

**Massachusetts Department of Public Health
Office of Emergency Medical Services
Part D: Place of Business**

Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances (Make as many copies of this form as needed).

1) Service Number 	2) Ambulance Service Name
3) PLACE OF BUSINESS	
Address	
City	State
Zip	
Business Phone Number [For this location] ()	Emergency Phone Number (non 911) ()

4) Is this location your headquarters? YES NO Fax Phone Number () _____

5) Number of vehicles normally operated at this location				
Class I	Class II	Class IV	Class V	

6) Is service from this place of business provided 24 hours a day, 7 days a week? YES NO

If no, please explain:

7) What type of service(s) is being provided from this location? (Check all that apply)	<input type="checkbox"/> Basic <input type="checkbox"/> ALS-Intermediate <input type="checkbox"/> ALS-Paramedic
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8) How many hours per day is ALS-Intermediate service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat

9) How many hours per day is ALS-Paramedic service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat

10) ALS Information	
Mass Controlled Substance Registration # _____	Expiration _____ Schedule _____
Hospital with which you have an Affiliation Agreement _____.	