

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

License period January 1 to December 31.

\$1,000.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check (✓) one: () Individual
() Partnership
(X) Corporation

1. **NAME OF APPLICANT** (if individual) _____
BUSINESS NAME PARATECH AMBULANCE SERVICE, INC. Phone (414) 358-1111
Business Address 9401 W. BROWN DEER RD. MILWAUKEE WI Zip 53224
Have any people on this application been convicted of violating any federal or state laws, or local ordinances?
Yes _____ No XX If 'yes' name of person (s), date, charge and penalty: _____

2. **PARTNERSHIP:** (if applicable)
Name _____ **Home Address** _____
City, State, Zip _____ **Phone** _____ **Date of Birth** _____
Name _____ **Home Address** _____
City, State, Zip _____ **Phone** _____ **Date of Birth** _____
3. **NAME OF CORPORATION:** PARATECH AMBULANCE SERVICE, INC.
Address, City, State, Zip 9401 W. BROWN DEER RD., MILWAUKEE, WI 53224
Date and Place of Incorporation JANUARY 1, 1979 STATE OF WISCONSIN
President ROBERT A. RAUCH **Home Address** 480 WOODVIEW TRACE
City, State, Zip COLGATE, WI 53017 **Phone** (262) 628-9244 **Date of Birth** 4/22/49
Vice President RICHARD ROMANSHEK **Home Address** N90 W20881 SCENIC DR.
City, State, Zip MENOMONEE FALLS, WI 53051 **Phone** (262) 255-6486 **Date of Birth** 3/24/53
Secretary RICHARD ROMANSHEK **Home Address** SAME AS ABOVE
City, State, Zip _____ **Phone** _____ **Date of Birth** _____
Treasurer ROBERT A. RAUCH **Home Address** SAME AS ABOVE
City, State, Zip _____ **Phone** _____ **Date of Birth** _____
Agent _____ **Home Address** _____
City, State, Zip _____ **Phone** _____ **Date of Birth** _____

4. **OTHER REQUIREMENTS:**

Do you have on file with the Health Department a valid and current certificate of insurance for this license period? XX Yes No

Do you have a valid State of Wisconsin Inspection Certificate? XX Yes No

Do you participate in the Emergency Medical Services System? XX Yes No

If 'yes', list service area number: 1

Do you wish to participate in the Emergency Medical Services System? XX Yes No

Total number of vehicles in service: 21

Please attach a separate page listing all vehicles including city assigned number, and description (year, make and van number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

17th day of September, 192003

Paula A. Bianchetti

Notary Public, State of Wisconsin

My commission expires 10/12/03

Robert A. Paul

(Individual/Corporate President/Partner)

Rob Lomb

(Additional Partner/Corporate Vice-President)

Rob Lomb

(Corporate Secretary)

Robert A. Paul

(Corporate Treasurer)

Do Not Write Below This Line

Clerk License # New Renewal Date Filed Date Granted

<u>LIC#</u>	<u>VEHICLE ID NUMBER</u>	<u>YEAR/MAKE</u>	<u>PURCHAS IN SERVICE</u>	
SQ 1	1FDJE30M2RHB00959	1994 FORD	NEW	5/16/1994
SQ 2	1FDJE30F0SHB07643	1995 FORD	NEW	8/4/1995
SQ 3	1FDSE35F81HA96984	2001 FORD	NEW	8/1/2001
SQ 4	1FDSE35F9YHA37615	2000 FORD	NEW	6/9/2000
SQ 5	1FDSE35FOYHB24156	2000 FORD	NEW	6/9/2000
SQ 6	1FDKE30M2JHB18936	1988 FORD NEO-NATAL UNIT	NEW	8/1/1988
SQ 7	1FDJE30MORHB00961	1994 FORD	NEW	4/14/1994
SQ 8	1FDSE35FXYHB25055	2000 FORD	NEW	6/30/2000
SQ 9	1FDSE30F9WHA39918	1998 FORD	NEW	5/15/1998
SQ 10	1FDSE30F8WHA39926	1998 FORD	NEW	5/15/1998
SQ 11	1FDSE30FXWHA06362	1998 FORD	NEW	5/15/1998
SQ 12	1FDJE30F3SHB31001	1995 FORD	NEW	9/15/1995
SQ 13	1FDJE30F5SHB31002	1995 FORD	NEW	9/15/1995
SQ 14	1FDJE30M4RHB00963	1994 FORD	NEW	4/14/1994
SQ 15	1FDJE30F2SHB07644	1995 FORD	NEW	8/4/1995
SQ 16	1FDKE30M7RHB55668	1994 FORD TYPE III	NEW	7/28/1994
SQ 17	1FDJE30F0THA70899	1996 FORD	NEW	4/30/1996
SQ 18	1FDJE30F3THA70900	1996 FORD	NEW	4/30/1996
SQ 19	1FDJE30F5THA70901	1996 FORD	NEW	4/30/1996
SQ 20	1FDSE30F9WHA39921	1998 FORD	NEW	5/15/1998
SQ 21	1FDWE30F9WHA14521	1998 FORD TYPE III	NEW	5/21/1998

PARATECH AMBULANCE SERVICE, INC.

