LAW OFFICES
DAVID M. HOLLAR, PLLC
8 Tower Bridge, Suite 400
161 Washington Street
Conshohocken, PA 19428

Telephone: 610.729.2900
Fax: 610.729.2910

September 16, 2011

Commonwealth of Pennsylvania
Pennsylvania Public Utility Commission
PO Box 3265
Harrisburg, PA 17105-3265

Re: *Application of United Medical Transport, Ltd.*
PUC No. A-2010-2189481

Dear Sir/Madam:

Enclosed is an original and one (1) copy of the Applicant's *Verified Statement and Verified Statement in Support of the Application.*

Please return a time-stamped copy in the enclosed self-addressed envelope. Should you have any questions, please feel free to contact me.

Very truly yours,
DAVID M. HOLLAR, PLLC

Cara Nelson

Cara E. Nelson
Legal Assistant to David Hollar

/cen
Enc

VERIFIED STATEMENT OF APPLICANT

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THE APPLICANT'S FITNESS TO OPERATE. STATEMENTS SHOULD BE TYPED OR PRINTED. ILLEGIBLE STATEMENTS WILL DELAY YOUR APPLICATION.

A-2010-2189481
PUC Application Docket No.

United Medical Transport, Ltd.
Legal Name of Applicant

Trade Name, if any

12301 McNulty Road, Unit M	Philadelphia	PA	19154
Street Address (principal place of business)	City or Municipality	State	Zip Code

The Verified Statement of the Applicant is more or less a business plan, or your proposal for providing the transportation service for which you are making application. Prior to deciding to make application for operating authority from the Public Utility Commission, you likely gave much consideration to the manner in which you would operate the business in order that you could provide satisfactory service to your customers and so that you could make a reasonable profit. As part of the application process, you must provide the Commission with your proposal to provide the transportation service.

At minimum, the Verified Statement of the Applicant should include a discussion of the numbered items listed below and on the following pages. You are encouraged to provide as much information as possible about the particular subject as is necessary to fully explain your plan. If you fail to provide sufficient information about the subjects listed below, it may cause the review of your application to be delayed until you provide the necessary information. If you need more space to provide your explanation, please attach additional pages that list the appropriate item by number.

1. Identify the person making the Verified Statement on behalf of the applicant. If the applicant is a sole proprietor making the statement, this will be the same information as provided above. If an employee/officer of applicant is making the statement, give name, title, business address and telephone number, and indicate that the applicant's directors/owners/partners/etc. have authorized the witness to speak for the business.

   Eduard Davidyuk, President and Director, 8312 State Road, Rear Bldg., Philadelphia, PA 19136. Mr. Davidyuk is the sole shareholder.

2. List the applicant's affiliation (owner, manager, controls) with any other carrier, with the description of affiliation.

   Mr. Davidyuk owns a 50% interest in, is an officer and director, and is involved in the day-to-day business operations of Universal Medical Response, Inc., 8312 State Road, Philadelphia, PA 19136 which provides advanced life support ambulance services in southeastern Pennsylvania. Universal Medical Response is a licensed basic and advanced life support ambulance service, Pennsylvania Department of Health, Bureau of Emergency Medical Services, License No. 5191.

3. Describe your business experience, particularly any experience relating to the operation of a transportation service. You may also include an explanation of education or training that you believe may be relevant.

United Medical Transport Ltd. ("United Medical") was incorporated September 30, 2003 and is an experienced basic life support ambulance service. A copy of United Medical's current Pennsylvania Department of Health Certificate of Licensure, License No. 4039, is attached. United Medical provided 7303 trips in 2007; 8048 trips in 2008; and, 8840 trips in 2009. United Medical anticipates in excess of 9000 trips in 2010.

Mr. Davidyuk also owns a 50% interest in, and is an officer and director involved in the day-to-day business operations of Summit Waste Systems, Inc., One Woodhaven Mall, Suite 202, Bensalem, PA 19020 which provides waste hauling services in Pennsylvania, New Jersey and Delaware.

4. Describe your facilities, record maintenance plan and your communication network. Please include a description of your physical location, to include the office area, office machines that will be utilized, and the facility to house vehicles. Household goods in use carriers should include a description of their storage facilities, if applicable. Please include an explanation of your plan to maintain records required by the PUC, as well as normal business records. In regard to your communication network, please explain how you will receive customer requests for transportation, how you will dispatch the vehicles to fulfill the request, and how you will maintain continuous communication with your drivers. Finally, please state your intended business hours.

OFFICE: 12301 McNulty Road, Unit M, Philadelphia, PA 19154; 1-story light commercial with 3,666 sq ft. office and warehouse/garage space;
PARKING: Indoor parking at 12301 McNulty Road, Unit M, Philadelphia, PA 19154;
DISPATCH: 8312 State Road, Rear Bldg., Philadelphia, PA 19136, 1-story light commercial with approx. 32,000 sq ft. office and warehouse/garage space;
GARAGE: Fleet Services, Inc. 8312 State Road, Front Bldg, Philadelphia, PA 19136

Currently, United Medical Transport dispatches ambulances through a centralized communications center shared with Universal Medical Response and Romed Ambulance Service. The dispatch center operates 24 hours per day, maintains multiple land-lines, and two-way radio communications. Each United Medical Transport driver carries a cellular telephone with Nextel 2-way communication capability. If a paratransit license is issued, the Applicant intends to utilize the same dispatch system. Dispatch, patient and billing records are maintained at the DISPATCH is facility.

Vehicles are stored, supplied and dispatched from offices located at the OFFICE and PARKING facility. Complete vehicle and employee records are maintained at the OFFICE facility.

United Medical Responses' record maintenance plan currently comports with the requirements of the Pennsylvania Department of Health and third-party payors. Any additional PUC record maintenance requirements we be added and incorporated into the existing records maintenance plan. All records are maintained in excess of three years.

5. *Please state the number of employees you intend to use, along with a description of their duties.* Please explain why that number of employees is appropriate to provide reasonable and efficient service to the geographical territory you will be serving. **(Do not address drivers in your explanation about this item; drivers are addressed separately in item # 6).**

UMT currently employs four full-time management employees who will be involved in day-to-day paratransit operations. The Shift Supervisor manages the personnel and vehicles during each shift. The Human Resources Manager manages the hiring, training, and scheduling of employees. The General Manager manages matters relating to customers, patients and vehicles. The Chief Executive Officer oversees all business operations. The management structure has proven effective in UMT's BLS ambulance service and is readily transferrable to the management of the contiguous three-county paratransit territory.

6. Please state the number of drivers you intend to use or hire in your business and explain why that number of drivers is appropriate for the size of the geographical territory you will be serving. In addition, please explain:

a. Your hiring standards for drivers;
b. Your system to ensure prospective drivers will be subject to a criminal background check;
c. Your driver training program;
d. Your system for ensuring that your drivers are properly licensed at all times;
e. Your system to ensure that all drivers will be subject to a criminal background check every two years;
f. Your policies regarding alcohol and drug use by your drivers.

UMT currently employs forty (40) Drivers, First Responders and/or EMTs providing a sufficient and readily available pool of drivers for the contiguous three-county paratransit territory.

Each prospective employee must be 21 years of age or older and complete an application and provide education, training and work history, references, verification of legal eligibility for employment, social security number, a valid driver's license, a clean driving record, and successful completion of EVOC training. (*See* Application Packet, UMT035-043, attached). Criminal background checks are conducted through the Pennsylvania State Patrol and/or corporate counsel's office.

All applicants to whom an offer of employment is made must agree to a 120-day probationary period of employment. (UMT 042)

Probationary employees with less than six (6) months field experience must complete a 7-day training period. (UMT 042).

All applicants who accept an offer of employment are provide a copy of United Medical Transport's Employee Policy Manual (UMT 044-059, attached) and must submit to drug screening and random drug testing. United Medical Transport maintains a "zero tolerance" policy regarding on-the-job alcohol or drug use or intoxication. A verified positive drug test and/or refusal to provide a sample constitutes grounds for immediate termination of employment.

United Medical Transport's insurance agent performs driver's license and history verification for new hires and periodic and annual verification for existing employees. Period and bi-annual criminal background checks are conducted through the Pennsylvania State Patrol and/or corporate counsel's office.

7. Please state the number of vehicles you plan to use in your business and why that number is appropriate to provide reasonable and efficient service to the geographical territory you will be serving. If you have already obtained vehicles for your business, please list them in the chart below. Taxicabs and limousines may not be used if the vehicle's age is greater than eight model years.

See Vehicle List, attached. If a paratransit license is issued, United Medical Transport intends to purchase 3-10 new and/or or late model wheelchair-lift equipped Ford E350 6-passenger van(s) with air-conditioning. United Medical Transport estimates that these passenger vans will be sufficient to provide transportation for a projected passenger volume of 100 trips per month. United Medical Transport has sufficient access to capital to acquire additional vehicles, should they become necessary.

8. Describe your vehicle safety program. Please include the following in your explanation:
   a. Your periodic vehicle maintenance plan;
   b. Your system for ensuring your vehicles will continuously comply with Pennsylvania's equipment standards (67 Pa. Code, Chapter 175) that are applicable to the type of vehicles used in your business;
   c. Your system for ensuring your vehicles will maintain compliance with the PUC's requirements for passenger service at 52 Pa. Code, Section 29.403 (applicable to passenger applicants only);
   d. Your system for replacing vehicles once they are greater than eight model years in age in compliance with 52 Pa. Code, Section 29.314(d) (applicable to taxicabs) or 52 Pa. Code, Section 29.333(e) (applicable to limousines);
   e. Your system for ensuring the filing of an annual vehicle list (taxicabs and limousines);
   f. Your system for ensuring your vehicles will comply with the requirements of 49 CFR Parts 393 and 396, as adopted by the PUC at 52 Pa. Code, Chapter 37 (applicable to HHG applicants).

