Check Type
☐ New
☐ Renew

Minneapolis
City of Lakes

Department of Regulatory Services
Div. of Licenses and Consumer Services
Room 1-C, City Hall, 350 So. 5th Street
Minneapolis, MN 55415 (Phone 673-2080)

For Office Use Only	
License ID Number	
License Clerk	Date

Δ APPLICATION FOR MEDICAL TRANSPORT COMPANY LICENSE Δ

Note: This application must be accompanied by the following items:	Note: If a corporation submit copy of:
☐ A picture of color scheme and insignia to be used ☐ Copy of Contract with HMO or Medical Facility ☐ Minneapolis Insurance Certificate covering all vehicles operated in Mpls.	☐ Certificate of Incorporation ☐ Articles of Incorporation ☐ List of shareholders ☐ Minutes of last meeting appointing officers.

NAME OF MEDICAL TRANSPORTATION COMPANY:	THIS IS A (CHECK ONE): ☐ REGISTERED TRADE NAME ☐ REGISTERED CORPORATION
ADDRESS OF MEDICAL TRANSPORTATION COMPANY:	Minnesota Tax I.D.:
PHONE NUMBER:	
DESIGNATED RESPONSIBLE PERSON OF ORGANIZATION:	
LETTERING USED ON VEHICLES TO NAME SERVICE:	

LIST ALL NAMES OF PRINCIPALS, PARTNERS OR CORPORATE OFFICERS

NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME (FIRST, FULL MIDDLE, AND LAST):	BIRTHDATE:	TITLE:	PHONE NUMBER:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

NAME OF MEDICAL ORGANIZATION CONTRACTED WITH:	ADDRESS OF MEDICAL ORGANIZATION:

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CONTACT PERSON:	PHONE #:
NAME OF MEDICAL ORGANIZATION CONTRACTED WITH:	ADDRESS OF MEDICAL ORGANIZATION:
CONTACT PERSON:	PHONE #:
NAME OF MEDICAL ORGANIZATION CONTRACTED WITH:	ADDRESS OF MEDICAL ORGANIZATION:
CONTACT PERSON:	PHONE #:

CONTINUED ON REVERSE SIDE

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LIST OF VEHICLES OPERATING AS MEDICAL TRANSPORT VEHICLES IN MINNEAPOLIS					
STATE LICENSE PLATE NUMBER	SERIAL NUMBER	SEATING CAPACITY	MAKE	YEAR MANUFACTURED	UNIT NUMBER

ATTACH ADDITIONAL PAGE IF NECESSARY

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I CERTIFY THAT THE ATTACHED APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I WILL NOTIFY THE DEPARTMENT IN WRITING OF ANY VEHICLES ADDED OR DROPPED FROM SERVICE WITH OUR COMPANY. I ALSO AGREE TO IMMEDIATELY NOTIFY THE DEPARTMENT IN WRITING OF ANY NEW CONTRACTS WITH MEDICAL ORGANIZATION AND PROVIDE COPIES OF SUCH AND OF THE TERMINATION OF ANY SUCH CONTRACT.

SIGNATURE OF APPLICANT:	REPRESENTING MEDICAL TRANSPORTATION ORGANIZATION:

NOTARY SEAL	
SUBSCRIBED AND SWORN TO BEFORE ME THIS: _____ DAY OF _____ 19 _____	
SIGNATURE OF NOTARY:	MY COMMISSION EXPIRES:
NOTARY PUBLIC: _____ COUNTY _____ (STATE)	