



EMS Service and Vehicle License Application Packet

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In order to process your request:

**Mail your application and
other documents to:**

EMS Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instruction Checklist

When your application for EMS Service and Vehicle License is received by the Department of Health (DOH), it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

Indicate type of application—new, change of ownership, amended, or renewal.

- **New**—First time requesting an initial EMS Service and Vehicle License.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed service.
- **Amended**—Request the addition or elimination of information on the EMS Service and Vehicle License. For example, a ‘Change of Response Area’ ‘Rural Services Approval’ or ‘Level of Care,’ etc.
- **Renewal**—Renew EMS Service and Vehicle License. Enter your current EMS Service license number.

Indicate Service Type: Ambulance (transport) or Aid Service (non-transport).

Check the level of care provided: Check which one applies to you.

Check One: Please check your legal owner/operator business structure type according to your Washington State Master Business License.

1. Demographic Information:

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/EMS Service Name: Enter the owner’s name as it appears on the UBI/Master Business License.

Legal Owner/EMS Service Mailing Address: Enter the owner’s complete mailing address.

Phone and Fax Numbers: Enter the owner’s phone and fax number.

Email and Web Address: Enter the owner’s email and Web addresses, if applicable.

EMS Service Name: Enter the name as advertised on signs or Web site. For example, ‘Fire District #99,’ ‘Woodbridge Fire and Rescue,’ etc.

EMS Service Physical Address: Enter the physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the phone and fax number.

Mailing Address: Enter the mailing address, if different than physical address.

2. Specific Information:

Organization Type: Please check the one organization that best applies to your service.

Response Information: Provide a number for each EMS activity. **Primary response**, first out/first alarm. **Secondary response**, responding at primary service's request, 2nd out alarm. First time applicants need not provide this information

3. Personnel Status:

Indicate your EMS Service staffing model, see definitions below.

Paid: All staff are compensated

Volunteer: All staff are volunteer

Combination: A combination of any of the following:

- Some staff are paid
- Some staff are volunteer and receive some form of nominal compensation
- Some staff are volunteer and receive no compensation

List the total number of Paid, Volunteer, Advanced First Aid (AFA) personnel, and the total number of Non-Medically Trained Driver (NMTD). NMTD are persons who do not hold a EMS certification issued by the Department of Health.

You must provide a copy of your current roster from EMS Certification online. If you need assistance please contact EMS credentialing 360-236-4859.

4. EMS Supervisor Information: Enter the name, phone number, and email address of the EMS Supervisor who is able to answer questions about licensing, vehicle licensing, and personnel association issues. Include a Department of Health credential number, if applicable.

5. Supervision: Enter name of the County Medical Program Director and their Department of Health credential number.

6. Additional Information:

Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, LLC members or manager, partners, etc. Attach additional completed pages if you need more space.

Change of Ownership Information: If applicable, list the previous legal owner name, previous name, previous service credential number, effective date of ownership change and physical address.

7. Emergency Medical Vehicles: Provide year, make and model, license plate number, actual address of vehicle, AMB or AID, and VIN. Attach additional completed pages if you need more space.

8. General Operation: Provide information regarding the organization's general operation. Attach additional completed pages if you need more space.

9. Rural Attestation: Complete this section if you are operating with approval, or requesting approval as a rural service with non-medically trained drivers as shown in [RCW 18.73.150](#). The representative must read the affirmation statement thoroughly to ensure the provision of this section are understood. Then, print and sign name and enter the date.

10. Signatures: The representative must read the affirmation statement thoroughly to ensure the provisions of this section are understood. Then, print and sign name and enter the date.

License Requirements

- Complete the application including the following:
 1. Dispatch Plan
 2. Response Plan (include station locations and system status management)
 3. Response Area
 4. Tiered Response and Rendezvous Plan
 5. Back-up Plan to Respond
- Include evidence of current liability insurance coverage to include professional, general and motor vehicle.

Provide a copy of the liability insurance coverage policy, an ACCORD certificate of insurance, or a letter from a licensed insurer verifying the required insurance will be in place for the service at the time verification goes into effect.
- Provide a map of Response Area

Note: Maps of Response Areas are available in the respective Regional EMS and Trauma Care Office and plans are posted on the [website](#). The minimum and maximum number of verified services by type and the distribution by response areas are specified in the approved regional EMS plans.

