EMERGENCY MEDICAL SERVICES SUPPLEMENTAL APPLICATION

Items required for Submission: Accord Application, Loss Runs currently valued (5 yrs included current)

General Information

1. Name of Organization: _____
2. Date Company was established: _____ # Years under current ownership: _____
3. How many employees do you have
   _____Drivers _____ Maintenance _____ Administrative _____Dispatchers
   _____Other, Describe _____
4. How many Volunteers? _____ Annual hours worked: _____ Do they drive? □ Yes □ No
5. Are Subcontractors utilized? □ Yes □ No Certificate of Insurance? □ Yes □ No
   What services are outsourced?
   □ Facility Maintenance □ Snow Removal □ Janitorial
   □ Grounds Keeping ……□ Other
6. What is your radius of operations? _____
7. What are your hours of operations? _____ AM to _____ PM

DRIVER QUALIFICATION

8. Defensive Driving:
   Do you have a drug testing policy in place? □ Yes □ No _____ □ Upon hire or □ For Cause?
   # of Agency owned vehicles _____ # of daily trips per vehicle _____
   MVR's obtained? □ Yes □ No □ Upon hire □ Annually □ Remedial
   Do you have an MVR criteria in place □ Yes □ No
   Is previous ambulance driving experience required □ Yes □ No If yes, how many years? _____

VEHICLE INFORMATION

9. How many types of Agency vehicles: _____ Ambulance _____ Passenger
   _____ Others, List _____

   What safety equipment does the vehicles have? □GPS □ Inside vehicle camera □ outside vehicle camera
   _____Other
   Is there a written fleet safety program: □ Yes □ No if yes, attach a Table of Contents
   Are the vehicles equipped with an Emergency Warning System (EWS) _____ if yes at what speed _____

10. Safety Programs (check all that apply)

□ Accident Investigation □ Driver Training □ Safety Committee
□ New Hire Orientation □ Workplace Violence □ Return to Work
□ Respiratory Protection □ Bloodborne Pathogens □ Personal Protective Equipment (PPE)
□ Fentanyl Protcol □ Hazard Communication □ Safe Patient Handling
□ Footwear Policy □ Other _____

11. Maintenance Program

Describe inhouse vehicle maintenance program: _____
Describe outside vehicle maintenance program: _____
Do you PRE or POST trip vehicle inspections**?** □ Yes □ No

12. Safe Patient Handling Controls, select all that apply & the number of each

□ X-Frame _____ □ Stryker _____ □ Bariatric Cot _____
□ Motorize Stair chair _____ □ Lateral Transfer Aids _____ □Power Cot _____
□ Fold Away Undercarriage _____ □ Other _____

13. Does your dispatch center assess the patient and surroundings prior to dispatching your employees? □ Yes □ No
If yes, please describe:

_____	_____	_____	_____
Applicant Name Please Print	Title	Signature	Date