If a paratransit license is issued, United Medical Transport plans to use vehicle check-out and check-in procedures similar to those used in its current ambulance service (See UMT 063-064).

Similarly, all UMT paratransit vehicles will be maintained using procedures similar to those used in its current ambulance service. Fleet Care Services performs service in conformity with manufacturer's service and maintenance schedules on all UMT vehicles, as well as any necessary repairs. Fleet Care Services maintains records on each UMT vehicle. Fleet Care Services is also available to provide annual state equipment and safety inspections services (67 Pa. Code, Ch. 175), and respond if a UMT vehicle develops a problem while in service.

Vehicle condition, including doors, seats, heat/air conditioning, tires and safety equipment are inspected at vehicle check-out. Vehicles must be refueled, cleaned and any problems reported at vehicle check-in per UMT's End of Shift Policy. (UMT 047)

9. Please explain what steps you have taken to determine if you can obtain and pay the premiums to maintain insurance coverage for the proposed number of vehicles for your business.

Mark Grossman is a licensed insurance agent employed by Remco Insurance Services, Inc., 80 Second Street Pike, Suite 8, Southhampton, PA 18966, and has placed motor vehicle insurance for United Medical Transport since 2003. Mr. Grossman has investigated the availability of insurance and has determined United Medical Transport can secure adequate future coverage at commercially reasonable rates.

10. Please describe your customer service standards. Within your description, please explain:
    a. Your plan to inform customers of the procedures for filing complaints with the PUC;
    b. Your intended customer complaint resolution procedure.

If a paratransit license is issued, United Medical Transport will hold its paratransit drivers to the same high standards of its EMTs and paramedics with regard to customer service. These standards are outlined in United Medical Transport's Code of Ethics (UMT 055-057).

Each vehicle have posted or affixed in a conspicuous location a placard or label providing the PUC's Bureau of Consumer Services mailing address, phone number and web address. The PUC's "Complaint Filing Process" flyer will be made available to any customer registering a complaint with the company.

UMT has a multi-tiered procedure for resolving customer complaints. Customer complaints are initially referred to Operations Manager, Sergey Korchuck, for resolution. If the Operations Manager is unable to resolve the customer complaint, then it is referred to the Office Manager, Ruvim Yadlovsky. In the rare instance that Mr. Yadlovsky is unable to resolve the customer complaint, the complaint is then referred to Mr. Davidyuk for a final evaluation and resolution.

11. Criminal Record. Have you been convicted of a misdemeanor or felony for which you remain subject to supervision by a court or correctional institution?

_____ YES __X NO

12. Financial Data. In addition to demonstrating your technical fitness, you must also demonstrate that you possess the financial fitness to provide the proposed transportation service. Therefore you must complete both parts of the "Statement of Financial Position", which follows this page. The first part is the Balance Sheet. You need only provide the applicable information. The second part of the Statement of Financial Position is the Projected Income Statement. The projection is your estimation of expected revenues and specific expenses for one year. You should use the projected information, along with the financial data reported on your balance sheet to help you determine if proposed business can be feasible. Please feel free to also provide clarification information with your "Statement of Financial Position", which explains why you believe you have sufficient funds to ensure your transportation business can provide reliable service to the public in a safe manner.

Verification of Statement

The undersigned deposes and says that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief. The undersigned understands that false statements herein are made subject to penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

(Signature)

9-12-11
(Date)

Eduard Davidyuk, President

UNITED MEDICAL TRANSPORT

Application for Employment

ATTORNEY DEVELOPED

Please Print

NOTICE TO APPLICANTS AND EMPLOYEES

Screening tests for illegal drug use may be required before hiring and during your employment here.

Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the Human Resources Department.

Name _____ Applicant ID # _____
Last First Middle

Address _____
Street City State ZIP Code

Telephone # (____) _____ Cellular/Other Phone # (____) _____ E-mail Address _____

Position(s) applied for _____ Date of application ____/____/____

Referral Source (Please check the appropriate category and list the source.)

- ☐ Walk-In _____
- ☐ Employee _____
- ☐ Advertisement _____
- ☐ Company's Website _____
- ☐ Other Internet _____
- ☐ School _____
- ☐ Job Fair _____
- ☐ Staffing Agency _____
- ☐ Government Employment Agency _____
- ☐ Other _____

If necessary, best time to call you is..... _____ : _____ AM PM
☐ Home ☐ Cellular/Other

May we contact you at work? ..... ☐ Yes ☐ No

If **yes**, work number and best time to call:

(____) _____ _____ : _____ AM PM

If you are under 18 and it is required, can you furnish a work permit? ..... ☐ Yes ☐ No

If **no**, please explain: _____

Have you submitted an application here before?..... ☐ Yes ☐ No

If **yes**, give date(s) and position(s): _____

_____

Have you ever been employed here before?..... ☐ Yes ☐ No

If **yes**, give dates: From ____/____/____ To ____/____/____

Is this application a request for reemployment following an extended military leave of absence from this company?..... ☐ Yes ☐ No

Are you legally eligible for employment in this country? ..... ☐ Yes ☐ No

Date available for work..... ____/____/____

What is your desired salary range or hourly rate of pay?

$ _____ Per _____

Type of employment desired: ☐ Full-Time ☐ Part-Time ☐ Educational Co-Op ☐ Seasonal ☐ Temporary

Will you relocate if job requires it? ..... ☐ Yes ☐ No

Will you travel if job requires it?..... ☐ Yes ☐ No

If they have been explained to you, are you able to meet the attendance requirements of the position?..... ☐ N/A ☐ Yes ☐ No

Will you work overtime if required? ..... ☐ Yes ☐ No

If **no**, please explain: _____

_____

Are you able to perform the "essential functions" of the job for which you are applying (with or without reasonable accommodation)?

This question is not designed to elicit information about an applicant's disability. Please do not provide information about the existence of a disability, particular accommodation, or whether accommodation is necessary. These issues may be addressed at a later stage to the extent permitted by law.

☐ Yes ☐ No ☐ Need more information about the job's "essential functions" to respond

Driver's license number required if driving may be required in the job for which you are applying:

_____ State _____

Have you ever been bonded? ..... ☐ Yes ☐ No

Answering "yes" to the following question does not constitute an automatic bar to employment. Factors such as date of the offense, seriousness and nature of the violation, rehabilitation and position applied for will be taken into account.

Have you ever pleaded "guilty" or "no contest" to or been convicted of a crime?..... ☐ Yes ☐ No

If **yes**, please provide date(s) and details: _____

_____

_____

Have you entered into an agreement with any former employer or other party (such as a noncompetition agreement) that might, in any way, restrict your ability to work for our company? ..... ☐ Yes ☐ No

If **yes**, please explain: _____

_____

Employment History

Starting with your most recent employer, provide the following information.

Employer
Telephone # ( )
Dates employed: Month / Year to Month / Year
Street address
City
State
Compensation (Starting)
☐ Hourly ☐ Salary $ per
Starting job title/final job title
Commission/Bonus/Other Compensation $
Immediate supervisor and title (for most recent position held)
May we contact for reference? ☐ Yes ☐ No ☐ Later
Compensation (Final)
☐ Hourly ☐ Salary $ per
Why did you leave?
E-mail:
Commission/Bonus/Other Compensation $
Summarize the type of work performed and job responsibilities.
What did you like most about your position?
What were the things you liked least about the position?

Employer
Telephone # ( )
Dates employed: Month / Year to Month / Year
Street address
City
State
Compensation (Starting)
☐ Hourly ☐ Salary $ per
Starting job title/final job title
Commission/Bonus/Other Compensation $
Immediate supervisor and title (for most recent position held)
May we contact for reference? ☐ Yes ☐ No ☐ Later
Compensation (Final)
☐ Hourly ☐ Salary $ per
Why did you leave?
E-mail:
Commission/Bonus/Other Compensation $
Summarize the type of work performed and job responsibilities.
What did you like most about your position?
What were the things you liked least about the position?

Employer
Telephone # ( )
Dates employed: Month / Year to Month / Year
Street address
City
State
Compensation (Starting)
☐ Hourly ☐ Salary $ per
Starting job title/final job title
Commission/Bonus/Other Compensation $
Immediate supervisor and title (for most recent position held)
May we contact for reference? ☐ Yes ☐ No ☐ Later
Compensation (Final)
☐ Hourly ☐ Salary $ per
Why did you leave?
E-mail:
Commission/Bonus/Other Compensation $
Summarize the type of work performed and job responsibilities.
What did you like most about your position?
What were the things you liked least about the position?

Employer
Telephone # ( )
Dates employed: Month / Year to Month / Year
Street address
City
State
Compensation (Starting)
☐ Hourly ☐ Salary $ per
Starting job title/final job title
Commission/Bonus/Other Compensation $
Immediate supervisor and title (for most recent position held)
May we contact for reference? ☐ Yes ☐ No ☐ Later
Compensation (Final)
☐ Hourly ☐ Salary $ per
Why did you leave?
E-mail:
Commission/Bonus/Other Compensation $
Summarize the type of work performed and job responsibilities.
What did you like most about your position?
What were the things you liked least about the position?

