

## INDIAN RIVER COUNTY DEPARTMENT OF EMERGENCY SERVICES

## APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY (COPCN)

APPLICANT NAME:	National Health Transport Inc	DATE: 7/08/202	5
	FEE: \$100.00 APPLIES TO INITIAL AP		•
☐ This is a renewal o	cation; fee is attached. f our present COPCN. f our present COPCN with ownership or	classification changes.	
	ON OF CERTIFICATE REQUESTED pplicable boxes and options.		
Governmental	BLSALS entities that use advanced life support ve ALS/BLS service.	ehicles to conduct a pre-	
	⟨_BLS X_ALS provide non-emergency ambulance interested in the least of the lea	-facility medical transport	
Agencies that p	BLSALS provide non-emergency ambulance interspecial clinical capabilities and require a		
Class D □ _ Agencies that p out of county tr	provide non-emergency ambulance med	ical transports limited to	

II.	CC	OMPANY DETAILS		
1	. NA	ME OF AGENCY: National Health Transport		
	MAILING ADDRESS: 2290 NW 110th Ave			
		CITY Sweetwater COUNTY Miami Dade	·	
		ZIP CODE: 33172 BUSINESS PHONE: (305) 636-500	0	
2.	TY!	PE OF OWNERSHIP (i.e. Private, Government, Volunteer, Pa.):	artnership,	
		Corporation (Private)		
3.		MANAGER'S NAME: Michael DeSouza, Director of Operations		
		ADDRESS: 871 S Kings Hwy Fort Pierce, Florida 33145		
		PHONE #: (954) 616-9000		
4.		PROVIDE NAME OF OWNER(s) OR LIST ALL OFFICERS, DIRECTORS, AND SHAREHOLDERS, IF A CORPORATION separate sheet if necessary):		
<u>N</u> .	AME	<u>ADDRESS</u>	POSITION	
Raul Rodriguez 2290 NW 110th Ave, Sweetwater, FI 33172 Pres		3172 President		
5.		PROVIDE NAMES AND ADDRESSES OF AT LEAST THRE REFERENCES	E (3) LOCAL	
N/	AME	ADDRESS	PHONE #	
Cory Richter		714 W. Fischer Cir. Sebastian, Fl 33958	772-633-3929	
Sandra Serra		1800 Tiffany Ave PSL, FI 34952	772-398-3800	

5160 NW Milner Drive PSL 34983

Brian Gonzalez

772-621-3400

	6.	FUNDING SOURCE: Self					
	7.	RATE SCHEDULE ATTACHED	?	YES 🗵	NO □	N/A □	
	8.	LIST THE ADDRESS OF YOU	R BA	SE AND ALL S	SUB-STATIO	NS:	
871 S King	ıs Hwy l	Fort Pierce, Florida 33145					
	III.	COMMUNICATIONS INFORMA	ATIO	N:			
	ES OF F	RADIOS/EQUIPMENT:					
Motorola							
Soc attached		DIO FREQUENCY (ies) ct with Highland Wireless		2. RAI WQYV483	DIO CALL NU	JMBER(s)	
See attached	Contrac	St with riighland vvii eless	,	VVQ1 V+05			
			-				
			•				
		ST ALL HOSPITALS AND OTHE HICH YOU HAVE DIRECT RADI				TH	
		FROM AMBULANCE		FR	OM BASE ST	TATION	
All Via N	/led-10		All	via phone			
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## IV. ADDITIONAL INFORMATION REQUIRED TO BE SUBMITTED WITH THIS APPLICATION:

## RENEWAL APPLICANTS NEED ONLY #'s 4 - 9

- Factual Statement indicating the public need and services, including studies 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.
- Factual statement of the proposed services to be provided, including type of service, hours and days of operation, market to be served, geographic areas to be serviced, and any other pertinent data you wish to be considered.
- 3. Factual Statement indicating the ability of the applicant to manage and provide the proposed services, including the management plan, maintenance facilities, insurance program, accounting system, system for handling complaints, system for handling accidents and injuries, system for providing the county monthly operating reports and any other pertinent data you wish to be considered.
- 4. Copy of Standard Operating Procedures.
- 5. Copy of Medical Protocols.
- 6. Copy of your insurance policy must show coverage limits -
- 7. Vehicle Information. For each vehicle provide the following:
  - a. Make, Model, Year, Manufacturer
  - b. Mileage
  - c. VIN#
  - d. Tag Number
  - e. Passenger capacity (E/E1 classification)
  - f. Indicate ALS/BLS (A-D classification)
- 8. Personnel Roster. For each employee provide the following:
  - a. Name Last, First and Middle Initial
  - b. Driver's License # (if commercial, specify class) & Expiration Date ADDITIONAL INFO REQUIRED FOR A-D classifications
  - Emergency Medical Service Certification and # (EMT or Paramedic)
  - d. Expiration date of Certification
  - e. Whether or not has an Emergency Vehicle Operation Certificate.
- 9. Fee Schedule Incl: Service Type, Base Rate, Mileage, Waiting & Special Charges

V. NOTARIZED STATEMENTS	
I, Rau Rockiguez, the re	epresentative of
National Health Transport Inc., do Business Name of Service	hereby attest that
the above named service will provide continuous service on a week basis. I do hereby attest that the above named service in requirements for operation of an ambulance service in the Sta provided in Chapter 401, Part III, Florida Statutes, Chapter 64E Administrative Code, and that I agree to comply with all the pr 304, Life Support Services.	neets all the ite of Florida as i-2, Florida
ALL APPLICANTS	
I further acknowledge that discrepancies discovered duperiod of the Certificate of Public Convenience and Necethis service and its authorized representatives to correct penalty provided in the referenced authority and that to knowledge, all statements on this application are true are PELICANT SIGNATURE.	essity will subject tive action and the best of my and correct.
Before me personally appeared the said <u>Rau Rodnguz</u> .  that he/she executed the above instrument of his/her own free will and a knowledge of the purpose thereof. Sworn and subscribed in my presence of the purpose thereof. Sworn and subscribed in my presence of the purpose thereof.  ALISSA D. GARCIA  MY COMMISSION # HH 151116  EXPIRES: July 10, 2025  Bonded Thru Notary Public Underwriters	ce this day of