

Public Auto Supplemental Application Social Service and Ambulance

1. What is the primary purpose of your operation and how are these services provided? _____

Number of years in business: _____ Number of years under current management: _____

2. Is this operation for: profit nonprofit

Source of funding: _____

3. What are the total number of trips per year? _____

Percent wheelchair/stretchers transport: _____

Of those, what is the number of emergency? _____ and non-emergency? _____

4. How many of the vehicles have lights and sirens? _____

5. Who dispatches your calls? 911 Outside sources In-house by your own employees or volunteers

6. Do you distribute any medical supplies or equipment? Yes No

If yes, please provide details: _____

7. Indicate number of individuals who drive and/or provide client care (full-time, part-time, pair or volunteer): _____

	EMT BASIC	EMT ADVANCED	EMT PARAMEDIC	OTHER	NONE
EMPLOYEES					
VOLUNTEERS					

If "other" marked above, please explain: _____

8. Identify the types of special driver training programs that your drivers receive:

- | | |
|---|--|
| <input type="checkbox"/> General driver orientation | <input type="checkbox"/> Defensive driving |
| <input type="checkbox"/> Primary first aid | <input type="checkbox"/> Advanced first aid |
| <input type="checkbox"/> CPR | <input type="checkbox"/> Passenger assistance training |
| <input type="checkbox"/> Human relations skills | <input type="checkbox"/> Nonmedical emergency training |
| <input type="checkbox"/> Emergency vehicle evacuation | |

9. What is your criteria for driver selection? _____

10. What safety procedures are in place? _____

11. Do you have specific wheelchair tie-down procedures? Yes No

If yes, please describe: _____

12. Is there an accident review procedure? Yes No

If yes, briefly describe: _____

13. What type of vehicle maintenance is there? _____

14. Does Applicant have professional coverage? Yes No

Policy No.: _____ Term: _____

Name of carrier: _____

15. Has this service ever operated under another name? Yes No

If yes, what name? _____

16. Are all vehicles owned by you? Yes No

If no, please explain: _____

Are they leased, etc.? Yes No

Give details: _____

17. Do employees use their own vehicles in your business? Yes No

If yes, describe how often and if there is client transport: _____

18. Any other pertinent information about your business: _____

19. A. In which major cities does applicant provide transportation (list cities): _____

B. Of Applicant's total operations, what percentage involves transportation in these major cities? _____

20. Does Applicant have General Liability coverage? Yes No

Policy No.: _____ Term: _____

Carrier: _____

21. Are all drivers covered by Worker's Compensation? Yes No

If yes, provide carrier name: _____

22. Are MVR's ordered prior to allowing employee to drive? Yes No

FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement Of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement Of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner, or executive officer.)

AGENT NAME: _____ AGENT LICENSE NUMBER: _____
(Applicable to Florida Agents Only)