

APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

| APPLICATION TYPE: | ☐ NEW ☑ RENEWAL | | | | | | | |
|----------------------------|---|-----------------------------------|---|-----------------------|--|--|--|--|
| SERVICE TYPE: | ☐ Wheelchair Transport☐ Stretcher Transport | ✓ ALS Interfacili ☐ ALS Helicopte | | | | | | |
| TYPE OF ENTITY: | ☐ Sole Proprietor ☐ Parti | nership 🔲 Non-Pr | rofit Corporation | poration | | | | |
| ORGANIZATION NAME: | | | HOURS OF OPERATION: | ☑24-HOUR | | | | |
| JOHNS HOPKINS A | LL CHILDREN'S LIFELIN | NE | A.M. to | □A.M. / □P.M. | | | | |
| ADDRESS 1: | | | PHONE: | | | | | |
| 501 6TH AVE SOUT | Ή | | 727-767-7337 | | | | | |
| ADDRESS 2: | | | FAX: | | | | | |
| | | | 727-767-4837 | | | | | |
| CITY, STATE, ZIP CODE: | | | | | | | | |
| ST PETERSBURG, | FLORIDA 33701 | | | | | | | |
| OFFICER/DIRECTOR NAME & TI | TLE: | PHONE NUMBER & E-MA | IL: | | | | | |
| RADEK HOFFMAN | LIFELINE DIRECTOR | 727-767-8941 rl | noffm31@jhmi.edu | | | | | |
| VICE OFFICER/DIRECTOR NAM | | PHONE NUMBER & E-MA | | | | | | |
| | LINE PROGRAM MAN | 727-767-7337 jbacon11@jhmi.edu | | | | | | |
| BUSINESS HOURS POINT-OF-C | ONTACT: | PHONE NUMBER & E-MA | | | | | | |
| JULIE BACON | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | | pacon11@jhmi.edu | 719-70- | | | | |
| AFTER HOURS POINT-OF-CONT | TACT: | PHONE NUMBER & E-MA | | | | | | |
| JULIE BACON | | 407-432-5498 jbacon11@jhmi.edu | | | | | | |
| Incorporation, Certificati | ENTS: Record Keeping Ver on of Fictitious Name (d.b.a) i schedule. Also include any n | f applicable, Insuran | ce Verification for the high | nest level of service | | | | |
| | sentative of the above named e firm fails to meet all of the re | | | | | | | |
| SIGNATURE OF APPLICANT: | is happolet | ے ۔ | DATE: 10 /24/202 | .3 | | | | |
| STATE OF FLORIDA | 1 | | | | | | | |
| COUNTY OF MINE! | 195 | | | | | | | |
| Subscribed and sworn to | o (or affirmed) before me this | 10 24 2023 6 | y Anthony Napo | ITOMO, who | | | | |
| is/are personally known | to me or has/have produced _ | UKNOWN JOTO | nally) as ide | entification. | | | | |
| | LENE GAT | | | | | | | |
| | ON8-22 | 1 05 | | | | | | |
| (SEAL) | No. 14 A | aligne | Avlane Gen | dran | | | | |
| Form A. Rev. 02/06/2017 | 0.023480 | (Name o | Aviene Gen of Notary typed, printed or | Form stamped) | | | | |
| , | VA 7. 2010 | | | | | | | |

Once the application forms and attachments are prepared, submit the completed application package to the Pinellas County EMS Authority, 12490 Ulmerton Rd, Ste 134, Largo, FL 33774.

COUNTY DRIVER APPLICATION & CERTIFICATION REQUIREMENTS:

Copies of the following documentation must be submitted to the Pinellas County EMS Authority for all new drivers:

- □ 1. Completed <u>Background Screening Affidavit</u> with background check (<u>verification must be less than</u> <u>45 days old</u>).
- 2. Current CPR and First Aid certification. For Florida Department of Health licenses, include a copy of the web inquiry, verifying the license is "CLEAR/ACTIVE", as well as attach any discipline on file (http://www.flhealthsource.gov/).
- □ 3. Valid driver's license.
- □ 4. Completed verification applicant is not listed on the U.S. Department of Health and Human Services Exclusions Database (https://exclusions.oig.hhs.gov/).
- ☐ 5. Color photo in JPEG format.