AS OF AUGUST 2001

ACORD

CERTIFICATE OF LIABILITY INSURANCE

CSR 09
PARAT-1DATE (MM/DD/YY)
07/17/01

PRODUCER

AIS GROUP LTD. -1
P.O. Box 1180
Menomonee Falls WI 53052-1180
Phone: 262-255-5100

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

INSURED

Paratech Ambulance Service, Inc
P.O. Box 240076
Milwaukee WI 53224-9004

INSURER A: Norman-Spencer McKernan Inc
INSURER B:
INSURER C:
INSURER D:
INSURER E:

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	3XZ115100	06/15/01	06/15/02	EACH OCCURRENCE \$ 1,000,000 FIRE DAMAGE (Any one fire) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	3XZ115100	06/15/01	06/15/02	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	GARAGE LIABILITY ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
A	EXCESS LIABILITY OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE RETENTION \$	79775112	06/15/01	06/15/02	EACH OCCURRENCE \$ 3,000,000 AGGREGATE \$ 3,000,000 \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	OTHER Blanket Property	3XZ115100	06/15/01	06/15/02	\$1,397,000

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

City of Milwaukee is additional insured as respects named insured's operation as an ambulance service

APPROVED AS TO FORM

AND EXECUTION THIS 14th

DAY OF November 2001

[Signature]
Assistant City Attorney

CERTIFICATE HOLDER

N

ADDITIONAL INSURED; INSURER LETTER:

CANCELLATION

CITYM-2

City of Milwaukee
Health Department
Attn: Clarence Anderson
841 N. Broadway Rm 112
Milwaukee WI 53202-3653

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL _____ MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, _____

ALICE BARBELN

Alice Barbeln


046199

REFERENCE NO.	DESCRIPTION	INVOICE DATE	INVOICE AMOUNT	DISCOUNT TAKEN	AMOUNT PAID
09302001		9/14/01	1,000.00		1,000.00

RECEIVED
2001 SEP 19 PM 1:20
MILWAUKEE HEALTH
DEPARTMENT

CHECK DATE	CHECK NO.	PAYEE	DISCOUNTS TAKEN	CHECK AMOUNT
8/1/01	046199	CITY OF MILW. HEALTH DEPT.		\$1,000.00

THIS CHECK IS VOID IF MICRO PRINT SIGNATURE LINE IS UNREADABLE UNDER MAGNIFICATION



Paratech
AMBULANCE SERVICE
...help is on the way.
P.O. Box 240076
Milwaukee, WI 53224-9004

M&I Bank of Menomonee Falls
Menomonee Falls, Wisconsin
79-1216/759


046199

CHECK NO.	DATE	AMOUNT
046199	Aug 1, 2001	*****\$1,000.00

Memo:

PAY One Thousand and 00/100 Dollars

TO THE ORDER OF CITY OF MILW. HEALTH DEPT.
841 N BROADWAY 3RD FLOOR
MILWAUKEE, WI 53202-3653


AUTHORIZED SIGNATURE

⑈046199⑈ ⑆075912155⑆ 00034⑈97472⑈

THE FACE OF THIS CHECK HAS A SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF THE WORD VOID IS VISIBLE

RECEIVED
2001 SEP 19 PM 1:20
MILWAUKEE HEALTH
DEPARTMENT

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

License period January 1 to December 31.

\$1,000.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check (✓) one: () Individual
() Partnership
(✓) Corporation

1. NAME OF APPLICANT (if individual) _____
BUSINESS NAME MEDA-CARE AMBULANCE Phone 342-0225
Business Address 2515 W. VLIET ST. MILWAUKEE Zip 53205
Have any people on this application been convicted of violating any federal or state laws, or local ordinances?
Yes _____ No X If 'yes' name of person (s), date, charge and penalty: _____

2. PARTNERSHIP: (if applicable)
Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
3. NAME OF CORPORATION: MEDA-CARE AMBULANCE, INC.
Address, City, State, Zip 2515 W. VLIET ST. MILWAUKEE, WI 53205
Date and Place of Incorporation _____
President YVONNE LARSEN Home Address 568 W18118 ISLAND DR.
City, State, Zip MUSKEGO, WI 53150 Phone 262-679-0290 Date of Birth 9/24/37
Vice President _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Secretary JULIE JOHNSON Home Address 15980 W. MAPLE RIDGE
City, State, Zip NEW BERLIN, WI 53151 Phone 262-821-3891 Date of Birth 2/09/63
Treasurer _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Agent LINDA WIEDMANN Home Address W351 N6018 BAKERS LN
City, State, Zip Oconomowoc, WI 53066 Phone 262-560-0399 Date of Birth 06/14/54

4. OTHER REQUIREMENTS:

Do you have on file with the Health Department a valid and current certificate of insurance for this license period? ☒ Yes ☐ No

Do you have a valid State of Wisconsin Inspection Certificate? ☒ Yes ☐ No

Do you participate in the Emergency Medical Services System? ☒ Yes ☐ No

If 'yes', list service area number: 2

Do you wish to participate in the Emergency Medical Services System? ☒ Yes ☐ No

Total number of vehicles in service: 20

Please attach a separate page listing all vehicles including city assigned number, and description (year, make and van number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

