MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL RESPONSE AGENCY LICENSE APPLICATION

FOR DOH OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ **INITIAL LICENSURE**

☐ **RELICENSURE**

INSPECTOR ASSIGNED

_____

EMRA LICENSE # ☐☐ ☐☐ ☐☐

DATE APPLICATION REC'D. ☐☐ ☐☐ ☐☐

DATE INSPECTOR ASSIGNED ☐☐ ☐☐ ☐☐

DATE OF FIRST INSPECTION ☐☐ ☐☐ ☐☐

DATE PASSED INSPECTION ☐☐ ☐☐ ☐☐

DATE LICENSED ☐☐ ☐☐ ☐☐

EXPIRATION DATE ☐☐ ☐☐ ☐☐

APPLICANT MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

1. TRADE NAME OF EMERGENCY MEDICAL RESPONSE AGENCY

LOCATION OF EMERGENCY MEDICAL RESPONSE AGENCY *(STREET, ROUTE, CITY, STATE, ZIP)*

2. OPERATOR OF EMERGENCY MEDICAL RESPONSE AGENCY

NAME OF POLITICAL SUBDIVISION OR CORPORATION		NAME OF MANAGER	TELEPHONE NUMBERBUSINESS ( )
MAILING ADDRESS *(STREET, ROUTE, ETC.)*			TELEPHONE NUMBER-EMERGENCY ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

3. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)* ☐ M.D. ☐ D.O.

MAILING ADDRESS *(STREET, ROUTE, ETC.)*			OFFICE TELEPHONE NUMBER ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an emergency medical response agency medical director and I agree to serve as medical director. ***(USE INK OR INDELIBLE PENCIL)***

_____ _____

SIGNATURE OF EMERGENCY MEDICAL RESPONSE AGENCY MEDICAL DIRECTOR **DATE**

4. EMERGENCY MEDICAL RESPONSE AGENCY LICENSEE

NAME OF POLITICAL SUBDIVISION OR CORPORATION		NAME OF CEO	TELEPHONE NUMBER-BUSINESS ( )
BUSINESS ADDRESS *(STREET, ROUTE, ETC.)*			TELEPHONE NUMBER-EMERGENCY ( )
CITY	STATE ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Emergency Medical Response Agency has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 1998.

I have attached all Emergency Medical Response Agency licensure and related administrative licensure actions taken against this Emergency Medical Response Agency or owner by any state agency in any state.

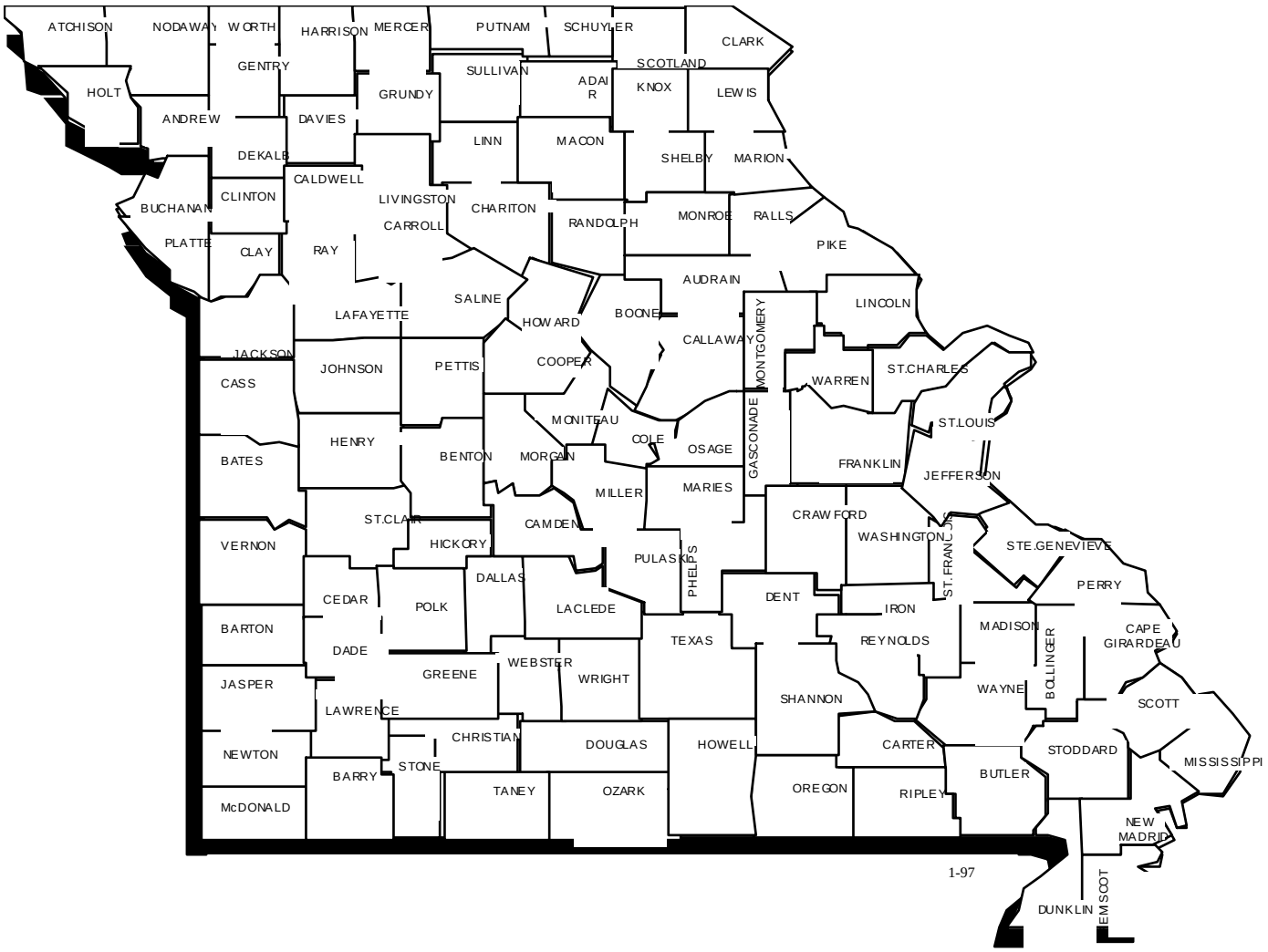
_____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF EMERGENCY MEDICAL RESPONSE AGENCY LICENSEE **DATE**

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri statutes 575.060.

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102

MAP OF EMERGENCY MEDICAL RESPONSE AGENCY SERVICE AREA – Clearly show your service area on the map below:



Provide a legal description of the emergency medical response agency service area below:

_____

_____

_____

_____

_____

List names of ambulance services in your response area:

1. _____

2. _____

3. _____

Do you have a memorandum of understanding with each of the ambulance services listed above?

YES ☐ **NO** ☐