

ROUTINE AMBULANCE SERVICE LICENSE APPLICATION INFORMATION SHEET

Governed by Lincoln Municipal Code Chapter [7.06](#)

Revised 4/17/2020

- **Location:** Applicant must maintain a **permanent** site within the City limits of Lincoln where ambulances are to be stationed.
- **Term:** Licenses shall be valid from the date of issuance until the following Sept. 30th. Renewal Applications should be submitted **at least** 60 days prior to expiration date.
- **Fees:** \$75.00 Application Fee due at time of submission of application. Make checks payable to **City of Lincoln**. (Please note: Payments by check authorize the City to make a one-time electronic fund transfer. Funds may be withdrawn immediately and your check will not be returned.)
- **Processing Time:** 60 days from date application is submitted.
- **Notification of Update of Information Required:** The applicant/license holder shall notify the City Clerk **immediately** with updates of any such information throughout the term of the license: 1) name and address of the applicant, 2) the authorized area of operation, 3) the location(s) at which ambulances will be stationed in the City, 4) the telephone number(s) to be dialed to request ambulance transport, 5) fee schedule.

APPLICANTS MUST ATTACH THE FOLLOWING:

- Copy of your State of Nebraska Emergency Medical Service License.
- Set of financial statements prepared in accordance with generally accepted accounting principles.
- Fee schedule showing the maximum charge to be billed for services rendered: BLS Non-Emergency, BLS Emergency, ALS Emergency, ALS 2, ALS Non-Emergency, Mileage per loaded mile, Paramedic Ambulance Standby, supplies, oxygen, medications, etc.
- A complete list of all employees, including their certification number with expiration date.
- **Certificate of Public Liability Insurance** in the minimum amount of \$5,000,000 per claim and \$10,000,000 aggregate claims per occurrence and automobile liability insurance in the minimum amount of \$5,000,000 combined single limit (bodily injury and property damage) and \$10,000,000 per occurrence combined single limit (bodily injury and property damage).
 - The City of Lincoln shall be named as an additional insured.
 - 30 day Cancellation Notice required.
- **Certificate of Professional Liability Insurance** in an amount of not less than \$10,000,000 per occurrence for each claim.
 - The City of Lincoln shall be named as an additional insured on all such policies of insurance
 - 30 day Cancellation Notice required.

Questions Contact: Brandi Lehl, 402-441-7439, blehl@lincoln.ne.gov

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**Each question must be completely answered & all attachments included OR
your application will be returned as **INCOMPLETE!****

Please PRINT using blue or black ink only.

IF APPLICANT IS AN INDIVIDUAL

Name:		
Street Address:		
City, State, Zip:		
Date of Birth:		
Length of Time Applicant has been a Resident of the City of Lincoln:		

IF APPLICANT IS A BUSINESS, PARTNERSHIP, OR ASSOCIATION

Type of Applicant (Corporation, Partnership, Association, Etc.):	
Applicant's Name (Full Name of Entity):	
Street Address:	
City, State, Zip:	
Owner's, President's, or CEO's Full Name:	
Length of Time such person has resided in Lincoln:	

NAMES OF PARTNERS, OFFICERS/DIRECTORS/CO-OWNERS AND LENGTH OF TIME SUCH PERSONS HAVE RESIDED IN LINCOLN:

Names:	Length of Time Resided in Lincoln:

CONTACT INFORMATION

Who the City should notify in the event of questions/comments and to notify regarding hearings/status of the license.

Name:		Title:	
Street Address:		City, State & Zip:	
Phone #:		E-mail Address:	
Emergency, After-Hours Telephone #:			

PHONE #(S) TO USE TO REQUEST TRANSPORT		

LOCATION WHERE AMBULANCES ARE TO BE STATIONED	
Name:	
Street Address:	
Zip Code:	
Phone #:	

OPERATIONS INFORMATION	
Do you agree to have at least one ambulance available for routine ambulance service twenty-four (24) hours daily: <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many ambulances do you propose to have available for service at one time:	

PLEASE DETAIL APPLICANT'S EXPERIENCE IN THE PROVISION OF AMBULANCE OR OTHER TYPES OF OUT-OF-HOSPITAL EMERGENCY MEDICAL SERVICES, INCLUDING BUT NOT LIMITED TO YEARS OF SERVICE, LOCATIONS OF PAST OR CONCURRENT SERVICE, TYPES OF SERVICES PROVIDED, AND ANY LICENSES OR CERTIFICATES (INCLUDING FROM THE STATE OF NEBRASKA) HELD BY THE APPLICANT (AND ITS EMPLOYEES) <i>(use separate sheet of paper if necessary). Attach a copy of your State of Nebraska Emergency Medical Service License.</i>

HAS THE APPLICANT, OR ANY PERSON IN A RESPONSIBLE POST IN APPLICANT'S ORGANIZATION, EVER BEEN CONVICTED OF ANY FELONY OR OTHER OFFENSE INVOLVING MORAL TURPITUDE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES , list name(s) of person(s) & where it occurred & explain <i>(use separate sheet of paper if necessary)</i> :		
NAME	CITY & STATE WHERE IT OCCURRED	EXPLANATION