14 day of September, 2001

[Signature]
Notary Public, State of Wisconsin

My commission expires 8/2004

[Signature]
(Individual/Corporate President/Partner)

N/A
(Additional Partner/Corporate Vice President)

[Signature]
(Corporate Secretary)

N/A
(Corporate Treasurer)

Do Not Write Below This Line

Clerk _____ License # _____ New _____ Renewal _____ Date Filed _____ Date Granted _____

Ambulance List Updated 7/17/2001

Ambulance Number	VIN Number	License Number	Renewal Date	Inspection Date	License Type	Location of Inspection	Year manufactured	Year Purchased
KIDS-1	1FDXE40FXWHC12633	KIDS ONE	2001/Nov.	May 21,2001	Special Use	535 S. 92 nd Street	1998	1998
KIDS-2	1FDKE30M4NHB24582	KIDS TWO	2001/Nov.	May 21,2001	Special Use	535 S. 92 nd Street	1992	1998
STAT-201	1FDKE30M6MHB07961	STAT 1	2001/Dec	Feb. 05, 1999	911/ALS	535 S. 92 nd Street	1991	1996
STAT-202	1FDKE30M8MHB07962	STAT-2	2001/Dec	May 22,2001	911/ALS	535 S. 92 nd Street	1991	1996
STAT-203	1FDKE30M9KHA07429	MZT-456	2001/Oct	May 22,2001	911/ALS	535 S. 92 nd Street	1989	1994
STAT-204	1FDKE30M0LHB27461	NXE-155	2002/Jun	May 22,2001	911/ALS	535 S. 92 nd Street	1990	1995
STAT-206	1FDKE30M0NHA02804	PNF-526	2001/Dec	May 21,2001	911/ALS	535 S. 92 nd Street	1992	1996
210	1FDKE30M8LHA92376	256-AWM	2001/Oct	May 07,2001	911/BLS	535 S. 92 nd Street	1993	2001
36/ 211	1FDHS34M4JHA95477	PAJ-941	2002/Apr.	May 21,2001	911/BLS	535 S. 92 nd Street	1988	1995
212	1FDHS34M3JHB53692	VDW-603	2001/Nov.	May 22,2001	911/BLS	535 S. 92 nd Street	1988	1999
213	1FDH534M9LHA41885	WCK-637	2002/Jan	May 21,2001	911/BLS	535 S. 92 nd Street	1990	2000
45/214	1FDHS34M9KHA58166	JPD-179	2002/Feb	Feb. 02, 1999	911/BLS	535 S. 92 nd Street	1989	1992
35/215	1FDHS34M9KHA51895	JZL-358	2002/Jun	Feb. 05, 1999	911/BLS	535 S. 92 nd Street	1989	1992
32/216	1FDHS34M1KHC33185	MRJ-759	2002/Mar	May 22,2001	911/BLS	535 S. 92 nd Street	1989	1994
217	1FDHS34MXLHB30171	UCJ-529	2001/Dec	May 22,2001	911/BLS	535 S. 92 nd Street	1988	1998
43/218	1FDHS34M4MHA56893	HFT-329	2002/May	May 22,2001	911/BLS	535 S. 92 nd Street	1991	1991
34/219	1FDHS34M3MHB17506	KWW-687	2001/Dec	May 22,2001	911/BLS	535 S. 92 nd Street	1991	1992
220	1FDJS34M4PHB20873	683-BTU	2002/Apr	PENDING	911/BLS	535 S. 92 nd Street	1993	2001
48/221	1FDJS34M3NHA21524	PZY-322	2002/Mar	May 23,2001	911/BLS	535 S. 92 nd Street	1992	1992
47/222	1FDJS34M6NHB27210	WCK-636	2002/Jul	May 21,2001	911/BLS	535 S. 92 nd Street	1992	1992
44/223	1FDJS34M0PHA20431	WHV-894	2002/Mar	Dec. 20, 1999	911/BLS	535 S. 92 nd Street	1993	1996
42/224	1FDJE30M1PHA23644	WECNHLP	2002/Mar	May 22,2001	911/ALS	535 S. 92 nd Street	1993	1996
41/225	1FDHS34M4MHA31413	Out	Of	Service	911/BLS	535 S. 92 nd Street	1991	1991
227	1FDHS34M8KHA38443	VCG-925	2001/Oct	May 23,2001	911/BLS	535 S. 92 nd Street	1989	1999

DATE (MM/DD/YY)
02/26/2001

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURER A:	Kemper Insurance Group
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS
The City of Milwaukee is additional insured concerning the legal liability of the insured.

AND EXECUTION THIS 14
DAY OF November 2001
Bruce Lehman
FEDERAL CLERK OF COURT

City of Milwaukee
Health Department
Attn: Cathy Miller
841 N Broadway
Milwaukee, WI 53202

10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT,
 XXXXXHAGTOMASXXX XXXXCESHXXXIMPOCKXXX XXXXAMONDOXXX XXXX
 XXXXNYXXXPOCKXXX XXXXCOCKXXX XXXXGEXXX XXXXGEXXX XXXXMAHXXX XXXXXXXX
 XXXXXXXX

William Katzfey

MEDA-CARE AMBULANCE SERVICE, INC.

