



Health Department

John O. Norquist
Mayor

Seth L. Foldy, MD
Commissioner of Health

Bevan K. Baker, CHE
Health Operations Director


Administration



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

MEMORANDUM

TO: Jeffery Osterman
Legislative Reference Bureau

FROM: Bernita Zollicoffer 
Dr. Foldy's Assistant

DATE: November 26, 2003

SUBJECT: Applications for Ambulance Certification 2004

Attached are the completed Ambulance Certification Applications for your file.

If you have any questions, comments or concerns, please feel free to contact me, Bernita at extension 5708.

Thank you

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, Inc. Phone (414) 486-2000

Business Address 549 East Wilson Street Zip 53207-0550

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 COPORATION: Bell Ambulance, Inc.

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

Date and Place of Incorporation October 1, 1978 - Milwaukee, WI

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

City, State, Zip Mequon, WI 53092 Phone (262) 241-1990 Date of Birth 06/15/48

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

City, State, Zip Milwaukee, WI 53207 Phone (414) 486-4013 Date of Birth 12/24/52

Secretary Eric E. Hobbs Home Address 2302 East Newberry Boulevard

City, State, Zip Milwaukee, WI 53211 Phone (414) 225-4991 Date of Birth 01/16/60

Treasurer Wayne Jurecki Home Address 1707 North Prospect Avenue

City, State, Zip Milwaukee, WI 53202 Phone (414) 486-4042 Date of Birth 10/20/66

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? X Yes ___ No

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

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

If 'yes', list service area number: 4

Do you wish to participate in the Emergency Medical System? X 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 van number)

- 5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied the 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 regular 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 the discretion of the Common Council.
- 7. I have the knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath deposition 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 October, 2003

Julie M. Duckler
Notary Public, State of Wisconsin

My commission expires 11/20/2005

R. A. Z...
(Individual/Corporate President/Partner)

Joe P. Salado
(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 _____

Bell Ambulance, Inc.

Squad Listing

Squads in Operation

# of Squads	Squad #	VIN	BodyType	ChasYear	Lic. Plate
1	401	1FDJE30F7SHB24620	Moduvan	1995	BELL 401
2	402	1FDJE30F9SHB24621	Moduvan	1995	BELL 402
3	404	1FDJE30F6SHB24625	Moduvan	1995	BELL 404
4	405	1FDJE30F0THA04725	Moduvan	1996	BELL 405
5	409	1FDJE30F6THA04731	Moduvan	1996	BELL 409
6	412	1FDJE30F2VHA39401	Moduvan	1997	BELL 412
7	414	1FDSE30F7WHA10997	Moduvan	1998	BELL 414
8	415	1FDSE30F4XHB57473	Moduvan	1999	BELL 415
9	416	1FDSE30F6XHB57474	Moduvan	1999	BELL 416
10	417	1FDSE35F1YHB25056	Moduvan	2000	BELL 417
11	418	1FDSE35F5YHB25058	Moduvan	2000	BELL 418
12	420	1FDSE35F92HA33961	Moduvan	2002	BELL 420
13	421	1FDSE35F22HA33963	Moduvan	2002	BELL 421
14	422	1FDSE35FX2HA33967	Moduvan	2002	BELL 422
15	423	1FDSE35F82HA57684	Moduvan	2002	BELL 423
16	424	1FDSE35F93HA80666	Moduvan	2003	BELL 424
17	425	1FDSE35FO3HA80667	Moduvan	2003	BELL 425
18	426	1FDSE35F23HA80668	Moduvan	2003	BELL 426
19	427	1FDWE35F63HA96860	III	2003	BELL 427
20	483	1FDXE45F32HA45678	III	2002	BELL 483
21	484	1FDXE45F23HA42191	III	2003	BELL 484
22	485	1FDXE45F43HA68758	III	2003	BELL 485
23	403	1FDJE30F2SHB24623	Moduvan	1995	BELL 403
24	406	1FDJE30F2THAO4726	Moduvan	1996	BELL 406
25	410	1FDJE30F1VHA42385	Moduvan	1996	BELL 410
26	411	1FDJE30F1VHA39406	Moduvan	1997	BELL 411
27	482	1FDLE40F3VHA18796	III	1997	BELL 482

BELL AMBULANCE, INC. 12-91
P.O. BOX 070550
MILWAUKEE, WI 53207-0550
(414) 486-2000

PARK BANK
MILWAUKEE, WI 53216
12-66/750

64969

PAY TO THE
ORDER OF City of Milwaukee Health Department

10/22/2003

One Thousand One Hundred and 00/100*****
\$ **1,100.00

City of Milwaukee Health Department

DOLLARS

MEMO Application for Ambulance Certification

⑆061969⑆ ⑆075000666⑆ ⑆107333660⑆

VOID AFTER 180 DAYS

BELL AMBULANCE, INC.

