



**GEORGIA OFFICE OF EMS and Trauma  
EMS LICENSE APPLICATION VERIFICATION FORM**

Date Received \_\_\_\_\_

<input type="checkbox"/> New License	<input type="checkbox"/> Anniversary	<input type="checkbox"/> Renewal	<input type="checkbox"/> Revision
<input type="checkbox"/> First Responder	<input type="checkbox"/> Ground Ambulance	<input type="checkbox"/> Neonatal Transport	<input type="checkbox"/> Air Ambulance

**SERVICE NAME** \_\_\_\_\_

**COUNTY** \_\_\_\_\_

LICENSE NUMBER(s)	LICENSE TYPE
	<i>Medical First Responder</i>
	<i>Ground Ambulance</i>
	<i>Neonatal Transport</i>
	<i>Air Ambulance</i>

DOCUMENT	VERIFICATION
<input type="checkbox"/> GAEMS 1000 MAIN APPLICATION FORM	
<input type="checkbox"/> SUPPLEMENTAL FORM (IF APPLICABLE)	
<input type="checkbox"/> PHOTOGRAPH ( If New Application)	
<input type="checkbox"/> (GAEMS 3012 or Electronic) INSPECTION FORM	
<input type="checkbox"/> (SCHEDULE A) INSURANCE CERTIFICATE	
<input type="checkbox"/> (SCHEDULE B) MEDICAL DIRECTOR	
<input type="checkbox"/> (SCHEDULE C) PHARMACY / IV CONTRACT	
<input type="checkbox"/> DRUG / IV LIST	
<input type="checkbox"/> (SCHEDULE D) AFFIDAVIT OF RESIDENCY	
<input type="checkbox"/> (SCHEDULE E) PERSONNEL INFORMATION FORM	
<input type="checkbox"/> (SCHEDULE F) VEHICLE INFORMATION FORM	
<input type="checkbox"/> EXTRICATION LETTER From EMS Program Director	
<input type="checkbox"/> CORPORATION REGISTRATION (if required)	
<input type="checkbox"/> LICENSE FEE (\$2,500.00 + \$1,400.00 PER Ground Ambulance Air Ambulance or Neonatal Vehicle)	\$
<input type="checkbox"/> OTHER DOCUMENTS:	

<b>REGIONAL EMS COORDINATOR:</b>	<b>DATE:</b>
<b>INSPECTOR:</b>	<b>DATE:</b>
<b>APPROVED:</b>	<b>DATE:</b>



**EMERGENCY MEDICAL SERVICES LICENSURE APPLICATION**  
**GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA**  
**GA-EMS 1000 Main Form**

CLASSIFICATION				
1 (Select One)	<input type="checkbox"/> New	<input type="checkbox"/> Anniversary	<input type="checkbox"/> Renewal	<input type="checkbox"/> Revision
2 Type of License: (Select all that apply)	<input type="checkbox"/> First Responder	<input type="checkbox"/> Ground Ambulance	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Air Ambulance
3 Service Delivery Contract	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>(If service Delivery Contract then omit 22-24)</i>	

OWNERSHIP				
4 (Select One)	<input type="checkbox"/> Individual <input type="checkbox"/> State <input type="checkbox"/> Government	<input type="checkbox"/> Partnership <input type="checkbox"/> County <input type="checkbox"/> Government	<input type="checkbox"/> Corporation <input type="checkbox"/> City <input type="checkbox"/> Government	<input type="checkbox"/> Private Hospital <input type="checkbox"/> Hospital <input type="checkbox"/> Authority
5a Name of Owner:		5b Email Address:		
6a Owner Street Address or P.O. Box:			6b Business Phone:	
7a City:	7b State:	7c Zip Code:	7d Fax Number:	
8a Authorized Agent:		8b Email Address:		
9a Street Address or P.O. Box:			9b Business Phone:	
10a City:	10b State:	10c Zip Code:	10d Fax Number:	
11a Registered Agent if a Corporation		11b Email Address:		
12a Street Address or P.O. Box:			12b Business Phone:	
13a City:	13b State:	13c Zip Code:	13d Fax Number:	