2515 W. VLIET ST.
MILWAUKEE, WI 53205

20650

Copy

12-5
750 157

DATE 9/14/01

PAY
TO THE
ORDER OF

City of Milwaukee Health Department
One Thousand & 00/100

\$ 1000.00

DOLLARS

Security Features
Included.
Details on Back.

M&I Marshall & Ilsley Bank

FOR _____

Paul Wilson

NP

⑈020650⑈ ⑆07500005⑆ 00242 26653⑈

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

License period January 1 to December 31.

\$1,000.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check (✓) one: () Individual
() Partnership
☒ Corporation

1. NAME OF APPLICANT (if individual) _____

BUSINESS NAME Bell Ambulance Service Phone 414-486-2000

Business Address 549 East Wilson Street, Milwaukee, WI Zip 53207-0550

Have any people on this application been convicted of violating any federal or state laws, or local ordinances?

Yes _____ No XX If 'yes' name of person (s), date, charge and penalty: _____

2. PARTNERSHIP: (if applicable)

Name _____ Home Address _____

City, State, Zip _____ Phone _____ Date of Birth _____

Name _____ Home Address _____

City, State, Zip _____ Phone _____ Date of Birth _____

3. NAME OF CORPORATION: R. A. Zehetner & Associates, Inc.

Address, City, State, Zip 549 East Wilson Street, Milwaukee, WI 53207-0550

Date and Place of Incorporation October 1, 1978

President R. A. Zehetner Home Address 212 East Ravine Drive

City, State, Zip Mequon, WI 53092 Phone 262-241-1990 Date of Birth 06/15/1948

Vice President James P. Lombardo Home Address 549 East Wilson Street

City, State, Zip Milwaukee, WI 53207 Phone 414-486-4013 Date of Birth 12/24/1952

Secretary Eric E. Hobbs Home Address 2302 East Newberry Blvd

City, State, Zip Milwaukee, WI 53211 Phone 414-225-4991 Date of Birth 01/16/1960

Treasurer Wayne Jurecki Home Address 1707 North Prospect Ave.

City, State, Zip Milwaukee, WI 53202 Phone 414-486-4042 Date of Birth 10/20/1966

Agent _____ Home Address _____

City, State, Zip _____ Phone _____ Date of Birth _____

OTHER REQUIREMENTS:

Do you have on file with the Health Department a valid and current certificate of insurance for this license period? XX Yes No

Do you have a valid State of Wisconsin Inspection Certificate? XX Yes No

Do you participate in the Emergency Medical Services System? XX Yes No

If 'yes', list service area number: 4

Do you wish to participate in the Emergency Medical Services System? XX Yes No

Total number of vehicles in service: 23

Please attach a separate page listing all vehicles including city assigned number, and description (year, make and van number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

19th day of September, 192001

[Signature]
Notary Public, State of Wisconsin

My commission expires 6/15/03

[Signature]
(Individual/Corporate President/Partner)

[Signature]
(Additional Partner/Corporate Vice President)

[Signature]
(Corporate Secretary)

[Signature]
(Corporate Treasurer)

Do Not Write Below This Line

Clerk License # New Renewal Date Filed Date Granted

Squad Roster

<i>SquadNum</i>	<i>VTN</i>	<i>LicensePlate</i>	<i>BodyType</i>	<i>DeliveryDateNew</i>
400				/
401	1FDJE30F7SHB24620	BELL 401	Moduvan	5/8/95
402	1FDJE30F9SHB24621	BELL 402	Moduvan	5/8/95
403	1FDJE30F2SHB24623	BELL 403	Moduvan	5/25/95
404	1FDJE30F6SHB24625	BELL 404	Moduvan	5/25/95
405	1FDJE30F0THA04725	BELL 405	Moduvan	2/2/96
406	1FDJE30F2THA04726	BELL 406	Moduvan	2/2/96
407	1FDJE30F6THA04728	BELL 407	Moduvan	2/2/96
408	1FDJE30F8THA04729	BELL 408	Moduvan	2/2/96
409	1FDJE30F6THA04731	BELL 409	Moduvan	2/2/96
410	1FDJE30F1VHA42385	BELL 410	Moduvan	2/7/97
411	1FDJE30F1VHA39406	BELL 411	Moduvan	2/7/97
412	1FDJE30F2VHA39401	BELL 412	Moduvan	3/10/97
414	1FDSE30F7WHA10997	BELL 414	Moduvan	11/20/97
415	1FDSE30F4XHB57473	BELL 415	Moduvan	6/29/99
416	1FDSE30F6XHB57474	BELL 416	Moduvan	6/29/99
417	1FDSE35F1YHB25056	BELL 417	Moduvan	5/26/00
418	1FDSE35F5YHB25058	BELL 418	Moduvan	5/26/00
419	1FDSE35F7YHB25059	BELL 419	Moduvan	5/26/00
455	1FDJS34M3NHA15013	BELL 455	II	3/20/92
456	1FDJS34M8NHA28226	BELL 456	II	4/20/92
457	1FDJS34M3NHA69136	BELL 457	II	5/13/92
480	1FDKE30M7NHA12813	BELL 480	III	7/13/92
482	1FDLE40F3VHA18796	BELL 482	III	12/23/97

