

Application for Motor Contract Carrier of Persons

This application is required to request a Permit to operate as a contract carrier of persons, when providing transportation for compensation between points in Pennsylvania. A contract carrier does not offer its services to the general public, but only provides transportation to those as specified in a contract with a specific organization.

1. **Legal Name of Applicant** (Individual, Partnership or Corporation)

Euphrates Trans LLC

- If you are an individual who has not formed any type of corporate entity, you should enter your name **as it will appear on your insurance documents**.
- If you are filing for a partnership, but **not a limited liability partnership**, the names of all partners must be entered on this line. Those names should be entered **as they will appear on your insurance documents**. This includes husbands and wives filing jointly.
- If you are filing for a corporate entity (corporation, limited liability company, or limited liability partnership), **even if you are the sole shareholder member**, you must enter the name **exactly as it appears on the registration papers from the Corporation Bureau of the Pennsylvania Department of State**.

2. **Trade Name** (Attach a copy of fictitious name registration if applicable)

This is any name which you will be operating under which differs from the **LEGAL NAME OF APPLICANT**. A **TRADE NAME** is considered a **FICTITIOUS NAME** if the identity of the applicant cannot be readily determined. *EXAMPLE: John Doe is the applicant and wants to use the name "Johnboy Vans" as his trade name. People cannot readily determine that John Doe is the actual operator; therefore, the name is fictitious and must be registered as such. Trade names such as "John Doe Vans" or "J. Doe Vans" are not considered fictitious and would not have to be registered.*

3. **Do you currently hold PUC Authority?** NO **Previous Authority?** _____

If YES, at PUC No. A- _____

4. **Are you a business entity registered with the PA Dept. of State?** Yes
If NO, you must register (see checklist on how to register).

If YES, provide your PA Corporation Bureau Entity ID Number

7167543

(See checklist and indicate type of business entity registered.)

5. If either a corporation or limited liability company, please list members (LLC) or shareholders and officers (corporation).

Alain Denis _____

6. **Mailing Address**

1132 Hamilton St
Street Address

Allentown Pennsylvania 18101 Lehigh
City, State and Zip Code County

973-204-9129
Telephone Number

alaindenis053@gmail.com
E-mail Address

This is the e-mail address to which the Commission will send all official documents issued by the Commission until further notice.

7. **Physical Address** (if different from Physical Address. Do not use a PO Box.)

Street Address

City, State and Zip Code County

Telephone Number

E-mail Address

The address entered here should reflect the actual location of the business. This is the address the Commission needs in order to dispatch Enforcement Officers to inspect equipment. If left blank, it will be assumed that the **PHYSICAL ADDRESS** is the same as the **MAILING ADDRESS**

8. **Attorney** (if applicable)

Attorney's Name & Telephone Number for this Filing

Attorney's Address E-mail Address

An attorney's name should only be entered if an attorney is filing the application for a client and the application is being sent under the attorney's cover letter.

9. **Does applicant have a USDOT Number?**

No _____ Yes, at No. _____

10. **Describe the service area proposed by this application.**
(Use the space below or attach additional sheet if space provided is not sufficient).

Lehigh County To transport people for MTM
as a Medical Assistance Transportation Contractor

Examples:

- To transport people in motor vehicles as a contract carrier for ABC, Inc. between points in the counties of Bucks, Chester, and Delaware.
- To transport people in motor vehicles under the Medical Assistance Transportation Program as a contract carrier for 123, LLC, from points in the city and county of Philadelphia to points in PA, and return.

11. **Certification:**

Applicant certifies that it is not now engaged in unauthorized intrastate transportation for compensation between points in Pennsylvania and will not engage in said transportation unless and until authorization is received from the Pennsylvania Public Utility Commission.

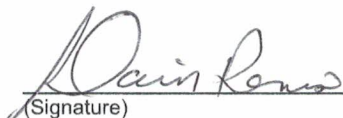
Applicant further certifies that it understands the requirements of the Pennsylvania Public Utility Commission, especially as they relate to safety and insurance and that it may be subject to civil penalties, suspension or cancellation of the Certificate for failure to comply with Commission requirements.

Verification of Application

I/We hereby state that the statement(s) made in this application is/are true and correct to the best of my/our knowledge 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.

Alain Denis
(Print Name)


(Signature)

1-27-2021
(Date)

The verification of the application must be completed by the applicant appearing on Line 1 of the application by the named individual, all partners if a partnership, a member (if a limited liability company), or by the President or Secretary (if a corporation).

