



APPLICATION FOR EMS/AMBULANCE PERMIT

DATE: 10-28-20

APPLICANT: Care Flite

ADDRESS: 630 N. Graham Stephenville, TX 76401

MAILING ADDRESS (IF DIFFERENT): 3108 S. Great South West PKwy, Grand Prairie TX 75052

PHONE: 972-339-4260 NO. OF YEARS IN EMS BUSINESS: 41

LIST LEVEL AND TYPE OF SERVICE TO BE PROVIDED:

[Blank lines for service details]

LIST NUMBER OF AMBULANCE UNITS AND NUMBER OF PERSONNEL TO BE PROVIDED:

1 unit 2 crew per shift 1) Paramedic and 1) EMT

HOURS OF OPERATION AND AVAILABILITY: 24 hours

LIST ANY EXPERIENCE THE APPLICANT HAS HAD IN RENDERING SUCH SERVICES

[Blank lines for experience]

If a partnership, the names, of all partners, general and limited. If a corporation, its name, date, and place, of incorporation, the address of its principal place of business, the names of all its officers and directors. (Provide this information on a separate page).

NAME OF COMPANY: Care Flite - Non Profit

ADDRESS: 3108 S. Great Southwest PKwy, Grand Prairie

PHONE: 972-339-4260 TX 75052



APPLICATION FOR EMS/AMBULANCE PERMIT

INSURANCE COMPANY: VFIS of Texas

AGENT: Cottingham + Butler

POLICY NUMBER: VFNU-TR-0022977

EFFECTIVE PERIOD: 10-1-20 - 10-1-21

AMOUNT OF LIABILITY: \$10,000,000.00

PLEASE ATTACH COPIES OF CURRENT INSURANCE POLICY AND TEXAS DEPARTMENT OF HEALTH PROVIDER LICENSE.

I certify that the statements in this application are true and correct. I realize they will be investigated and thereby authorize the release of any pertinent and appropriate information. I understand that misrepresentations on my part in completing this application will cause my application to become null and void.

SIGNED: [Signature] Bryan Crane

DATE: 10/28/20 10-28-20

RECEIVED BY: _____ DATE: _____

REVIEWED BY PUBLIC HEALTH AND SAFETY COMMITTEE: _____

APPROVED BY COUNCIL: _____

FEE PAID: _____



CERTIFICATE OF LIABILITY INSURANCE

CAREF-1

OP ID: BN

DATE (MM/DD/YYYY)

10/09/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
VFIS of Texas
3420 Executive Center Dr #301
Austin, TX 78731
Cottingham & Butler

800-252-9435

CONTACT NAME: Cottingham & Butler
PHONE (A/C, No, Ext): 800-252-9435
E-MAIL ADDRESS: jbair@cottinghambutler.com
FAX (A/C, No): 512-448-9929

INSURED
CareFlite
3110 S. Great Southwest Pkwy
Grand Prairie, TX 75052

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	National Union Fire Ins Co	
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL/SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> PHCL GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:		VFNU-TR-0022977	10/01/2020	10/01/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 10,000,000 PRODUCTS - COMP/OP AGG \$ 10,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY		VFNU-TR-0022977	10/01/2020	10/01/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$		VFNU-TR-0022977	10/01/2020	10/01/2021	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N <input type="checkbox"/> N/A If yes, describe under DESCRIPTION OF OPERATIONS below					PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Proof of Insurance Only

CERTIFICATE HOLDER

City of Stephenville, Texas
Attn: Sheryl Tuss
298 W Washington St.
Stephenville, TX 76401

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Barbara R. Marzjan

ACORD 25 (2016/03)



TEXAS
Health and Human
Services

Texas Department of State
Health Services

This certifies that

CAREFLITE-GROUND

License Number: 300046

has submitted acceptable evidence of compliance with the Texas Health and Safety Code, Chapter 773, the Texas EMS Act, and is hereby granted a License as a **TEXAS EMERGENCY MEDICAL SERVICES PROVIDER**. This License is not transferable and is valid only for use by the provider named above.

Expiration Date: 11/30/2021

JOHN HELLERSTEDT MD
COMMISSIONER

If you have a complaint about the services you have received from this EMS Provider or if you have a reason to believe that a violation of Texas EMS regulations has occurred, please report your concerns to the Texas Department of State Health Services at:

1-800-452-6086 or by email to **EMS_Complaint@dshs.texas.gov**