



**ARIZONA DEPARTMENT
OF HEALTH SERVICES**

PREPAREDNESS

Bureau Of Emergency Medical Services & Trauma System
150 N. 18th Avenue, Suite 540, Phoenix, Arizona 85007-3248; 602-364-3150
APPLICATION FOR CERTIFICATE OF NECESSITY RENEWAL

APPLICATION FORM

I. IDENTIFICATION

Legal business or corporate name

Identifying Name (DBA)

Legal address

Mailing address if different

Telephone number

Facsimile number

E-mail address

II. MANAGEMENT

Provide the following for each applicant and individual responsible for managing the ground ambulance service:

| NAME | TITLE | ADDRESS | TELEPHONE NUMBER |
|------|-------|---------|------------------|
| | | | |
| | | | |
| | | | |

Provide the following for the business representative or designated manager:

| NAME | TITLE | ADDRESS | TELEPHONE NUMBER |
|------|-------|---------|------------------|
| | | | |

Provide the following for the individual to contact to access the ground ambulance service's records required in R9-25-910:

| NAME | TITLE | ADDRESS | TELEPHONE NUMBER |
|------|-------|---------|------------------|
| | | | |

Provide the following for the statutory agent for the ground ambulance service, if applicable:

| NAME | TITLE | ADDRESS | TELEPHONE NUMBER |
|------|-------|---------|------------------|
| | | | |

III. CLASSIFICATION

| | | | |
|--|--|--|---|
| Type of Business | Proprietary <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation for profit <input type="checkbox"/> Limited liability corporation <input type="checkbox"/> Other _____ | Non-profit <input type="checkbox"/> Corporation <input type="checkbox"/> Other _____ | Governmental <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Municipal |
| Level of Service: (Check Most Approp) | <input type="checkbox"/> Advanced Life Support | <input type="checkbox"/> Advanced Life Support & Basic Life Support | <input type="checkbox"/> Basic Life Support |
| Type of Service (Check all Applicable) | <input type="checkbox"/> Immediate Response Transport | <input type="checkbox"/> Interfacility Transport | <input type="checkbox"/> Convalescent Transport |
| Hours of Operation | <input type="checkbox"/> 24 hrs/7 days a week | <input type="checkbox"/> Other (explain in detail on an attached sheet) | |

DOCUMENTS REQUIRED AS PART OF THE APPLICATION PACKET

The following documents, required as part of the application packet, are attached:

1. Proof of continuous insurance coverage or a statement of continuing self-insurance, including a copy of the current certificate of insurance or current statement of self-insurance required in R9-25-909;
2. Proof of continued coverage by a surety bond if required under A.R.S. §§ 36-2237(B); and
3. A certificate holder that charges patients for disposable supplies, medical supplies, medications, and oxygen-related costs shall submit to the Department a list of the items and the proposed charges as required in R9-25-1109.

APPLICATION FILING FEE

A \$50 application filing fee for renewal of a certificate of necessity, required as part of the application, is attached with the application packet.

ACKNOWLEDGMENT/SIGNATURE

I hereby certify, under penalty of perjury, that

- * I am duly authorized and qualified to act for or on behalf of the certificate holder submitting this application.
- * The certificate holder has and is continuing to meet the conditions of the certificate of necessity, including assessing only those rates and charges approved and set by the Director
- * That the information and documentation contained in the application form, attached to the application form, submitted as part of the application packet, or submitted in any subsequent amendment or filing to this application has been compiled from records I have verified, and I know that the facts recited herein are true and correct.

X
Signature of the applicant or the applicant's designated representative

Date