DOES THE APPLICANT (OR THE ORGANIZATION THE APPLICANT REPRESENTS) HAVE ANY CLAIMS OR JUDGMENTS AGAINST IT (WHETHER PENDING OR RESOLVED) FOR DAMAGES ARISING FROM ANY CLAIM REGARDING CRIMINAL, RECKLESS, OR NEGLIGENT PROVISION OF AMBULANCE, PARAMEDIC, OR ANY OTHER OUT-OF-HOSPITAL EMERGENCY MEDICAL CARE: ☐ Yes ☐ No
If YES, please explain *in detail (use separate sheet of paper if necessary)*:

DOES THE APPLICANT (OR THE ORGANIZATION APPLICANT REPRESENTS) HAVE ANY CLAIMS OR JUDGMENTS (WHETHER PENDING OR RESOLVED) AGAINST IT STEMMING FROM ANY CLAIM OF DISCRIMINATORY PRACTICES RELATING TO RACE, COLOR, RELIGION, SEX, DISABILITY, NATIONAL ORIGIN, ANCESTRY, AGE, OR MARITAL STATUS? ☐ Yes ☐ No
If YES, please explain *in detail (use separate sheet of paper if necessary)*:

APPLICANT MUST ATTACH A SET OF FINANCIAL STATEMENTS PREPARED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPALS. IN ADDITION, APPLICANT MAY DISCUSS APPLICANT'S FINANCIAL ABILITY & RESPONSIBILITY BELOW IF DESIRED (*use separate sheet of paper if necessary*).

FOR EACH AMBULANCE THE APPLICANT WILL HAVE IN SERVICE WITHIN THE CORPORATE LIMITS OF THE CITY OF LINCOLN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

VEHICLE #1'S INFORMATION				VEHICLE #2'S INFORMATION			
Year:		Make:		Year:		Make:	
Model:				Model:			
VIN #:				VIN #:			
MAINTENANCE HISTORY: _____				MAINTENANCE HISTORY: _____			
_____				_____			
_____				_____			
VEHICLE #3'S INFORMATION				VEHICLE #4'S INFORMATION			
Year:		Make:		Year:		Make:	
Model:				Model:			
VIN #:				VIN #:			
MAINTENANCE HISTORY: _____				MAINTENANCE HISTORY: _____			
_____				_____			
_____				_____			

VEHICLE #5'S INFORMATION				VEHICLE #6'S INFORMATION			
Year:		Make:		Year:		Make:	
Model:				Model:			
VIN #:				VIN #:			
MAINTENANCE HISTORY: _____				MAINTENANCE HISTORY: _____			
_____				_____			
_____				_____			
_____				_____			

DOES EACH OF THE VEHICLES LISTED ABOVE MEET THE REQUIREMENTS OF THE FEDERAL GOVERNMENT & THE STATE OF NEBRASKA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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HAS THE APPLICANT (AND/OR ORGANIZATION THE APPLICANT REPRESENTS) EVER BEEN EXCLUDED FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM: <input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please explain <i>in detail</i> (use separate sheet of paper if necessary):

PLEASE DESCRIBE <i>IN DETAIL</i> APPLICANT'S COMMUNICATIONS SYSTEM & EQUIPMENT, INCLUDING DETAILS REGARDING APPLICANT'S ABILITY TO IMPLEMENT AN NAEMD APPROVED PRIORITIZATION OF CALLS SYSTEM. INCLUDE INFORMATION REGARDING TRAINING IN THIS REGARD, AND INDICATE WHETHER APPLICANT IS NAEMD CERTIFIED (USE SEPARATE SHEET OF PAPER IF NECESSARY):

PLEASE ANSWER THE FOLLOWING QUESTIONS:	YES	NO
Do you understand that it may be necessary to supply additional or more detailed information and do you agree to furnish such information in a timely manner upon request from the Finance Director?		
Do you agree that by submitting this application you are acknowledging that you are familiar with the provisions of Title 7 of the Lincoln Municipal Code and that you agree to abide by and follow the law as set forth therein?		
Do you agree that by submitting this application you are requesting a license to operate a routine ambulance service as defined in Title 7 of the Lincoln Municipal Code and that such license will not and does not authorize you to perform any other type of ambulance service within the corporate limits of the City of Lincoln?		

PLEASE READ & SIGN BELOW IN FRONT OF A NOTARY

State of _____)
County of _____) ss:

_____ (*applicant's name*), being first duly sworn and on oath, deposes and says that he/she is the _____ (*title*), of _____ (*Business & Trade Name*) and that he/she is authorized to act for & on behalf of said company, partnership, corporation, or entity; that he/she has read the foregoing application for a license to perform routine ambulance service within the corporate limits of the City of Lincoln, and states that the best of his/her knowledge, all of the facts and statements set forth herein are true.

Printed Name of Applicant

Date

Applicant's Signature

Subscribed in my presence and sworn to before me this _____ day of _____, 20____.

Notary Public