



Today's Date: _____

BASIC INFORMATION:

1. Named Insured: _____ 2. DBA: _____
3. Mailing Address: _____
4. Physical Address: _____
5. Phone: _____ 6. Fax: _____
7. Website Address: _____
8. Owners Name: _____ 9. Email Address: _____
10. Safety Manager's Name, Cellphone Number & Email Address: _____
11. Type Of Entity: Corporation Individual Partnership Joint Venture LLC
12. FEIN/Social Security Number: _____
13. Date business started under current ownership: _____ Is this a new venture? Yes No
14. Are ICC, PUC or other filings required? Yes No (If yes, provide copies.)
15. Is your business a subsidiary or division of a parent company? Yes No If yes, name of company: _____
16. Has your business, its owner(s), officers, directors or employees ever been party to any civil, criminal or regulatory proceedings resulting in an administrative sanction or license suspension or revocation? Yes No If yes, please explain on a separate sheet.
17. Has your business had a change of ownership in the past 3 years? Yes No
 If yes, please explain: _____

OPERATIONAL INFORMATION:

1. List the major metropolitan area(s) served:
 A. _____ B. _____
2. The number of ambulance calls in the past 12 months? Emergency _____ Non Emergency _____
 The estimated ambulance calls in the next 12 months? Emergency _____ Non Emergency _____
3. The number of paratransit/wheelchair calls in the past 12 months: _____
 The estimated paratransit/wheelchair calls in the next 12 months: _____
4. Does your service perform the following?
Thrombolytic Therapy Conscious Sedation Endotracheal Intubation Capnography or Capnometry Pulse Oximetry
Manual Defibrillation 12-Lead EKG Monitoring Telemetry Mechanical Ventilation IV Therapy or Monitoring
5. Does your service have a Medical Director? Yes No
6. Number of full and part time employees/volunteers that drive or provide patient care:
 _____ Paramedics
 _____ Critical Care Paramedics
 _____ Registered Nurses
 _____ Advanced EMT (EMT-A or EMT-I)
 _____ Emergency Medical Tech (EMT-B)
 _____ Emergency Medical Responder (EMR, First Responder)
 _____ Other
 _____ TOTAL

7. What are the vehicle counts for the following classifications:

Type of Auto	As of Today	Renewal Date 1 year ago	Renewal Date 2 years ago
Ambulances			
Paratransit/Wheelchair			
First Responder			
Service (all other autos)			

8. Patient Handling: Stretcher

a) Select all Stretcher types used at your service and give the brand and number of each type:

Type of Stretcher	Brand	Number
X-Frame		
Fold Away Undercarriage		
Power Cot		
Bariatric Cot		
Other		

b) Does your service use knee, hip, chest and over the shoulder safety restraints on your stretchers? Yes No

c) Does your service have a mandatory lift assist policy? Yes No

d) Select the engineering controls used at your service and given the brand and number of each type:

Engineering Control	Brand	Number
Specialty Vehicles (Bariatric Units)		
Ramps with Winches		
Lateral Transfer Aids		
Motorized Stair Chairs		
Other		

9. Patient Handling: Wheelchair

a) Name the wheelchair tie-down occupant restraint system (WTORS) you use:

b) Provide product documentation that the WTORS meets SAE J2249 (WTORS) ISO 10542 standards.

c) If you do not use a commercially developed WTORS, please provide a copy of the section of your SOP that outlines the manner in which you use the system to tie down a wheelchair and restrain its occupant.

d) Please provide the section of your SOP that addresses the transportation of a scooter and its user.

10. Do you transport prisoners or others whose pick up site is determined by their legal status? Yes No

If yes, please list the contracts responsible for these transports and provide a copy of your restraint policy including obligations regarding client escape: _____

11. Onboard Monitoring (OBM) (black box, cameras, GPS, stickers)

a) Brand name of system(s): _____

b) Date the system was installed: _____

c) Number of vehicles currently installed with the system: _____

d) Employee responsible for the management of the OBM:

Name: _____ Phone Number: _____

Email: _____

12. Dispatch

a) Is your dispatch center a Public Safety Answering Point (PSAP)? Yes No

If no, please check the following if it applies:

PSAP directly dispatches your units

PSAP refers calls to your service for internal dispatch.

You do not interact with a PSAP.

b) Check the functions performed by your internal dispatchers:

Dispatch emergency requests for your service.

Screen calls to determine whether or not an ambulance will be sent.

Dispatch non-emergency requests for you service.