Applicants must complete an orientation provided by the Provider Agency, as well as be in compliance with all Protocols, Rules and Regulations of the EMS System. Once the applicant receives approval of the EMS Medical Director, they will receive initial Certification.

All certified wheelchair/stretcher drivers must continue to provide updated documentation to maintain County Certification. Direct any questions about driver certification to the EMS & Fire Administration at (727) 582-5872.

RULES AND REGULATIONS:

- <u>Pinellas County Emergency Medical Services Rules and Regulations</u> Addresses the obligations and duties of the Pinellas County EMS System.
- Florida Municipal Codes, Chapter 54 Emergency Services
 Copy of Florida State laws governing EMS and Transportation Services.

FORMS:

The forms included in this application packet may be copied and used for reporting to the Office of the Medical Director.

- Monthly Activity Report
 - > Used to record wheelchair, stretcher, and reclining wheelchair van service data.
 - > Must be filed with the Medical Director within ten (10) working days of month's end.
- Medical Incident Report
 - > Used to document any event or patient requiring an Incident Report.
 - Must be filed within 72 hours of the event.



WHEELCHAIR/STRETCHER SERVICE RECORD KEEPING VERIFICATION FORM

Pinellas County Rules and Regulations, as Amended

| Name of Service: | Med-Trans Corp DBA Lifeline All Children's |
|------------------|--|
| | |

Date: 10/23/2023

| Section | Inspection Items | Initials | | | | | | |
|---------|---|----------|--|--|--|--|--|--|
| 8.1 | Record all telephone lines when used for requests for transport, including cell phones.* | JB | | | | | | |
| | *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. | | | | | | | |
| 8.1 | Written record contains: | | | | | | | |
| | Date Call Received | | | | | | | |
| | Time Call Received | JB | | | | | | |
| | Pick-up & Destination Address | JB | | | | | | |
| | Arrival Time at Destination | JB | | | | | | |
| | Client's Name | JB | | | | | | |
| | Person Ordering Transport | JB | | | | | | |
| | Telephone Number of Caller (*if applicable) | JB | | | | | | |
| 8.1 | Audio dispatch records shall be kept for a minimum of six (6) months. | JB | | | | | | |
| 8.1 | Written or electronic dispatch shall be kept for a minimum of three (3) years. | | | | | | | |
| 8.1 | Dispatch audio & written/electronic records shall be available for inspection. | JB | | | | | | |

Form B Rev. 02/06/2017

| Form C-1 R | 12. | .3 | 9 | ,∞ | 7. | , or | 5, | ,4 | 3. | 2. | | Unit |
|--------------------------|-----|----|---|----|----|------|----|----|----|-----|----------------|---------------------------------------|
| Form C-1 Rev. 02/06/2017 | | | | | | | | | | 393 | | Florida Vehicle Tag Number |
| 7 | | | | | | | | | | | Not applicable | Vehicle Identification Number |
| EMS I | | | | | | | | | | | | Client compartment observation mirror |
| EMS INSPECTOR: | | | | | | | | | | | | Passenger floor properly maintained |
| OR: | | | | | | | | | | / | | Fire extinguisher 2A:10B:C |
| | | | | | | | 7 | | | | | Operable interior lights |

