NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

BLSFR Agency Information Application / Update Form

Name of Service	Code # if Update:
DBA or Assumed Name if any	
Physical Location / Address	
Mailing Address	County: :
City, State, Zip Code	City: State: Zip:
Describe / list your response area	☐ Check Box if Fire/Amb District
Business Phone # and FEIN Φ	Federal Employer ID No:
Fax Phone Number & Email	Email Address:
Emergency Phone Number	☐ Check Box if Called Thru 911
Chief Operations Officer & Title	Print Name: Print Title:
Chief Officer Day Phone	
Chief Officer Hm / Night Phone	Cell / Pager #:
Name of Dispatching Agency	☐ Check box if Self Dispatched
Dispatch Communications	Radio Frequency: FCC Callsign:
Number of Trained Providers	First Aid: PAD*: CFR: EMT: ALS**:
Number of members that are also members of another EMS Agency	First Aid: PAD*: CFR: EMT: ALS**:
Number EMS Response Vehicles	Service owned: Privately Owned:
PrimaryTransporting Ambulance Service	Agency Code #:
Additional Transporting Ambulance Service	Agency Code #:
Additional Transporting Ambulance Service	Agency Code #:
Number of EMS Calls Annually****	# EMS Calls Dispatched to: #Calls with Patient Care given:
Printed Name and Title of Person Completing this Information Form	Print Name: Print Title:
Signature and Date of Person Completing This Information Form	Signed: Date:

* NOTE: PAD trained personnel may ONLY provide defibrillation care with service that has filed notice per PHL 3000b.
** NOTE: ALS Certified personnel may ONLY provide care at BLS level when responding with BLSFR authorized service.
****NOTE: Services not yet providing EMS – Please provide estimate of call volume based on info from local EMS dispatch.
Services providing EMS – Provide call volume based on calls to which you were dispatched to provide EMS.
EMS calls: indicate all EMS dispatches. Calls w/pt care: do not include RMAs, No Pt found, standbys, cancelled calls.
Φ NOTE: **Federal Employer ID # must be provided for any service intending to apply for EMS training reimbursement from NYS DOH.**

Please complete this form with your agency Information and send it to the address to the right. If you have questions about Filling out this form, please contact the DOH Bureau of EMS, Operations Section for Assistance at 518-402-0996 extension 2.

Return Completed Form to:

Attn: BLSFR Update - OPS
NYS DOH Bureau of EMS
433 River Street Suite 303
Troy, New York 12180-2299

Do Not Write or Mark in Box Below

App Rcd:	Chk list complete:	Date Reviewed:	Code #: