



Arizona Department of Health Services

Bureau of Emergency Medical Services and Trauma System

Air Ambulance Licensure Application

Bureau Date Stamp Here

This application is designed to allow you to type into the spaces in each section and move the document down as the entries are completed. Use your tab key or your mouse to move through the document. You will notice that the application may expand downward and possibly increase total pages as information is entered into specific sections. Once the sections have been completed simply save it on your local computer, print and submit a signed copy to the Bureau of Emergency Medical Services and Trauma System with all applicable documents and information as required in the referenced rule shown in each section of the application.

Please click on this [Air Ambulance](#) link for the current licensure rules before beginning this application. If you do not have Internet access, or need additional assistance please contact the Air and Ground Ambulance Services Program Manager at (602) 364- 3173 to request a copy.

SELECT APPLICATION TYPE

<input type="checkbox"/>	INITIAL APPLICATION	If Initial, the Bureau will assign a license number to you upon approval.
<input type="checkbox"/>	RENEWAL APPLICATION	If renewal, provide your Bureau issued license number here ►

1	APPLICANT INFORMATION:	R9-25-704-A-1
Please provide the legal name of the person that holds a controlling legal or equitable interest and authority in the air ambulance service. "Person" means (a) an individual; (b) a business organization; or (c) an administrative unit of the U.S. government, state government, or a political subdivision of the state.		
Name		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	

2	OWNER INFORMATION	R9-25-704-A-1
Please provide the legal name of the person that holds a controlling legal or equitable interest and authority in the air ambulance service. "Person" means (a) an individual; (b) a business organization; or (c) an administrative unit of the U.S. government, state government, or a political subdivision of the state.		
Name <input type="checkbox"/> Same as Applicant		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	

3	BUSINESS NAME INFORMATION	R9-25-704-A-2
Please provide each name in which the air ambulance service does business (i.e., each DBA). List each business name to be used for the Air Ambulance Service: <input type="checkbox"/> Separate Sheet Attached		
Business Name:		
Use this space to add any comments for this item: ►		

4	BUSINESS MAILING ADDRESS	R9-25-704-A-3
Please provide each mailing address to be used for the air ambulance service (i.e., each office, base station, dispatch center, etc.), if different from Applicant's mailing address: <input type="checkbox"/> Separate Sheet Attached		



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Mailing Address		
City	State	Zip Code

Mailing Address		
City	State	Zip Code

5	BUSINESS PHYSICAL ADDRESS	R9-25-704-A-3
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Please provide each physical and mailing address to be used for the air ambulance service (i.e., each office, base station, dispatch center, etc.), if different from Applicant's mailing address: **Separate Sheet Attached**

Mailing Address		
City	State	Zip Code

Mailing Address		
City	State	Zip Code

6	TYPE OF BUSINESS ORGANIZATION	R9-25-704-A-5-a
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If the applicant is a business organization, please indicate below the type of business organization.

<p style="text-align: center;">Proprietary</p> <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation for Profit <input type="checkbox"/> Limited liability company <input type="checkbox"/> Other:	<p style="text-align: center;">Non-profit</p> <input type="checkbox"/> Corporation <input type="checkbox"/> Other:	<p style="text-align: center;">Governmental</p> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Municipal <input type="checkbox"/> Other:
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Use this space to add any comments for this item: ►

7	OFFICERS AND BOARD MEMBERS OR TRUSTEES INFORMATION	R9-25-704-A-5-c
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If the applicant is a business organization, please provide below the name, title, and address of each officer and board member or trustee.
 Separate Sheet Attached

Name <input type="checkbox"/> Officer <input type="checkbox"/> Board Member <input type="checkbox"/> Trustee		
Title:		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	

Name <input type="checkbox"/> Officer <input type="checkbox"/> Board Member <input type="checkbox"/> Trustee		
Title:		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	



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Name <input type="checkbox"/> Officer <input type="checkbox"/> Board Member <input type="checkbox"/> Trustee		
Title:		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	

8	PRIMARY CONTACT REGARDING APPLICATION	R9-25-704-A-5-b
If the applicant is a business organization, please provide the name; mailing address; fax number, if any; and telephone number about the individual who is to serve as the primary contact for information regarding the application.		
Name:		
Title:		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	
Use this space to add any comments for this item: ►		

9	STATUTORY AGENT OR INDIVIDUAL DESIGNATED	R9-25-704-A-4
Please provide the name, title, address, and telephone number of the applicant's statutory agent or the individual designated by the applicant to accept service of process and subpoenas for the air ambulance service.		
Name: <input type="checkbox"/> Statutory Agent <input type="checkbox"/> Individual Designated		
Title:		
Mailing Address		
City	State	Zip Code
Telephone Number	Fax Number (if any)	
Use this space to add any comments for this question: ►		

10	AIR AMBULANCE SCOPE OF MISSION	R9-25-704-A-9
Please indicate below all scope of mission types that apply and will be provided.		
<input type="checkbox"/> Basic Life Support Missions <input type="checkbox"/> Advanced Life Support Missions <input type="checkbox"/> Critical Care Missions <input type="checkbox"/> Emergency Medical Services Transports		<input type="checkbox"/> Convalescent Transports <input type="checkbox"/> Interfacility Transports <input type="checkbox"/> Interfacility Maternal Transports <input type="checkbox"/> Interfacility Neonatal Transports
Use this space to add any comments for this item: ►		