ACORD CERTIFICATE OF LIABILITY INSURANCEOP ID BJ
BELLA-1DATE (MM/DD/YY)
10/05/01**PRODUCER**

Robertson Ryan & Assoc., Inc.
Two Plaza East, Suite 650
330 East Kilbourn Avenue
Milwaukee WI 53202
Phone: 414-271-3575 Fax: 414-271-0196

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ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE
HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR
ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

RA Zehetner & Associates, Inc.
d/b/a Bell Ambulance
P O Box 07550
Milwaukee WI 53207

INSURERS AFFORDING COVERAGE

INSURER A: St Paul Fire & Casualty Ins Co
INSURER B: THE CINCINNATI INS. COMPANIES
INSURER C: UNITED HEARTLAND INS
INSURER D:
INSURER E:

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	<input checked="" type="checkbox"/> GENERAL LIABILITY	FK06604427	01/01/01	01/01/02	EACH OCCURRENCE \$ 1000000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY				FIRE DAMAGE (Any one fire) \$ 100000
	<input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR				MED EXP (Any one person) \$ 5000
	<input checked="" type="checkbox"/> Professional Liability				PERSONAL & ADV INJURY \$ 1000000
	GEN'L AGGREGATE LIMIT APPLIES PER				GENERAL AGGREGATE \$ 1000000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				PRODUCTS - COMP/OP AGG \$ 1000000
					Prof Aggr 3000000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY	FK06604427	01/01/01	01/01/02	COMBINED SINGLE LIMIT (Ea accident) \$ 1000000
	<input type="checkbox"/> ANY AUTO				BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS				BODILY INJURY (Per accident) \$
	<input type="checkbox"/> SCHEDULED AUTOS				PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS				
	<input type="checkbox"/> NON-OWNED AUTOS				
	<input type="checkbox"/> GARAGE LIABILITY				
	<input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$
					OTHER THAN EA ACC \$
					AUTO ONLY \$
B	<input checked="" type="checkbox"/> EXCESS LIABILITY	CCC4472542	01/01/01	01/01/02	EACH OCCURRENCE \$ 2000000
	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE				AGGREGATE \$ 2000000
	<input type="checkbox"/> DEDUCTIBLE				\$
	<input type="checkbox"/> RETENTION \$				\$
					\$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	0400026879	01/01/01	01/01/02	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
	E.L. EACH ACCIDENT \$ 500000				
	E.L. DISEASE - EA EMPLOYEE \$ 500000				
	E.L. DISEASE - POLICY LIMIT \$ 500000				
	OTHER				

APPROVED AS TO FORM

AND EXECUTION THIS 14th DAY OF November 2001

Brian D. Schulte
Assistant City Attorney

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

Certificateholder is additional insured on the general liability policy as respects the named insured's operations as ambulance service, but only for claims arising out of the negligence of the named insured.

CERTIFICATE HOLDER

Y

ADDITIONAL INSURED; INSURER LETTER:

A

CANCELLATION

MILW373

Milwaukee Health Dept
Cathy Miller
841 N Broadway, Room 112
Milwaukee WI 53202

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

Michael R. Schulte

BELL AMBULANCE SERVICE 12-91
PO BOX 070550
MILWAUKEE, WI 53207-0550

PARK BANK
MILWAUKEE, WI 53216
12-66/750

60941

9/20/2001

PAY TO THE
ORDER OF Milwaukee, City of, Health Department

\$ **1,000.00

One Thousand and 00/100***** DOLLARS

Milwaukee, City of, Health Department

MEMO 2001 Ambulance Certification Application

R.A. Zehner

⑈060941⑈ ⑆075000666⑆ ⑆1⑈733 366 0⑈

BELL AMBULANCE SERVICE
Milwaukee, City of, Health Department

60941

Date	Type	Reference	Original Amt.	Balance Due	9/20/2001 Discount	Payment
09/20/2001	Bill	2001 Amb Cert	1,000.00	1,000.00		1,000.00
				Check Amount		1,000.00

General Checking Acc 2001 Ambulance Certification Application

1,000.00

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

License period January 1 to December 31.

\$1,000.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check (✓) one: () Individual
() Partnership
(X) Corporation

1. NAME OF APPLICANT (if individual) _____
BUSINESS NAME CROSS AMBULANCE SERVICE, INC Phone 414-546-8500
Business Address 5436 W. Rogers / West Allis, WI Zip 53219
Have any people on this application been convicted of violating any federal or state laws, or local ordinances?
Yes _____ No X If 'yes' name of person(s), date, charge and penalty: _____

2. PARTNERSHIP: (if applicable)
Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
3. NAME OF CORPORATION: CROSS AMBULANCE SERVICE, INC
Address, City, State, Zip SEE ABOVE
Date and Place of Incorporation WIS 1980
President ROBERT E. BLAHUT Home Address 2617 W. Chestnut
City, State, Zip Mequon, WI 53092 Phone 414-546-8500 Date of Birth 9/4/37
Vice President Same Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Secretary Same Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Treasurer Same Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Agent Same Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____

4. OTHER REQUIREMENTS:

Do you have on file with the Health Department a valid and current certificate of insurance for this license period? ☒ Yes ☐ No