City of Milwaukee Health Department

64969

Date 10/22/2003
Type Bill
Reference

Original Amt.
1,100.00

Balance Due 10/22/2003
1,100.00

Discount
Check Amount
Payment
1,100.00
1,100.00

General Checking Acc Application for Ambulance Certification

1,100.00

ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID BJ
BELLA-1
DATE (MM/DD/YYYY)
10/22/03

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

INSURED
Bell Ambulance, Inc.
Mike Kresovic
P O Box 070550
Milwaukee WI 53207

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 NAIC #

INSURER A: THE CINCINNATI INS. COMPANIES
INSURER B: Lloyd's of London
INSURER C: UNITED HEARTLAND INS
INSURER D: Granite State Insurance Co
INSURER E: Underwriters at Lloyd's London

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 ADD'L LTR	INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
B	X	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Professional Liability is Incl GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	A2002LP0001301	12/31/02	01/01/04	EACH OCCURRENCE \$ 1000000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100000 MED EXP (Any one person) \$ 5000 PERSONAL & ADV INJURY \$ 1000000 GENERAL AGGREGATE \$ 2000000 PRODUCTS - COMP/OP AGG \$ 2000000
APPROVED AS TO FORM AND EXECUTION THIS <u>2nd</u> DAY OF <u>November</u> , 20 <u>03</u> <i>David D. Schulte</i> Assistant City Attorney						
D		AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	ARB26932257	01/01/03	01/01/04	COMBINED SINGLE LIMIT (Ea accident) \$ 1000000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
E		<input checked="" type="checkbox"/> Comp Ded: \$1,000	FPD10309	01/01/03	01/01/04	PROPERTY DAMAGE (Per accident) \$
E		<input checked="" type="checkbox"/> Coll Ded: \$1,000	FPD10309	01/01/03	01/01/04	PROPERTY DAMAGE (Per accident) \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
A		EXCESS/UMBRELLA LIABILITY <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> DEDUCTIBLE RETENTION \$10,000	CCC4972542	01/01/03	01/01/04	EACH OCCURRENCE \$ 2000000 AGGREGATE \$ 2000000 \$ \$ \$
C		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below OTHER	0400036817	01/01/03	01/01/04	<input checked="" type="checkbox"/> WC STATUTORY LIMITS OTH-ER E.L. EACH ACCIDENT \$ 500000 E.L. DISEASE - EA EMPLOYEE \$ 500000 E.L. DISEASE - POLICY LIMIT \$ 500000

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

MILW373

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
Michael R. Schulte
 Michael R. Schulte

AFFIDAVIT OF "NO INTEREST" MUST ACCOMPANY EACH CERTIFICATE
OF INSURANCE ISSUED, INCLUDING NEW AND RENEWALS.

AFFIDAVIT

STATE OF WISCONSIN
COUNTY OF MILWAUKEE

Michael R. Schulte, BEING FIRST DULY SWORN, on oath deposes and says that
he/she is the agent of the The Cincinnati Insurance Co., insurer on the attached
certificate of insurance or bond issued to Bell Ambulance, Inc.

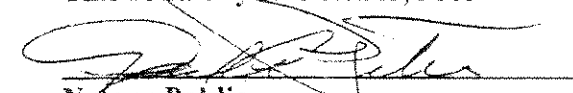
Affiant further deposes and says that no officer, official or employee of the City of
Milwaukee has any interest, directly or indirectly, or is receiving any premium,
commission, fee or other thing of value on account of the sale or furnishing of said
insurance or bond.


