




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: Med-Line Medical Transport		HOURS OF OPERATION: <input type="checkbox"/> 24-HOUR 7 A.M. to 7 P.M. <input type="checkbox"/> A.M. / <input checked="" type="checkbox"/> P.M.
ADDRESS 1: 1037 Paddington Terr		PHONE: 689-209-4025
ADDRESS 2:		FAX: 407-604-6703
CITY, STATE, ZIP CODE: Heathrow, FL 32746		
OFFICER/DIRECTOR NAME & TITLE: Jose Olvera	PHONE NUMBER & E-MAIL: 689-209-4025 info@med-linemedicaltransport.com	
VICE OFFICER/DIRECTOR NAME & TITLE:	PHONE NUMBER & E-MAIL:	
BUSINESS HOURS POINT-OF-CONTACT: Jose Olvera	PHONE NUMBER & E-MAIL: 689-209-4025 info@med-linemedicaltransport.com	
AFTER HOURS POINT-OF-CONTACT: Jose Olvera	PHONE NUMBER & E-MAIL: 689-209-4025 info@med-linemedicaltransport.com	
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: <i>Dr Jose Olvera</i> Jose Olvera		DATE: 5/8/2026
STATE OF FLORIDA COUNTY OF <u>Broward</u>		
Subscribed and sworn to (or affirmed) before me this <u>05/08/2026</u> by <u>Jose Olvera</u> , who is/are personally known to me or has/have produced <u>PASSPORT</u> as identification.		
Commission Expires: 09/30/2028 Commission No.: HH 597522		
(SEAL) 	Antonio Garcia Online Notary	
(Name of Notary typed, printed or Form stamped)		

Please download and complete this form.

Upload the notarized the COPCN Notary Form here

[Change File](#) 2026 COPCN Application Packet.pdf 2.pdf

Name
COPCN Notary Form

Document Type
Supporting Documents

Application Type

	Initial	Renewal
Wheelchair Transport	<input checked="" type="checkbox"/>	
Stretcher Transport	<input checked="" type="checkbox"/>	
ALS Helicopter	<input type="checkbox"/>	
ALS Interfacility	<input type="checkbox"/>	
ALS Non-Transport	<input type="checkbox"/>	
ALS Transport	<input type="checkbox"/>	
Wheelchair and Stretcher Van		

Type of Entity

*Type of Entity

- Sole Proprietor
- Partnership
- Non-Profit Corporation
- Corporation

Organization Type

Sole Proprietor

Company Information (Form A)

Company Information

Organization Name

Med-Line Medical Transport

*Street 1

1037 Paddington Terr

Street 2

*Postal Code

32746

City

Heathrow

State

Florida

Phone

689 - 209 - 4025 Ext:

Fax

407 - 604 - 6703

*Hours of operation

7AM-7PM

Company Contacts

Position

Officer/Director

*Action to take

Update record in the service

This is the action that will be taken within the service for the User you select below.

*Search Contact

Olvera, Jose

*Work Phone

689 - 209 - 4025 Ext:

Email

info@med-linemedicaltransport.com

Position

Vice Officer/Director

*Search Contact

Olvera, Jose

*Work Phone

689 - 209 - 4025 Ext:

*Email

info@med-linemedicaltransport.com

Position	Search Contact	Work Phone	Email
<input checked="" type="checkbox"/> Business Hours Point-of-Contact	Olvera, Jose	689-209-4025	info@med-linemedicaltransport.com
<input checked="" type="checkbox"/> Business Hours Point-of-Contact	Olvera, Jose	689-209-4025	info@med-linemedicaltransport.com

Position

After Hours Point-of-Contact

*User

Olvera, Jose

*Work Phone

689 - 209 - 4025 Ext:

*Email

info@med-linemedicaltransport.com

Record Keeping Verification Form (Form B)

Inspection Items

Section 8.1

Record all telephone lines when used for requests for transport, including cell phones.*

*Initials

*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.

*Initials

Section 8.1

Written record contains:

- 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)

*Initials

Section 8.1

Audio dispatch records shall be kept for a minimum of six (6) months.

*Initials

Section 8.1

Written or electronic dispatch shall be kept for a minimum of three (3) years.

*Initials

Section 8.1

Dispatch audio & written/electronic records shall be available for inspection.

