Oklahoma State Department of Health
Protective Health Services
Financial Management
Emergency Systems/EMS Division
PO Box 268823
Oklahoma City, OK 73126-8823
Telephone: 405-426-8480
Fax: 405-900-7560

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
PO Box 268823
Oklahoma City, OK 73126-8823

**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