Signature (same as it appears on cert)

Michael R. Schulte, (414) 271-3575
Typed Name and Phone Number

Subscribed and sworn to before me

This 23rd day of October, 2003


Notary Public,
My Commission expires 2-19-06

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: Same As Above

Address, City, State, Zip _____

Date and Place of Incorporation _____

President ROBERT E. BLAHT Home Address 2617 W. Chestnut

City, State, Zip Mequon, WI 53092 Phone 262-242-4658 Date of Birth 9/4/37

Vice President _____ Home Address _____

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

Secretary _____ Home Address _____

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

Treasurer _____ Home Address _____

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? Yes

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

Do you participate in the Emergency Medical Services System? Yes

If 'yes', list service area number: _____ West Milwaukee

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

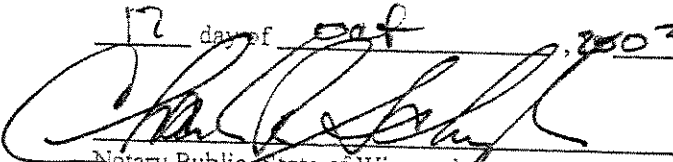
Total number of vehicles in service: 1

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 shall not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for hire 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 at 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, I hereby declare and say that I am the person named above and that all statements made in the foregoing application are true and correct.

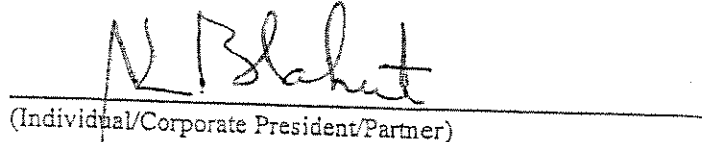
SUBSCRIBED AND SWORN TO BEFORE ME THIS

17 day of oct, 2003



Notary Public, State of Wisconsin

My commission expires 6-26-05


(Individual/Corporate President/Partner)

(Additional Partner/Corporate Vice President)

(Corporate Secretary)

(Corporate Treasurer)

Do Not Write Below This Line

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

CROSS AMBULANCE SERVICE, INC
VEHICLE LIST 11/12/03

#	YEAR	MAKE	ID #
500	1989	FORD	1FDKE30M6KHA40825
591	1994	FORD	1FDJE30M1RHB00872
592	1994	FORD	1FDJE30M9RHB43307
593	1989	FORD	1FDKE30M0KHA73365
594	1988	FORD	1FDHS34M7JHC12579
595	1990	FORD	1FDHS34M5LHB81562
598	1989	CHEV	1GBHR34N7KJ105605

RECEIVED

2003 NOV 17 PM 1:37

MILWAUKEE HEALTH
DEPARTMENT

ACORD™ CERTIFICATE OF INSURANCE

DATE (MM/DD/YY)

11/14/03

PRODUCER
 Security Ins. & Fin. Serv, Inc.
 2725 S. Moorland Road
 New Berlin, WI 53151

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
ACumis Ins. Society, Inc. (McNeil & Co)
- COMPANY
BEMC Insurance Company
- COMPANY
C
- COMPANY
D

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

COVERAGES

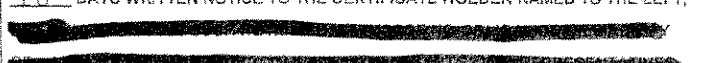
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE 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 CLAIMS MADE <input type="checkbox"/> OCCUR OWNER'S & CONTRACTOR'S PROT	ZDZ5633213	04/01/03	04/01/04	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 ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS	ZDZ5633213	04/01/03	04/01/04	COMBINED SINGLE LIMIT \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE \$ AUTO ONLY-EA ACCIDENT \$ OTHER THAN AUTO ONLY: EACH ACCIDENT \$ AGGREGATE \$
	GARAGE LIABILITY ANY AUTO				
A	EXCESS LIABILITY <input checked="" type="checkbox"/> UMBRELLA FORM OTHER THAN UMBRELLA FORM	UHZ5634111	04/01/03	04/01/04	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 <input type="checkbox"/> EXCL	2H4352802	04/01/03	04/01/04	<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
21st
DAY OF November 2003

 Assistant City Attorney

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

CERTIFICATE HOLDER
 City of Milwaukee
 Health Department
 840 n Broadway
 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,

 AUTHORIZED REPRESENTATIVE

AFFIDAVIT OF "NO INTEREST" MUST ACCOMPANY EACH CERTIFICATE OF INSURANCE ISSUED, INCLUDING NEW AND RENEWALS

AFFIDAVIT

STATE OF WISCONSIN)
MILWAUKEE COUNTY)

GORDON A. RATHKE , BEING FIRST DULY SWORN, on oath deposes and says that he/she is the agent of the CUMIS INSURANCE COMPANY, insurer, on the attached certificate or bond issued to CROSS AMBULANCE SERVICE, INC

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.

