City of Arcadia
Paramedic Membership Program
Business Application

1) Name of Business: _____ 2) Name of Owner: _____

3) Business Address: _____

4) Billing Address (If Different): _____

5) Contact Number: _____ 6) Number of Employees: _____

7) Provide the names of all the employees you would like to enroll for your business (include an attachment, as needed).

Use the fee schedule below to calculate your annual membership fee:

# of Employees	$ Total	# of Employees	$ Total
1-10	$ 54	121-130	$414
11-20	$ 84	131-140	$444
21-30	$114	141-150	$474
31-40	$144	151-160	$504
41-50	$174	161-170	$534
51-60	$204	171-180	$564
61-70	$234	181-190	$594
71-80	$264	191-200	$624
81-90	$294	201-210	$654
91-100	$324	211-220	$684
101-110	$354	221-230	$714
111-120	$384		

Paramedic Membership Program Agreement:
(Please **read** carefully and **sign**.)

I understand the membership fee provides protection for all enrolled employees of my business from Arcadia Fire Department's emergency paramedic and ambulance fees. I agree to provide a list of the names of the enrolled employees. I understand that membership fees are non-refundable. I understand that my business must be located within the City of Arcadia; businesses located outside the City's boundaries are ineligible. I also understand that Arcadia Fire Department reserves the right to bill any insurance that I or any of my **permanent** employees may have and any payment received by the employee or business or the City of Arcadia will be accepted as payment for emergency medical services rendered. I also agree to immediately forward any payment received by me or any **permanent** employee of this business to the City of Arcadia. I further authorize the release of emergency medical/insurance information for the purpose of emergency medical service billing only. I understand members must notify the Fire Department upon rendering of service to ensure coverage. I understand membership begins upon receipt of payment by the Fire Department. I understand this membership is non-transferable and any violations of the terms of this agreement and/or other abuses of membership as deemed by the Fire Chief could result in the cancellation of my membership.

Authorized Member's Signature: _____ Date: _____

Please submit: 1) this application (completed with a list of names of the enrolled employees) and 2) a check or payment for one year of membership (payable to "City of Arcadia") to:

Attn: Paramedic Membership Program
Arcadia Fire Department
710 S. Santa Anita Avenue
Arcadia, CA 91006

If you have any questions about the Paramedic Membership Program, please call (626) 574-5126.