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Date
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EMS Service and Vehicle License Application

This is for: New Change of Ownership Amendment
 Renewal License # _____

Service Type: Ambulance (transport) Aid Service (non transport)

Level of care provided - Check only one: BLS ILS ALS

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | |

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
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Legal Owner/EMS Service Name

Mailing Address

City	State	Zip Code	County
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Phone (enter 10 digit #)	Fax (enter 10 digit #)
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Email Address	Web Address:
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Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip Code	County
------	-------	----------	--------

Phone (enter 10 digit #)	Fax (enter 10 digit #)
--------------------------	------------------------

Mailing Address (If different than physical address)

City	State	Zip Code	County
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2. Specific Information

Organization Type: (check one only)

- | | | |
|--|---|--|
| <input type="checkbox"/> City Fire Department | <input type="checkbox"/> Fire District | <input type="checkbox"/> Municipal (city/county) |
| <input type="checkbox"/> City/Fire District Combined | <input type="checkbox"/> Hospital District | <input type="checkbox"/> Private Volunteer Association |
| <input type="checkbox"/> EMS District | <input type="checkbox"/> Industrial Fire Department | <input type="checkbox"/> Search & Rescue |
| <input type="checkbox"/> Federal Fire Department | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Other _____ |

Response Information

Please provide the number for each EMS activity listed below, for your last full calendar year (if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information):

Primary Responses	<input type="text"/>	Transports Primary/Secondary	<input type="text"/>
Secondary Responses	<input type="text"/>	Inter-facility Transports Only	<input type="text"/>

3. Personnel Status

Please submit your current roster from the Department of Health EMS Certification Online.

Staffing Model: Paid Volunteer Combination

Number of EMS personnel that are: _____ Paid _____ Volunteer _____ Combination

Number of personnel non-credentialed that are: _____ AFA (Advanced First Aid) _____ Non-Medically Trained Drivers

4. EMS Supervisor Information

EMS Supervisor	WA State DOH Credential # (if applicable)
Email Address	Phone (enter 10 digit #)

5. Supervision

Name of County Medical Program Director	WA State DOH Credential #
Name of MPDD/Agency Physician	WA State DOH Credential #

6. Additional Information

Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone (enter 10 digit #)	Title

Change of Ownership Information

Previous Name of Legal Owner	Previous Service Credential #
Previous Name of Service	Effective Date of Change

7. Emergency Medical Vehicles

Please provide the following information for all vehicles to be licensed. Vehicle location is the address in which the vehicle is physically located. Indicate the type of vehicle(s):

AMB = ambulance; AID = aid vehicle (as defined in [RCW 18.73.030](#) and consistent with [RCW 70.168](#)).

See our website for the complete [EMS and Trauma Care System Statutes](#).

Physical address of vehicle

City	State	Zip Code	County
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Vehicle Information

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
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License Plate Number	VIN
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Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
------	----------------	---

License Plate Number	VIN
----------------------	-----

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
------	----------------	---

License Plate Number	VIN
----------------------	-----

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
------	----------------	---

License Plate Number	VIN
----------------------	-----

Physical address of vehicle

City	State	Zip Code	County
------	-------	----------	--------

Vehicle Information

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
------	----------------	---

License Plate Number	VIN
----------------------	-----

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
------	----------------	---

License Plate Number	VIN
----------------------	-----

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
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License Plate Number	VIN
----------------------	-----

Year	Make and Model	<input type="checkbox"/> AMB <input type="checkbox"/> AID
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License Plate Number	VIN
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8. General Operation

Please describe the general operation of your service; including how it will operate in a manner consistent with [WAC 246-976](#), the Regional Plan, and approved Regional Patient Care Procedures. For more information on agency and vehicle licensing see [website](#).

Provide an explanation of your:

1. Dispatch plan _____

2. Response plan _____

3. Response area _____

4. Tiered response and rendezvous _____

5. Back-up plan to respond (may not apply to agencies doing interfacility transports only) _____

Note: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach additional completed pages if you need more space.

9. Rural Attestation:

To be completed by agencies with non-medically trained ambulance drivers

I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. We have verified that each non-medically trained driver is at least 18 years of age.
2. We have performed a Washington State Patrol background check and have verified that each non-medically trained driver has no reported offenses.
3. We have verified that each non-medically trained driver holds a valid driver's license with no restrictions.

Signature of Owner/Operator

Date

Print Name

Print Title

10. Signatures

I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. We operate in a manner that is consistent with the Washington State Triage tools; EMS and Trauma Care Council Regional Plan, pre-hospital Patient Care Procedures, and department approved County Operating Procedures.
2. Our current certified EMS personnel are familiar with and utilize a Department of Health approved Medical Program Director (MPD) patient care protocols.
3. The vehicles identified on page three meet the minimum equipment requirements for the level requested by our service.
4. We meet the minimum staffing requirements as identified on page four.
5. We maintain current liability insurance coverage.
6. In accordance with [RCW 43.70.490](#), our certified EMS personnel are adequately trained in and familiarized with techniques, procedures, and protocols for best handling situations in which persons with particular disabilities are present at the scene of an emergency.

Signature of Owner/Operator

Date

Print Name

Print Title

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Emergency Medical Services and Trauma System, RCW 18.71](#)

[Emergency Medical Services and Trauma System, RCW 18.73](#)

[Emergency Medical Services and Trauma System, WAC 246-976](#)

Online

[Emergency Medical Services and Trauma System web page](#)