Gordon A Rathke
Signature (same as it appears on Certificate)

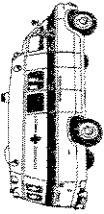
GORDON A. RATHKE

Subscribed and sworn to before me

this 14th day of november, 2003

ME
NOTARY PUBLIC

My Commission expires 6-5-2005



CROSS AMBULANCE SERVICE, INC.
 5436 W. ROGERS ST.
 WEST ALLIS, WI 53219

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

23323

11/12/03

PAY TO THE
 ORDER OF City of Milwaukee

\$ 1,100.00

Eleven Hundred And 00/100 Dollars*** DOLLARS

City of Milwaukee
 health dept, 841 n broadway, 3d floor
 milwaukee,, WI 53202-3653

Robert

MEMO

⑆023323⑆ ⑆275082510⑆ 8100071835⑆

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 10/17/1969 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 G. 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? Yes

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

Do you participate in the Emergency Medical Services System? Yes

If 'yes', list service area number: 3

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

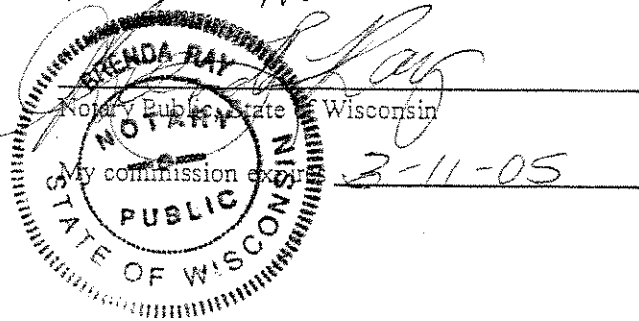
Total number of vehicles in service: 15

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 shall not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for hire 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 at 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, do hereby affirm 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

13th day of November, 2003



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

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

Ramona E. Ringler
(Corporate Secretary)

James J. Baker
(Corporate Treasurer)

Do Not Write Below This Line

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

Curtis Ambulance Service
Vehicle Registration

Unit #:	Vehicle I.D. #:	Year/Make	Type:
320	1FDSE30F0XHB75338	1999'/Ford E-350	Wheelcoach
322	1FDKE30M8NHA31841	1992'/Ford E-350	Wheelcoach
326	1FDJE30M0PHB25307	1993'/Ford E-350	Wheelcoach
329	1FDKE30M7MHA43655	1991'/Ford E-350	Wheelcoach
351	1FDSE30F2XHB75339	1999'/Ford E-350	Wheelcoach
352	1FDKE30L7GHB63886	1988'/Ford E-350	Horton
353	1FDJS34F6THB56687	1996'/Ford E-350	Wheelcoach
354	1FDJS34F1THB56693	1996'/Ford E-350	Wheelcoach
371	1FDKE30M8MHB27337	1991'/Ford E-350	Wheelcoach
377	1FDKE30M5NHA00708	1992'/Ford E-350	Wheelcoach
378	1FDKE30F4 SHA65109	1995'/Ford E-350	Wheelcoach
379	1FDKE30M8RHB61124	1994'/Ford E-350	MedTech
391	1FDJE30M2PHB25275	1993'/Ford E-350	Wheelcoach
392	1FDJE30M1PHB54055	1992'/Ford E-350	Wheelcoach
NL-1	1FDLE40F6VHB62892	1997'/Ford E-350	Wheelcoach

Back-up only:

324	1FDJE30M7RHA11761	94'/Ford E-350	Wheelcoach
327	1FDJE30M1RHB00967	94'/Ford E-350	Wheelcoach
376	1FDKE30F1VHA10640	97'/Ford E-350	Wheelcoach

AFFIDAVIT OF "NO INTEREST" MUST ACCOMPANY EACH CERTIFICATE OF INSURANCE ISSUED, INCLUDING NEW AND RENEWALS.