Employment History (continued)

Explain any gaps in your employment, other than those due to personal illness, injury or disability. _____

_____

_____

If not addressed on previous page, have you ever been fired or asked to resign from a job? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Skills and Qualifications

Summarize any special training, skills, licenses and/or certificates that may assist you in performing the position for which you are applying:

_____

_____

Computer Skills (Check appropriate boxes. Include software titles and years of experience.)

☐ Word Processing_____ Years:_____ ☐ Internet_____ Years:_____

☐ Spreadsheet_____ Years:_____ ☐ Other_____ Years:_____

☐ Presentation_____ Years:_____ ☐ Other_____ Years:_____

☐ E-mail_____ Years:_____ ☐ Other_____ Years:_____

Educational Background

Starting with your most recent school attended, provide the following information.

School (include City and State)	Years Completed	Completed	GPA Class Rank	Major/Minor
		☐ Diploma ☐ GED ☐ Degree_____ ☐ Certification_____ ☐ Other_____		
		☐ Diploma ☐ GED ☐ Degree_____ ☐ Certification_____ ☐ Other_____		
		☐ Diploma ☐ GED ☐ Degree_____ ☐ Certification_____ ☐ Other_____		
		☐ Diploma ☐ GED ☐ Degree_____ ☐ Certification_____ ☐ Other_____		

References

List names and telephone numbers of three business/work references who are *not* related to you and are *not* previous supervisors.
If not applicable, list three school or personal references who are *not* related to you.

Name	Title	Relationship to You	Telephone	E-mail	# of Years Known
			( )		
			( )		
			( )		

Social Security Number

SS#_____ - _____ - _____

We will use this information only for employment purposes and make reasonable efforts to safeguard your privacy.

Related Information

To what job-related organizations (professional, trade, etc.) do you belong?

Exclude memberships that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve, National Guard or any other similarly protected status.

Organization	Offices Held

List special accomplishments, publications, awards, etc.

Exclude information that would reveal race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve, National Guard or any other similarly protected status.

In your current or a previous job, have you ever written instructions or directions to be followed by employees or customers?

☐ Yes ☐ No ☐ Not Applicable

If yes, please explain: _____

Is there any other job-related information you want us to know about you? _____

Applicant Statement

I certify that all information I have provided in order to apply for and secure work with this employer is true, complete and correct.

I expressly authorize, without reservation, the employer, its representatives, employees or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resumé or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees or representatives, for seeking, gathering and using truthful and non-defamatory information, in a lawful manner, in the employment process and all other persons, corporations or organizations for furnishing such information about me.

I understand that this employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or eliminating any applicant from consideration for employment on any basis prohibited by applicable local, state or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary for me to reapply and fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and with or without prior notice, and the employer reserves the same right to terminate my employment at any time, with or without cause and with or without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of the employer is authorized to make any assurances to the contrary and that no implied oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the employer's president.

I also understand that if I am hired, I will be required to provide proof of identity and legal authorization to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

This Company does not tolerate unlawful discrimination in its employment practices. No question on this application is used for the purpose of limiting or excluding an applicant from consideration for employment on the basis of his or her sex, race, color, religion, national origin, citizenship, age, disability, or any other protected status under applicable federal, state, or local law. This Company likewise does not tolerate harassment based on sex, race, color, religion, national origin, citizenship, age, disability, or any other protected status. Examples of prohibited harassment include, but are not limited to, unwelcome physical contact, offensive gestures, unwelcome comments, jokes, epithets, threats, insults, name-calling, negative stereotyping, possession or display of derogatory pictures or other graphic materials, and any other words or conduct that demean, stigmatize, intimidate, or single out a person because of his/her membership in a protected category. Harassment of our employees is strictly prohibited, whether it is committed by a manager, coworker, subordinate, or non-employee (such as a vendor or customer). The Company takes all complaints of harassment seriously and all complaints will be investigated promptly and thoroughly.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) eliminate me from further consideration for employment, or (ii) may result in my immediate discharge from the employer's service, whenever it is discovered.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT.

I certify that I have read, fully understand and accept all terms of the foregoing Applicant Statement.

Signature of Applicant _____ **Date** ____/____/____

DOCUMENTS NEW HIRED MUST PRESENT

1. EMT CERTIFICATION PA OR EMERGENCY RESPONDER CERTIFICATION
2. CPR CERTIFICATION
3. DRIVER LICENCE
4. EVOC
5. SS CARD

United medical transport

12301 McNulty Road Unit B
Philadelphia, PA 19154

FAIR CREDIT ACT DISCLOSURE STATEMENT

In accordance with the provisions of Section 604 (B)(2)(A) of The Fair Credit Report Act, Public Law 91-508, as amended by the Consumer Credit Report Act of 1996 (Title II, Subtitle D, Chapter 1, of the Public Law 104-208), you are being informed that reports verifying your previous employment, previous drug and alcohol test results, and your driving record may be obtained on you for employment purposes. These reports are required by Section 382.413.391.23 and 391.25 of the Federal Motor Carrier
Safety Regulations.

NAME AS IT APPEARS ON YOUR DRIVER LICENSE:

_____ _____
First Name Last Name

Driver's License Number _____ State _____

Date of Birth: ____/____/_____ Social Security # _____-____-
_____

Applicant's Signature: _____ Date:____/____/_____

EMS VERIFICATION OF CERTIFICATION

The following individual has applied for a position at United Medical Transport. We are requesting verification of his/her certification:

Name: _____

EMS Certification Number: _____

Expires: _____

Certification Level: ○ EMT ○ Paramedic

Employee Request and Release of Information

I authorize United Medical Transport to check with the Office of Emergency Medical Services to provide verification of my current certification and good standing.

I hereby release and will hold United Medical Transport and the Office of Emergency Medical Services harmless from any all liability in connection with obtaining this information.

_____ _____/_____/_____

Signature Date

_____

Print name in full

EMS Use Only

Does the above named individual have any complaints/issues on file with OEMS?

□ Yes □ No

□ The Office of Emergency Medical Services verifies that the above information is correct and up to date.

□ The above information is incorrect for the following reasons:

_____

_____ _____/_____/_____

Signature Date

_____ _____

Print Name Title

Probationary Employment Agreement

I, _____ (print full name) understand and agree that if I'm hired; my employment at United Medical Transport will be subjected to a probationary period, which will consist of one hundred and twenty (120) days starting from the date of hire.

I understand that during my probationary period, I can be discharged and /or terminated due to unsatisfactory performance, or failure to comply with Company requirements.

Upon successful completion of my probationary period, I will be entitled to all Employee Benefits available to me based on my employment (FT / PT) status.

Signature: _____

Date: ____/____/_____

Training period

During the probationary period field employees, who have less than 6 months of field experience, may be subjected to field training (up to 7 days), provided by United Medical Transport.

Employees will be paid $7.25 per hour for their training period. After training period has been successfully completed, employee will be paid their agreed starting rate.

I _____ (print full name) fully understand that I will get paid for my training period at the training rate of $7.25 per hour.

Signature: _____

Date: ____/____/_____

APPLICATION	
COVER SHEET	
CPR CARD	
DRIVERS LICENSE	
EMPLOYEE POLICY	
EMPLOYMENT ELIGIBILITY	
EMT CARD	
EVOC	
FAIR CREDIT ACT	
PROBATION AGREEMENT	
RELEASE FORM	
SOCIAL SECURITY CARD	
UNIFORM RECEIPT	
VACCINATION FORM	
W4 FORM	

EMPLOYEE POLICY

CONTENTS

BEGINNING OF SHIFT POLICY

1) Each field employee coming to work must be:

- In uniform and ready to work on scheduled time every day.
- Employee may not clock in more than 10 minutes prior to beginning of shift, unless gets a prior authorization to do so from manager, supervisor or the dispatcher on duty.
- Employee must be at place of work, and clocked in no more than 5 minutes after start of shift. Anyone clocking in more than 5 minutes after start of shift will be considered late.
- If lateness is repetitive, a warning will be issued, if problem persists, employee will be subject to termination.

2) Once employee is clocked in:

- Employee must contact dispatch by radio provided for the assigned truck for that day.
- Employee must start the check out of the assigned truck for that day (regardless weather or not the partner is present).
- Once check out is complete, it should be deposited into the "check out collection box".
- Once check of vehicle is complete:
- If partner is present, crew must advice dispatch immediately of their availability, and dispatch will provide an assignment.
- If partner is not present, employee must advise dispatch of completion of check out, and dispatch will provide an assignment.

_____

Signature of employee / Print Name

____/____/____

Date

END OF SHIFT POLICY

1. United Medical Transport reserves 90 minutes after the scheduled end of shift time. A Crew may not refuse to take an assignment while within the scheduled shift time (i.e. if a crew is scheduled to work until 17:00, and is dispatched to a call (emergency or non emergency) at 16:59, the crew has a duty to respond to the call.
2. At arrival to base, refuel your vehicle.
3. All trash and used gloves/sheets must be emptied from the vehicle. Do not leave any food, drinks, or newspapers in the vehicle, any spills must be cleaned, and the exterior of the vehicle washed.
4. Stretcher must be made with clean sheet, and belts must be buckled.
5. Complete the end of shift check out, and park your vehicle at it's assigned spot.
6. Turn in all completed paperwork to the dispatcher.
7. Clock out immediately after completion of cleaning the vehicle and doing the end of shift check out.
8. Personal vehicles may not be washed at UNITED MEDICAL TRANSPORT.