Revised 9/25/20

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.

Euphrates Trans LLC

Legal Name of Applicant

Trade Name, if any

1132 Hamilton St. Allentown PA 18101

Street Address (principal place of business)

City or Municipality

State

Zip Code

The Verified Statement of the Applicant factual details about your proposed transportation service. Your Verified Statement must answer all of the items listed below and on the following pages. Provide as much information as possible to prevent delay in processing your application. If you need more space to provide your answer, please attach additional pages identifying the appropriate item number.

1. Identify the person making the Verified Statement on behalf of the applicant. If an employee/officer of applicant is making the statement, give name, title, business address and telephone number.

Alain Denis Owner

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

N/A

3. Describe your facilities, record maintenance plan and your communication network. Please include a description of your physical location, to including office machines that will be utilized, and the facility to house vehicles. As a carrier of household goods in use, applicant should include a description of storage facilities, if applicable. Please include an explanation of your plan to maintain records required by the PUC, as well as normal business records. With 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.

All records will be kept in filing cabinets in a separate room, daily vehicle maintenance is done to ensure safety and operation is maintain. Office machines include fax, copier, scanner. Communication will be utilize through cell phones and two way communication. The office is approximately 783sq feet.

4. 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 territory you will be serving. In addition, please explain:
- Your hiring standards for drivers,
 - Your system for conducting criminal background checks,
 - Your driver training program,
 - Your system for conducting driver license checks,
 - Your policies regarding alcohol and drug use by your drivers.

The number of drivers will be based on the amount of clients given by the broker for starter I believe 2 drivers will suffice. All drivers must pass preliminary screening eg. drug testing, Occoscreen performs background checks, ie. County and National, Labcorp will perform drug and alcohol screening. DMV checks will be done every 6 months. Driver must demonstrate their efficiency through driver's Training through MTM.

5. 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 territory you will be serving. If you have already obtained vehicles for your business, please list them in the chart below.

<u>YEAR</u>	<u>MAKE</u>	<u>MODEL</u>	<u>SEATING CAPACITY*</u>	<u>VEHICLE ID #</u>	<u>MILEAGE</u>
00	Ford	E-450	Ambulance	02	48,620
97	Ford	E-45	Ambulance	01	118,182
07	Dodge	Caravan	7	3	123,240
06	Dodge	Carava	7	4	101,123

6. Describe your vehicle safety program. Please include the following in your explanation:
- Your periodic vehicle maintenance plan
 - Your system for ensuring your vehicles will continuously comply with applicable Pennsylvania vehicle equipment standards (67 Pa. Code, Chapter 175).

All vehicle has oil changes every 3000 miles except for the diesel every 5000 miles, front suspension, steering are checking, brake lights, head lights, directional signals tires tread checked etc.

7. Please explain what steps you have taken to determine if you can obtain insurance and pay the required insurance premiums. I have insurance in place.

8. State whether the applicant has been convicted of a misdemeanor or felony. If applicant is partnership, limited liability partnership, corporation, or limited liability company this question applies to all members, officers, and/or shareholders. If "YES", explain.

X YES NO CDS 1996

9. Financial Data. Complete the "Statement of Financial Position", which follows this page. Please feel free to also provide additional information explaining 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. § 4904 relating to unsworn falsification to authorities.

Alain Denis
(Signature)

1-27-2021
(Date)

Alain Denis (Owner)
(Name and Title, printed or typed)

Statement of Financial Position (Balance Sheet)
 As of (date) 1-21-2021

ASSETS

Current Assets			
Cash		<u>200,000</u>	
Other Current Assets (specify)			
Total Current Assets			<u>200,000</u>
Tangible Assets			
Motor Vehicle Equipment		<u>49,000.00</u>	
Property (buildings, land, etc.)		<u>0</u>	
Office Equipment			
	TOTAL ASSETS		<u>249,000</u>

LIABILITIES

Current Liabilities (Due within one year of date)			
Loans		<u>0</u>	
Credit cards/revolving credit		<u>765.00</u>	
Other Liabilities (Attach schedule)		<u>300.00</u>	
Total Current Liabilities			<u>1065.00</u>
Long Term Liabilities (Due after one year of date)			
Mortgage		<u>2700.00</u>	rent
Long term commercial loan		<u>0</u>	
Other Liabilities (Attach Schedule)		<u>0</u>	
Total Long-Term Liabilities			
	TOTAL LIABILITIES		<u>2760.00</u>

PA liabilities

Office space \$ 765.00 per month

Medical director \$ 300.00



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/17/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

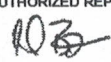
PRODUCER Holman Insurance Services, LLC 444 East Kings Highway Maple Shade, NJ 08052	CONTACT NAME: PHONE (A/C, No, Ext): (856) 380-8080	FAX (A/C, No):	
	E-MAIL ADDRESS:		
INSURED Euphrates Trans LLC 136 Freeway Dr East Orange, NJ 07018	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: Hudson Insurance Company		
	INSURER B:		
	INSURER C:		
	INSURER D:		
	INSURER E:		
INSURER F:			

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			HST-000145-00	8/13/2020	8/13/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NJ) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below			N/A			PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER NJ Department of Health Office of Emergency Medical Services P.O. Box 360 Trenton, NJ 08625	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE 



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
09/28/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Empire Risk Solutions 49-B 16TH AVENUE NEWARK NJ 07103		CONTACT NAME: Yolanda Hinton PHONE (A/C, No. Ext): 973-286-0410 E-MAIL ADDRESS: empire222@verizon.net FAX (A/C, No.): 973-286-0412	
INSURED Euphrates Transportation LLC 136 Freeway Dr E East Orange NJ 07018-4000		INSURER(S) AFFORDING COVERAGE INSURER A: Lloyds of London INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INBR LTR	TYPE OF INSURANCE	ADDL SUBR INSD / RVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:		12717094	09/15/2020	09/15/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ - MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 Fire Damage \$ 50,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NY) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A			PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Sexual Abuse and Molestation		12717094	09/15/2020	09/15/2021	LIMITS \$ 300,000 AGGREGATE \$ 100,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Non Emergency Medical Transportation Company;

CERTIFICATE HOLDER NJ Department of Health Office of Emergency Medical Services PO BOX 360 Trenton NJ 08825	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. <i>EMPIRE RISK</i> AUTHORIZED REPRESENTATIVE YOLANDA DORCH <i>Yolanda Dorch</i> P.O BOX 571 Roselle, NJ 07203
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NCCI CARRIER CODE NO. 28746

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
 INFORMATION PAGE**

N.J. Taxpayer Identification No. 462950253000

1. The Insured: Euphrates Transportation,
 LLC

Policy No. CWC20266205104

Renewal of: CWC19266205103

Mailing address: 136 Freeway Dr
 East Orange, NJ 07018

Individual Partnership
 Corporation or Limited Liability
 Company

Federal Employers I.D.# See Schedule
 Inter/Intrastate Risk I.D.#
 Other I.D.#

Other Workplaces not shown above: See Schedule

2. The policy period is from 06-03-20 to 06-03-21 Effective 12:01 A.M. Standard Time at the Insured's mailing address.
 3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: NJ

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident	\$1,000,000	each accident
Bodily Injury by Disease	\$1,000,000	policy limit
Bodily Injury by Disease	\$1,000,000	each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:
 All states except those listed in Item 3.A. of the Information Page and ND OH WA and WY

D. This policy includes these endorsements and schedules: See Schedule

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans.
 All information required below is subject to verification and change by audit.

Classification	Code No.	Premium Basis Total Annual Estimated Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
See Item 4. Extension	WC 00 00 01 EXT			
Deposit Premium	\$ 233.12	Total Estimated Annual Premium	\$	1913.43
Minimum Premium	\$ 950 (NJ) 7381	Expense Constant	\$	160

See Item 4. Extension WC 00 00 01 EXT for the Taxes and Surcharges for:
 NJ

Premium Adjustment Period: Annual Countersigned by: _____

Servicing Office: Glendale Office Date: 06-12-2020

Producer: Risk Transfer Insurance Agency, LLC
 219 East Livingston Street Orlando, FL 32801-1538
 Producer Code: 00528



STATE OF NEW JERSEY BUSINESS REGISTRATION CERTIFICATE

Taxpayer Name:	EUPHRATES TRANS LIMITED LIABILITY COMPANY
Trade Name:	
Address:	136 FREEWAY DR EAST ORANGE, NJ 07018
Certificate Number:	1808356
Effective Date:	September 12, 2013
Date of Issuance:	November 19, 2020

For Office Use Only:

20201119132745602