



**PALM BEACH COUNTY
DEPARTMENT OF PUBLIC SAFETY
OFFICE OF EMERGENCY MEDICAL SERVICES**



**APPLICATION FOR SECONDARY PROVIDER
CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY (COPCN)**

Section 1:

The below named Agency is hereby applying for a new Secondary Provider Certificate of Public Convenience and Necessity (COPCN) for a term from _____ (fill in proposed start date) through June 30, 2027, with an Advanced Life Support (ALS) Endorsement, and the following additional Endorsements (check all that apply):

- Secondary ALS Transport Services
- Basic Life Support (BLS) Inter-Facility Transfer Services

(Secondary Providers may respond to emergency medical calls upon the request of a Primary Provider).

Section 2: AGENCY INFORMATION

Exact Full Legal Name of Agency _____

Mailing Address _____

Base Station Address _____

Phone # _____

Agency is Public Sector _____ Private Sector _____

Managers/Owner's Name _____

Medical Director's Name _____

Medical Director's Business Address _____

Medical Director's Medical License# _____ Exp. Date _____

If applicant is a private sector agency, provide a list of all owner(s), officers, directors, primary shareholders. Include each person's position/interest, and business address. (Please attach separate list referencing question #6)

Section 3: ATTACHMENTS REQUIRED

Applicants shall submit the application for COPCN as set forth in Chapter 13, Article II, Division 1, of the Palm Beach County Code (EMS Ordinance), and satisfy all requirements therein. In addition, applicants shall also provide satisfactory completion of the following requirements. **Please be sure to include with the application, as separately numbered attachments in a three (3) ring binder, the following:**

1. Statement indicating the public need and areas for the proposed services by your agency, including studies, if available, supporting the demonstrated demand and feasibility for the proposed service(s) and deficiencies in existing services and any other pertinent data you wish to be considered.
2. Copy of current State Emergency Medical Services (EMS) license(s) and/or current COPCN, if any.
3. Copy of profile sheet(s) relating to current Florida State license(s), if any, or the equivalent information sheet(s) listing all of the agency's vehicles in the State of Florida. In order to maintain an acceptable level of service response time, all applicants must have a sufficient number of ALS vehicles available for response. This number will vary based on the area of assignment. In no event shall any COPCN holder have less than one ALS Unit and one ALS Vehicle fully staffed, operationally available, and in service at all times ready for simultaneous response to calls. The COPCN holder must also have one ALS spare Unit fully equipped in the event that their primary ALS Unit is not in service. It is the intent of this provision that each COPCN holder is responsible to have sufficient ALS Units available as necessary to demonstrate ability to ensure continuity of operations and to provide mutual assistance as reasonably required upon request.
4. The minimum number of ALS Units, ALS Vehicles, and BLS Transfer Units that the applicant will have dedicated to Palm Beach County, which are operationally available, and fully staffed in accordance with Chapter 401, Florida Statutes, Chapter 64J-1, Florida Administrative Code ("F.A.C."), and any other applicable laws, to provide Secondary Provider services in Palm Beach County.
5. A list of the names of the personnel, and their EMS certifications, certification numbers and expiration dates that the applicant will dedicate to Palm Beach County to provide Secondary Provider services in Palm Beach County. Personnel must meet all certification and training requirements in Chapter 401, Florida Statutes, Chapter 64J-1, F.A.C., and any other applicable laws. The applicant must have at least one (1) supervisory or higher level employee who possesses a minimum of three (3) years of experience in pre-hospital ALS Services.
6. Identify whether or not the applicant has an automatic vehicle locator (AVL) system that would allow the Administrator and the requesting facility to track a responding vehicle's location, and provide details about any such AVL system and its capabilities.

