



City
of
Milwaukee

Tom Barrett
Mayor

Bevan K. Baker, FACHE
Commissioner of Health

Health Department Office of the Commissioner

www.milwaukee.gov/health

Frank P. Zeidler Municipal Building, 841 North Broadway, 3rd Floor, Milwaukee, WI 53202-3653 phone (414) 286-3521 fax (414) 286-5990
web site: www.milwaukee.gov/health

TO: Jim Owczarski
City Clerk

FROM: Bevan K. Baker, FACHE
Commissioner of Health

DATE: September 30, 2013

RE: Ambulance Company's Applications for Approval

Attached are the ambulance company's applications for certification. Per Chapter 75-15-13 the Milwaukee Health Department is to submit these to your office after receiving approval from the Milwaukee Police Department. That approval letter is attached along with the applications.

If you have any questions or require further information to open this file, please contact Ali Reed at x3524.

Thank you.

Think Health. Act Now!



MILWAUKEE POLICE DEPARTMENT MEMORANDUM

Date: Wednesday, September 18, 2013



TO: Regina Howard
Police Captain

FR: Chad Raden
Police Sergeant

CC:

RE: Ambulance Applications

Ma'am,

On Wednesday, September 18, 2013, the License Investigation Unit processed the following ambulance applications: Paratech, Bell, Meda-care, and Curtis. The LIU conducted a background check on each application. At the conclusion of the LIU's investigation it is my recommendation to approve the applications that were provided.

Respectfully submitted,

Police Sergeant Chad Raden
License Investigation Unit

INSPECTOR OF POLICE STRATEGIC MANAGEMENT

Received 9-30-13

Referred COS Plapt

By [Signature]

OFFICE OF MANAGEMENT, ANALYSIS AND PLANNING	
RECEIVED	<u>9/18/13</u>
REFERRED	<u>[Signature]</u>
SIGNATURE	

-Recommendation Approval

RM13-0120



Tom Barrell
Mayor

Bevan K. Baker, FACHE
Commissioner of Health

Health Department Office of the Commissioner


OFFICE	
CHIEF OF POLICE	
Received	SEP 13 2013
Referred	Sgt Kaden

www.milwaukee.gov/health

Frank P. Zeldler Municipal Building, 841 North Broadway, 3rd Floor, Milwaukee, WI 53202-3653 phone (414) 286-3521 fax (414) 286-5990
web site: www.milwaukee.gov/health

MEMORANDUM

TO: Edward Flynn
Chief of Police

FROM: Bevan K. Baker, FACHE
Commissioner of Health 

DATE: September 9, 2013

RE: Ambulance Company's Applications for Approval

Attached are copies of the ambulance company's applications for certification. Please approve or deny application based on qualifications described in city ordinance 75-15 (6).

Upon completion, please return your recommendations for allowance or denial to my office.

If you have any questions or require further information, please contact Ali Reed at x3524.

Thank you.

CC: Joel Plant

Think Health. Act Now!



13.0742

Application for Ambulance Certification

Fee Must Accompany Application.

The license period is from January 1 to December 31.

\$1,100.00 - 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: 414-344-4444

Business Address: 2515 W. Vliet St.

City: Milwaukee State: WI Zip: 53205

Have any people on this application been convicted of violating any federal or state laws, or local ordinances? Yes No

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: 2515 W. Vliet St. Milwaukee, WI 53205

Date and Place of Incorporation: 1/10/72 Milwaukee, WI

President: Yvonne Larsen

Home Address: 568 W 18118 Island Dr.

