



Vendor Information

Company Name:

Address:

Phone:

Fax:

City:

Cell:

Zip:

Email:

Federal Tax ID SSN (WHICHEVER APPLIES):

SERVICES PROVIDED (Circle each that apply)

Taxi, Cab, Limo, Other	Wheelchair Equipment 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 Miles__ 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, \$ ____)

Do you charge "Unloaded Miles" after transport id complete? Yes / No (If Yes, \$ ____)

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 LIFT	PER MILE	WAIT TIME	NO SHOW	MINIMUM
Regular - Taxi					
Wheelchair Van					
Stretcher / Gurney					
BLS					
ALS					
Air Transport					

Signature _____ Date _____