Do you have a valid State of Wisconsin Inspection Certificate? ☒ Yes ☐ No

Do you participate in the Emergency Medical Services System? ☒ Yes ☐ No

If 'yes', list service area number: 5

Do you wish to participate in the Emergency Medical Services System? ☒ Yes ☐ No

Total number of vehicles in service: 8

Please attach a separate page listing all vehicles including city assigned number, and description (year, make and van number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

29 day of September, 192001

[Signature]
Notary Public, State of Wisconsin

My commission expires 6-5-2005

[Signature]
(Individual/Corporate President/Partner)
[Signature]
(Additional Partner/Corporate Vice President)
[Signature]
(Corporate Secretary)
[Signature]
(Corporate Treasurer)

Do Not Write Below This Line

Clerk _____ License # _____ New _____ Renewal _____ Date Filed _____ Date Granted _____

CROSS AMBULANCE SERVICE, INC
AMBULANCE VEHICLE LIST
SEPTEMBER 27, 2001

VECHICLE #	YEAR & MAKE & TYPE	VIN #
92	90 FORD II	1FDHS34M9LHB75229
93	89 FORD III	1FDKE30M9KHA73365
94	88 FORD II	1FDHS34M7JHC12579
95	90 FORD II	1FDHS34M5LHB81562
98	89 CHEV III	1GBHR34N7KJ105605
99	91 FORD II	1FDHS34M9MHA14428
96	86 FORD III	1FDKE3016GHC28063
500	89 FORD III	1FDKE30M6KHA40825

ACORD™ CERTIFICATE OF INSURANCEDATE (MM/DD/YY)
10/09/01

PRODUCER

Security Ins. & Fin. Serv, Inc.
2725 S. Moorland Road
New Berlin, WI 53151THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION
ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE
HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR
ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

COMPANY

A Masachuetts Bay Ins.Co. (McNeil & Co

COMPANY

B Employers Mutual Casualty Company

COMPANY

C The Hanover Insurance Company

COMPANY

D

INSURED

Cross Ambulance Service, Inc.
5436 W. Rogers Street
West Allis, WI 53214

COVERAGES

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.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> OWNER'S & CONTRACTOR'S PROT	ZDZ5633213	04/01/01	04/01/02	GENERAL AGGREGATE \$2,000,000 PRODUCTS-COMP/OP AGG \$2,000,000 PERSONAL & ADV INJURY \$1,000,000 EACH OCCURRENCE \$1,000,000 FIRE DAMAGE (Any one fire) \$ 100,000 MED EXP (Any one person) \$ 5,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	ZDZ5633213	04/01/01	04/01/02	COMBINED SINGLE LIMIT \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY-EA ACCIDENT \$ OTHER THAN AUTO ONLY: EACH ACCIDENT \$ AGGREGATE \$
C	EXCESS LIABILITY <input checked="" type="checkbox"/> UMBRELLA FORM <input type="checkbox"/> OTHER THAN UMBRELLA FORM	UHZ5634111	04/01/01	04/01/02	EACH OCCURRENCE \$1,000,000 AGGREGATE \$1,000,000 \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY THE PROPRIETOR/ PARTNERS/EXECUTIVE OFFICERS ARE: <input checked="" type="checkbox"/> INCL EXCL	2H4352802	04/01/01	04/01/02	<input checked="" type="checkbox"/> STATUTORY LIMITS EACH ACCIDENT \$ 100,000 DISEASE-POLICY LIMIT \$ 500,000 DISEASE-EACH EMPLOYEE \$ 100,000
	OTHER				

APPROVED AS TO FORM

AND EXECUTION THIS

DAY OF November 2001

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

The City of Milwaukee is an additional insured for general liability
coverage, but only as respects work performed by the named insured.
(See Attached Schedule.)

CERTIFICATE HOLDER

City of Milwaukee
Community of Health
840 North Broadway Street
Room 315
Milwaukee, WI 53202

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE
EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL MAIL
10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT,
BUT SHALL NOT BE OBLIGATED TO REIMBURSE OR INDEMNIFY THE CERTIFICATE HOLDER FOR ANY LOSS OR DAMAGE.

AUTHORIZED REPRESENTATIVE



Coverage includes 10 day written notice of cancellation.

AFFIDAVIT

Affiant further deposes and says that no officer, official or employee of the City of Milwaukee has any interest, directly or indirectly, or is receiving any premium, commission, fee or other thing of value on account of the sale or furnishing of said insurance or bond.

Sylvia J. Schaefer
Notary Public,
My Commission expires 10-06-02



CROSS AMBULANCE SERVICE, INC.

5436 W. ROGERS ST.
WEST ALLIS, WI 53219

WISCOR CREDIT UNION
WEST ALLIS, WISCONSIN 53219
79-8251-2750

22131

09/28/01

PAY TO THE
ORDER OF City of Milwaukee

\$ 1,000.00

One Thousand And 00/100 Dollars***

DOLLARS

City of Milwaukee

F.P. Zeidler Building, 841 N. Broadway

Milwaukee, WI 53202-3653

MEMO

Robert E. Schmidt

⑈022131⑈ ⑆275082510⑆ 8100074635⑈

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

License period January 1 to December 31.

