



Oklahoma State Department of Health
 Protective Health Services
 Financial Management
 Emergency Systems/EMS Division
 123 Robert S. Kerr Ave suite 1702
 Oklahoma City, OK 73102-6406
 Telephone: 405-426-8480
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Ambulance Service Amendment Form

Ground[310:641-3-14] Air[310:641-13-7] Specialty Care[310:641-3-14] Stretcher Aid Van[310:641-3-14]

Ambulance Service Name: _____ License No. _____

Reason for Amendment:

Items in this section require the \$100 amendment fee.*

Change in the Name of the Service: _____
New Service Name

Change in Level of Care: New Level(select one): Basic Life Support Intermediate Life Support
AEMT Life Support Paramedic Life Support

Change in Service Area: Provide an updated coverage area map. If the updated coverage area includes added city or county jurisdiction, a Letter of Governmental Support must be included for each new governmental entity.

Addition of Substation: _____
New Substation Name Address City, State, Zip

If the Substation is outside of your current coverage area, provide an updated coverage area map. If the updated coverage area includes added city or county jurisdiction, a Letter of Governmental Support must be included for each new governmental entity.

Type of Service: Indicate on a separate page the changes being made to your type of service.

*Items in this section do not require an amendment fee.**

Mailing Address Change: _____
New Mailing Address City, State, Zip

Physical Address Change
 (Coverage area remains the same) : _____
New Physical Address City, State, Zip

Record Retention Address Change: _____
New Record Retention Address City, State, Zip

Changing of Substation: _____ Remove Substation Address Change
Name of Substation to be changed

_____ New Substation Address City, State, Zip

Voluntary Downgrade to an Emergency Medical Response Agency

Change in Ownership: Complete the Change in Ownership information on the following page.

I hereby certify that all information on this form is complete, true and correct to the best of my knowledge.

Signature _____ Date _____

Print Name _____ Title _____

Change in Ownership

Section 1 – Type of Ownership

- Government Ownership (City, State or Federal)-Give Description_____
- Sole Proprietorship. List name of owner:_____
- Partnership. List partners:_____
- Corporation. Name of corporation:_____
- Disclosing Entity receives money from or contracts with a 522 District. Name 522 District:_____
- Disclosing Entity receives money from or contracts with an Ambulance Service District. Name of District:_____
- Other. Specify:_____

Section 2-Indirect Ownership

Attach a list of names and addresses of individuals, organizations or other entities having a direct or indirect ownership interest(s), separately or in combination, amounting to an ownership interest of 5% or more in the Disclosing Entity.

Section 3-Mortgage

Attach a list of names and addresses of individuals, organizations or other entities having an interest in the form of the mortgage or other obligation, secured by disclosing entity equal to at least 5% of the assets.

Section 4-Corporation Officers/Directors

Attach a list of names, titles and addresses of all of the Corporation’s officers and directors

Section 5-Felony Statement

Has any owner, principal or director been convicted of a felony? Yes No

If “yes,” please provide details on a separate page. The applicant may also submit court documents detailing the felony conviction.

Section 6-EMS District Board (522 or Title 19 District)

If the disclosing entity is a 522 District Board or receives money from a 522 District Board, Attach a list of names, titles or positions and addresses of the officers and directors. If the Disclosing Entity is not owned or operated by the District, attach a contact contracts to provide ambulance service with this form.

Section 7-Other ownership or controlling interests

If the disclosing entity is an Ambulance District Board established by Title 19 or receives money from an Ambulance District Board(522 or Title 19), a city, county or council, Attach a list of names, titles or positions, ownership percentage, addresses and phone numbers of the officers, directors, commissioners or council. Give meeting times and dates and other pertinent information. If the Disclosing Entity is not owned or operated by the District, attach contracts to provide ambulance service to this form.

Section 8-Signature

I hereby certify that all information is complete and that all information to this report and supplemental attachments is true and correct to the best of my knowledge. The party or parties who sign this application shall be considered the owner agency (certificate holder) and responsible for compliance of the Act and rules.

Print Name _____ Title _____ Date _____ Signature _____
Signed on _____ My commission expires _____
Date _____ Exp. Date _____ Notary Signature _____

*If your amendment requires the \$100 amendment fee:

Mail all required forms and fees to:

Financial Management
Emergency Systems
Oklahoma State Department of Health
123 Robert S. Kerr Ave Suite 1702
Oklahoma City, OK 73102-6406

**If your amendment does not require the fee:

Completed forms can be emailed to esystems@health.ok.gov
Or Faxed to: 405-900-7560
Or mailed to:

Emergency Systems
Oklahoma State Department of Health
123 Robert S. Kerr Ave Suite 1702
Oklahoma City, OK 73102-6406