BASIC QUALIFICATIONS			
14 Has the owner or any party to this application had any certification or license revoked or had any other disciplinary actions levied from any state or federal agency? <span style="float:right">__ Yes    __ No</span>			
<i>* If "yes," attach documentation explaining the circumstances.</i>			
15 Has the owner or any party to this application ever been convicted of a felony by this or any other state or federal court? <span style="float:right">__ Yes    __ No</span>			
<i>* If "yes," attach documentation explaining the circumstances.</i>			
16 Is the owner or any party to this application currently in any pending matter referred to in the preceding two items? <span style="float:right">__ Yes    __ No</span>			
<i>* If "yes," attach documentation explaining the circumstances.</i>			
17a Doing Business as:			17b License Number
<b>Name of Service(s):</b>	<b>Type of Service :</b>	<b>License Number:</b>	<b>Level of Care:</b>
18a	FIRST RESPONDER	18b	18c
19a	GROUND AMBULANCE	19b	19c
20a	NEONATAL	20b	20c
21a	AIR AMBULANCE	21b	21c

**22 Types and Number of Personnel Employed**

EMTs: <b>22a</b>	Intermediates: <b>22b</b>	Advanced EMTs: <b>22c</b>	Cardiac Technicians: <b>22d</b>	Paramedics: <b>22e</b>
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<b>23 Types and Number of Vehicles</b>	First Responder: <b>23a</b>	Ground Ambulance: <b>23b</b>	Neonatal: <b>23c</b>	Air Ambulance: <b>23d</b>
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**24 Total Number of Vehicles:** \_\_\_\_\_

**BASE LOCATION**

<b>25a</b> Base Location – Street Address:	<b>25b</b> County:
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<b>26a</b> City:	<b>26b</b> State: <b>Georgia</b>	<b>26c</b> Zip Code:	<b>26d</b> Zoned Provider:
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<b>27a</b> Director:	<b>27b</b> Email Address:
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<b>28a</b> Business Phone:	<b>28b</b> Emergency Phone:	<b>28c</b> Fax Number:	<b>28d.</b> Additional Locations? __ Yes __ No
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**ADDITIONAL LOCATION(S) MUST BE RECORDED ON FORM GA-EMS 1000 – SUPPLEMENTAL**

**INFECTIOUS DISEASE EXPOSURE CONTROL**

<b>29a.</b> Name of Direct Contact:	<b>29b.</b> Email Address:
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**30a** Street Address:

<b>31a</b> City:	<b>31b</b> State:	<b>31c</b> Zip Code:	<b>31d</b> 24-Hour Contact Number:
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**COMMUNICATION**

<b>32a</b> Agency or Company Name:	<b>32b</b> Name of Contact Representative:
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<b>33a</b> Email Address:	<b>33b</b> Business Phone:	<b>28c</b> Fax Number:
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<b>34a</b> Street Address:	<b>34b</b> Emergency Phone:
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<b>35a</b> City:	<b>35b</b> State:	<b>35c</b> Zip Code:	<b>35d</b> County
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**CERTIFICATION**

**I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE, AND THAT I WILL NOTIFY THE OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA IN WRITING OF ANY CHANGE IN MY EMPLOYMENT AGENCY, HOME OR MAILING ADDRESS, TELEPHONE NUMBER OR EMAIL ADDRESS. I UNDERSTAND THAT ANYONE WHO MAKES FALSE STATEMENTS TO THE DEPARTMENT MAY BE SUBJECT TO CRIMINAL PROSECUTION UNDER OFFICAL CODE OF GEORGIA SECTION 16-10-20; AND, THAT FALSE STATEMENTS MAY FURNISH GROUNDS FOR THE DENIAL OR REVOCATION OF A LICENSE.**

**36** Owner's Name:

<b>37a.</b> Signature:	<b>37b.</b> Date:
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**38** Authorized Agent's Name:

<b>39a.</b> Signature:	<b>39b.</b> Date:
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**INSURANCE INFORMATION**

Name of Service	License Number(s)	License Type	Base Location
1a	1b	MEDICAL FIRST RESPONDER	1c
2a	2b	GROUND AMBULANCE	2c
3a	3b	NEONATAL	3c
4a	4b	AIR AMBULANCE	4c

