



APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

APPLICATION TYPE: NEW RENEWAL

SERVICE TYPE: Wheelchair Transport ALS Interfacility ALS Non-Transport Stretcher Transport ALS Helicopter ALS Transport

TYPE OF ENTITY: Sole Proprietor Partnership Non-Profit Corporation Corporation

ORGANIZATION NAME: Vicare Medical Transport, LLC	HOURS OF OPERATION: <input type="checkbox"/> 24-HOUR 7 A.M. to 7 <input type="checkbox"/> A.M. / <input checked="" type="checkbox"/> P.M.
ADDRESS 1: 1936 Bruce B. Downs Blvd	PHONE: 813-609-2460
ADDRESS 2: STE 470	FAX:
CITY, STATE, ZIP CODE: Wesley Chapel FL 33543	

OFFICER/DIRECTOR NAME & TITLE: Hardeep Dhalwal	PHONE NUMBER & E-MAIL: 813-609-2460 <i>VICAREMEDICALTRANSPORT@gmail.com</i>
VICE OFFICER/DIRECTOR NAME & TITLE: Gursharan Sohal	PHONE NUMBER & E-MAIL: 727-487-1565
BUSINESS HOURS POINT-OF-CONTACT: Hardeep Dhalwal	PHONE NUMBER & E-MAIL: Same As Above
AFTER HOURS POINT-OF-CONTACT: Gursharan Sohal	PHONE NUMBER & E-MAIL: Same As Above

REQUIRED ATTACHMENTS: Record Keeping Verification Form, Vehicle Roster(s), Driver Roster(s), Certificate of Incorporation, Certification of Fictitious Name (d.b.a) if applicable, Insurance Verification for the highest level of service provided, and retail rate schedule. Also include any new applications per County Driver Certification Requirements

I, the undersigned representative of the above named firm, do hereby acknowledge this certificate may be suspended or revoked if at any time the firm fails to meet all of the requirements of the Pinellas County Code or Rules and Regulations.

SIGNATURE OF APPLICANT: 	DATE: 4/13/2020
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STATE OF FLORIDA
COUNTY OF FLORIDA

Subscribed and sworn to (or affirmed) before me this 4/13/2022 by Hardeep Dhalwal who is/are personally known to me or has/have produced FLDL 0440 320682290 as identification.



(Name of Notary typed, printed or Form stamped)



**WHEELCHAIR/STRETCHER SERVICE
RECORD KEEPING VERIFICATION FORM**

Pinellas County Rules and Regulations, as Amended

Name of Service: VCAZE MEDICAL TRANSPORT LLC

Date: 4/10/2020

Section	Inspection Items	Initials
8.1	Record all telephone lines when used for requests for transport, including cell phones.* *Initial here if standard business practice is to receive requests via fax and/or e-mail and written records are maintained of such contacts in accordance with written records criteria.	[Signature]
8.1	Written record contains: <ul style="list-style-type: none"> • Date Call Received • Time Call Received • Pick-up & Destination Address • Arrival Time at Destination • Client's Name • Person Ordering Transport • Telephone Number of Caller (*if applicable) 	[Signature]
8.1	Audio dispatch records shall be kept for a minimum of six (6) months.	[Signature]
8.1	Written or electronic dispatch shall be kept for a minimum of three (3) years.	[Signature]
8.1	Dispatch audio & written/electronic records shall be available for inspection.	[Signature]



WHEELCHAIR VEHICLE ROSTER
Pinellas County Rules and Regulations, as Amended

Name of Service: V-Care Medical Page: 1 of 1

Provide Unit, Tag and VIN numbers for all vehicles. If more lines are needed, it is acceptable to copy this form. A Company Roster may be attached, as long as all required information is included. Contact EMS & Fire Administration for a Vehicle Inspection appointment.

Unit Number	Florida Vehicle Tag Number	Vehicle Identification Number (VIN)	Client compartment observation mirror	Passenger floor properly maintained	Fire extinguisher 2A:10B:C	Operable interior lights	Free of dent/rust that interferes with safe operation	Equipment in patient compartment safely secured	Doors, latches, and handles working properly	Patient lift platform working properly	Positive means of securing/locking wheelchair/stretchers	Properly designed passenger safety belts and/or straps	Radio/tablet/cell phone for communication with base station	Exterior lights – high, low, turns, brake, tails, backup	Interior clean, sanitary and in good working order
1.	NAV N74	1FDZX2CMSFK44744													
2.	NAV N73	1FD2X2CM9FK44742													
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															

EMS INSPECTOR: _____ Date: _____



WHEELCHAIR / STRETCHER DRIVER ROSTER
Pinellas County Rules and Regulations, as Amended

Name of Service: VCA RE MEDICAL TRANSPORT, LLC Page: 1 of 1

Attach a copy of the Class E Driver's License for each listed Driver. If more lines are needed, it is acceptable to copy this form. A Company Roster may be attached, as long as all required information is included.

	Name (Last, First) Also list "nick-name" if applicable	Class E Driver's License Number	Expiration Date	Date of Birth	Assigned EMS ID #
1.	HARDEEP DHALIWAL.	D440-320-68-229-0	6/29/25	6/29/68	
2.	GURSHJEAN S SORVAL	S400-297-79-341-0	9/21/25	9/21/79	
3.	BRANDON S Walker	W426-078-96-136-0	4/16/23	4/16/1996	
4.	WILLIAM MEDINA JR	M350-920-90-32-0	10/2/20	10/2/26	
5.	CATHERINE L HODGES	H322-132-84-87-0	8/27/84	8/27/27	
6.	LUIS A-COSTA.	C230-531-54-287-0	8/7/25	8/7/54	
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/04/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER DATTANI AND PATEL INSURANCE GROUP LLC PO BOX 593429 ORLANDO, FL 32859	CONTACT NAME: SATYAM PATEL PHONE (A/C, No, Ext): 407-353-0454 E-MAIL ADDRESS: SPATEL.INSURANCE@GMAIL.COM	FAX (A/C, No): 407-530-0184
	INSURER(S) AFFORDING COVERAGE	
INSURED VCARE MEDICAL TRANSPORT LLC 1936 Bruce B Down Blvd, Suite 470 Wesley Chapel, FL 33543	INSURER A: SCOTTSDALE INSURANCE	
	INSURER B: NATIONAL INDEMNITY	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	X	X	CPS3258550	09/23/2019	09/23/2020	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	X	X	74APS089167	09/09/2019	09/09/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 300,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ PJP \$ 10,000
	UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB OCCUR <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER
 PINELLAS COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF FL
 400 S FORT HARRISON DR
 CLEARWATER, FL 33756

CANCELLATION
 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

SATYAM H. PATEL

