



Transportation Vendor Information

Company Name: _____

Address: _____

Phone: _____

Fax: _____

City: _____

Cell: _____

Zip: _____

Email: _____

Federal Tax ID Number: _____

SERVICES PROVIDED (Circle each that apply)

Taxi, Limo, Other	Wheelchair Equipped Van	Stretcher Equipped Van	Basic Life Support	Advanced Life Support, Air Transport
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How far from your location would you travel to pick up a passenger?

10 Miles _____ 25 Mile _____ 50 Miles _____ 100 Miles _____ 200+Miles _____

Will you quote flat rates? Yes _____ No _____ Is this a metered service? Yes _____ No _____

Do you charge "Unloaded Miles"? Yes _____ No _____ (If Yes, \$ _____/mile)

If a passenger can transfer from their wheelchair to your vehicle, can you accommodate a folding wheelchair?
Yes _____ No _____

Does your company employ Multi-Lingual Drivers? Yes _____ No _____

If Yes, please list languages _____

SERVICES	PER LOAD	PER MILE	WAIT TIME	NO SHOW	MINIMUM (miles 1-way)
Regular - Taxi					
Wheelchair Van					
Stretcher / Gurney					
BLS					
ALS					
Air Transport					

Signature _____ Date _____

****All vendors are paid Net 30, from the date the invoice is received.***