City: Muskego State: WI Zip: 53150

Phone 262-679-0290 Date of Birth 09/24/37

Vice President: /

Home Address: _____

City: _____ State: _____ Zip: _____

Phone _____ Date of Birth: _____

Secretary: Ted LARSEN
 Home Address: 20905 Villa Ct.
 City: Brookfield State: WI Zip: 53186
 Phone: 262-798-3425 Date of Birth: 11/12/65
 Treasurer: same as Secy
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Agent: Linda Wiedmann
 Home Address: 39612 Cedar Ln
 City: Oconomowoc State: WI Zip: 53066

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 listed
 Please attach a separate page listing all vehicles including city assigned number, and description (year, make and vin 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 _____ day of _____, 20 _____

Individual/Corporate President/Partner: Spencer Larsen

Additional Partner/Corporate Vice President: _____

Notary Public, State of Wisconsin: _____

My commission expires: 5/8/17

Corporate Secretary: [Signature]

Corporate Treasurer: [Signature]

Do Not Write Below This Line

Clerk	License #	New	Renewal	Date Filed	Date Granted



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
9/10/2013

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 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 R & R Insurance Services, Inc. 1581 E Racine Avenue PO Box 1610 Waukesha WI 53106	CONTACT NAME: Julio Liebalt PHONE: (262) 574-7000 FAX: (262) 574-7080 E-MAIL: julio.liebalt@rrins.com ADDRESS: julio.liebalt@rrins.com
INSURED Meda-Care Ambulance Service Inc 2515 W Vliet St Milwaukee WI 53205-1035	INSURER(S) AFFORDING COVERAGE INSURER A: Arch Insurance Company INSURER B: United Wisconsin Ins Co 29157 INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: CL1391044711 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.

CLASS	TYPE OF INSURANCE	ADDITIONAL SOURCE	POLICY NUMBER	POLICY EFF. DATE (MM/DD/YYYY)	POLICY EXP. DATE (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		MAPK07055600	2/1/2013	2/1/2014	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED EQUIPMENT (See 0803/0202) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADVISORY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMMOD AGG \$ 3,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> Hired AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS		MAPK07055600	2/1/2013	2/1/2014	COMBINED SINGLE LIMIT (Each accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Unk/insured motorists \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DENY <input type="checkbox"/> RETENTION \$		MAUN06305200	2/1/2013	2/1/2014	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OF FIRM MEMBER EXCLUDED? (Mandatory in WI) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	0400126469	2/1/2013	2/1/2014	<input checked="" type="checkbox"/> WC STATU-ORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 100,000 E.L. DISEASE - EA EMPLOYEE \$ 100,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 The City of Milwaukee is additional insured concerning work performed by the insured.

CERTIFICATE HOLDER City of Milwaukee Health Department 841 N Broadway Milwaukee, WI 53202	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
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MEDA-CARE AMBULANCE vehicle list as of August 26, 2013

UNIT #	YEAR	MAKE	ID#
202	2006	FORD TYPE 11	1FDSS34P26DA92043
203	2006	FORD TYPE 11	1FDSS34P86HA92878
204	2004	FORD TYPE 11	1FDSS34P34HA96656
205	2007	FORD TYPE 11	1FDSS34F53HA16666
206	2004	FORD TYPE 11	1FDSS34P14HB09503
207	2005	FORD TYPE 11	1FDSS34P65HB44572
208	2006	Ford Type 11	1FDSS34P46DA88818
209	2006	Ford Type 11	1FDSS34P26DA88820
210	2004	FORD TYPE11	1FDSS34P54HA96657
212	1994	FORD TYPE111	1FDKE30M2RHA13034
217	1998	FORD TYPE111	1FDXE40FXWHC12633
219	2005	FORD TYPE 11	1FDSS34P35HB25025
221	2005	FORD TYPE 11	1FDSS34PX5HB49418
224	2004	FORD TYPE 11	1FDSS34P84HB04962
231	2003	FORD TYPE 111	1FDXE45F63HB49017
232	2003	FORD TYPE 111	1FDXE45F83HB49018
233	2007	FORD TYPE 111	1FDXE45P97DA27533
234	2007	FORD TYPE 111	1FDXE45P97DA38063
235	2006	FORD TYPE 111	1FDXE45P56HA37226
236	2005	FORD TYPE 111	1FDXE45P35HB39573

AFFIDAVIT

STATE OF WISCONSIN)
Waukesha County} SS

Julia Liebelt, being first duly sworn, on oath deposes and says
(Agent)

that he/she is the agent of the ARCH Insurance Co., insurer
(Company name)

on the attached certificate issued to Meda-Care Ambulance Service Inc
(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 any other thing of value on account of the sale of furnishing of said insurance certificate.

