



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) Daytime Telephone: _____ 6) Number of Employees: _____

7) Please provide the names of all the employees you would like to enroll for your business. List the names on the back of this form.

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	\$684
91-100	\$324	211-220	\$714
101-110	\$354	221-230	\$744
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 I must be a business located within the City of Arcadia; businesses located outside the City's boundaries are ineligible. I also understand the Arcadia Fire Department reserves the right to bill any insurance that 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 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 insure coverage. I understand membership begins upon receipt of payment by 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 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.