



**Para-Transit Pro Application**  
(Must be attached to Acord Application)



**Para-Transit Pro**

PO Box 440549 Kennesaw, GA 30160  
Phone: (678) 290-2100  
www.thomcoins.com

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 para-transit/wheelchair calls in the past 12 months? \_\_\_\_\_  
The estimated para-transit/wheelchair calls in the next 12 months? \_\_\_\_\_

3. Please advise the following regarding the use of oxygen:
- a. Do you provide oxygen to passengers? Yes No
  - b. Do you transport passengers who are carrying a portable oxygen system? Yes No
  - c. Do you have a policy that requires the securement of the passenger's portable oxygen system? Yes No
  - d. Do you refill oxygen tanks? Yes No
  - e. Are your employees involved with the administration of oxygen? Yes No

4. Number of full and part time employee/volunteer drivers:

_____	Drivers
_____	Management
_____	Registered Nurses
_____	EMTs
_____	Other
_____	TOTAL

5. 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
Wheelchair Vans			
Stretcher Vans			
Ambulatory Vehicles			
Service (all other autos)			

6. 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		

7. 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.

8. 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: \_\_\_\_\_

9. Is your service involved in activities or operations other than medical transportation? 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

**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. Are your vehicles always locked when unattended? Yes No

4. Do you transport prisoners? Yes No

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

5. Does your service maintain accident files? Yes No If yes, for how long do you keep the files? \_\_\_\_\_

6. Are safety violations (i.e. auto crashes) part of your progressive discipline process? 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 \$1,000

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.