Signature of employee / Print Name

Date ____/____/_____

DRIVING POLICY

Ambulance driver must:

a. Maintain a valid drivers license.
b. Have EVOC
c. Report any and all points and/or accidents on his/her driving record.
d. Adhere to any and all medical restrictions on his/her drivers license (example; Eye glasses…).

I) ALL United Medical Transport drivers must follow and obey all traffic signs and signals.

II) Use of a cellular phone is prohibited under any circumstances while driving the company vehicle

III) Driving in emergency mode:

a. An ambulance **RESPONDING TO** emergency call must get an order and approval from dispatcher to use audio and light warning devices (lights and sirens).
b. When **TRANSPORTING A PATIENT**, it is up to the crew to decide weather to drive in regular or emergency mode.
c. If a crew is transporting a patient and decide to proceed in emergency mode, the crew should notify the dispatcher of their decision (for the record)
d. When driving in emergency mode, the driver must come to a complete stop and than proceed with caution at every stop sign, red light, etc.
e. When driving in emergency mode, driver should take into consideration the weather and road condition, and cautiously proceed to get the patient to a hospital as fast and safe as possible.
f. If a driver drives in emergency mode UNAUTHORIZED, he/she is subject to suspension and/or termination.

VI) If a driver is found driving under the influence of alcohol or other controlled substance, he/she is subject to termination.

VII) If a driver has prescribed medication by a physician, he/she must check with the physician and/or pharmacist on the effect of the medication on driving abilities. If medication is said to impair the driving abilities, he/she must report to dispatcher and/or supervisor on duty.

_____

Signature of employee / Print Name

____/____/____

Date

ACCIDENT POLICY

1) If a United Medical Transport vehicle is involved in an accident, the dispatcher and police must be notified immediately.
2) Driver may not leave the scene of the accident unless released by the dispatcher and/or supervisor on duty and police.
3) For every incident or accident, the crew must fill out an accident report form supplied in every clipboard.
4) Every accident will be investigated and if the driver is found at fault, up to $500.00 will be charged for the damages.
5) If an accident occurs while a driver is breaking the "STAND-BY LOCATION" policy, the driver will be charged $500.00 for damages whether or not the driver is found to be at fault for the given accident.

The crew must collect all information about other car(s) involved in an accident.

_____

Signature of employee / Print Name

____/____/____

Date

RADIO POLICY

1) The use of company (NEXTEL) radio and cellular telephone is limited to company business only.
2) The crew must report to the dispatcher via radio of all of their actions. (Example: on location, enroute with patient, on stand by location, etc.....)
3) The personal use of company cellular phone is forbidden.
4) If a phone statement shows the use of cellular phone, $.30 per minute will be deducted from the check of the user.
5) The use of the cellular phone will only be permitted by a dispatcher or supervisor, and only will be used for official UNITED MEDICAL TRANSPORT business i.e. calling hospital ER, a patient's residence, etc...
6) Person using company cellular phone for personal business will be subject to suspension and/or termination.

_____

Signature of employee / Print Name

____/____/____

Date

STAND-BY POLICY

I) When a crew has no assignments or transports, a dispatcher will provide the crew with a "Stand-By" location.
Usual stand by locations can be an intersection, a mall, a hospital, or another public place (example: Roosevelt Mall, Welsh rd.& Roosevelt blvd., Rt. 611& Rt. 73, PCOM Dialysis unit....).

II) A crew on stand-by time must find a place to park the ambulance that;

a. Will be out of traffics way and not interfere with moving traffic.
b. Will not block the view of a traffic signal or sign for the passing motorists.
c. Will not cause as an obstruction of way and/or view to passing pedestrians and/or motorists.
d. Will not park on the fire lane, handicapped parking, or any other illegal parking spot or location.

III) The crew has to be in the area provided by the dispatcher at all times.

a. Crew may not move more than two city blocks away from the stand-by location
b. Crew may not leave or change the stand by location unless approved by the dispatcher.
c. The stand-by policy will be strictly enforced! If this policy is not adhered to, one or both of the crew members are subject to suspension and/or termination.

_____

Signature of employee / Print Name

____/____/____
Date

DRESS CODE POLICY

All ambulance attendants are required to wear the following uniform:

a. Navy blue button down shirt with all appropriate patches
b. Fitted navy blue pants
c. Black or white under shirt
d. Black shoes or boots, absolutely NO SNEAKERS
e. Black socks and belt
f. Hats can be worn only in navy blue color to match the uniform, ABSOLUTLY NO hats worn backwards
g. Seasonal jackets will be issued by UNITED. Each employee will receive a raincoat and a winter jacket with appropriate patches

Personal appearance:

a. Absolutely NO facial piercing (eye brow, chin, nose etc.) *Small* earrings are fine.
b. All facial hair must be kept trimmed and groomed
c. All shirts must be clean and tucked in
d. No chains or necklaces should be worn on top of your shirts, tuck it in under your shirts during working hours

The dress code policy will be strictly enforced! If this policy is not adhered to, employee will be subjected to suspension and/or termination.

Signature: _____

Date: _____-_____-_____

UNIFORM POLICY

1. Dress code must be adhered all the time.

2. Each field employee on the first day of employment receive the necessary items of uniform:
   a. Turtlenecks (navy blue) cost: $19.00
   b. Navy blue button down shirts cost: $36.00
   c. Winter coat (navy blue) cost: $65.00
   d. Rain coat (navy blue) cost: $35.00

Company does not provide, but requested to wear for field employees: Black shoes with black socks, navy blue pants, black belt. This is the responsibility of the employee to purchase these items of uniform outside of the company, no reimbursement is offered for these items.

Additional items of uniform provided by the company are available for employee at any time for the price listed above.

3. Employees are responsible for maintaining the cleanliness of their uniform and replacing damage uniform.

4. Employees are financially responsible for cost of uniform on the following pro rated scale due upon termination of employment:
   Probation period (120 days) – 100% of cost
   Four to six month of employment since hiring date – 75%
   Seven to nine months – 50%
   Ten to twelve months – 25%

After twelve months of employment – 0%

5. On each annual anniversary all employees will receive additional uniform, free of charge, as follows: full time field employee – 2 sweat shirts and 2 T-shirts, part time field employee – one of each kind. Winter coat and raincoat will be replaced once in 3 years.

Employee Signature _____ Date _____

AGREEMENT

I, _____ agree to reimburse United Medical Response by way of payroll deduction for uniform items provided to me by United Medical Response on the following prorated scale should my employment status change or end.

During:

Probation Period – 100% of cost
Four to six months of employment – 75%
Seven to nine months – 50%
Ten to twelve months – 25%
After twelve months – 0%

Signature: _____

Print Name: _____

Date: _____/____/_____

CODE OF ETHICS

Definition of Customer is Direct and Indirect which can mean the following:

- Patient
- Attending Nursing Staff
- Family and Friends

Good Customer Service Defined:

- 1st Appearance Defined
  - ✓ To look like a professional well dressed groomed
  - ✓ To present yourself professional while your doing your job body language
  - ✓ To sound like a professional
- 2nd The customer is always right even if they're wrong
  - ✓ Always right defined:
    - If a nurse told you something and you disagree with her do not argue with her
- 3rd The customer always gets what they want even if it is out of your job description.
  - ✓ Always gets what they want defined:
    - If they told you to do even if you may disagree just do it do not argue
    - Turn your lights and sirens off just prior to entering the facility premises
- 4th The customer is shown and given respect.
  - ✓ Respect defined
    - Do not laugh at morbidly obese patients, do not comment on how badly a patient smells or is overweight.
- 5th The customer has to be pleased even if it means going the extra mile.
  - ✓ You should be as concerned with as important to please the customer
- 6th To the customer time is important
  - ✓ Do not present an image that you're slow
    - If you need more time with the patient let it be in the ambulance but not in sight of the nursing staff.

To maintain good customer service the following is crucial:

- EMT must report to Street Supervisors or Base Supervisors any and all incidents
  - ✓ Do not present an image that you're slow

- Incident Defined:
  - Delay in administration of patient care by our service
  - Delay in providing a service
  - Any and all problem or complaint
  - Any and all occurrences that are outside of normal operations
  - Any time you felt that the transfer did not go smoothly
  - Nothing worse than for a supervisor to hear from the customer for the first time of any event

✓ Even if there's a mess up: do not make a stink of it or prolong the situation, instead do your best to resolve the issue as and please the customer as soon as practically possible.

As a full service ambulance provider there is no reason why we cannot provide care to a patient cannot transport a patient.

- Full Service Defined:
  - ✓ ALS, BLS, morbidly obese, emergency response, non-emergency response
  - ✓ Never say this is beyond me ALS is on the way
  - ✓ Never say this is beyond me call someone else

Why customer service is important: = Image = Call Volume = Income = Employee Benefits

- Crew environment (equipment + atmosphere)
- Pay raise
- Plenty of hours
- No layoffs
- More opportunities for growth with company as company grows
- Bottom line customer service will determine if this company makes it or goes bankrupt. We are not a state agency we are a for profit organization that totally depends on its people to make it work.

Clean Ambulance:

- At end of shift clean ambulance (inside and outside)
- Refuel ambulance
- Restock ambulance

Ambulance Checklist:

- At start of shift check out ambulance don't just mark the checklist
- At end of shift check out ambulance. If there is anything wrong, mark it off on the checklist and notify mechanics.

Dispatch Room:

- *Please do not bother dispatch. Dispatch center is not for all employees to hang* out, only dispatchers are allowed in.
- Call for times and use the ten codes after your cleared from all calls

End of Shift:

- Hand in all run sheets along with any paperwork that goes along with each transport
- Make sure all the run sheets are signed by both partners

Prior to you physically transporting the patient on a stretcher out of a facility the nursing staff should have the following paperwork available for you.