*Initials

Vehicles (Form C)

Section 1

Vehicle	Unit Number	Vehicle Tag Number	Vehicle Identification Number(VIN)	Active
<input checked="" type="checkbox"/> [New]	5	32fcqw	3C6LRVDG8RE107283	Yes
<input checked="" type="checkbox"/> [New]	4	31fcqw	3C6LRVDG9RE111665	Yes
<input checked="" type="checkbox"/> [New]	3	fpax61	3C6LRVDGXRE107544	Yes
<input checked="" type="checkbox"/> [New]	1	figc97	3C6LRVDG9RE107552	Yes
<input checked="" type="checkbox"/> [New]	2	dr71xd	3C6LRVDG8RE110362	Yes
<input checked="" type="checkbox"/> [New]	7	f813993	3?6LRVDG3SE534103	Yes
<input checked="" type="checkbox"/> [New]	8	382370v	3C6LRVDGOSE534107	Yes
<input checked="" type="checkbox"/> [New]	6	dr70xd	3C6LRVDG4RE107295	Yes

Personnel (Form D)

Section 1

meggers	User	Position
	Olvera, Jose (none)	Officer/Director, After Hours Point-of-Contact, Vice Officer/Director, Business Hours Point-of-Contact

Required Documents

Insurance verification

Provide a copy of the Certificate of Insurance showing limits for the highest level of service provided detailing vehicle liability, property damage coverage, and the expiration date of the policy (See Rules & Regulations 8.2)

Policy Type

Number

Issued Date

 Today

Expiration Date

 Today

***Insurance Verification**

Change File Liability insurance.pdf

Name

Document Type

Certificate of Incorporation

***Certificate of Incorporation**

Change File Article of incorporation.pdf

Name

Document Type

Retail Rate Schedule

***Retail Rate Schedule**

Change File RETAIL_RATES.pdf

Name

Document Type

Certification of Fictitious Name (d.b.a.)

Please upload a copy of your Certification of Fictitious Name (d.b.a.).

Certification of Fictitious Name

[Change File](#) SUNBIZ.pdf

Name

Certification of Fictitious Name

Document Type

Certification of Fictitious Name

Signature

Signature

*Today's Date

05/08/2026

[Today](#)

*Signature

Signed on May 8, 2026 1:06:32 PM by Jose Olvera

**Electronic Articles of Organization
For
Florida Limited Liability Company**

L24000117073
FILED 8:00 AM
March 05, 2024
Sec. Of State
crico

Article I

The name of the Limited Liability Company is:
MED-LINE MEDICAL TRANSPORT "LLC"

Article II

The street address of the principal office of the Limited Liability Company is:
1037 PADDINGTON TER
HEATHROW, FL. UN 32746

The mailing address of the Limited Liability Company is:
1037 PADDINGTON TER
HEATHROW, FL. UN 32746

Article III

The name and Florida street address of the registered agent is:
MONICA MENDEZ
1037 PADDINGTON TER
HEATHROW, FL. 32746

Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relating to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.

Registered Agent Signature: MONICA MENDEZ

Article IV

The name and address of person(s) authorized to manage LLC:

Title: MGR
MONICA MENDEZ
1037 PADDINGTON TER
HEATHROW, FL. 32746 UN

L24000117073
FILED 8:00 AM
March 05, 2024
Sec. Of State
crico

Article V

The effective date for this Limited Liability Company shall be:

03/01/2024

Signature of member or an authorized representative

Electronic Signature: MONICA MENDEZ

I am the member or authorized representative submitting these Articles of Organization and affirm that the facts stated herein are true. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S. I understand the requirement to file an annual report between January 1st and May 1st in the calendar year following formation of the LLC and every year thereafter to maintain "active" status.

EXHIBIT A

SERVICE FEES

Rate with-in Pinellas County		
Non - Ambulance Service Rates		Non-Ambulance Service Rates
Stretcher flat Rate	\$ 150.00	Stretcher
Wheelchair flat Rate	\$ 75.00	Bariatric / per attendant
		\$ N/A
- Transportation Out Of Pinellas County		
Non - Ambulance Service Rates		Non-Ambulance Service Rates
WC Base Rate	\$75.00	Stretcher load fee
		\$ 150.00
		\$ 3.50 per mile
		Bariatric / per attendant
		\$ 100.00
		Appointment Wait Time
		\$ 25 per 15 min
Non - Ambulance Service Rates		Ambulance Service Rates
Sedan	\$ N/A	Stretcher
Wheelchair	\$ N/A	BLS
		ALS
		ACLS
Non - Ambulance Service Rates		Ambulance Service Rates
Sedan	\$ N/A	Stretcher
Wheelchair	\$ N/A	BLS
		ALS
		ACLS
Non - Ambulance Service Rates		Ambulance Service Rates
Per Leg Min Mileage Threshold		
Sedan	N/A	\$ N/A
Wheelchair	N/A	\$N/A
Per Leg Min Mileage Threshold		
Stretcher	N/A	\$ N/A
BLS	N/A	\$ N/A
ALS	N/A	\$ N/A
ACLS	N/A	\$ N/A

***In the event Med-line Medical Transport fails to perform the agreed-upon Services consistent with-in Referral's parameters (each, a "Service Failure"), Provider shall forfeit all or part of the Service Fee (depending on the extent of the Service Failure).

***Bariatric weight surcharge will only apply if patient requires Bariatric equipment or exceeds 250lbs.

***Additional fees may apply for patient that exceeds 300 lbs/ Super Bariatric Patients that will require more than two safety staff.