT SERVICE OF LEGAL PROCESS

If a partnership, indicate the names address and percentage of partnership each holds

Name of Partners	Address	% Interest Held

Type of service applying for (check one)

Air Ambulance Service		Rescue Aircraft Service	
Litter Van & Wheelchair Van Service		Standby or Special Event	
Other (please state):			

Operating area(s) applying for: _____

I certify under penalty of perjury under the laws of the State of California that the information contained herein is true and correct. As a condition for the issuance of a Contract or Permit, I acknowledge that I have read all sections of the "County Emergency Medical Service and Medical Transportation Ordinance " and agree to submit the information detailed in the Contract and Permit Requirements Application as well as any additional information that may be requested, and to conduct all phases of the business in a business-like manner and in accordance with all applicable laws, ordinances, and regulations including the County Emergency Medical Service and Medical Transportation Ordinance.

_____ _____
Applicant Signature Date

_____ _____
Name Printed Title