



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



EMRA Amendment Form
[310:641-15-9]

EMRA Name: _____ License No. _____

Reason for Amendment:

Change in the Name of the Service:

 New Service Name

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.

Mailing Address Change: _____

 New Mailing Address City, State, Zip

Physical Address Change
 (Coverage area remains the same) : _____

 New Mailing Address City, State, Zip

Record Retention Address Change: _____

 New Record Retention Address City, State, Zip

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. If the substation is being added as a Satellite station which is operated under your EMRA certification but is operated by a separate entity, proof of insurances (Auto Liability, General Liability and Workers comp) must be provided.

Changing of Substation: _____ Remove Substation Address Change

 Name of Substation to be changed

 New Substation Address City, State, Zip

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

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 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 _____ Date _____ My commission expires _____ Exp. Date _____ Notary Signature _____

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

or mailed to:
OSDH – Emergency Systems
123 Robert S. Kerr Ave., Suite
1702 Oklahoma City, OK
73102-6406