The following info the sending facility may present to you separately/ directly or as part of a sealed info packet that is destined for the receiving facility. (You may open the sealed packet of info)

Face Sheet:

- Provided a Copy to EMT
- Current Diagnosis & Past Medical History have available for EMT, only if not already listed on face sheet

Medical Necessity Form: A.K.A. "PMNC", "Med. Nec" or "Physician's Certification Statement"

- Filled out by facility staff and provided to EMT

Transfer Sheet:

- This will include patient diagnosis for going out, patient insurance information, and other patient information.

List of Allergies:

- Available for EMT to view or copy

List of Current Medications (Medication Name Only)

- Available for EMT to view or copy

Do Not Resuscitate Order A.K.A. "DNR" or "Comfort Care Form"

- Available for EMT to view or copy

If you see that the nursing staff is busy or there are delays/ problems with this list of items then, please work with the staff to ensure a satisfactory customer service is provided by you.

_____

Signature of employee / Print Name

____/____/____

Date

EXPOSURE AND VACCINATION STATUS

My duties as an EMT/First Responder, require me to be exposed to blood or bodily fluids. I _____, understand
(Print Name)
that as part of my occupational experiences I am at risk of exposure to blood or bodily fluids.

Please check one of the following:

__ Yes, I would like to receive the hepatitis B vaccine at no charge to me.

__ I have been immunized against hepatitis B.

AND

__ I refuse to be vaccinated at this time. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring the hepatitis B virus infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine. However, I decline the vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.
If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Date: _____/_____/_____

Please Print Your

Name: _____

Employee Signature: _____

UNIFORM RECEIPT

I, _____, received from
(Employee's name)

United Medical Transport required items of uniform:

- ☐ Navy blue Turtlenecks (2)
- ☐ Navy blue Button Down Shirts (2)
- ☐ Navy blue Rain Jacket (1)
- ☐ Navy blue Winter coat (1) .

Employee's Signature _____ Date ___/___/_____

Additional/Replacement items received:

- ☐ Navy blue Sweatshirts (cost $19.00 each)
- ☐ Navy blue Shirts (cost $36.00 each)
- ☐ Navy blue Rain Jacket (cost $40.00 each)
- ☐ Navy blue Winter coat (cost $65.00 each)

Total cost $_____

Employee's Signature _____ Date ___/___/_____

Amount Paid in full $_____ (Cash / Check)

If Check, Check #_____

Management _____ Date ___/___/_____
(Signature)

I, _____, hereby authorize United Medical Transport to deduct the amount of $_____ from single / each of my payroll checks toward my payments for received additional/replacement items of uniform .

Date of first/only payment:___/___/____ Date of last payment:___/___/____

Employee's Signature _____ Date ___/___/_____

Print Name _____ SSN ___-___-_____

866-478-7700
P.O. Box 21028
Philadelphia, PA 19114-0528

OTHER ENCLOSED ITEMS:
_____Incident Reports _____Vehicle Damage Report

RETURN TO DISPATCH BY:_____#_____

OPENED & VERIFIED BY:(1)_____#_____

(2)_____#_____

OCT 04 2010

VEHICLE INSPECTION SHEET

Date_____/_____/_____ Vehicle_____

BEGINNING MILEAGE_____ENDING MILEAGE_____ FUEL READING E 1/4 1/2 3/4 F

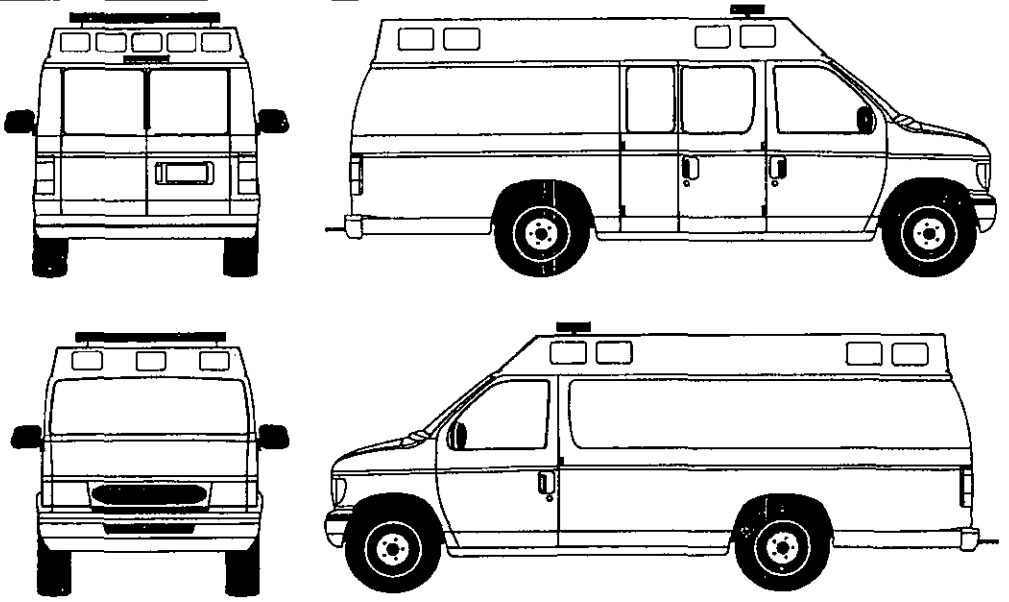
VEHICLE

___E-Z Pass ___Exterior markings ___Light Bar ___Backup Alarm ___Check Tires
___2 Way Radio / Radio Charger ___Fire Extinguisher (with tag) ___Interior Lights ___Rear Light ___Siren
___VHF Radio ___Stop Light ___Emergency Lights ___Engine Oil / Coolant
___MAP's PA/NJ ___Head Lights ___Turn Signals ___Fuel Receipt

CLIP BOARD

___Run Sheets (15) ___Photo Camera ___Medical Necessity Forms (10) ___Accident Reports (3)
___Pens / United Cards & Stickers ___Insurance / Reg. Card /

Please Document any Damage



CREW IS RESPONSIBLE FOR CLEANING OF THE OUTSIDE OF THE VEHICLE, PATIENT COMPARTMENT AND CABIN DAILY

Driver_____(Print) Signature_____

CERTIFICATE OF LICENSURE

pennsylvania
DEPARTMENT OF HEALTH

Universal Medical Response
8312 State Rd, Rear Bldg
Philadelphia, PA 19136

Pursuant to the Act of July 3, 1985, P.L. 164, No. 45, the Emergency Medical Services Act, and duly promulgated rules and regulations, as amended, the Pennsylvania Department of Health hereby issues a license to the above organization to operate in the Commonwealth of Pennsylvania.

License Number: 05191
Operate As: A Basic and Advanced Life Support Ambulance Service
Issued On: January 08, 2009 - AMENDED: March 16, 2010
Expires On: January 01, 2012
Region(s): Delaware County EHS Council, Inc.

Types of ALS Ambulances: ALS Mobile Care
Station Locations: 8312 State Rd, Rear Bldg, Philadelphia, PA 19132

This LICENSE shall expire on the above date unless, for good cause, suspended or revoked sooner.

Joseph W. Schmider
Director of EMS

Everette James
Secretary of Health

UMT00065

No.	Year	Make	Model	Mileage	Placed in Service	VIN	License	Pass Capacity	A/C	Whichr Accessible	Other Features
201											**Out of Service**
202	2006	Ford	E350 Amb			1FDSS34P66DA24781	EV31631	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
203	2002	Ford	E350 Amb			1FDSS34F32HA37871	EV33054	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
204											**Out of Service**
205											**Out of Service**
206											**Out of Service**
207	2000	Ford	E350 Amb			1FDSS34F1YHA54015	EV30827	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
208	2002	Ford	E350 Amb			1FDSE3572HB59381	EV33057				Oxygen, medical emergency, life support, emergency lighting
209	2003	Ford	E350 Amb			1FDSS34F43HA91701	EV33056	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
210											**Out of Service**
211	2001	Ford	E350 Amb			1FDSS34F31HB13684	EV33055	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
212	2001	Ford	E350 Amb			1FDSS34F71HB55498	EV30831	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
213	2003	Ford	E350 Amb			1FDSS34F13HA41886	EV32450	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
214	2004	Ford	E350 Amb			1FDSS34P54HB45856	EV33052	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
215	2004	Ford	E350 Amb			1FDSS34P24HB27329	EV33053	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
216	2004	Ford	E350 Amb			1FDSS34P54HB28765	EV30830	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
217	2001	Ford	E350 Amb			1FDSS34F71HB03059	EV30828	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting
218	2001	Ford	E350 Amb			1FDSS34F61HB25845	EV33058	1	Y	Y	Oxygen, medical emergency, life support, emergency lighting

FINANCIAL STATEMENTS

Statement of Financial Position (Balance Sheet)
As of (date) December 31, 2010
* See 2010 IRS Form 1120S, Schedule L attached

ASSETS

Current Assets				
Cash		9,853		
Accounts Receivable				
Notes Receivable				
Other Current Assets (specify)				
Total Current Assets				9,853
Tangible Assets				
Motor Vehicle Equipment		353,764		
Less: Accumulated Depreciation -		270,829	=	82,935
Building and Structures				
Less: Accumulated Depreciation	-		=	
Office Equipment				
Less: Accumulated Depreciation	-		=	
Land				
Investments and Funds (specify)				
Intangible Assets				
Other Assets (advances and idle equipment – specify)				3,500
TOTAL ASSETS				96,288

LIABILITIES

Current Liabilities (Due within one year of date)				
Accounts Payable				
Notes Payable		83,474		
Equipment Obligations				
Other Liabilities (Attach schedule)		28,795		
Total Current Liabilities				112,269
Long Term Liabilities (Due after one year of date)				
Accounts Payable				
Notes Payable		127,935		
Equipment Obligations				
Other Liabilities (Attach Schedule)				
Total Long Term Liabilities				127,935
TOTAL LIABILITIES				240,204

OWNER'S EQUITY (Corporations only)				
Capital Stock				2,050
Additional Paid-in Capital				
Retained Earnings		(152,881)		
Less: Treasury Stock	-		=	(152,881)
Total Owner's Equity				(150,831)
TOTAL LIABILITIES & OWNER'S EQUITY				89,373

Form **1120S**

Department of the Treasury
Internal Revenue Service

U.S. Income Tax Return for an S Corporation

▶ Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.
▶ See separate instructions.