Schedule routine ambulance transfers.

Schedule wheelchair/paratransit transfers.

- c) How many years experience are dispatchers required to have prior to hiring? _____
- d) Are your dispatchers Emergency Medical Dispatch Certified? Yes No
- e) Describe your in-house training for dispatchers, including length of training: _____

f) The name of the dispatch software used: _____

13. Is your business involved in:
- Air Ambulance Water Rescue Off-Shore EMS Aerial Rescue Tactical Medic Services Confined Space Rescue
 - Special Events: Car/Motocross Races Horse Races Concerts High School Sports Professional Sports
 - Night Clubs Rave Events
- Total Annual Receipts from the above contracts: _____
14. Is your service involved in activities or operations other than EMS? Yes No
 If yes, explain: _____

VEHICLE MAINTENANCE

- 1. Is a condition report completed on each transport vehicle and its equipment on each shift? Yes No
 If no, please explain: _____
- 2. Does the maintenance schedule for your fleet meet or exceed the manufacturer's recommendations? Yes No
 If no please explain: _____
- 3. Who performs the maintenance on your fleet? _____
 Are they certified by the manufacturer? Yes No
- 4. Do you keep maintenance repair records on file for each vehicle? Yes No
 If no, please explain: _____
- 5. Do you perform any after-market vehicle modifications? Yes No
 If no, please explain: _____

HUMAN RESOURCE

- 1. Please provide the following information for the person who is responsible for new employee orientation:
 Name: _____ Title: _____
 Cell Phone: _____ Email: _____
- 2. Check all that apply to your employee selection process:
Written Application Job Specific Physical Examination Psychological Testing Criminal Background Check
MVR Check Obtain evidence of Pertinent Certification Licensure Post Employment Drug Screening
- 3. Is previous ambulance driving experience required on new hires? Yes No
 If yes, how many years? _____
- 4. Please provide the name of the driver training program(s) that you provide or participate in : _____
 # of Classroom Hours: _____ # of Behind the Wheel Hours: _____
- 5. What is your employee turnover rate? _____

SAFETY/RISK MANAGEMENT

- 1. Is a record kept of each request for service? Yes No
- 2. Is a trip ticket for billing purposes completed for each transport? Yes No
- 3. Is a patient care report (PCR) completed for each transport in which medical care, evaluation or observation has been performed? Yes No N/A

4. What % of your trip tickets and call reports are reviewed for completeness, legibility and when applicable, clinical content? _____
 How frequently are they reviewed? Daily Weekly Other _____
 Who is responsible for the reviews?
 Name: _____ Title: _____
 Phone #: _____ Email: _____
5. At what speed may your ambulances operate with the Emergency Warning Systems (EWS) activated? _____
6. Who determines when the EWS is to be activated? _____
7. Are your vehicles always locked when unattended? Yes No
8. Do you require third party riders (non patient/ non EMS personnel) to sit in the front passenger seat unless the patient's well being requires the rider to be in the back of the ambulance? Yes No
9. Does your service maintain accident files? Yes No If yes, for how long do you keep the files? _____
10. Are safety violations (i.e. auto crashes) part of your progressive discipline process? Yes No
11. Does your service have a Medical Equipment Failure policy? Yes No
 If yes, does it address checking, charging and replacing batteries for medical equipment? Yes No
12. Do you have a violent patient restraint policy? Yes No

WORKERS' COMPENSATION

Name of Carrier: _____
 Policy #: _____ Eff. Dates: _____ to _____
 Employers Liability Limit: \$ _____
 Bodily Injury by Accident: \$ _____ Each Accident
 Bodily Injury by Disease: \$ _____ Policy Limit
 Bodily Injury by Disease: \$ _____ Each Employee

LIMITS OPTIONS

Automobile Liability Limits (check one):
\$500,000 Combined Single Limit Bodily Injury & Property Damage
\$1,000,000 Combined Single Limit Bodily Injury & Property Damage

Professional Liability and General Liability Limits (check one):
\$500,000 any one claim/\$1,000,000 annual aggregate
\$1,000,000 any one claim/\$2,000,000 annual aggregate
\$1,000,000 any one claim/\$3,000,000 annual aggregate

Excess Liability:
 Please provide limit: _____

Inland Marine (medical equipment/inventory): Blanket limit: _____ Deductible: \$500 \$1000

Auto Physical Damage Deductible Options (check one):
\$500 \$1,000 \$2,000

Is Property Coverage desired? Yes No If yes, please complete the Acord Property application.