EXHIBIT A

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVI CES AGENCY

APPLICATION FOR AMBULANCE OPERATOR'S LICENSE

READ ALL INSTRUCTION BEFORE COMPLETING APPLICATION

Full name of applicant: ______________________________ **Tel. No.: (______)** ____________________

Full name of business: ____
STATE WHETHER CORPORATION, PARTNERSHIP, INDIVIDUAL PROPREITORSHIP OR OTHER STATUS

Address of business: ____
NUMBER STREET CITY ZIP CODE

Mailing address (if different): ____
STREET/P.O.BOX CITY ZIP CODE

If a corporation, exact corporate name: ____

Date of Incorporation: ______________________**Incorporation in the State of:** _________________

NAME OF OFFICERS	ADDRESSES	TITLES

IDENTIFY OFFICER(S) DULY AUTHORIZED TO ACCEPT SERVICE OF LEGAL PROCESS WITH AN ASTERISK (*)

If a partnership, indicate the names, address(es) and percentage of partnership each holds:

NAME OF PARTNERS	ADDRESSES	%INTEREST HELD

Type of license applying for (check one):

______ **Ambulance** ______ **Ambulance/Ambulette** ______**Special Event**

I certify (or declare) the information contained herein is true and correct to the best of my knowledge and belief. As a condition for the issuance of the license applied for, I agree to submit any additional information that may be requested and to conduct all phases of the business and ambulance operations in accordance with all applicable laws, ordinances and regulations.

Date: ________________ **Applicant's Signature/Title:** ____
NOTE: ***All Officers/Directors must sign***
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