OMB No. 1545-0130

2010

For calendar year 2010 or tax year beginning , ending

A S election effective date: 09/30/03	TYPE OR PRINT	Name: UNITED MEDICAL TRANSPORT, LTD	D Employer identification number: 20-0314012
B Business activity code number (see instructions): 485990		Number, street, and room or suite no. If a P.O. box, see instructions.: 8001 CASTOR AVE. - STE 349	E Date incorporated: 09/30/2003
C Check if Sch. M-3 attached ☐		City or town, state, and ZIP code: PHILADELPHIA PA 19152	F Total assets (see instructions): $ 96,288

G Is the corporation electing to be an S corporation beginning with this tax year? ☐ Yes ☒ No If "Yes," attach Form 2553 if not already filed

H Check if: (1) ☐ Final return (2) ☐ Name change (3) ☐ Address change (4) ☐ Amended return (5) ☐ S election termination or revocation

I Enter the number of shareholders who were shareholders during any part of the tax year ▶ 1

Caution. Include only trade or business income and expenses on lines 1a through 21. See the instructions for more information.

Income	1a	Gross receipts or sales: 2,179,919	b Less returns and allowances:	c Bal ▶ 1c	2,179,919
	2	Cost of goods sold (Schedule A, line 8)		2	
	3	Gross profit. Subtract line 2 from line 1c		3	2,179,919
	4	Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)		4	
	5	Other income (loss) (see instructions – attach statement)		5	
	6	Total income (loss). Add lines 3 through 5 ▶		6	2,179,919
Deductions (see instructions for limitations)	7	Compensation of officers		7	5,400
	8	Salaries and wages (less employment credits)		8	963,887
	9	Repairs and maintenance		9	3,173
	10	Bad debts		10	
	11	Rents		11	26,366
	12	Taxes and licenses		12	151,796
	13	Interest		13	
	14	Depreciation not claimed on Schedule A or elsewhere on return (attach Form 4562)		14	55,730
	15	Depletion (Do not deduct oil and gas depletion.)		15	
	16	Advertising		16	4,996
	17	Pension, profit-sharing, etc., plans		17	
	18	Employee benefit programs		18	105,114
	19	Other deductions (attach statement) SEE STMT 1		19	746,078
	20	Total deductions. Add lines 7 through 19 ▶		20	2,062,540
	21	Ordinary business income (loss). Subtract line 20 from line 6		21	117,379
Tax and Payments	22a	Excess net passive income or LIFO recapture tax (see instructions)	22a		
	b	Tax from Schedule D (Form 1120S)	22b		
	c	Add lines 22a and 22b (see instructions for additional taxes)		22c	
	23a	2010 estimated tax payments and 2009 overpayment credited to 2010	23a		
	b	Tax deposited with Form 7004	23b		
	c	Credit for federal tax paid on fuels (attach Form 4136)	23c		
	d	Add lines 23a through 23c		23d	
	24	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐		24	
	25	Amount owed. If line 23d is smaller than the total of lines 22c and 24, enter amount owed		25	
	26	Overpayment. If line 23d is larger than the total of lines 22c and 24, enter amount overpaid		26	
	27	Enter amount from line 26 Credited to 2011 estimated tax ▶ Refunded ▶		27	

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

May the IRS discuss this return with the preparer shown below (see instructions)? ☒ Yes ☐ No

Signature of officer EDUARD DAVIDYUK Date PRESIDENT Title

Paid Preparer Use Only

Print/Type preparer's name: CHARLES E. HAIG, CPA	Preparer's signature	Date	Check ☐ if self-employed	PTIN: P00146237
Firm's name ▶ PASTOR, HAIG & ASSOCIATES, P.C.			Firm's EIN ▶ 23-2692056	
Firm's address ▶ 4636 STREET RD TREVOSE, PA 19053-6612			Phone no. 215-953-9950	

For Paperwork Reduction Act Notice, see separate instructions. Form **1120S** (2010)

DAA

EXHIBIT

Schedule A Cost of Goods Sold (see instructions)

1	Inventory at beginning of year	1	
2	Purchases	2	
3	Cost of labor	3	
4	Additional section 263A costs (attach statement)	4	
5	Other costs (attach statement)	5	
6	Total. Add lines 1 through 5	6	
7	Inventory at end of year	7	
8	**Cost of goods sold.** Subtract line 7 from line 6. Enter here and on page 1, line 2	8	
9a	Check all methods used for valuing closing inventory:(i) ☐ Cost as described in Regulations section 1.471-3		
	(ii) ☐ Lower of cost or market as described in Regulations section 1.471-4		
	(iii) ☐ Other (Specify method used and attach explanation.) ▶		
b	Check if there was a writedown of subnormal goods as described in Regulations section 1.471-2(c) ▶ ☐		
c	Check if the LIFO inventory method was adopted this tax year for any goods (if checked, attach Form 970) ▶ ☐		
d	If the LIFO inventory method was used for this tax year, enter percentage (or amounts) of closing inventory computed under LIFO	9d	
e	If property is produced or acquired for resale, do the rules of section 263A apply to the corporation?	☐ Yes	☐ No
f	Was there any change in determining quantities, cost, or valuations between opening and closing inventory? If "Yes," attach explanation.	☐ Yes	☐ No

Schedule B Other Information (see instructions)

		Yes	No
1	Check accounting method: a ☒ Cash b ☐ Accrual c ☐ Other (specify) ▶		
2	See the instructions and enter the: a Business activity ▶ SERVICE b Product or service ▶ AMBULANCE TRANSPOR		
3	At the end of the tax year, did the corporation own, directly or indirectly, 50% or more of the voting stock of a domestic corporation? (For rules of attribution, see section 267(c).) If "Yes," attach a statement showing: (a) name and employer identification number (EIN), (b) percentage owned, and (c) if 100% owned, was a qualified subchapter S subsidiary election made?		X
4	Has this corporation filed, or is it required to file, **Form 8918**, Material Advisor Disclosure Statement, to provide information on any reportable transaction?		X
5	Check this box if the corporation issued publicly offered debt instruments with original issue discount ▶ ☐ If checked, the corporation may have to file *Form 8281, Information Return for Publicly Offered Original Issue Discount Instruments.*		
6	If the corporation: (a) was a C corporation before it elected to be an S corporation or the corporation acquired an asset with a basis determined by reference to the basis of the asset (or the basis of any other property) in the hands of a C corporation and (b) has net unrealized built-in gain in excess of the net recognized built-in gain from prior years, enter the net unrealized built-in gain reduced by net recognized built-in gain from prior years (see instructions) ▶ $		
7	Enter the accumulated earnings and profits of the corporation at the end of the tax year. $		
8	Are the corporation's total receipts (see instructions) for the tax year and its total assets at the end of the tax year less than $250,000? If "Yes," the corporation is not required to complete Schedules L and M-1		X
9	During the tax year, was a qualified subchapter S subsidiary election terminated or revoked? If "Yes," see instructions		X

Schedule K Shareholders' Pro Rata Share Items

				Total amount
Income (Loss)	1	Ordinary business income (loss) (page 1, line 21)	1	117,379
	2	Net rental real estate income (loss) (attach Form 8825)	2	
	3a	Other gross rental income (loss) 3a		
	b	Expenses from other rental activities (attach statement) 3b		
	c	Other net rental income (loss). Subtract line 3b from line 3a	3c	
	4	Interest income	4	
	5	Dividends: a Ordinary dividends	5a	
		b Qualified dividends 5b		
	6	Royalties	6	
	7	Net short-term capital gain (loss) (attach Schedule D (Form 1120S))	7	
	8a	Net long-term capital gain (loss) (attach Schedule D (Form 1120S))	8a	
	b	Collectibles (28%) gain (loss) 8b		
	c	Unrecaptured section 1250 gain (attach statement) 8c		
	9	Net section 1231 gain (loss) (attach Form 4797)	9	
	10	Other income (loss) (see instructions) Type ▶	10	