Pinellas County Rules and Regulations, as Amended WHEELCHAIR VEHICLE ROSTER

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. Name of Service: Page: of

ADMINISTRATION

| Form C-1 R | 12. | 11. | 10. | 9 90 | σ | 7. | ņ | ў. | 4 | ω | 2. | 1 | Unit |
|--------------------------|-----|-----|-----|------|---|----|---|----|---|---|----|----------------|---|
| Form C-1 Rev. 02/06/2017 | | | | | | | | | | | | | Florida Vehicle Tag Number |
| 7 | | | | | | | | | | | | Not applicable | Vehicle Identification Number |
| EMS IN | | | | | | | | | | | | | Client compartment observation mirror |
| EMS INSPECTOR: | | | | | | | | | | | | | Passenger floor properly maintained |
| 유 | | | | | | | | | | | | | Fire extinguisher 2A:10B:C |
| | | | | | | | | 7 | | | | | Operable interior lights |
| | | | | | | | | A | > | | | | Free of dent/rust that interferes with safe operation |
| | | | | | | / | | | | | | | Equipment in patient compartment safely secured |
| F | | | | | | | | | | Ė | | | Doors, latches, and handles working properly |
| Date: | | | , | | | K | | | | | | | Patient lift platform working properly |
| .s. | | / | | | | | | | | | | | Positive means of securing/locking wheelchair/stretcher |
| l | | | | | | | | | | | | | Properly designed passenge 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 |

Form C-2 Rev. 02/06/2017

Date:

12.

10.

EMS INSPECTOR:

Pinellas County Rules and Regulations, as Amended STRETCHER VAN ROSTER

Name of Service: *Such vehicles may not be equipped, marked or operated as an Ambulance*

ADMINISTRATION

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.

| 12. | 11. | 10. | 9 | 8. | 7. | ò | 'n | 4. | ω | 2. | r | Unit |
|-----|-----|-----|---|----|----|---|----|----|----|----|----------------|---|
| | | | | | | | | | | | | Florida Vehicle Tag Number |
| | | | | | | | | | | | Not applicable | Vehicle Identification Number |
| | | | | | | | | | | | | Client compartment observation mirror |
| | | | | | | | | | 81 | | | Passenger floor properly maintained |
| | | | | | | | | | | | | Fire extinguisher 2A:10B:C |
| | | | | | | | | | | | | Operable interior lights |
| | | | | | | | | | / | | | Free of dent/rust that interferes with safe operation |
| | | | | | | | | 4 | | | | Equipment in patient compartment safely secured |
| | | | | | | | | 1 | | | | 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 |

Page: <u>으</u>



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

| Name of Service: | Page: | of |
|---|-----------------|-----------|
| 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 # |
|--|------------------------------------|-----------------|---------------|----------------------|
| SCHULTHESIS, JONATHAN | S432-438-90-180-0 | 05/20/2027 | 05/20/1990 | EMT56478 |
| ² COOK, CRYSTAL | C200-108-83-746-0 | 07/06/2025 | 07/06/1983 | EMT36784 |
| DAHMASH, HASHIM | D520-321-99-420-0 | 11/20/2023 | 11/20/1999 | EMT574044 |
| ADCOCK, AMOS | A322-005-92-062-0 | 02/22/2031 | 02/22/1992 | EMT580505 |
| 5. BAUGHMAN, RILEY | B255-733-03-177-0 | 5/17/2024 | 5/17/2003 | EMT579516 |
| 6. | | | | |
| 7. | | | | |
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| 15. | | | | |
| 16. | | | | |