**5 Vehicle Identification Number (s) of Vehicles (s) Insured:**

1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

**6 Policy Number(s):**

<b>7a Amount of Coverage: (must be equal to or in excess of \$1,000,000 CSL)</b>			<b>7b Date of Effective Coverage:</b>		
<b>Person:</b>	<b>Accident:</b>	<b>Property:</b>	<b>Month/Day/Year</b>	<b>to</b>	<b>Month/Day/Year</b>

***The undersigned further certifies, as an agent for the company, that the above information is true and correct and if the insurance is terminated for any reason (canceled, revoked, expired, etc.) the company or its agent will within ten (10) calendar days, provide written notice to the Department at the address listed below.***

**Georgia Department of Public Health  
Office of Emergency Medical Services and Trauma  
1680 Phoenix Boulevard, Suite 200  
Atlanta, Georgia 30349**

<b>7a Printed Name of Insurance Agent or Insurance Representative:</b>	<b>7b Insurance Company Providing Coverage:</b>
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<b>8a Signature of Insurance Agent or Insurance Company Representative:</b>	<b>8b Date:</b>	<b>8c Business Phone:</b>
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<b>9 Address:</b>	Street	City	State	Zip Code
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<b>10a Service Owner or Authorized Agent's Name</b>	<b>10b Title:</b>
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<b>11a Service Owner or Authorized Agent's Signature</b>	<b>11b Date:</b>
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## Medical Director Agreement

EMS PROVIDER INFORMATION			
Name of Service	License Number(s)	License Type	County
1a	1b	MEDICAL FIRST RESPONDER	1c
2a	2b	GROUND AMBULANCE	2c
3a	3b	NEONATAL	3c
4a	4b	AIR AMBULANCE	4c

MEDICAL DIRECTOR INFORMATION			
5a Name of Medical Director:		5b Email Address:	
6a Street Address or P.O. Box:			6b Business Phone:
7a City:	7b State:	7c Zip Code:	7d Fax Number:
8a Area of Specialty:			8b Georgia License Number:

AGREEMENT
<p>I am a physician licensed to practice medicine in Georgia and have agreed to serve as the Medical Director for the above-identified EMS Provider. This contract is valid for a maximum of twenty five (25) months from the date of signing and must be renewed in conjunction with the license renewal.</p> <p>As Medical Director, I will provide medical direction and training in conformance with O.C.G.A. 31-11, Department Rules and Regulations, and Policies established by the Office of Emergency Medical Services and Trauma. I have read and do hereby affirm that I understand and will abide by all requirements contained therein.</p> <p>If I should decide to relinquish my role as Medical Director, I will notify the Department of Public Health (DPH), Office of Emergency Medical Services and Trauma (address below), and the EMS Provider in writing not less than ten (10) calendar days prior to the termination of the agreement.</p> <p style="text-align: center;"><i>Georgia Department of Public Health  Office of Emergency Medical Services and Trauma  1680 Phoenix Boulevard, Suite 200  Atlanta, Georgia 30349</i></p>

SIGNATURES	
9 Owner or Authorized Agent:	
10a Signature:	10b Date:
11 EMS Medical Director:	
12a Signature:	12b Date:



### Pharmaceutical Agreement

EMS PROVIDER INFORMATION			
Name of Service	License Number(s)	License Type	County
<b>1a</b>	<b>1b</b>	MEDICAL FIRST RESPONDER	<b>1c</b>
<b>2a</b>	<b>2b</b>	GROUND AMBULANCE	<b>2c</b>
<b>3a</b>	<b>3b</b>	NEONATAL	<b>3c</b>
<b>4a</b>	<b>4b</b>	AIR AMBULANCE	<b>4c</b>

PHARMACY INFORMATION			
<b>5a</b> Name of Pharmacy:		<b>5b</b> Georgia License Number:	
<b>6a</b> Street Address or P.O. Box:		<b>6b</b> Business Phone:	
<b>7a</b> City:	<b>7b</b> State:	<b>7c</b> Zip Code:	<b>7d</b> Fax Number:
<b>8</b> Email Address:			