AFFIDAVIT

STATE OF WI)
)
Waukesha COUNTY)

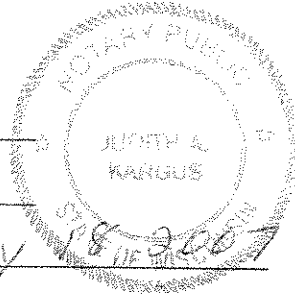
John M Protiva, BEING FIRST DULY SWORN, on oath deposes and says that he/she is the agent of the INEX Insurance (Insurance or Bonding Company) or bond issued to Curtis-Universal Ambulance Co.

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.

John M Protiva
Signature (same as it appears on cert)
John M Protiva 262-827-0600
Typed Name and Phone Number

Subscribed and sworn to before me
this 6th day of November, 2003

Judith A. Kargus
Notary Public,
My Commission expires FEBRUARY 18, 2007



SECURITY FEATURES INCLUDED DETAILS ON BACK

CASHIER'S CHECK

1364863

REMITTER CURTIS UNIVERSAL, INC.

DATE 11/13/2003

79-57
759

One Thousand One Hundred Dollars and 00 cents

PAY TO THE ORDER OF CITY OF MILWAUKEE***

\$1,100.00

\$


Associated Bank
Wisconsin

[Handwritten signature]

⑈ 364863⑈ ⑆075900575⑆

90000034⑈

RECEIVED

2003 NOV 14 PM 12:41

MILWAUKEE HEALTH
DEPARTMENT

*12:29
Dkt stamp
J. Baker*

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 414-342-4444
Business Address 2515 W. Viet St. Milwaukee 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, City, State, Zip 2515 W. Viet St. Milwaukee, WI 53205
Date and Place of Incorporation Milwaukee, WI 11/01/72
President Vivonne Larsen Home Address 568 W18118 Island Dr.
City, State, Zip Muskegon, MI 53150 Phone 262-679-0290 Date of Birth 9/24/37
Vice President NONE Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Secretary TED LARSEN Home Address 20905 Villa Ct.
City, State, Zip Waukesha, WI 53186 Phone 262-798-0654 Date of Birth 11/12/65
Treasurer NONE Home Address _____
City, State, Zip _____ Phone _____ Date of Birth _____
Agent LINDA WIEDMANN Home Address W351 N6018 BAUCKS LN
City, State, Zip Oconomowoc, WI 53066 Phone 262-560-0399 Date of Birth 6/14/54

4. OTHER REQUIREMENTS:

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

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

Do you participate in the Emergency Medical Services System? Yes

If 'yes', list service area number: 2

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

Total number of vehicles in service: 22

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 application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for hire 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 so 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, 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

5 day of November, 2003

[Signature]
Notary Public, State of Wisconsin

My commission expires 8/04

[Signature]
(Individual/Corporate President/Partner)

(Additional Partner/Corporate Vice President)

[Signature]
(Corporate Secretary)

(Corporate Treasurer)

