EMERGENCY VEHICLE ADD SHORT FORM APPLICATION

INSTRUCTIONS

This application is to be completed in full by the applicant. You are strongly encouraged to contact your Regional EMS Coordinator for any assistance you may require in completing this application. Please review Connecticut General Statutes and Connecticut General Statutes section 19a-180(i)(j) governing adding a vehicle once every three years prior to completing this application.

The Office of Emergency Medical Services (OEMS) shall review the application for completeness. It shall be the sole responsibility of the OEMS to deem the application complete.

Except in the case where a primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner not later than fifteen calendar days after receiving such notice, the application shall be deemed approved thirty calendar days after filing.

NOTE: Local EMS Planning is the responsibility of the municipality. Any affected municipality should be included in discussions regarding modifying EMS resource deployment or system design.

The following must be included in your submission:

1. A completed application;
2. Required attachments:
   a. Explanation justification for adding this vehicle
   b. List of EMS organizations notified of intent to add this vehicle. This must include all PSARs within and abutting the municipality in which applicant intends to add vehicle.
   c. Proof notification was sent to PSARs within or abutting the municipality where the additional vehicle will be utilized. Please find the list posted on the OEMS Homepage.
   d. Proof of insurance that includes vehicle accident, property, and medical malpractice coverage as required in CGS Section 19a-180 (a).

Submit the original application (including all required attachments) to the address below, to the attention of the Regional EMS Coordinator.
Please remember to retain a copy for your records.

Department of Public Health
Office of Emergency Medical Services
410 Capitol Avenue, MS#12EMS
PO Box 340308
Hartford, CT 06134-0308
(860) 509-7975

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

EMERGENCY VEHICLE ADD SHORT FORM APPLICATION

PROVIDER INFORMATION

Legal Name of Service: _____

Business Address: _____

_____

Person completing this form: _____

Title: _____

Primary Telephone: _____ Secondary Telephone: _____

Email: _____

Vehicle requesting to add:

☐ Ambulance ☐ Paramedic non-transport vehicle ☐ Other (specify) _____

Provide the following data for the previous 12 month period:

Total number of 911 requests for service	
Average response time (in minutes)	
Total number of passed calls	

ATTACHMENTS (REQUIRED)

All attachments must be clearly numbered and referenced.
Example: "See ATTACHMENT 1 – EXPLANATION JUSTIFICATION FOR ADDING VEHICLE"

☐ **ATTACHMENT 1 - EXPLANATION JUSTIFICATION FOR ADDING VEHICLE**
Provide a narrative justifying the reason for requesting the addition of this vehicle.

☐ **ATTACHMENT 2 – LIST OF EMS ORGANIZATIONS NOTIFIED**
Provide a list of EMS organizations notified of intent to add this vehicle. This must include all PSARs within and abutting the municipality in which applicant intends to add vehicle.

☐ **ATTACHMENT 3 - PROOF OF NOTIFICATION**
Provide proof that notification required in Attachment 2 was sent (ie – signed USPS return receipt request forms).

☐ **ATTACHMENT 4 – PROOF OF INSURANCE**
Provide Proof of insurance that includes vehicle accident, property, and medical malpractice coverage.

FOR OEMS USE ONLY	
DATE RCVD:	RC REVIEW COMPLETE:
DEEMED COMPLETE DATE:	OEMS DIRECTOR SIGNATURE

SIGNATURE PAGE FOR CHIEF EXECUTIVE OFFICER OR OTHER AUTHORIZED AGENT

I, the undersigned, acknowledge that the information provided within this application is current and accurate. I understand and agree that the approval of this upgrade is contingent upon the continuance of medical direction and compliance with the Connecticut General Statutes and Regulations of Connecticut State Agencies governing the delivery of emergency medical services.

Name (print)	**Signature**
Title	**Date**

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