\$1,000.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check (✓) one: () Individual
() Partnership
(✓) Corporation

1. NAME OF APPLICANT (if individual) _____
Curtis Universal Ambulance, Inc.
BUSINESS NAME d/b/a Curtis Ambulance Phone 414-933-7600
414-276-7711
Business Address P.O. Box 2007, Milwaukee, WI Zip 53201-2007
- Have any people on this application been convicted of violating any federal or state laws, or local ordinances?
Yes _____ No X If 'yes' name of person (s), date, charge and penalty: _____
2. PARTNERSHIP: (if applicable)
- Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
- Name _____ Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
3. NAME OF CORPORATION: Curtis Universal Ambulance, Inc.
Address, City, State, Zip P.O. Box 2007, Milwaukee, WI 53201-2007
Date and Place of Incorporation 10/17/69 Wisconsin
- President James G. Baker, Jr. Home Address W310 N8370 Kilbourn Rd.
City, State, Zip Hartland, WI 53029 Phone 262-966-1853 Date of Birth 12/17/55
- Vice President James G. Baker, Jr. Home Address same as above
City, State, Zip _____ Phone _____ Date of Birth _____
- Secretary Ramona Lenger Home Address 12045 W Holt Ave.
City, State, Zip West Allis, WI 53227 Phone 414-327-9984 Date of Birth 06/20/46
- Treasurer James J. Baker, Jr. Home Address same as above
City, State, Zip _____ Phone _____ Date of Birth _____
- Agent James G. Baker, Jr. Home Address same as above
City, State, Zip _____ Phone _____ Date of Birth _____

4. OTHER REQUIREMENTS:

Do you have on file with the Health Department a valid and current certificate of insurance for this license period? X Yes ___ N

Do you have a valid State of Wisconsin Inspection Certificate? X Yes ___ N

Do you participate in the Emergency Medical Services System? X Yes ___ N

If 'yes', list service area number: 3

Do you wish to participate in the Emergency Medical Services System? ___ Yes ___ N

Total number of vehicles in service: 17

Please attach a separate page listing all vehicles including city assigned number, and description (year, make and van number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS

28th day of September, 2001

Kathleen M. Oster
Notary Public, State of Wisconsin

My commission ~~expires~~ is permanent

James D. Baker
(Individual/Corporate President/Partner)

James D. Baker
(Additional Partner/Corporate Vice President)

Ramona E. Langer
(Corporate Secretary)

James D. Baker
(Corporate Treasurer)

Do Not Write Below This Line

Clerk _____ License # _____ New _____ Renewal _____ Date Filed _____ Date Granted _____

**CURTIS-UNIVERSAL AMBULANCE, INC. VEHICLE LIST
MILWAUKEE**

September 17, 2001

LICENSE #	LICENSE EXPIRATION	UNIT #	VEHICLE ID#	MAKE	YEAR
VGA 506	09/02	320	1FDSE30FOXHB75338	FORD	1999
PGT 413	07/02	322	1FDKE30M8NHA31841	FORD	1992
UZD 719	07/02	323	1FDKE30L0EHB98508	FORD	1984
VFV 836	12/02	324	1FDJE30M7RHA11761	FORD	1994
SPU 291	07/02	325	1FDJE30M4PHB25309	FORD	1993
SPU288	07/02	326	1FDJE30M0PHB25307	FORD	1993
MSN440	04/02	327	1FDJE30M1RHB00967	FORD	1994
SUB 706	08/02	329	1FDKE30M7MHA43655	FORD	1991
SNW 115	07/02	340	1FDJE30M20HB25275	FORD	1993
SNW 111	07/02	341	1FDJE30M1PHB54055	FORD	1993
TYC 620	12/00	370	1FDKE30M1MHB32251	FORD	1991
SRV 405	06/02	371	1FDKE30M8MHB27337	FORD	1991
SJX 845	06/02	372	1FDKE30M8KHC33414	FORD	1989
SAL 919	03/02	376	1FDKE30F1VHA10640	FORD	1997
TJK 883	04/02	377	1FDK330M5NHA00708	FORD	1992
NRJ 206	03/02	380	1FDKE30L1GHC15755	FORD	1986
UDV 888	12/02	751	1FDKE30L7GHB63886	FORD	1986



The State of Wisconsin
DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH

License, Permit or Registration

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Wisconsin statutes and is hereby authorized to engage in the activity as indicated below.

Paramed/Basic AED with all skills

Activity	Expiration Date	I.D. Number
Ambulance Service Provider	06/30/2002	6000098
Mailing Address	NOT TRANSFERABLE Business or licensee address	

• CURTIS UNIV AMB SV INC-MILW

P O BOX 2007
MILWAUKEE, WI 53201

DOH 7216 (Rev. 06/96)

Cut on this line ↓

The State of Wisconsin DEPARTMENT OF HEALTH AND FAMILY SERVICES DIVISION OF HEALTH	
License, Permit or Registration	I.D. Number
Expiration Date	6000098
06/30/2002	
Activity	
Paramed/Basic AED with all skills	
NOT TRANSFERABLE Ambulance Service Provider CURTIS UNIV AMB SV INC-MILW	

Cut on this line ↑

DOH 7216

REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION

ACORD™ CERTIFICATE OF INSURANCEDATE (MM/DD/YY)
08/20/01**PRODUCER**

Security Ins. & Finc. Serv. Inc.
2725 S. Moorland Road
New Berlin, WI 53151-0925
(262) 785-9490
(262) 785-9753 Fax No.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE**COMPANY**

A United 24

COMPANY B

GROUP OF UNITED HEARTLAND

COMPANY C

W.C.