Do Not Write Below This Line

Ambulance List Updated 2/3/03

	Ambulance Number	VIN Number	License Number	Renewal Date	Inspection Date	License Type	Location of Inspection	Year manufactured	Year Purchased
1	KIDS-1	1FDXE40FXWHC12633	KIDS ONE	2003/Nov.	4/23/03	Special Use	535 S. 92 nd Street	1998	1998
2	KIDS-2	1FDKE30M4NHB24582	KIDS TWO	2003/Nov.	4/23/03	Special Use	535 S. 92 nd Street	1992	1998
3	STAT-201	1FDKE30M6MHB07961	STAT 1	2003/Dec	4/24/03	911/ALS	535 S. 92 nd Street	1991	1996
4	STAT-202	1FDKE30M8MHB07962	STAT2	2003/Dec	4/24/03	911/ALS	535 S. 92 nd Street	1991	1996
5	STAT-203	1FDKE30M9KHA07429	545-ERC	2004/Oct	4/24/03	911/ALS	535 S. 92 nd Street	1989	1994
6	204	1FDKE30MARHC16879	888-EKN	2004/Sep	2/6/03	911/BLS	535 S. 92 nd Street	1994	2002
7	STAT-205	1FDKE30M0RHB15500	887-EKN	2004/Sep	4/23/03	911/BLS	535 S. 92 nd Street	1994	2002
8	STAT-206	1FDKE30M0NHA02804	PNF-526	2003/Dec	4/23/03	911/ALS	535 S. 92 nd Street	1992	1996
9	207	1FDJE30F6SHB33437	794-EZJ	2003/Jan	4/23/03	911/BLS	535 S. 92 nd Street	1995	2002
10	STAT-208	1FDKE30M4MHB04119	315-EVU	2003/Nov.	4/24/03	911/ALS	535 S. 92 nd Street	1991	2002
11	210	1FDKE30M8LHA92376	256-AWM	2004/Oct	4/24/03	911/BLS	535 S. 92 nd Street	1993	2001
12	211	1FDHS34M4JHA95477	PAJ-941	2003/Apr.	May. 21, 2001	911/BLS	535 S. 92 nd Street	1988	1995
13	212	1FDHS34M3JHB53692	VDW-603	2003/Nov.	4/24/03	911/BLS	535 S. 92 nd Street	1988	1999
14	213	1FDH534M9LHA41885	673-GBS	2004/Jan	4/24/03	911/BLS	535 S. 92 nd Street	1990	2000
15	214	1FDHS34M5JHC13035	537-FGL	2004/Mar	4/24/03	911/BLS	535 S. 92 nd Street	1988	2002
16	217	1FDHS34MXLHB30171	UCJ-529	2003/Dec	4/24/03	911/BLS	535 S. 92 nd Street	1990	1998
17	219	1FDHS34M3MHB17506	544 EWW	2004/Dec	4/24/03	911/BLS	535 S. 92 nd Street	1991	1992
18	222	1FDJS34M6NHB27210	WCK-636	2004/Jul	4/24/03	911/BLS	535 S. 92 nd Street	1992	1992
19	223	1FDJS34F0SHA56177	793-EZJ	2003/Jan	4/23/03	911/BLS	535 S. 92 nd Street	1995	2002
20	224	1FDJE30M1PHA23644	WECNHLP	2003/Mar	4/24/03	911/ALS	535 S. 92 nd Street	1993	1996
21	225	1FDHS34M4MHA31413	PVD-960	2004/Jan	4/24/03	911/BLS	535 S. 92 nd Street	1991	1991
22	227	1FDHS34M8KHA38443	VCG-925	2004/Oct	4/23/03	911/BLS	535 S. 92 nd Street	1989	1999
23	New Stat	1FDKE30F1THA42940	672-GBS	2004/Aug		911/BLS	535 S. 92 nd Street	1996	2003
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25									

NOT ASSIGNED FOR CITY CALLS

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20499

MEDA-CARE AMBULANCE SERVICE, INC.

2515 W. VLIET ST.
MILWAUKEE, WI 53205

DATE 11/5/03

12-5 6100
750

PAY
TO THE
ORDER OF

City of Milwaukee

\$ 1100.00

One thousand one hundred + 00/100

DOLLARS

M&I Marshall & Isley Bank
Milwaukee, Wisconsin 53202

FOR

[Signature]

⑈020499⑈ ⑆07500005⑆ 00242⑈26653⑈

RECEIVED
2003 NOV 13 PM 3:55
MILWAUKEE HEALTH
DEPARTMENT

City of Milwaukee Health Department
APPLICATION FOR AMBULANCE CERTIFICATION

Fee Must Accompany Application

Check (✓) one: () Individual

License period January 1 to December 31.

() Partnership

\$1,000.00 - New Applicants and Renewals

(XX) Corporation

Make check payable to the City of Milwaukee Health Department

1. NAME OF APPLICANT (if individual) _____

BUSINESS NAME PARATECH AMBULANCE SERVICE, INC Phone (414) 358-1111

Business Address 9401 W. Brown Deer Road 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 ROAD, 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 53051 Phone (262) 628-9244 Date of Birth 4/22/1949

Vice President RICHARD ROMANSHEK Home Address N90 W20881 SCENIC DR.

City, State, Zip MENOMONEE FALLS, WI 53051 Phone (262) 255-6486 Date of Birth 3/24/1953

Secretary RICHARD ROMANSHEK Home Address SAME AS ABOVE

City, State, Zip SAME AS ABOVE Phone _____ Date of Birth _____

Treasurer ROBERT RAUCH Home Address SAME AS ABOVE

City, State, Zip SAME AS ABOVE 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

Do you have a valid State of Wisconsin Inspection Certificate? XX Yes

Do you participate in the Emergency Medical Services System? XX Yes

If 'yes', list service area number: 1

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

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 the 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

