



APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND
NECESSITY July 1, 2018 – June 30, 2019

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: <u>AMERICHAIR TRANSPORT SERVICE, INC.</u>	HOURS OF OPERATION: <input type="checkbox"/> 24-HOUR <u>5</u> A.M. to <u>8</u> <input type="checkbox"/> A.M. / <input checked="" type="checkbox"/> P.M.
ADDRESS 1: <u>701 28TH AVE S</u>	PHONE: <u>727-201-0075</u>
ADDRESS 2:	FAX: <u>727-209-3397</u>
CITY, STATE, ZIP CODE: <u>ST. PETERSBURG, FL. 33705</u>	

OFFICER/DIRECTOR NAME & TITLE: <u>CORNELIUS CLARK</u>	PHONE NUMBER & E-MAIL: <u>518-588-6850 ncalcla@nycap.rr.com</u>
VICE OFFICER/DIRECTOR NAME & TITLE: <u>CHRISTOPHER CLARK</u>	PHONE NUMBER & E-MAIL: <u>518-588-4349 christopher.tadion@gmail.com</u>
BUSINESS HOURS POINT-OF-CONTACT: <u>CHRISTOPHER CLARK</u>	PHONE NUMBER & E-MAIL: <u>11</u>
AFTER HOURS POINT-OF-CONTACT: <u>CHRISTOPHER CLARK</u>	PHONE NUMBER & E-MAIL: <u>11</u>

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: [Signature] DATE: 4/18/18

STATE OF FLORIDA
COUNTY OF Pinellas

Subscribed and sworn to (or affirmed) before me this 18th of April by Christopher Clark, who is/are personally known to me or has/have produced _____ as identification.



[Signature]
(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: AMERICAN TRANSPORT SERVICE

Date: 4/18/2018

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.	<u>cc</u>
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)	<u>cc</u> <u>cc</u> <u>cc</u> <u>cc</u> <u>cc</u> <u>cc</u> <u>cc</u>
8.1	Audio dispatch records shall be kept for a minimum of six (6) months.	<u>cc</u>
8.1	Written or electronic dispatch shall be kept for a minimum of three (3) years.	<u>cc</u>
8.1	Dispatch audio & written/electronic records shall be available for inspection.	<u>cc</u>



WHEELCHAIR VEHICLE ROSTER **Pinellas County Rules and Regulations, as Amended**

Name of Service: AMERICAIR TRANSPORT SERVICE

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/stretcher	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
001	8889VQ	2CARDGCG2FR591380	X	X	X	X	X	X	X	X	X	X	X	X	X
002	8890VQ	2CARDGCG6FR591835	X	X	X	X	X	X	X	X	X	X	X	X	X
003	8888VQ	2CARDGCG2FR745053	X	X	X	X	X	X	X	X	X	X	X	X	X
004	JHPH09	1FTNE1AWA8DA05508	X	X	X	X	X	X	X	X	X	X	X	X	X



STRETCHER VAN ROSTER
Pinellas County Rules and Regulations, as Amended

Name of Service: _____

Such vehicles may not be equipped, marked or operated as an Ambulance

Page: _____ of _____

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.															
2.															
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: AMERICAN TRANSPORT SERVICE INC.

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.	CAIN, KARL	C500-506-60-016-0	1/16/2025	1/16/1960	
2.	GOLDEN, KELSEY	6435-510-86-952-0	12/12/2024	12/12/1986	
3.	BUJANSKI, JOSEPH	B252-481-64-189-0	5/29/2024	5/29/1964	
4.	IVY, SONYA	I100-784-67-526-0	1/26/2026	1/26/1967	
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					



AMERTRA-05

WPRITCHETT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

06/15/2017

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 have ADDITIONAL INSURED provisions or 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

Sovereign Risk Solutions, LLC
1640 Powers Ferry Road SE, Bldg 28
Marietta, GA 30067

CONTACT

NAME:

PHONE

(A/C, No, Ext): (678) 996-3400

FAX

(A/C, No): (678) 996-3401

E-MAIL

ADDRESS:

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURER A: Illinois National Insurance Co

23817

INSURER B: Ace American Insurance

22667

INSURER C:

INSURER D:

INSURER E:

INSURER F:

INSURED

Americhair Transport Service, Inc.
701 28th Ave S
Saint Petersburg, FL 33705

COVERAGES

CERTIFICATE NUMBER: 3

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 SUBR INSD 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	X	MLP G28129191 002	06/13/2017	06/13/2018	EACH OCCURRENCE \$ 1,000,000
						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000
						MED EXP (Any one person) \$ 5,000
						PERSONAL & ADV INJURY \$ 1,000,000
						GENERAL AGGREGATE \$ 3,000,000
						PRODUCTS - COMP/OP AGG \$ 1,000,000
						SAM \$ Included
B	AUTOMOBILE LIABILITY					
	<input type="checkbox"/> ANY AUTO	X	CAL H08462872	06/13/2017	06/13/2018	COMBINED SINGLE LIMIT (Ea accident) \$ 500,000
	<input checked="" type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS					BODILY INJURY (Per person) \$
	<input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY					BODILY INJURY (Per accident) \$
						PROPERTY DAMAGE (Per accident) \$
						\$
	UMBRELLA LIAB					EACH OCCURRENCE \$
	EXCESS LIAB					AGGREGATE \$
	DED					\$
	RETENTION \$					\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY					PER STATUTE OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N	N/A			E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below					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)

Access 2 Care is listed as additional insured under the auto and general liability policy where required by written contract and signed by an authorized representative of the named insured.

CERTIFICATE HOLDER

Access 2 Care
6200 South Syracuse Way # 200
Greenwood Village, CO 80111

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



AMERTRA-05

AGRIER

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/22/2018

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 have **ADDITIONAL INSURED** provisions or 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

Sovereign Risk Solutions, LLC
1640 Powers Ferry Road SE, Bldg 28
Marietta, GA 30067

CONTACT

NAME:

PHONE

(A/C, No, Ext): (678) 996-3400

FAX

(A/C, No): (678) 996-3401

E-MAIL

ADDRESS:

INSURER(S) AFFORDING COVERAGE

NAIC

INSURER A : Illinois National Insurance Co

23817

INSURER B : Ace American Insurance

22667

INSURER C :

INSURER D :

INSURER E :

INSURER F :

INSURED

Americhair Transport Service, Inc.
701 28th Ave S
Saint Petersburg, FL 33705

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 SUBR INSD 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	MLP G28129191 002	06/13/2017	06/13/2018	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 SAM \$ Included
B	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	X	CAL H08462872	06/13/2017	06/13/2018	COMBINED SINGLE LIMIT (Ea accident) \$ 500,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)
National MedTrans, LLC is listed as an Additional Insured under the Commercial and General Liability policy

CERTIFICATE HOLDER

National MedTrans, LLC
992 South 2nd St.
Ronkonkoma, NY 11779

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