[Handwritten Signature]
(Signature of above Agent)

Subscribed and sworn to before me

this 10th day of September, 20 13

[Handwritten Signature]
Notary Public, State of Wisconsin

My Commission expires 1-8-16

Notary Seal Must Be Affixed.

Please note the following requirements:

- 1) The name and signature of the agent or authorized representative must be included and match the agent or authorized who signed the insurance certificate.
- 2) The full name of the Insurance Company must be listed and match exactly the Insurance Company's name from the insurance certificate.
- 3) The date the notary signed and dated the affidavit must be the same as the date of the insurance certificate.
- 4) The Notary must sign, date and stamp the form.
- 5) The correct county and state must be listed. (If outside the state of Wisconsin, please cross out Wisconsin and write/type in correct state.)

Print Form

City of Milwaukee Health Department

Application for Ambulance Certification

Fee Must Accompany Application.
The license period is from January 1 to December 31.
\$1,100.00 - 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: Paratech Ambulance Service, Inc. Phone: (414) 358-1111
Business Address: 9401 W. Brown Deer Road
City: Milwaukee State: WI Zip: 53224
Have any people on this application been convicted of violating any federal or state laws, or local ordinances? Yes No
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: 9401 W. Brown Deer Road, Milwaukee, WI 53224
Date and Place of Incorporation: January 1st, 1979 State of Wisconsin
President: Robert A. Rauch
Home Address: 9401 W. Brown Deer Road
City: Milwaukee State: WI Zip: 53224
Phone (414) 358-1111 Date of Birth 4/22/1949
Vice President: Richard Romanshek
Home Address: N90 W20881 Scenic Drive
City: Menomonee Falls State: WI Zip: 53051
Phone (262) 255-6486 Date of Birth: 3/24/1953

continued on other side

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: _____

Agent: _____

Home Address: _____

City: _____ State: _____ Zip: _____

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: 1
Do you wish to participate in the Emergency Medical Services System? Yes No

Total number of vehicles in service: 35
Please attach a separate page listing all vehicles including city assigned number, and description (year, make and vin 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 22nd day of August, 2013

Individual/Corporate President/Partner: [Signature]

Additional Partner/Corporate Vice President: [Signature]

Notary Public, State of Wisconsin: Kathleen J. Hahn

My commission expires: January 1, 2015

Corporate Secretary: [Signature]

Corporate Treasurer: [Signature]

Do Not Write Below This Line

Clerk	License #	New	Renewal	Date Filed	Date Granted
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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/22/2013

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 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 R & R Insurance Services, Inc. N80 W14824 Appleton Ave PO Box 160 Menomonie Falls WI 53052-0160	CONTACT NAME: Linda Jensen PHONE (A/C, Ho, Ext): (262) 502-3858 FAX (A/C, Ho): (262) 502-0941 E-MAIL ADDRESS: linda.jensen@rxins.com	
	INSURER(S) AFFORDING COVERAGE	
INSURED Paratech Ambulance Service Inc 9401 W. Brown Deer Road Milwaukee WI 53224	INSURER A: Markel Insurance Company	
	INSURER B: Acuity A Mutual Ins Co	
	INSURER C:	
	INSURER D:	
	INSURER E:	

