



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services



Application for Sale or Transfer of Ownership of a Primary Service area Responder (PSAR)

In accordance with Conn. Gen. Stat. § 19a-181g, any person who intends to obtain ownership or control of more than fifty per cent of a Primary Service Area Responder's (PSAR) ownership interest or assets in a sale or transfer, must submit an application to the Department of Public Health.

Instructions and approval process:

1. Complete this application and submit the original, including all attachments, to the Office of Emergency Medical Services (OEMS). **Be sure to retain a copy for your records.**
2. OEMS shall render a decision on the application within forty-five calendar days after receipt of the application. The commissioner shall consult with any municipality or sponsor hospital in the primary service area in making a determination on the application and may hold a hearing on the application.
3. The applicant and affected PSAR(s) shall receive written notification of such decision. OEMS shall notify the appropriate regional council(s) of the decision.

Send the original, completed application to:

Office of Emergency Medical Services
Department of Public Health
410 Capitol Ave., MS #12EMS
P.O. Box 340308
Hartford, CT 06134-0308

OEMS main number:
(860) 509-7975

If you have questions or need assistance,
contact your Regional EMS Coordinator:

Region 1: Michele Connelly (860) 509-7973
michele.connelly@ct.gov

Region 2: Judi Reynolds (860) 509-7721
judith.reynolds@ct.gov

Region 3: John Spencer (860) 509-7981
john.spencer@ct.gov

Region 4: Michael Rivers
michael.rivers@ct.gov

Region 5: Jean Speck (860) 509-7829
jean.speck@ct.gov



SALE OR TRANSFER OF OWNERSHIP OF PSAR APPLICATION

APPLICANT INFORMATION

Official Legal Name: _____

Street Address: _____

Mailing Address: _____

(If different than above) _____

Chief Executive Officer: _____

Email: _____

Telephone Numbers: Business: () _____ - _____

Fax: () _____ - _____

Cell: () _____ - _____

CURRENT PSAR INFORMATION

Official Legal Name: _____

Street Address: _____

Mailing Address: _____

(If different than above) _____

Chief Executive Officer: _____

Email: _____

Telephone Numbers: Business: () _____ - _____

Fax: () _____ - _____

Cell: () _____ - _____

MUNICIPAL CHIEF ELECTED OFFICIAL INFORMATION

(Please include information for each affected municipality. If more than one, use a separate sheet of paper.)

Official Legal Name: _____

Street Address: _____

Mailing Address: _____

(If different than above) _____

Chief Executive Officer: _____

Email: _____

Telephone Numbers: Business: () _____ - _____

Fax: () _____ - _____

Cell: () _____ - _____



SALE OR TRANSFER OF OWNERSHIP OF PSAR APPLICATION

Percent of ownership interest or assets to be sold or transferred _____ %

Has the current PSAR notified the Department of Public Health and the chief elected official or the chief executive officer of the municipality of the intended sale or transfer? YES
NO
IF YES, include a copy of each notification.

ATTACHMENTS

Provide these as attachments. Be sure to use the numbering provided as they appear in each heading.

ATTACHMENT 1 - PRIMARY SERVICE AREA

This portion of the application must detail the boundaries of the Primary Service Area. If the coverage area is the official municipal boundary, so indicate and provide a map of the area. If the coverage area does not follow the official municipal boundary, provide both a narrative description, including GPS coordinates, and a map of the geographic area to be covered.

ATTACHMENT 2 – APPLICANT PERFORMANCE HISTORY

Provide performance history in Connecticut or any other state where you hold a license or certificate. This should include any disciplinary documentation, consent orders, or revocation.

ATTACHMENT 3 – PERFORMANCE EXPLANATION

Provide an explanation of how the Applicant will perform the responsibilities of the PSAR in accordance with the Local EMS Plan.

ATTACHMENT 4 – FINANCIAL INFORMATION

Provide proof of Applicant’s financial ability to perform the responsibilities of the PSAR in accordance with the Local EMS Plan.

ATTACHMENT 5 – PROOF OF INSURANCE

Provide certificate of Insurance for 1) General or Public Liability coverage **and** 2) Malpractice or Professional Liability coverage.

Signature of Applicant

Chief Executive Officer or Other Authorized Agent

Date

Name (print)

Title