CITY OF URBANA

AMBULANCE SERVICE APPLICATION

Fiscal Period Covered July 1, 2023 - June 30, 2024

LICENSE FEE: $14,500.00

FINANCE OFFICE USE ONLY
Business Account #: _____
License #: _____
Date Received: _____

Mail to: 400 South Vine Street, Attn: Finance Department, Urbana, IL 61801

1. NAME AND ADDRESS OF APPLICANT
Applicant's name, address and trade name or other assumed name under which the applicant proposes to operated the ambulance service.

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

2. NAME AND ADDRESS OF EACH OWNER OF THE AMBULANCE SERVICE
Please attach a list if more space is needed.

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

3. NUMBER OF AMBULANCES TO BE USED: _____
Please attach a description of each ambulance and state certification to be used in the operations during the period of the license.

PLEASE COMPLETE OTHER SIDE ⟶

Application for Renewal of Ambulance Service License (cont'd)

4. BUSINESS LOCATION AND ADDRESS

Please attach a list of the addresses and locations from which an ambulance or ambulances will be operated, stored, dispatched or maintained by the ambulance service whether located in or outside the city.

5. NUMBER OF PERSONNEL: _____

Please attach a list of personnel of the ambulance service with EMT certification and the personnel's respective EMT certifications.

6. SCHEDULE OF FEES AND RATES

Please attach a list of the fees and rates used to calculate the charges made for patient care and transportation services.

7. SERVICE GOALS AND OBJECTIVES

Please attach a list of the service goals and objectives used to measure the quality, effectiveness and efficiency of the ambulance service provided by the applicant. Examples include response time goals, ALS unit staffing level policy and goals for the delivery of clinical procedures such as defibrillation, intubations and IV/Drug therapy.

Submitted by: _____ Date: _____

URBANA FIRE DEPARTMENT OFFICE USE ONLY

If approved:

Approved by:_____ Date: _____

If denied:

Denied by: _____ Date: _____

Reason for denial: _____

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