	Shareholders' Pro Rata Share Items (continued)		Total amount
Deductions	11 Section 179 deduction (attach Form 4562)	11	
	12a Contributions SEE STMT 2	12a	400
	b Investment interest expense	12b	
	c Section 59(e)(2) expenditures(1) Type ▶ (2) Amount ▶	12c(2)	
	d Other deductions (see instructions) Type ▶	12d	
Credits	13a Low-income housing credit (section 42(j)(5))	13a	
	b Low-income housing credit (other)	13b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468)	13c	
	d Other rental real estate credits (see instructions) Type ▶	13d	
	e Other rental credits (see instructions) Type ▶	13e	
	f Alcohol and cellulosic biofuel fuels credit (attach Form 6478)	13f	
	g Other credits (see instructions) Type ▶	13g	
Foreign Transactions	14a Name of country or U.S. possession ▶		
	b Gross income from all sources	14b	
	c Gross income sourced at shareholder level	14c	
	Foreign gross income sourced at corporate level		
	d Passive category	14d	
	e General category	14e	
	f Other (attach statement)	14f	
	Deductions allocated and apportioned at shareholder level		
	g Interest expense	14g	
	h Other	14h	
	Deductions allocated and apportioned at corporate level to foreign source income		
	i Passive category	14i	
	j General category	14j	
	k Other (attach statement)	14k	
	Other information		
	l Total foreign taxes (check one): ▶ ☐ Paid ☐ Accrued	14l	
	m Reduction in taxes available for credit (attach statement)	14m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	15a Post-1986 depreciation adjustment	15a	10,006
	b Adjusted gain or loss	15b	
	c Depletion (other than oil and gas)	15c	
	d Oil, gas, and geothermal properties – gross income	15d	
	e Oil, gas, and geothermal properties – deductions	15e	
	f Other AMT items (attach statement)	15f	
Items Affecting Shareholder Basis	16a Tax-exempt interest income	16a	
	b Other tax-exempt income	16b	
	c Nondeductible expenses	16c	
	d Distributions (attach statement if required) (see instructions)	16d	107,928
	e Repayment of loans from shareholders	16e	
Other Information	17a Investment income	17a	
	b Investment expenses	17b	
	c Dividend distributions paid from accumulated earnings and profits	17c	
	d Other items and amounts (attach statement)		
Reconciliation	18 **Income/loss reconciliation.** Combine the amounts on lines 1 through 10 in the far right column. From the result, subtract the sum of the amounts on lines 11 through 12d and 14l	18	116,979

Schedule L Balance Sheets per Books

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash		31,131		9,853
2a Trade notes and accounts receivable				
b Less allowance for bad debts	( )		( )	
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities (see instructions)				
6 Other current assets (attach statement)				
7 Loans to shareholders				
8 Mortgage and real estate loans				
9 Other investments (attach statement)				
10a Buildings and other depreciable assets	353,764		353,764	
b Less accumulated depreciation	(215,099)	138,665	(270,829)	82,935
11a Depletable assets				
b Less accumulated depletion	( )		( )	
12 Land (net of any amortization)				
13a Intangible assets (amortizable only)				
b Less accumulated amortization	( )		( )	
14 Other assets (attach statement) STMT 3		3,500		3,500
15 Total assets		173,296		96,288
Liabilities and Shareholders' Equity				
16 Accounts payable				
17 Mortgages, notes, bonds payable in less than 1 year		148,256		83,474
18 Other current liabilities (attach statement) STMT 4		56,987		28,795
19 Loans from shareholders				
20 Mortgages, notes, bonds payable in 1 year or more		127,935		127,935
21 Other liabilities (attach statement)				
22 Capital stock		2,050		2,050
23 Additional paid-in capital				
24 Retained earnings		-161,932		-152,881
25 Adjustments to shareholders' equity (attach statement)				
26 Less cost of treasury stock		( )		( )
27 Total liabilities and shareholders' equity		173,296		89,373

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note: Schedule M-3 required instead of Schedule M-1 if total assets are $10 million or more – see instructions

1 Net income (loss) per books	116,979	5 Income recorded on books this year not included on Schedule K, lines 1 through 10 (itemize):	
2 Income included on Schedule K, lines 1, 2, 3c, 4, 5a, 6, 7, 8a, 9, and 10, not recorded on books this year (itemize):		a Tax-exempt interest $	
3 Expenses recorded on books this year not included on Schedule K, lines 1 through 12 and 14l (itemize):		6 Deductions included on Schedule K, lines 1 through 12 and 14l, not charged against book income this year (itemize):	
a Depreciation $		a Depreciation $	
b Travel and entertainment $			
		7 Add lines 5 and 6	
4 Add lines 1 through 3	116,979	8 Income (loss) (Schedule K, line 18). Line 4 less line 7	116,979

Schedule M-2 Analysis of Accumulated Adjustments Account, Other Adjustments Account, and Shareholders' Undistributed Taxable Income Previously Taxed (see instructions)

	(a) Accumulated adjustments account	(b) Other adjustments account	(c) Shareholders' undistributed taxable income previously taxed
1 Balance at beginning of tax year	-161,932		
2 Ordinary income from page 1, line 21	117,379		
3 Other additions			
4 Loss from page 1, line 21	( )		
5 Other reductions STMT 5	(400)		
6 Combine lines 1 through 5	-44,953		
7 Distributions other than dividend distributions	107,928		
8 Balance at end of tax year. Subtract line 7 from line 6	-152,881		

Statement 1 - Form 1120S, Page 1, Line 19 - Other Deductions

Description	Amount
ACCOUNTING/PAYROLL SERVICE	$ 3,675
AMBULANCE CONTRACTORS	201,055
AUTO GAS, REPAIRS & MAINTENAN	78,096
BANK CHARGES	6,966
CONSULTING	56,140
CONTINUING EDUC & SEMINARS	642
DUES & SUBSCRIPTIONS	
FLEET CARE SERVICES	66,564
INSURANCE	289,961
LEGAL & PROFESSIONAL	6,098
LICENSES & PERMITS	570
MEDICAL SUPPLIES	6,498
OFFICE EXPENSES	4,536
POSTAGE	133
STAFF MEALS	1,499
TELEPHONE	19,867
TRASH REMOVAL	981
TRAVEL	
UNIFORMS	810
UTILITIES	1,987
TOTAL	$ 746,078

Statement 2 - Form 1120S, Page 3, Schedule K, Line 12a - Cash Contributions

Description	Cash Contrib 50%	Cash Contrib 30%	Total
DONATIONS	$ 400	$	$ 400
TOTAL	$ 400	$ 0	$ 400

Statement 3 - Form 1120S, Page 4, Schedule L, Line 14 - Other Assets

Description	Beginning of Year	End of Year
SECURITY DEPOSIT	$ 3,500	$ 3,500
TOTAL	$ 3,500	$ 3,500

Statement 4 - Form 1120S, Page 4, Schedule L, Line 18 - Other Current Liabilities

Description	Beginning of Year	End of Year
PAYROLL TAXES	$ 56,987	$ 28,795
TOTAL	$ 56,987	$ 28,795

Statement 5 - Form 1120S, Page 4, Schedule M-2, Line 5(a) - Other Reductions

Description	Amount
CHARITABLE CONTRIBUTIONS	$ 400
TOTAL	$ 400

STATEMENT OF FINANCIAL POSITION

One Year Projected Income Statement

*See June 30, 2011 YTD Profit & Loss attached

REVENUE and GAINS	
Operating Revenue	2,723,640
Net Revenue from non-carrier operations	
Dividend and interest revenues	
Other non-operating revenue	
Gains	
Total Revenue and Gains	2,723,640
EXPENSES	
Equipment Maintenance and Garage Expense	401,244
Insurance Expense	351,340
Employee Salaries	1,073,500
Supervisory Salaries	349,098
Officer Salaries	207,132
Fuel Expense	105,982
Purchased Transportation (Lease Expense)	
Materials and Supplies Expense	2,608
General Office Expense	10,160
Advertising Expense	24,490
Telephone Expense	9,802
Accounting Expense	670
Legal Expense	11,550
Uncollectible Revenue	
Depreciation Expense	
Amortization	
Operating Taxes and Licenses	11,916
Rent Expense	28,764
Loss	21,056
Total Operating Expenses and Losses	2,609,312
Net Income Before Taxes	114,328
Provision for Income Taxes	
Net Income (Loss)	114,328

United Medical Transport LTD
Profit & Loss
January through June 2011

	Jan - Jun 11
Income	
Cash Deposit	3,418.86
medicare payment	776,508.49
private insurance payment	581,791.56
Refund	101.22
Total Income	1,361,820.13
Expense	
Accountants Service	335.00
Auto	
Fuel	52,990.99
Lease	37,736.16
Parts	2,110.92
Registration	6,462.00
Repairs	12,000.00
Service	132,131.00
Towing	3,555.00
Total Auto	246,986.07
Building maintence	1,860.51
Cash Withdraw	174,549.31
Child support	668.32
Consulting Service	103,566.00
Donation	8,000.00
Education	119.00
Employee Benefit, Business	764.00
Insurance	
Auto Insurance	45,196.90
Health Insurance	49,455.80
Worker's Comp. Insurance	60,010.32
Insurance - Other	21,007.08
Total Insurance	175,670.10
Legal-Prof Fees	
Traffic Citation	100.00
Legal-Prof Fees - Other	675.01
Total Legal-Prof Fees	775.01
Licenses and Permits	1,758.00
Marketing	12,245.00
Meals & Entertn	267.13
Medical	200.00
Medical Supply	747.16
Office	3,266.82
parts	2,238.89
Postage and Delivery	70.00
Radio Equipment	4,856.76
Rent	14,381.40
Returns	
Refund	5,528.48
Total Returns	5,528.48
Supplies, Bus	557.12
Tax	
Fed	4,000.00
State	200.00
Total Tax	4,200.00
Transfer to payroll account	536,750.00
Travel, Bus	1,724.00
uniform	459.28

United Medical Transport LTD
Profit & Loss
January through June 2011

	Jan - Jun 11
Utilities	
Gas & Electric	1,250.61
Internet	78.16
Telephone	4,901.13
Total Utilities	6,229.90
Waste	
Waste removal	488.00
Total Waste	488.00
Total Expense	1,309,261.26
Net Income	52,558.87

BUCKS

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Laureen Gallagher, Finance Manager Neshaminy Manor
Name of Supporter

1660 Easton Road Warrington PA 18976
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Wheelchair van service

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Doylestown Hospital, Doylestown area Doctor's office

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  Weekly

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  no shows

- Have you supported similar applications in the past? If so, please supply name and docket number. Pro-Mobile Transportation

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Laureen Gallagher 12/8/10
(Signature) (Date)

Laureen Gallagher
(Name, printed or typed)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Gale Primodie
Name of Supporter

221 W Fairwood DR Chalfont PA 18914
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.
  W/C and Stretcher
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.
  Doylestown Area
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?
  Weekly
- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?
  Poor Service, Rude, No show
- Have you supported similar applications in the past? If so, please supply name and docket number. YES

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Gale Primodie
(Signature)

12/8/10
(Date)

Gale PRIMODIE
(Name, printed or typed)

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Name of Supporter: Anna M. Packer

Street Address: 621 Campus Dr City or Municipality: Bucks State: PA Zip Code: 18944

Name of Applicant: United Medical Transport, Ltd.