COMPANY D**INSURED**

Curtis-Universal Ambulance, Inc.
P O Box 2007
316 N. Milwaukee St., Suite 330
Milwaukee, WI 53201-2007

COVERAGES

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.

TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
GENERAL LIABILITY				GENERAL AGGREGATE \$
<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY				PRODUCTS-COMP/OP AGG \$
<input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR				PERSONAL & ADV INJURY \$
<input type="checkbox"/> OWNER'S & CONTRACTOR'S PROT				EACH OCCURRENCE \$
				FIRE DAMAGE (Any one fire) \$
				MED EXP (Any one person) \$
AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT \$
<input type="checkbox"/> ANY AUTO				BODILY INJURY (Per person) \$
<input type="checkbox"/> ALL OWNED AUTOS				BODILY INJURY (Per accident) \$
<input type="checkbox"/> SCHEDULED AUTOS				PROPERTY DAMAGE \$
<input type="checkbox"/> HIRED AUTOS				
<input type="checkbox"/> NON-OWNED AUTOS				
GARAGE LIABILITY				AUTO ONLY-EA ACCIDENT \$
<input type="checkbox"/> ANY AUTO				OTHER THAN AUTO ONLY:
				EACH ACCIDENT \$
				AGGREGATE \$
EXCESS LIABILITY				EACH OCCURRENCE \$
<input type="checkbox"/> UMBRELLA FORM				AGGREGATE \$
<input type="checkbox"/> OTHER THAN UMBRELLA FORM				\$
WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	0400030008	08/01/01	08/01/02	<input checked="" type="checkbox"/> STATUTORY LIMITS
<input type="checkbox"/> THE PROPRIETOR/PARTNERS/EXECUTIVE OFFICERS ARE:				EACH ACCIDENT \$100,000
<input checked="" type="checkbox"/> INCL				DISEASE-POLICY LIMIT \$500,000
<input type="checkbox"/> EXCL				DISEASE-EACH EMPLOYEE \$100,000
OTHER				

APPROVED AS TO FORM
AND EXECUTION THIS 14th
DAY OF November 2001

[Signature]
Assistant City Attorney

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

See Attached Schedule.)

CERTIFICATE HOLDER

City of Milwaukee
Department of Health
841 North Broadway, Room 112
Milwaukee, WI 53202

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY ON ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
[Signature]

12/1301

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

INSURER: CNA Insurance Co.

INSUREA B:

INS 1856 C.

INSURER D.

INSURANCE C-

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

APPROVED AS TO FORM

AND EXECUTION THIS

DAY OF December 20 01

Assistant City Attorney

CERTIFICATE HOLDER

ADDITIONAL INSURED; INSURER LETTER:

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ~~PROVIDE~~ TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT ~~BY MAIL TO THE CERTIFICATE HOLDER NAMED TO THE LEFT~~

ATTN: Dr. Seth Foldy

AUTHORIZED REPRESENTATIVE

ACORD 25-S (7/87)

© ACORD CORPORATION 1988

AFFIDAVIT

STATE OF WISCONSIN }
 }
MILWAUKEE COUNTY }

SS

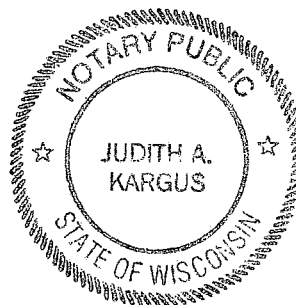
JOHN M. PROTIVA, being first duly sworn, on oath deposes and says that
(AGENT)
he/she is the agent of the CNA INSURANCE CO.,
(COMPANY NAME)
insurer, on the attached certificate issued to CURTIS-UNIVERSAL AMBULANCE CO.
(LEGAL ENTITY OF INSURED)

Affiant further deposes and says that no officer, official or employee of the City of Milwaukee
has any interest, directly or indirectly, or is receiving any premium, commission, fee or other
thing of value on account of the sale or furnishing of said insurance certificate

John M. Protiva
(Signature of Agent above)

Subscribed and sworn to before me
this 13th day of DECEMBER, 2001

Judith A. Kargus
Notary Public, Milwaukee County, WI
My Commission expires FEB. 23, 2003





CURTIS-UNIVERSAL, INC.
P.O. BOX 2007
MILWAUKEE, WI 53201-0007

12-66,
750

No.

1144

Date

9/28/2001

PAY TO THE
ORDER OF

City of Milwaukee Health Dept.

\$ 1,000.00

One thousand and no/100

THOUSANDS

Security features
inscribed.
Details on back.

PARK BANK

DOWNTOWN • CAPITOL DRIVE • BROOKFIELD
MILWAUKEE, WISCONSIN 53216

Memo

James B. Baker

MP

⑆075000666⑆ ⑈61001 3793⑈ 1144

MEDALLION