PERSONNEL RECORDS

| NAME LAST,FIRST | PROFESSIONAL LICENSE NUMBER | LICENSE ISSUE DATE | LICENSE EXPIRATION | CPR/ALCS EXP |
|------------------------------------|--------------------------------|--------------------|--------------------|--------------|
| HYDOK, KRISTEN | RN9424794 | 01/21/2016 | 04/30/2025 | 2024 |
| JONES, NATHAN | RN9486637 | 06/11/2018 | 04/30/2024 | 2024 |
| BRYAN, KELLY | RN9259068 | 10/14/2011 | 4/30/2025 | 2024 |
| MEEKE, CORI | RN9510502 | 05/08/2019 | 4/30/2025 | 2024 |
| DILLWORTH, FAITH | RT9523 | 08/07/2008 | 05/31/2025 | 2024 |
| MCAULIFFE, JEREMY | RT7236 | 04/22/2003 | 05/31/2025 | 2024 |
| LEFKOWITZ- WEBB, SARA | ARNPN9200051 | 03/06/2008 | 07/31/2024 | 2024 |
| PEARCE, CARRON | RN9301513 | 12/15/2009 | 04/30/2025 | 2024 |
| SPENGLER, KRISTOPHER | RT10095 | 06/24/2009 | 05/31/2025 | 2024 |
| RHYMES, WHITNEY | TT12959 | 05/01/2006 | 05/31/2025 | 2024 |
| LUNDEEN, CHRISTOPHER | RT16684 | 03/09/2018 | 05/31/2025 | 2024 |
| MILLER, WALTER | RT7184 | 03/05/2003 | 05/31/2025 | 2024 |
| SAYERS ONEIL GARDNER CHERYL | RN2061792 | 09/18/1989 | 04/30/2024 | 2024 |
| OCHIPA, PATRICA | RN1850662 | 08/31/1987 | 04/30/2024 | 2024 |
| ARMSTRONG, MICHELE | RN9168224 | 06/12/2000 | 04/30/2024 | 2024 |
| HULL, GLENN | RT7540 | 02/24/2004 | 05/31/2025 | 2024 |
| MONAHAN, MEGAN | RT9306 | 04/08/2008 | 05/31/2025 | 2024 |
| FORDYCE, BRENDEN | RT22515 | 02/17/2022 | 05/31/2025 | 2024 |
| BACON, JULIE PROGRAN MANAGER | RN1797622 | 03/23/1987 | 04/30/2024 | 2024 |

STATE OF FLORIDA DEPARTMENT OF HEALTH EMERGENCY MEDICAL SERVICES APPLICATION FOR VEHICLE PERMIT(S)

| EMS Provider JO | HNS H | OPKINS ALL CH | Provider #_5109 | |
|-------------------|---------|---------------|-----------------|---|
| Business Address | 501 6 A | VE SOUTH - DE | PT 7340 | district to the second |
| City_ST. PETERSBL | JRG | State_FLA | Zip Code 33701 | County PINELLAS |

PERMIT TYPE

VEHICLE DATA

| | | | 11 | ICIAILI I I I | | | , Elliell Billi | | | | | |
|----|-----------|-----|---------|---------------|-----------|-------|-----------------|----------|---------|-------------------|--|--|
| | DUPLICATE | NEW | CURRENT | URRENT ALS | | BLS | YEAR | MAKE | MODEL | V.I.N. | | |
| | | | PERMIT# | TRANS | NON-TRANS | TRANS | =124 - 200 | | | | | |
| 1 | | | 20956 | Х | | | 2017 | KENWORTH | T370 | 2NKHHM6X0HM165535 | | |
| 2 | | | 25214 | Х | | | 2020 | KENWORTH | T270 | 2NKHHM6X7LM391757 | | |
| 3 | | | 25215 | Х | | | 2017 | KENWORTH | T270 | 2NKHHM6X2HM136408 | | |
| 4 | | - | | | | | | | | | | |
| 5 | | | | | A. | | | | 707-300 | | | |
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| 14 | 0 | | | | | | | | | | | |
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Enclose Permit Fee(s). **Do not send cash**. Checks should be made payable to Emergency Medical Services and mailed to 4052 Bald Cypress Way, Bin A22, Tallahassee, Florida 32399-1738. **All fees are nonrefundable** §401.34(1), Florida Statute, (F.S.).

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S., and Rule 64J-1, Florida Administrative Code (F.A.C.), are present and in working order on the above described vehicles. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicles will be staffed, during operation, in accordance with Chapters 395 and 401 F.S., and Chapter 64J-1 F.A.C.