COVERAGES CERTIFICATE NUMBER: CL133141516 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 INSR	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY		MTK7000083900	3/1/2013	3/1/2014	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY					DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR					MED EXP (Any one person) \$ 10,000
	<input checked="" type="checkbox"/> Prof Liab \$1mil/\$3mil					PERSONAL & ADV INJURY \$ 1,000,000
	<input checked="" type="checkbox"/> Abuse \$1mil/\$2mil					GENERAL AGGREGATE \$ 3,000,000
	GENL AGGREGATE LIMIT APPLIES PER:					PRODUCTS - COMPOP AGG \$ Included
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					
A	AUTOMOBILE LIABILITY		MTA7000083900	3/1/2013	3/1/2014	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO					BODILY INJURY (Per person) \$
	<input checked="" type="checkbox"/> ALL OWNED AUTOS	<input type="checkbox"/> SCHEDULED AUTOS				BODILY INJURY (Per accident) \$
	<input checked="" type="checkbox"/> HIRED AUTOS	<input checked="" type="checkbox"/> NON-OWNED AUTOS				PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB	<input checked="" type="checkbox"/> OCCUR	MTU7000083900	3/1/2013	3/1/2014	EACH OCCURRENCE \$ 2,000,000
	<input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$ 2,000,000
	<input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000					
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY					WC STATUTORY LIMITS OTHER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in III)	Y/N	N/A			E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below					E.L. DISEASE - EA EMPLOYEE \$
B	Property - Special Form - Repl Cost/ Blanket Limit		K28716	3/1/2013	3/1/2014	BLKT - Bldg & Contents - Per Policy

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
City of Milwaukee is an additional insured for liability as regards their interest in the insured's operation as an ambulance service. Form MGL1215(0912) applies.

CERTIFICATE HOLDER City of Milwaukee Dept of Health Attn: Health Commissioner 841 N Broadway, Room 112 Milwaukee, WI 53202-3653	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  Linda Jensen/10332

PARATECH AMBULANCE SERVICE SQUAD LIST FOR 2013

<u>SQ#</u>	<u>VEHICLE ID NUMBER</u>	<u>YEAR/MAKE</u>	<u>IN SERVICE</u>
101	1GBJG316971191611	2007 CHEVROLET	1/19/2009
102	1FDWE3FS7CDA07817	2012 FORD	11/22/2011
103	1FDXE45P95HA88466	2005 FORD	5/5/2010
104	1FDWE3FS2BDA42599	2011 FORD	6/8/2011
105	1GDJG316291138873	2009 GMC	6/16/2009
106	1FDWE3FS8DA61578	2013 FORD	8/2/2013
107	1FDWE3FS5BDA42600	2011 FORD	6/16/2011
108	1GDHG316991181220	2009 GMC	9/23/2009
109	1FDWE35P16D812628	2006 FORD	4/24/2007
110	1GBJG316871252639	2007 CHEVROLET	4/8/2008
111	1GBJG316471201753	2007 CHEVROLET	11/3/2008
112	1FDXE4FS9CDA70654	2012 FORD	10/1/2012
113	1FDXE45P55HB49442	2005 FORD	6/2/2010
114	1FDWE3FS68DA38684	2011 FORD	8/4/2011
115	1FDSE35P05HA58969	2005 FORD	5/12/2005
116	1GDHG316891180740	2009 GMC	1/7/2010
117	1FDSE35P05HA09271	2005 FORD	5/12/2005
118	1FDWE3FS1CDA28470	2012 FORD	2/28/2012
119	1FDWE35P66HA92465	2006 FORD	11/1/2005
120	1GBJG316171254474	2007 CHEVROLET	5/28/2008
121	1GBHG396371240501	2007 CHEVROLET	3/3/2008
122	1FDWE35P86DA61158	2006 FORD	4/5/2006
123	1FDWE3FS8DDA34946	2013 FORD	3/19/2013
124	1GBHG396091143534	2009 CHEVROLET	6/19/2009
125	1FDSE35P87DB00752	2007 FORD	7/31/2007
126	1FDXE45F53HA63844	2003 FORD	5/1/2008
127	1FDXE45F33HA63843	2003 FORD	5/1/2008
129	1FDXE45P56HA77143	2006 WHEEL COACH	10/4/2010
130	1FDXE45P16HA77138	2006 WHEEL COACH	10/4/2010
131	1FDWE3FS0BDA16177	2011 FORD	4/8/2011
132	1FDWE3FS8BDA38685	2011 FORD	4/8/2011
133	1FDWE3FS9BDA42602	2011 FORD	5/7/2012
134	1FDWE3FS3CDA90498	2012 FORD	8/20/2012
135	1FDXE45P88D801235	2008 FORD	3/19/2013
136	1FDXE45PX8D801236	2008 FORD	3/19/2013

