☐ **National Casualty Company**
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☐ **Scottsdale Indemnity Company**
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Columbus, Ohio 43215
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Scottsdale, Arizona 85258

☐ **Scottsdale Insurance Company**
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Columbus, Ohio 43215
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Scottsdale, Arizona 85258

☐ **Scottsdale Surplus Lines Insurance Company**
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Scottsdale, Arizona 85258

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AMBULANCE SUPPLEMENTAL APPLICATION

(Complete in addition to the Commercial Automobile Application)

PROVIDE COPIES OF DRIVER TRAINING MANUAL AND SAFETY PROCEDURES

Applicant's Name: _____

1. **Description of operations:** _____

_____

Number of years in business: ..... _____

Number of years under current management: ..... _____

2. **Is your service a subsidiary or division of another company?** ..... ☐ Yes ☐ No

If yes, advise the name of the company, their address and their relationship to you: _____

_____

3. **Has this service ever operated under another name?** ..... ☐ Yes ☐ No

If yes, what name? _____

4. ☐ **Profit** ☐ **Nonprofit—Source of funding:** _____

5. **Do your employees work more than one shift per day?** ..... ☐ Yes ☐ No

If yes, provide shift details: _____

_____

6. **Number of trips per year:** ..... _____

Number of emergency: ..... _____ Number of non-emergency: ..... _____

Percentage of wheelchair transport: ..... _____% Percentage of stretcher transport: ..... _____%

7. **Is transportation provided to non-medical destinations?** ..... ☐ Yes ☐ No

Daycare Centers: ..... _____% Heliport or Airport: ..... _____% Psychiatric Centers: ..... _____%

Schools: ..... _____% Shopping Centers: ..... _____% Workplaces: ..... _____%

Senior Centers: ..... _____% Other: ..... _____% Describe: _____

8. A. **List major cities entered:** _____

_____

B. **What percentage of the operations involves transportation in these cities?** ..... _____%

9. **Number of units equipped with lights and sirens?** ..... _____

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10. Who dispatches your calls? ☐ 911 ☐ Outside sources ☐ In-house by your own employees or volunteers

11. Do you distribute any medical supplies or equipment? ☐ Yes ☐ No

If yes, provide details: _____

_____

_____

12. Indicate level of training and number of individuals who drive and/or provide client care (full-time, part-time or volunteer):

	EMT BASIC	EMT ADVANCED	EMT PARAMEDIC	OTHER	NO CERTIFICATION
NUMBER OF EMPLOYEES					
NUMBER OF VOLUNTEERS					

If "other" marked above, explain: _____

13. Identify the types of special driver training programs that your drivers receive:

☐ General driver orientation ☐ Defensive driving ☐ Primary first aid
☐ Advanced first aid ☐ CPR ☐ Passenger assistance training
☐ Human relations skills ☐ Nonmedical emergency training ☐ Emergency vehicle evacuation
☐ Emergency vehicle operators course (EVOC)

14. Do you:

Screen employees and drivers' histories for sexual abuse charges and convictions? ☐ Yes ☐ No
Verify licenses/professional certificates? ☐ Yes ☐ No
Screen employees for previous involvement as defendants in malpractice litigation? ☐ Yes ☐ No

15. How many vehicles are equipped with the following wheelchair tie-down mechanism?

3 point tie-down: _____
4 point tie-down: _____

16. Describe wheelchair and stretcher tie-down procedures: _____

_____

17. Is scooter transport (electric scooters or mobility scooters) provided? ☐ Yes ☐ No

If yes, how are passengers secured? _____

_____

_____

If yes, how are scooters secured within the vehicle? _____

_____

_____

18. Are any vehicles not equipped with both lap belts and shoulder harnesses for the passengers? ☐ Yes ☐ No

19. Is there an accident review procedure? ☐ Yes ☐ No

If yes, describe: _____

_____

20. Describe vehicle maintenance program: _____

_____

21. Does Applicant carry Professional Liability coverage? ☐ Yes ☐ No

Policy Number	Carrier	Limits	Term	Is Loading and Unloading Included?
		$		☐ Yes ☐ No

22. Does Applicant carry General Liability coverage? ☐ Yes ☐ No

Policy Number	Carrier	Limits	Term
		$	

23. Are all vehicles owned by you? ☐ Yes ☐ No

If no, explain: _____

_____

Are they leased, etc.? ☐ Yes ☐ No

Give details: _____

_____

24. Do any employees/volunteers use their own vehicles in your business? ☐ Yes ☐ No

If yes, explain: _____

_____

Are any employees/volunteers' vehicles used for client transport? ☐ Yes ☐ No

25. Are all employees covered by Worker's Compensation? ☐ Yes ☐ No

If yes, provide carrier name: _____

_____

26. Any other pertinent information about your business: _____

_____

_____

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

Refer to the application form for State Fraud Warnings.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

(Must be signed by an active owner, partner or executive officer)

PRODUCER'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only)