

# APPLICATION FOR LONG-TERM PROVIDER

K.A.R. 109-5-3

Kansas Board of EMS      900 SW Jackson, Rm 1031      Topeka, KS 66612      785.296.7296

## PLEASE TYPE OR PRINT CLEARLY

Sponsoring Organization: \_\_\_\_\_ Service #: \_\_\_\_\_

Service Director: \_\_\_\_\_ Phone: \_\_\_\_\_

Service Director Email: \_\_\_\_\_

Program Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Program Manager Email: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Initial Application

Program Change

Education Plan is on file is current.     Yes     No

We the undersigned, as the institutions representatives, assure and certify that the institution understands and will comply with the authority and requirements of long-term approved providers pursuant to Kansas Statutes Annotated (K.S.A.) and Kansas Administrative Regulations (K.A.R.).

We further agree that submission of this form to the Kansas Board of Emergency Medical Services electronically or by facsimile will have the same force and effect as an original form under penalty of perjury.

Service Director: \_\_\_\_\_ Date: \_\_\_\_\_

Program Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director: \_\_\_\_\_ Date: \_\_\_\_\_