15th day of October, 2003

Paula Blumenthal
Notary Public, State of Wisconsin

My commission expires 10/12/07

[Signature]
~~(Notary Public)~~ / Corporate President ~~(XXXX)~~

[Signature]
~~(Notary Public)~~ / Corporate Vice President

[Signature]
(Corporate Secretary)

[Signature]
(Corporate Treasurer)

Do Not Write Below This Line

<u>SQ#</u>	<u>VEHICLE ID NUMBER</u>	<u>YEAR/MAKE</u>	<u>PURCHASE IN SERVICE</u>	
101	1FDSE35F32HA44132	2002 FORD	NEW	2/26/2002
102	1FDSE35F73HA78978	2003 FORD E350	NEW	3/10/2003
103	1FDSE35F81HA96984	2001 FORD E350 III	NEW	7/23/2001
104	1FDSE35F9YHA37615	2000 FORD E350 XL	NEW	6/9/2000
105	1FDSE35F0YHB24156	2000 FORD E350 XL	NEW	6/9/2000
106	1FDSE35F53HA78980	2003 FORD E350	NEW	3/10/2003
107	1FDSE35F12HA44131	2002 FORD	NEW	2/26/2002
108	1FDSE35FXYHB25055	2000 FORD E350	NEW	6/30/2000
109	1FDSE30F9WHA39918	1998 FORD	NEW	5/15/1998
110	1FDSE30F8WHA39926	1998 FORD	NEW	5/15/1998
111	1FDSE30FXWHA06362	1998 FORD	NEW	5/15/1998
112	1FDSE35F93HA78979	2003 FORD E350	NEW	5/1/2003
113	1FDSE35FX2HA44130	2002 FORD	NEW	2/26/2002
114	1FDSE35F73HA78981	2003 FORD E350	NEW	5/1/2003
115	1FDJE30F2SHB07644	1995 FORD MODUVAN III	NEW	8/4/1995
116				
117	1FDJE30F0THA70899	1996 FORD TYPE III	NEW	4/30/1996
118	1FDJE30F3THA70900	1996 FORD TYPE III	NEW	4/30/1996
119	1FDJE30F5THA70901	1996 FORD TYPE III	NEW	4/30/1996
120	1FDSE30F9WHA39921	1998 FORD	NEW	5/15/1998
121	1FDWE30F9WHA14521	1998 FORD	NEW	5/21/1998
122	1FDKE30M0PHB88539	1993 FORD	USED	4/8/2002
123	1FDJE30M0RHB48735	1994 FORD	USED	4/8/2002
124	1FDJE30F3VHB06720	1997 FORD	USED	4/8/2002

ACORD CERTIFICATE OF LIABILITY INSURANCE

CSR 09
PARAT-1

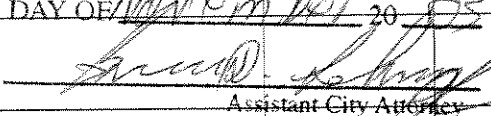
DATE (MM/DD/YYYY)
11/19/03

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	NAIC #
INSURED Paratech Ambulance Service, Inc 9401 W. Brown Deer Road Milwaukee WI 53224	INSURER A: <u>Royal Indemnity Company</u>	14184
	INSURER B: <u>Acuity Insurance Company</u>	
	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.

INSURED'S LTR INSRG	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 checked="" type="checkbox"/> Prof Liab Include GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	R2ST330605	06/15/03	06/15/04	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000
	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	R2ST330605	06/15/03	06/15/04	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
A	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$	RLX006688	06/15/03	06/15/04	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000 \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	OTHER Building/Contents	K28716	06/15/03	06/15/04	Blanket \$1,985,000

APPROVED AS TO FORM
 AND EXECUTION THIS 24th
 DAY OF November 2003

 Assistant City Attorney

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

CERTIFICATE HOLDER CITYM-2 City of Milwaukee Health Department Attn: Seth L. Foldy, M.D. 841 N. Broadway Rm 112 Milwaukee WI 53202-3653	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL SEND BY MAIL <u>10</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, UNLESS OTHERWISE SPECIFIED BY THE POLICY AUTHORIZED REPRESENTATIVE Alice Barbeln 
--	--

