DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02570 (11/2019)

STATE OF WISCONSIN
Office of Preparedness and Emergency Health Care

EMERGENCY MEDICAL SERVICES(EMS)
E-LICENSING SERVICE DEMOGRAPHIC INFORMATION

The purpose of this form is to maintain correct service information for the Emergency Medical Services licensing system and the Wisconsin Ambulance Run Data system. This information is required to complete the 2020-2023 Service Renewal Process.
Return completed form and necessary attachments to DHSEMSSMail@dhs.wisconsin.gov or Fax number is 608-261-6392.

DEMOGRAPHICS

Legal Name of Service	Service Classification
Telephone Number	Fax Number (If applicable)
Email Address	Web Page (If applicable)
Medical Control Hosptial	

Service Address (location where service records are kept)	Ship To/Mailing Address(Street, City, State and Zip Code)

Federal Employer Identification Number (FEIN)	National Provider Number (NPI) (If applicable)	Fire Department Identification Number (If applicable)

Drug Enforcement Agency Registration Number (If applicable)	DEA Issue Date	DEA Expiration Date

ORGANIZATIONAL

Type (Select)	Status (Select)	Tax Status (Select)	Primary Service (Select)

Secondary Service (Select all that apply)

- ☐ 911 transporting
- ☐ 911 non-transporting
- ☐ Air medical
- ☐ Hazmat
- ☐ Interfacility transfer
- ☐ Community EMS
- ☐ ALS intercept
- ☐ TEMS team
- ☐ Critical Care transport
- ☐ Training Center
- ☐ Dispatch

Public Safety Answering Point (PSAP)

PSAP Name	Dispatch Center Name
PSAP Phone Number	Center Business Phone Number

PSAP Name	Dispatch Center Name
PSAP Phone Number	Center Business Phone Number

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PSAP Phone Number	Center Business Phone Number

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PSAP Phone Number	Center Business Phone Number

SERVICE STAFF ROLES

Please complete the service staff roles information below. One person may serve/hold several of these positions, it does not have to be different people. These roles are required under DHS 110.47

Name of Service Director	Name of Medical Director
Name of Assistant Service Director (Optional)	Name of Training Designee
Name of Quality Assurance Designee	Name of Infection Control Designee
Name of Wisconsin Ambulance Run Data Designee	Name of Pediatric Emergency Care Coordinator (Optional)

STATION LOCATIONS

Complete the information below for all station locations. If needed submit additional pages.

Station Number or Identifier	Station Address

SERVICE COVERAGE AREAS

Complete the service coverage information below. If needed submit additional pages.

Name of Area Covered	Type of Municipality	Percentage of Population Served

Information completed by:

SIGNED – Service Director or Designated Staff Date Signed

Print Name and Title of Person signing above

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For assistance with your service please contact your EMS Regional Coordinator

EMS Program Municipal Signature and Population Verification, F-47255 https://www.dhs.wisconsin.gov/forms/f47255.pdf

Clear/Reset Entire Form