11	HOURS OF OPERATION	R9-25-704-A-7
Please indicate below the intended hours of operation for the air ambulance service.		



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Hours of Day <input type="checkbox"/> 24 hours a Day <input type="checkbox"/> Day Light Hours Only <input type="checkbox"/> After Dark Hours Only <input type="checkbox"/> Other:	Days of Week <input type="checkbox"/> Monday <input type="checkbox"/> Saturday <input type="checkbox"/> Tuesday <input type="checkbox"/> Sunday <input type="checkbox"/> Wednesday <input type="checkbox"/> All Days <input type="checkbox"/> Thursday <input type="checkbox"/> Other <input type="checkbox"/> Friday	Days of Year <input type="checkbox"/> 365 days a year <input type="checkbox"/> Other:
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Use this space to add any comments for this question: ►

12	PHYSICIAN TO SERVE AS MEDICAL DIRECTOR	R9-25-704-A-6
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Please indicate below the name and Arizona license number for the physician who is to serve as the medical director for the air ambulance service.

Name	Arizona Physician License Number
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Use this space to add any comments for this item: ►

13	REQUIRED ATTACHMENTS
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Have you attached a copy of the applicant business organization's articles of incorporation, articles of organization, or partnership or joint venture documents, if applicable?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-5-d
 Use this space to add any comments for this question: ►

Have you attached the intended schedule of rates for the air ambulance service?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-8
 Use this space to add any comments for this question: ►

Have you attached a copy of a current and valid Air Taxi Operator and Commuter Air Carrier Registration OST Form 4507 showing the effective date of registration and exemption under 14 CFR 298?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-10
 Use this space to add any comments for this question: ►

Have you attached a copy of the following issued by the Federal Aviation Administration a current and valid Air Carrier Certificate authorizing common carriage under 14 CFR 135?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-11-a
 Use this space to add any comments for this question: ►

If intending to operate a rotor-wing air ambulance, have you attached a copy of the current and valid operations specifications authorizing aero-medical helicopter operations, issued by the Federal Aviation Administration?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-11-b
 Use this space to add any comments for this question: ►

If intending to operate a fixed-wing air ambulance, have you attached a copy of the current and valid operations specifications authorizing airplane air ambulance operations, issued by the Federal Aviation Administration?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-11-c
 Use this space to add any comments for this question: ►

Have you attached a copy of a current and valid Certificate of Registration issued by the Federal Aviation Administration for each air ambulance to be operated?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-11-d
 Use this space to add any comments for this question: ►

Have you attached a copy of a current and valid Airworthiness Certificate issued by the Federal Aviation Administration for each air ambulance to be operated?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
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Refer to: R9-25-704-A-11-e

Use this space to add any comments for this question: ►

	YES	NO	N/A
Have you attached a copy of a certificate of insurance establishing that the Applicant has current and valid liability insurance coverage for the air ambulance service as required under A.A.C. R9-25-703(B)(5)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-704-A-13

Use this space to add any comments for this question: ►

	YES	NO	N/A
Have you attached a copy of a certificate of insurance establishing that the Applicant has current and valid malpractice insurance coverage for the air ambulance service as required under A.A.C. R9-25-703(B)(6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-704-A-13

Use this space to add any comments for this question: ►

	YES	NO	N/A
Is the certificate of liability and malpractice insurance coverage provided as part of the two previous sections above issued by an insurance company that is authorized to transact business in the State of Arizona?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: A.R.S. 36-2215-A

Use this space to add any comments for this question: ►

	YES	NO	N/A
Have you attached a copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4, for each air ambulance to be operated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-704-A-12-b

Use this space to add any comments for this question: ►

	YES	NO	N/A
If the Applicant holds current Commission on Accreditation of Medical Transport Systems, formerly known as the Commission on Accreditation of Air Medical Services (CAMTS) accreditation for the air ambulance service, have you attached a copy of the current CAMTS accreditation report?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-704-A-15

Use this space to add any comments for this question: ►

	YES	NO	N/A
If this is an initial Application, for each air ambulance to be operated for the air ambulance service, have you attached an application for registration that includes all of the information and items required under A.A.C. R9-25-802(C)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-704-A-12-a

Use this space to add any comments for this question: ►

	YES	NO	N/A
If this is a renewal application, for each air ambulance operated or to be operated for the air ambulance service, have you attached a copy of a current and valid certificate of registration, issued by the Bureau under 9 A.A.C. 25, Article 8; OR an application for registration that includes all of the information and items required under A.A.C. R9-25-802(C)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Refer to: R9-25-705-A-2-a and R9-25-705-A-2-b

Use this space to add any comments for this question: ►

Use this space to add any comments for this question: ►

14	ATTESTATION	R9-25-704(A)(16) &17
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According to A.A.C. R9-25-704, the application must be signed as follows:

1. If the Applicant is an individual, by the individual;
2. If the Applicant is a corporation, by an officer of the corporation;
3. If the Applicant is a partnership, by one of the partners;
4. If the Applicant is a limited liability company, by a manager or, if the limited liability company does not have a manager, a member of the limited liability company;
5. If the Applicant is an association or cooperative, by a member of the governing board of the association or cooperative;
6. If the Applicant is a joint venture, by one of the individuals signing the joint venture agreement;
7. If the Applicant is a governmental agency, by the individual in the senior leadership position with the agency or an individual designated in writing by that individual; and
8. If the Applicant is a business organization type other than those described in (2) through (6) above, by an individual who is a member of the business organization.