SIGNATURE

TITLE

DATE

FALSE OFFICIAL STATEMENTS: § 837.06, F.S.: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

DH Form 1510, April 2009



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/30/2023

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.

| | SUBROGATION IS WAIVED, subject is certificate does not confer rights to | | | ich end | lorsement(s) | | equire an endo | rsement | . A st | atement on |
|----------------|---|------------------------------|--|-----------------|------------------------------------|--|--|-------------------|----------|-------------|
| | DUCER | 20/0 | | CONTAC NAME: | Caitlin Gab | ell | | | | 4-5 |
| | igs, Counselman, Michaels & Down | es, Inc. | | | , Ext): 410-339 | 1 | | FAX (A/C, No): | 410-58 | 3-5459 |
| | 5 Fairmount Avenue wson MD 21286 | | 4 | | ss: cgabell@ | | | -17 | | |
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| | | | 9 | INSTIDE | | urance Comp | | | | 11150 |
| INSU | RED | | JOHNHOP-07 | INSURE | | arance comp | uny | | | 11100 |
| | nns Hopkins All Children's Hospital | | FACTURE-INCOME THE THE | | | | | | | |
| | Health System, Inc. | | | INSURE | | | | | | |
| | 7th Avenue South int Petersburg FL 33701 | | 6 | INSURE | | | | | W-10- | |
| Oai | int i cleisburg i L 5070 i | | | INSURE | | | | | | |
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| Α | AUTOMOBILE LIABILITY | | 11CAB1072100 | 6/30/2023 | 7/1/2024 | (Ea accident) \$2,000,000 BODILY INJURY (Per person) \$ | | | ,000 | |
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| | OWNED AUTOS ONLY SCHEDULED AUTOS | | | | | | PROPERTY DAMAG | | 02.0 | |
| | X HIRED X NON-OWNED AUTOS ONLY | | | | | | (Per accident) | J. | \$ | |
| | | | | | | 10.15 | | | \$ | |
| | UMBRELLA LIAB OCCUR | | | | | | EACH OCCURREN | CE | \$ | |
| | EXCESS LIAB CLAIMS-MADE | | | | | | AGGREGATE | | \$ | |
| | DED RETENTION\$ | | - West- | | | L | | 1 | \$ | |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | | | PER STATUTE | OTH- ER | | |
| | ANYPROPRIETOR/PARTNER/EXECUTIVE | N/A | | | | y. | E.L. EACH ACCIDE | NT | \$ | |
| | OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | N/A | | 1 | | | E.L. DISEASE - EA | EMPLOYEE | \$ | |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - POL | LICY LIMIT | \$ | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | /57 | 2/ VAY 1792 |
| DES | CRIPTION OF OPERATIONS / LOCATIONS / VEHIC dencing insurance coverage as respects | LES (ACO | ORD 101, Additional Remarks Schedu | ile, may b | e attached if mor | e space is requir | ed) | | | |
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| CE | RTIFICATE HOLDER | | | CANO | CELLATION | | | | | |
| | Johns Hopkins All Childrer Inc. Attn: Julie Kauzlarich | n's Hos | pital & Health System, | THE | EXPIRATION | N DATE TH | DESCRIBED POLICE EREOF, NOTICE CY PROVISIONS. | | | |
| | Risk Management 500 Building, Suite 204 | | | | RIZED REPRESE | 1141 | | | | |
| | 500 7th Avenue South | | | 12 | Le (). | معلد | | | | |

St. Petersburg FL 33701



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/30/2023

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.