- Describe the type of transportation service needed.
  Wheel Chair Van
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.
  Doylestown PA (Hospitals)
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?
  monthly
- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?
  New to this type of Transportation
- Have you supported similar applications in the past? If so, please supply name and docket number.
  NO

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

(Signature) _____ (Date) 12-8-10

Anna M Packer
(Name, printed or typed)

Bucks

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Dorothy Jacubowski
Name of Supporter

111 Delmorr Ave | Morrisville | PA | 19067
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Ambulance

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Depends on where Apt's. needed

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  Whenever Needed

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  NO

- Have you supported similar applications in the past? If so, please supply name and docket number.

  N/A

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Dorothy Jacubowski
(Signature)

10/01/10
(Date)

Dorothy Jacubowski
(Name, printed or typed)

Bucks

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Lori Harm
Name of Supporter

23 Prospect Drive Yardley PA 19067
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Wheelchair/Stretcher

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Yardley, Bensalem

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  maybe monthly

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  NA

- Have you supported similar applications in the past? If so, please supply name and docket number.

  NA

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

(Signature) 12/01/10 (Date)

Lori Harm
(Name, printed or typed)

CY Montgomery

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Cynthia Stauring
Name of Supporter

2893 Woodview Dr. | Hatfield | PA | 19440
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.
  ALS
- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.
  To & from Phila./Harleysville
- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?
  Daily
- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?
  Yes – Not professional
- Have you supported similar applications in the past? If so, please supply name and docket number.
  No

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Cynthia Stauring
(Signature)

12/14/10
(Date)

Cynthia Stauring
(Name, printed or typed)

C14 Montgomery

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Dawn Lauer
Name of Supporter

27 Fieldstone Lane Horsham PA 19044
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  ALS

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  To and from Philadelphia to Harleysville

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  Daily

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  Not qualified, not professional

- Have you supported similar applications in the past? If so, please supply name and docket number.

  no

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Dawnmarie Lauer
(Signature)

12/13/2010
(Date)

DAWNMARIE LAUER
(Name, printed or typed)

Montgomery

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Dana Cronthamel
Name of Supporter

404 Buchert Rd Pottstown Pa 19464
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

ALS

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

To & from Philadelphia to Glenmoore

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

Daily

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

not qualified, not professional

- Have you supported similar applications in the past? If so, please supply name and docket number.

no

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Dana Cronthamel
(Signature)

12/14/10
(Date)

Dana Cronthamel
(Name, printed or typed)

CN Montgomery

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Firely Pediatric Services
Name of Supporter

364 Maple Ave. Harleysville PA 19438
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- **Describe the type of transportation service needed.**
  ALS ambulance and wheelchair accessible vans.
- **What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.**
  Harleysville (origin) to surrounding area and Phila.
- **How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?**
  Monthly
- **Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?**
  Service is not as good.
- **Have you supported similar applications in the past? If so, please supply name and docket number.**

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

(Signature)

John M. Firely
(Name, printed or typed)

12/14/10
(Date)

C14 MONTGOMERY

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

MARIE JONES
Name of Supporter

826 TRICORN DRIVE UNSDALE, PA 19446
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  ALS

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  HARLEYSVILLE => PHILADELPHIA

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  DAILY

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  YES – NOT PROFESSIONAL

- Have you supported similar applications in the past? If so, please supply name and docket number.

  Ø

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Marie M Jones
(Signature)

12/14/2010
(Date)

MARIE JONES
(Name, printed or typed)

MONTCO

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Bonnie Jean Koresko (Montgomery Hospital

Name of Supporter

1159 Seaton Ross Rd Radnor PA 19087

Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.

Name of Applicant

- **Describe the type of transportation service needed.**
  Wheelchair Van
- **What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.**
  Montgomery Hospital to various nursing homes + pts homes. Transport home from hospital.
- **How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?**
  Daily.
- **Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?**
  Yes we have used other vendors, but United gives us good service.
- **Have you supported similar applications in the past? If so, please supply name and docket number.**
  NO

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Bonnie Jean Koresko 12-16-10

(Signature) (Date)

Bonnie Jean Koresko

(Name, printed or typed)

Phila

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Angeles Retamoso
Name of Supporter

612 Mayfair St. | Philadelphia | PA | 19120
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  ambulance

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  philadephia

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  H nessecary

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  NO

- Have you supported similar applications in the past? If so, please supply name and docket number.

  NO

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Angela Letamoso
(Signature)

12-10-10
(Date)

Angeles Retamoso
(Name, printed or typed)

Phila

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Chabeli Colon
Name of Supporter

101 APT A 10th Street | Philadelphia | PA | 19120
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Wheelchair

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Phila.

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  Weekly; Possibly daily

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  Yes

- Have you supported similar applications in the past? If so, please supply name and docket number.

  NO

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Chabeli Colon
(Signature)

12-11-10
(Date)

Chabeli Colon
(Name, printed or typed)

Phila

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Noami Canel
Name of Supporter

5424 Tabor Ave | Philadelphia | PA | 19120
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  wheelchair

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Philadelphia/Bensalem

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  anytime as needed

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  no

- Have you supported similar applications in the past? If so, please supply name and docket number.

  no

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Noami Canel
(Signature)

12-3-10
(Date)

Noami Canel
(Name, printed or typed)

Phila

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Mrs. Mary Ann Stella
Name of Supporter

6410-A Mayfair Street Phila Pa 19120
Street Address City or Municipality State Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Ambulance or wheelchair

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Philadelphia; Elkins Park

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  possibly monthly

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  only 911

- Have you supported similar applications in the past? If so, please supply name and docket number.

  N/A

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Mrs. Mary Stella
(Signature)

12/1/10
(Date)

Mary Stella
(Name, printed or typed)

Phila

VERIFIED STATEMENT IN SUPPORT OF THE APPLICATION

THE FOLLOWING INFORMATION IS REQUIRED BY THE COMMISSION TO DETERMINE THAT THERE IS A NEED FOR THE APPLICANT'S SERVICES. STATEMENT SHOULD BE TYPED OR PRINTED.

Katrina Williscroft
Name of Supporter

905 Valley Glen Rd. Phila Pa 19027
Street Address | City or Municipality | State | Zip Code

United Medical Transport, Ltd.
Name of Applicant

- Describe the type of transportation service needed.

  Medical - Ambulance

- What will be the usual origin and destination? Please give specific locations, such as names of cities, boroughs, or townships.

  Wherever I may need to go.

- How frequently is this service needed? Example: Is it on a daily, weekly, or monthly basis?

  Weekly/Monthly

- Have you tried to use other providers of service in this area, and if so, why do you prefer not to use them?

  Yes (limited service)

- Have you supported similar applications in the past? If so, please supply name and docket number.

  N/A

VERIFICATION OF STATEMENT

The undersigned deposes and says that he/she is the person who signed the Statement for the above-captioned applicant/application and that he/she is authorized to and does make this verification and that the facts set forth therein are true and correct to the best of his/her knowledge, information, and belief.

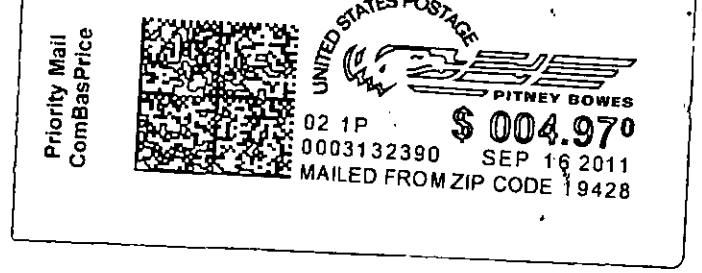
The undersigned understands that false statements herein are made subject to the penalties of 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.

Katrina Williscroft
(Signature)

12/3
(Date)

Katrina Williscroft
(Name, printed or typed)

DAVID M. HOLLAR; PLLC
8 TOWER BRIDGE, SUITE 400
161 WASHINGTON STREET
CONSHOHOCKEN, PA 19428



Commonwealth of PA
PA Public Utility Commission
PO Box 3265
Harrisburg, PA 17105-3265

2011 SEP 19 AM 10:58
SECRETARY'S BUREAU