### AGREEMENT

This is an agreement between the above listed agencies relative to the control, procurement, handling, and accountability of drugs and intravenous fluids (IVs). Attached to this document are copies of all appropriate agreements and contracts between the above-mentioned EMS Provider and Georgia Licensed Pharmacy or Wholesaler and a list of pharmaceutical agents approved for use, and related policies established and signed by the Medical Director of the licensed emergency medical service provider ("EMS Medical Director"). This agreement will be valid for a maximum of twenty five (25) months from the date of signing and must be renewed in conjunction with the license renewal, prior to the expiration of the twenty five (25) months.

The pharmacy entering into this Agreement agrees to supply drugs and/or IVs to the EMS Provider in accordance with O.C.G.A. §26-4-116. A wholesaler entering into this Agreement agrees to distribute drugs and/or IVs to the above-referenced EMS Provider in accordance with O.C.G.A. §16-13-72 and GA. Comp. r. & Regs. r. 480-7-.03(5) of the Rules of the State Board of Pharmacy. A pharmacy/wholesaler is also required to abide by the policies of the State Office of Emergency Medical Services and Trauma (OEMS) and the EMS Medical Director's instructions. The drugs and IVs approved for use will be treated as standard ward inventory, as defined by the Rules of the State Board of Pharmacy (Chapter 480-13). In the event that there are any local policies developed related to the procurement, control, storage, handling, accountability, and/or administration of pharmaceuticals, which conflict with the GA. Comp. r. & Regs. r. 511-9-2 of the Rules of the Department of Public Health (DPH) and the policies established by the State Office of Emergency Medical Services, as amended, the DPH rules and OEMS shall be followed, unless the local policies are more stringent. Copies of this agreement shall be maintained by the pharmacy or Wholesaler, EMS Medical Director and EMS Provider. The original will be given to the DPH and OEMS.

If for any reason this contract is cancelled or otherwise changed at any time, the Pharmacy and licensed EMS provider shall notify OEMS in writing no later than ten (10) days prior to such change or cancellation.

### SIGNATURES

<b>9a</b> Pharmacy Representative:	<b>9b</b> Owner or Authorized Agent:	<b>9c</b> EMS Medical Director:
<b>10</b> Title:		
<b>11a</b> Signature:	<b>11b</b> Signature:	<b>11c</b> Signature:
<b>12a</b> Date:	<b>12b</b> Date:	<b>12c</b> Date:



### GEORGIA DEPARTMENT OF PUBLIC HEALTH

#### Verification of Lawful U.S. Residency for License Application O.C.G.A. Section 50-36-1(e)(2)

As part of my application for licensure from the Georgia Department of Public Health, I hereby swear, under oath, that I am:

[Check one of the following]

- (1) \_\_\_\_\_ A citizen of the United States;
- (2) \_\_\_\_\_ A legal permanent resident of the United States;

or

- (3) \_\_\_\_\_ A qualified alien or non-immigrant under the Federal Immigration and Nationality Act. The alien number assigned to me by the United States Department of Homeland Security or other federal immigration agency is Alien Number \_\_\_\_\_.

I also swear that I am eighteen years of age or older, and that I have provided at least one secure and verifiable identity document with this affidavit, as required by O.C.G.A. Section 50-36-1(e)(1). The secure and verifiable document is my \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_.

*The original "secure and verifiable document" was shown to the notary public, and a true copy of the document is attached to my application with this affidavit.*

In making these representations, I understand that any person who knowingly and willfully makes a false statement in an affidavit on any matter within the jurisdiction of state government shall be guilty of a violation of O.C.G.A. Section 16-10-20 and face criminal penalties authorized by that statute.

\_\_\_\_\_  
Signature of Applicant

Subscribed and sworn before me this \_\_\_\_\_  
day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Printed Name Of Applicant

\_\_\_\_\_  
Notary Public

My Commission Expires \_\_\_\_\_

**Secure and Verifiable Documents Under O.C.G.A. § 50-36-2**

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver’s license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document for proof of or documentation of identity, that document will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]