AFFIDAVIT

STATE OF WISCONSIN }
Waukesha County } SS

Linda M. Jensen, being first duly sworn, on oath deposes and says
(Agent)

that he/she is the agent of the Market Insurance Company, insurer
(Company name)

on the attached certificate issued to Paratech Ambulance Service Inc
(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 any other thing of value on account of the sale of furnishing of said insurance certificate.

Linda M. Jensen
(Signature of above Agent)

Subscribed and sworn to before me

this 22nd day of August 20 13
Jenny L Hirth
Notary Public-State of Wisconsin

My Commission expires 11/10/2013

Notary Seal Must Be Affixed.

Please note the following requirements:

- 1) The name and signature of the agent or authorized representative must be included and match the agent or authorized who signed the insurance certificate.
- 2) The full name of the Insurance Company must be listed and match exactly the Insurance Company's name from the insurance certificate.
- 3) The date the notary signed and dated the affidavit must be the same as the date of the insurance certificate.
- 4) The Notary must sign, date and stamp the form.
- 5) The correct county and state must be listed. (If outside the state of Wisconsin, please cross out Wisconsin and write/type in correct state.)

Application for Ambulance Certification

Fee Must Accompany Application.

The license period is from January 1 to December 31.

\$1,100.00 - 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): _____ 414-933-7600

Business Name: Curtis Universal Ambulance, Inc. Phone: 414-276-7711

Business Address: 2266 N. Prospect Ave Suite 440, Milwaukee 53202

City: Milwaukee State: WI Zip: 53202

Have any people on this application been convicted of violating any federal or state laws, or local ordinances? Yes No

If 'yes', name of person(s), date, charge and penalty: _____

mailing Address: P. O. BOX 2007 Milwaukee, WI, 53201-2007

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, Inc.

Address: 2266 North Prospect Ave suite 440, Milwaukee WI 53202

Date and Place of Incorporation: October 17th 1969 - Wisconsin

President: James G. Baker, Jr.

Home Address: W310 N8370 Kilbourne Rd

City: Hartland State: WI Zip: 53029

Phone (262) 966-1853 Date of Birth 12-17-1955

Vice President: James G. Baker, Jr.

Home Address: Same as above

City: _____ State: _____ Zip: _____

Phone _____ Date of Birth: _____

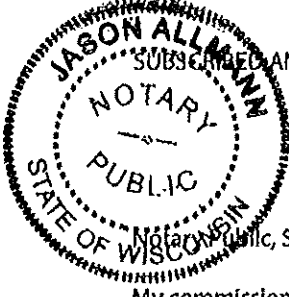
Secretary: Debra Baker
 Home Address: 100 Corrina Blvd. Apt # 427
 City: Waukesha State: WI Zip: 53186
 Phone _____ Date of Birth 03-04-1953
 Treasurer: James G. Baker, JR.
 Home Address: W310 N8370 Kilbourne Rd
 City: Hartland State: WI Zip: 53029
 Agent: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____

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: 3
 Do you wish to participate in the Emergency Medical Services System? Yes No

Total number of vehicles in service: 22
 Please attach a separate page listing all vehicles including city assigned number, and description (year, make and vin 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 3rd day of September, 2013

Individual/Corporate President/Partner: James G. Baker

Additional Partner/Corporate Vice President: James G. Baker

Notary Public, State of Wisconsin: [Signature]
 My commission expires: 09/14/16

Corporate Secretary: Debra Baker

Corporate Treasurer: James G. Baker

Do Not Write Below This Line

Clerk	License #	New	Renewal	Date Filed	Date Granted
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