

**Ambulance Supplemental Application**  
(Complete in addition to the Commercial Automobile Application)

**PROVIDE COPIES OF DRIVER TRAINING MANUAL AND SAFETY PROCEDURES**

**Applicant's Name:** \_\_\_\_\_

**1. Description of operations:** \_\_\_\_\_

Number of years in business: \_\_\_\_\_ Number of years under current management: \_\_\_\_\_

**2. Is your service a subsidiary or division of another company?** .....  Yes  No

If yes, advise the name of the company, their address and their relationship to you: \_\_\_\_\_

**3. Has this service ever operated under another name?**.....  Yes  No

If yes, what name? \_\_\_\_\_

**4.  Profit  Nonprofit—Source of funding:** \_\_\_\_\_

**5. Do your employees work more than one shift per day?** .....  Yes  No

If yes, provide shift details: \_\_\_\_\_

**6. Number of trips per year:** \_\_\_\_\_

Number of emergency: \_\_\_\_\_ Number of non-emergency: \_\_\_\_\_

Percentage of wheelchair transport:..... \_\_\_\_\_% Percentage of stretcher transport: ..... \_\_\_\_\_%

**7. Is transportation provided to non-medical destinations?** .....  Yes  No

Daycare Centers ..... \_\_\_\_\_% Heliport or Airport..... \_\_\_\_\_% Psychiatric Centers..... \_\_\_\_\_%

Schools ..... \_\_\_\_\_% Shopping Centers ..... \_\_\_\_\_% Workplaces ..... \_\_\_\_\_%

Senior Centers ..... \_\_\_\_\_% Other ..... \_\_\_\_\_% Describe: \_\_\_\_\_

**8. A. List major cities entered:** \_\_\_\_\_

**B. What percentage of the operations involves transportation in these cities?** ..... \_\_\_\_\_%

**9. Number of units equipped with lights and sirens?** \_\_\_\_\_

**10. Who dispatches your calls?**  911  Outside sources  In-house by your own employees or volunteers

11. Do you distribute any medical supplies or equipment?.....  Yes  No

If yes, provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Indicate level of training and number of individuals who drive and/or provide client care (full-time, part-time or volunteer):

	EMT BASIC	EMT ADVANCED	EMT PARAMEDIC	OTHER	NO CERTIFICATION
NUMBER OF EMPLOYEES					
NUMBER OF VOLUNTEERS					

If "other" marked above, explain: \_\_\_\_\_

13. Identify the types of special driver training programs that your drivers receive:

- General driver orientation                       Defensive driving                       Primary first aid
- Advanced first aid                                       CPR                                       Passenger assistance training
- Human relations skills                       Nonmedical emergency training                       Emergency vehicle evacuation
- Emergency vehicle operators course (EVOC)

14. Do you:

- Screen employees and drivers' histories for sexual abuse charges and convictions? .....  Yes  No
- Verify licenses/professional certificates?.....  Yes  No
- Screen employees for previous involvement as defendants in malpractice litigation? .....  Yes  No

15. How many vehicles are equipped with the following wheelchair tie-down mechanism?

3 point tie-down \_\_\_\_\_ 4 point tie-down \_\_\_\_\_

16. Are any vehicles not equipped with both lap belts and shoulder harnesses for the passengers?  Yes  No

17. Describe wheelchair and stretcher tie-down procedures: \_\_\_\_\_  
 \_\_\_\_\_

18. Is there an accident review procedure?.....  Yes  No

If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

19. Describe vehicle maintenance program: \_\_\_\_\_  
 \_\_\_\_\_

20. Does Applicant carry Professional Liability coverage? .....  Yes  No

Policy Number	Carrier	Limits	Term	Is Loading & Unloading Included?
				<input type="checkbox"/> Yes <input type="checkbox"/> No

21. Does Applicant carry General Liability coverage? .....  Yes  No

Policy Number	Carrier	Limits	Term

22. Are all vehicles owned by you? .....  Yes  No

If no, explain: \_\_\_\_\_

Are they leased, etc.? .....  Yes  No

Give details: \_\_\_\_\_

\_\_\_\_\_

23. Do any employees/volunteers use their own vehicles in your business? .....  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Are any employees/volunteers' vehicles used for client transport? .....  Yes  No

24. Are all employees covered by Worker's Compensation? .....  Yes  No

If yes, provide carrier name: \_\_\_\_\_

\_\_\_\_\_

25. Any other pertinent information about your business: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**FRAUD WARNING (APPLICABLE IN FLORIDA):**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**FRAUD WARNING (APPLICABLE IN MAINE):**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

APPLICANT'S NAME AND TITLE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

AGENT NAME: \_\_\_\_\_ AGENT LICENSE NUMBER: \_\_\_\_\_

(Applicable to Florida Agents Only)