ACORD CERTIFICATE OF LIABILITY INSURANCE

CSR 09
PARAT-1

DATE (MM/DD/YYYY)
11/19/03

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.	
INSURED Paratech Ambulance Service, Inc 9401 W. Brown Deer Road Milwaukee WI 53224		INSURERS AFFORDING COVERAGE	NAIC #
		INSURER A: Royal Indemnity Company	
		INSURER B: Acuity Insurance Company	14184
		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 ADD'L LTR	INSRD	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 checked="" type="checkbox"/> Prof Liab Include GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC	R2ST330605	06/15/03	06/15/04	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	\$ 1,000,000 \$ 300,000 \$ 5,000 \$ 1,000,000 \$ 3,000,000 \$ 3,000,000
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	R2ST330605	06/15/03	06/15/04	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	\$ 1,000,000 \$ \$ \$
		GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	\$ \$ \$
A		EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE RETENTION \$	RLX006688	06/15/03	06/15/04	EACH OCCURRENCE AGGREGATE	\$ 1,000,000 \$ 1,000,000 \$ \$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below OTHER				WC STATU-TORY LIMITS E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	OTH-ER \$ \$ \$
B		Building/Contents	K28716	06/15/03	06/15/04	Blanket	\$ 1,885,000

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

CERTIFICATE HOLDER

CITYM-2

City of Milwaukee
 Health Department
 Attn: Seth L. Foldy, M.D.
 841 N. Broadway Rm 112
 Milwaukee WI 53202-3653

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ~~SEND BY MAIL~~ MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, ~~WHICH SHALL BE THE~~ ~~INSURER'S OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.~~

AUTHORIZED REPRESENTATIVE
 Alice Barbeln *Alice Barbeln*

AFFIDAVIT

STATE OF WISCONSIN)
)
COUNTY OF WAUKESHA)

Alice M. Barbeln, being first duly sworn on oath, deposes and says that
he/she is the agent of the Royal Indemnity Company, insurer on the attached
certificate or bond issued to Paratech Ambulance Service, Inc.

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.

Alice Barbeln
Signature (same as on cert or bond)

Alice M. Barbeln :
Typed Name and Phone Number 255-5100

Subscribed and sworn to before me
this 23rd day of October, 2003

Jeanne Statkabe
Notary Public
My Commission Expires 02/05/06

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

052015

REFERRING NO.	DESCRIPTION	INVOICE DATE	INVOICE AMOUNT	DISCOUNT TAKEN	AMOUNT PAID
	ADDL FEE AMBULANCE CERTIFICATION	10/20/03	RECEIVED 2003 OCT 22 PM 3:54 MILWAUKEE HEALTH DEPARTMENT		100.00
CHECK DATE	CHECK NO.	PAYEE	DISCOUNT TAKEN	CHECK AMOUNT	
Oct 20, 2003	052015	CITY OF MILWAUKEE HEALTH DEPT		\$100.00	

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

THIS CHECK IS VOID IF THE REFERRED SIGNATURE LINE IS UNRECORDED UNDER MAGNETICATION
M&I Marshall & Ilsley Bank
12-5 222
750

MEMO: One Hundred and 00/100 Dollars
CITY OF MILWAUKEE HEALTH DEPT

TO THE ORDER OF:

052015
Oct 20, 2003
AMOUNT 100.00

052015

AUTHORIZED SIGNATURE
Arlene Clemente

⑈052015⑈ ⑆07500005⑆ 00034⑈97472⑈
THE FACE OF THIS CHECK HAS A SECURITY VOID BACKGROUND PATTERN. DO NOT CASH IF THE WORD VOID IS VISIBLE

052006

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

REFERENCE NO	DESCRIPTION	INVOICE DATE	INVOICE AMOUNT	DISCOUNT TAKEN	AMOUNT PAID
	RENEWAL AMBULANCE CERTIFICATION	10/15/03			1000.00

CHECK DATE	CHECK NO	PAYEE	DISCOUNT TAKEN	CHECK AMOUNT
Oct 15, 2003	052006	CITY OF MILWAUKEE HEALTH DEPT		\$1,000.00

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



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

M&I Marshall & Ilsley Bank

12-5 222
750

052006

CHECK NO
052006

DATE
Oct 15, 2003

AMOUNT
1,000.00

Memo:

One Thousand and 00/100 Dollars
CITY OF MILWAUKEE HEALTH DEPT

PAY TO THE ORDER OF:

Paula A. Clemente
AUTHORIZED SIGNATURE

⑈052006⑈ ⑆07500005⑆ 00034⑈97472⑈

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