



# INDIAN RIVER COUNTY DEPARTMENT OF EMERGENCY SERVICES

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

**APPLICANT NAME:** Coastal Care Corporation DBA Cleveland Clinic Advanced Medical Transport **DATE:** 01/06/2026

**APPLICATION FEE: \$100.00 APPLIES TO INITIAL APPLICATIONS ONLY.**

If payment applicable, make check payable to INDIAN RIVER COUNTY FIRE RESCUE.

- ☐ This is a new application; fee is attached.
- ☒ This is a renewal of our present COPCN.
- ☐ This is a renewal of our present COPCN with ownership or classification changes.

**I. CLASSIFICATION OF CERTIFICATE REQUESTED**

Please check applicable boxes and options.

**Class A** ☐     BLS     ALS

Governmental entities that use advanced life support vehicles to conduct a pre-hospital EMS ALS/BLS service.

**Class B** ☒ ✓ BLS ✓ ALS

Agencies that provide non-emergency ambulance inter-facility medical transport at the ALS/BLS level.

**Class C** ☐     BLS     ALS

Agencies that provide non-emergency ambulance inter-facility medical transports which require special clinical capabilities and require a physician's order.

**Class D** ☐     BLS     ALS

Agencies that provide non-emergency ambulance medical transports limited to out of county transfers.

## II. COMPANY DETAILS

1. NAME OF AGENCY: Coastal Care Corporation DBA Cleveland Clinic Advanced Medical Transport

MAILING ADDRESS: P.O. Box 9010

CITY Stuart COUNTY Martin

ZIP CODE: 34995 BUSINESS PHONE: 772-223-5945 Ext. 17028

2. TYPE OF OWNERSHIP (i.e. Private, Government, Volunteer, Partnership, etc.):

Non profit Hospital Based

3. MANAGER'S NAME: Kevin Kennedy

ADDRESS: 10050 SW Innovation Way Port St. Lucie, FL 34987

PHONE #: (772) 285-5275

4. PROVIDE NAME OF OWNER(s) OR LIST ALL OFFICERS, PARTNERS, DIRECTORS, AND SHAREHOLDERS, IF A CORPORATION (attach a separate sheet if necessary):

<u>NAME</u>	<u>ADDRESS</u>	<u>POSITION</u>
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See attached sheet

5. PROVIDE NAMES AND ADDRESSES OF AT LEAST THREE (3) LOCAL REFERENCES

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE #</u>
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<u>Chris Kammel, EMS Chief</u>	<u>800 SE Monterey Rd. Stuart, FL 34994</u>	<u>(772) 215-4495</u>
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<u>Brian Gonzalez, EMS Chief</u>	<u>5160 NW Milner Dr. Port St. Lucie, FL 34983</u>	<u>(772) 288-5361</u>
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<u>Jonathan Huneycut, EMS Chief</u>	<u>800 Martin Luther King jr. Blvd. Stuart, FL 34994</u>	<u>(772) 288-5361</u>
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6. FUNDING SOURCE: Transport Revenue

7. RATE SCHEDULE ATTACHED? YES ☒ NO ☐ N/A ☐

8. LIST THE ADDRESS OF YOUR BASE AND ALL SUB-STATIONS:

2150 SE Salerno Rd. Stuart, FL 34997

10000 SW Innovation Way Port St. Lucie, FL 34987

1000 36th St. Vero Beach, FL 32960

1095 St. Lucie West Blvd. Port St. Lucie, FL 34986

### III. COMMUNICATIONS INFORMATION:

#### TYPES OF RADIOS/EQUIPMENT:

Motorola CM200, CM300d, PM1500, and Portable Relay Radio

#### 1. RADIO FREQUENCY (ies)

UHF 450-470mhz and Portable Relay

#### 2. RADIO CALL NUMBER(s)

Base and Mobile Radio Systems- Med 1, Med 3, Med 4,

Med 5, Med 6, Med 7, Med 8, Med 9, Med 10, Med 11,

Med 14, and Med 15

#### 3. LIST ALL HOSPITALS AND OTHER EMERGENCY AGENCIES WITH WHICH YOU HAVE DIRECT RADIO COMMUNICATIONS:

##### FROM AMBULANCE

All Licensed Emergency Departments via

Med 8 radio.

##### FROM BASE STATION

None

**IV. ADDITIONAL INFORMATION REQUIRED TO BE SUBMITTED  
WITH THIS APPLICATION:**

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

1. 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.
2. 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
  - c. 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, Kevin R Kennedy, the representative of  
Applicant Name

CLEVELAND CLINIC ADVANCED MEDICAL TRANSPORT do hereby attest that  
Business Name of Service

the above named service will provide continuous service on a 24-hour, 7-day week basis. I do hereby attest that the above named service meets all the requirements for operation of an ambulance service in the State of Florida as provided in Chapter 401, Part III, Florida Statutes, Chapter 64E-2, Florida Administrative Code, and that I agree to comply with all the provisions of Chapter 304, Life Support Services.

ALL APPLICANTS

I further acknowledge that discrepancies discovered during the effective period of the Certificate of Public Convenience and Necessity will subject this service and its authorized representatives to corrective action and penalty provided in the referenced authority and that to the best of my knowledge, all statements on this application are true and correct.

[Signature]  
APPLICANT SIGNATURE

1/20/20  
DATE

Before me personally appeared the said Kevin Kennedy who says that he/she executed the above instrument of his/her own free will and accord, with full knowledge of the purpose thereof. Sworn and subscribed in my presence this 20 day of January, 2020.

[Signature]  
NOTARY PUBLIC

My commission expires: 10/25/2029