| | SUBROGATION IS WAIVED, subject his certificate does not confer rights t | | | | | | | equire an endorsemen | t. A st | atement on | |
|---|---|-----------------------|-----|---|-------------|--|---|--|--------------|------------|--|
| Riggs, Counselman, Michaels & Downes, Inc. 555 Fairmount Avenue Towson MD 21286 INSURED JOHNHOP-07 Johns Hopkins All Children's Hospital | | | | | | CONTACT NAME: Caitlin Gabell | | | | | |
| | | | | | | PHONE (A/C, No, Ext): 410-339-7263 FAX (A/C, No): 410-583-5459 | | | | | |
| | | | | | | ADDRESS: cgabell@rcmd.com | | | | | |
| | | | | | | INSURER(S) AFFORDING COVERAGE | | | | NAIC# | |
| | | | | | | INSURER A : Arch Insurance Company | | | | 11150 | |
| | | | | | | INSURER B: | | | | | |
| and Health System, Inc. 500 7th Avenue South Saint Petersburg FL 33701 | | | | | INSURER C: | | | | | | |
| | | | | | INSURER D : | | | | | | |
| - | | | | | | INSURER E : INSURER F : | | | | | |
| COVERAGES CERTIFICATE NUMBER: 449637529 | | | | | | REVISION NUMBER: | | | | | |
| IN C | HIS IS TO CERTIFY THAT THE POLICIES NDICATED. NOTWITHSTANDING ANY REPORTED OR MAY INCLUSIONS AND CONDITIONS OF SUCH | QUIR PERT POLIC | EME | NT, TERM OR CONDITION THE INSURANCE AFFORDS LIMITS SHOWN MAY HAVE | OF ANY | CONTRACT THE POLICIES EDUCED BY F | OR OTHER D DESCRIBED PAID CLAIMS. | OCUMENT WITH RESPE | CT TO V | WHICH THIS | |
| LTR | | | WVD | POLICY NUMBER | | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMI | rs | | |
| | COMMERCIAL GENERAL LIABILITY CLAIMS-MADE OCCUR | | | | | | | EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) | \$ | | |
| | | | | | | | | MED EXP (Any one person) | \$ | | |
| | | | | | | | | PERSONAL & ADV INJURY | \$ | | |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | | GENERAL AGGREGATE | \$ | | |
| | POLICY PRO- JECT LOC | | | | | | | PRODUCTS - COMP/OP AGG | \$ | | |
| 11or | OTHER: | | | | | | | COMPINED SINGLE LIMIT | \$ | | |
| Α | AUTOMOBILE LIABILITY | | | 11CAB1072100 | | 6/30/2023 | 7/1/2024 | COMBINED SINGLE LIMIT (Ea accident) | \$ 2,000,000 | | |
| | X ANY AUTO OWNED SCHEDULED | | | | | | | BODILY INJURY (Per person) | \$ | | |
| | AUTOS ONLY AUTOS | | | | | | | BODILY INJURY (Per accident) PROPERTY DAMAGE | | | |
| | X AUTOS ONLY X NON-OWNED AUTOS ONLY | | | | | | | (Per accident) | \$ | | |
| _ | | - | | | | | | | \$ | | |
| | UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS MADE | | | | | | | EACH OCCURRENCE | \$ | | |
| | CEANVIS-IVIADE | | | | | | | AGGREGATE | \$ | | |
| - | DED RETENTION \$ WORKERS COMPENSATION | | | | | | | PER OTH- STATUTE ER | \$ | | |
| | AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE | | | | | | | AND INCOME NOT THE PROPERTY OF | - | | |
| | OFFICER/MEMBER EXCLUDED? | 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 BEIOW | | | | | | | E.L. DISEASE - POLICY LIMIT | 3 | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | CRIPTION OF OPERATIONS / LOCATIONS / VEHICL idencing insurance. Certificate holder is i | | | | | | | d) | | | |
| CERTIFICATE HOLDER | | | | | | CANCELLATION | | | | | |
| CERTIFICATE HOLDER | | | | | | CANCELLATION | | | | | |
| Pinellas County, A Political Subdivision of the State of Florida | | | | | | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. | | | | | |

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AUTHORIZED REPRESENTATIVE