7. Insurance verification: A copy of an insurance policy, a self-insurance policy, or a Certificate of Insurance is acceptable, so long as the agency meets the minimum insurance limits as required by Chapter 64J-1, F.A.C. There must be a 30-day cancellation notice and **Palm Beach County shall be shown as the certificate holder with a mailing address of 301 N. Olive Ave, West Palm Beach, FL 33401**
8. The Medical Director must be a Florida licensed physician. Provide a copy of a fully executed contract or agreement. Include copies of current DEA and Florida Physician's License. Must meet requirements of 64J-1.004, F.A.C. and Section 401.265, Florida Statutes.
9. A letter from your Medical Director stating your agency has adopted minimum standard, pre-hospital treatment/transport protocols that, at a minimum, meet the requirements of all applicable laws and regulations.
10. A letter from your Medical Director stating your agency has adopted the countywide approved Trauma Transport Protocols, or more stringent standards as approved by the applicant's Medical Director.
11. Copy of proposed rate structure, if any.
12. The financial information of the applicant to ensure financial ability to provide and continue to provide service to the area. Such financial information shall include copies of the applicant's past two (2) Medicare audits if any. Privately held entities must provide copies of the past three (3) years of audited financial statements of the company and its parent company or holding company, if any. Government entities must provide the past three (3) year's Annual Comprehensive Financial Reports via hard copy, or electronically. For purposes of this application, a parent company or holding company shall mean any person, corporation or company holding, owning or in control of more than ten (10) percent stock or financial interest of another person, corporation or company.
13. Except for current COPCN holders a summary history of applicant's emergency services performance record, which provides proof that at the time of application, the applicant has demonstrated experience providing ALS or BLS services. Experience providing ALS or BLS services must include experience proving the full continuum of patient care from call initiation, during patient transport and through to final patient transfer to hospital or other final destination. This is not a personal reference for the agency but how the agency had provided ALS or BLS services in the past.
14. Disclosure of litigation involving patient care, for the past six (6) years which resulted in a judgment, award, or finding in favor of a patient or the complaining party, including case number, nature of the claim and allegations, and a copy of final judgment or award. The administrator may request additional information regarding the litigation.
15. Proof of satisfactory completion of all federal, state, and/or local agency vehicle and staff inspections for the last six (6) years including copies of all deficiency reports. Current COPCN Holders need not provide vehicle and staff inspections performed by the Palm Beach County Office of EMS (except deficiencies reports).
16. Records substantiating the implementation of a formal quality assurance system consistent with Florida Statute Section 401.265 and Rule 64J-1.004(3)(b), F.A.C., as may be amended.
17. Records substantiating that Secondary COPCN applicant has an Emergency Medical Dispatch (EMD) program or an agreement for appropriate EMD service consistent with

Section 768.1335, Florida Statutes, titled the “Emergency Medical Dispatch Act”, as may be amended.

18. A memorandum of understanding for radio communications that is executed between the applicant and Palm Beach County (Facilities Development and Operations Dept.).
19. The applicant must provide a certified letter from the COPCN holder’s Chief Executive Operating Office or Fire Chief that the applicant has met all applicable federal, state and local requirements pertaining to the delivery of EMS.
20. The applicant shall provide information on how the following business functions will be conducted and managed:
 - a) Employee and Driver training programs
 - b) Complaint handing system
 - c) System for handling accidents and/or injuries
 - d) Vehicle maintenance system
21. Minimum of three (3) letters of reference (to include one hospital) sealed and attached to application package.
22. Benchmark Response Times. Provide data for previous six months of transports (Form A)
23. A non-refundable application fee in the amount of five-hundred dollars (\$500.00) made payable to: “Palm Beach County Board of County Commissioners.”

SECTION 4: AUTHORIZED SIGNATURE

I, the undersigned Agency Representative of the applicant Agency, do hereby attest and represent that said Agency meets, and shall continue to meet, all the requirements of the EMS Ordinance, and any accompanying Rules and Regulations, as well as all the requirements for the operation of an emergency medical service as provided for in Chapter 401, Part III, Florida Statutes, and Chapter 64J, F.A.C.

I, the undersigned Agency Representative of the applicant Agency, further attest that this Agency is in compliance with the State of Florida EMS Communications Plan.

I, the undersigned Agency Representative of the applicant Agency, acknowledge that any discrepancies discovered by the PBC EMS staff during the annual mandatory inspections may subject my Agency and its representatives to corrective action and possible penalty as provided for by Florida law and applicable Rule. Further, I understand that an annual vehicle inspection permit-fee of one hundred fifty dollars (\$150.00) per-vehicle shall be paid for any EMS vehicle or ambulance utilized in Palm Beach County.

I, the undersigned Agency Representative of the applicant Agency, hereby submit this application on behalf of the applicant Agency, and hereby affirm that I am authorized to submit this application on behalf of the applicant Agency and that, to the best of my knowledge, all statements on this application and the included attachments in support of the application are true and correct.

Name of Agency

Print or Type Name of Agency Representative

Signature of Agency Representative

Date

**STATE OF FLORIDA
COUNTY OF PALM BEACH**

The foregoing Application was acknowledged before me by means of ____ physical presence or ____ online notarization, this _____ day of _____, 202____, by _____ (name of person) as _____ (title or type of authority) for _____ (name of entity on behalf of whom instrument was executed).

Signature of Notary Public
State of Florida

Notary Stamp/Seal:

Print, Type or Stamp Commissioned

Name of Notary Public

Personally Known ____ OR Produced Identification ____

Type of Identification Produced: _____

FOR OFFICIAL USE ONLY

Date Application Received _____

Date Reviewed by EMS Advisory Council _____ Recommended ____ Not Recommended ____
Reason for not recommending:

Dated reviewed by BCC _____ Approved ____ Not Approved ____
Reason for not Approving: