

**Philadelphia Department of Public Health
1101 Market Street, 9th Floor
Philadelphia, PA 19107**

Mobile Medical Services Provider Permit

The City of Philadelphia thanks you for your interest in serving individuals in need of medical services.

The Philadelphia Department of Public Health has developed this application pursuant to the Philadelphia Board of Health's Regulation Relating to Mobile Medical Service Providers to improve coordination among mobile medical service providers, to facilitate opportunities for continuity of care for patients, and to help ensure that mobile medical services are delivered by health care practitioners according to appropriate standards of care

This permit does not confer the right to provide mobile medical services in any particular location; additional approvals from other City departments (e.g., Licenses and Inspections, Public Property, Parks and Recreation) or other individuals may be needed.

Please complete the attached form, and submit it via email or US mail to:

Ben Hartung, Public Policy Advisory
Philadelphia Department of Public Health, Division of Chronic Disease and Injury Prevention
1101 Market Street, 9th Floor
Philadelphia, PA 19107
Email: Benjamin.Hartung@phila.gov
PLEASE PUT ON SUBJECT LINE: Mobile Medical Service Provider Application

THERE IS NO FEE FOR THIS PERMIT.

Once your application has been received by the Philadelphia Department of Public Health, it will be reviewed for completeness and accuracy. You will receive a permit if you have satisfied the requirements of Subsection 2 of the Philadelphia Board of Health Regulation Relating to Mobile Medical Service Providers.

If you need additional information or assistance, please contact us:

Ben Hartung, Public Policy Advisory
Philadelphia Department of Public Health, Division of Chronic Disease and Injury Prevention

Email: Benjamin.Hartung@phila.gov

Philadelphia Department of Public Health
Mobile Medical Services Provider Application

Organization Name (if applicable):

Phone Number: _____

Organization Address: _____

Contact Person: _____

Phone Number: _____

Email Address: _____

Address: _____

Alternative Contact Person: _____

Phone Number: _____

Email Address: _____

Address: _____

Vehicle Information

License Plate Number of Vehicle Providing Mobile Medical Services: _____

PENNDOT Vehicle Registration Information: _____

Physical Description of Vehicle: _____

Supervising Health Care Practitioner Information

Name: _____

Phone Number: _____

Email Address: _____

Address: _____

**Professional Licensure Information from Pennsylvania Department of State for
Supervising Health Care Practitioner**

State Board: _____

License Type: _____

License Number: _____

Description of the Mobile Medical Services to be Provided:

**Description of the Policies Related to Patient Care, Personnel Training, and Personnel
Supervision:**

I attest that the Mobile Medical Services provided by personnel from the permitted vehicle will be consistent with the accepted standards of care and safety standards.

I attest that the necessary medical materials and supplies required to meet the accepted standards of care and safety standards will be available to the personnel providing Mobile Medical Services from the permitted vehicle, including, where appropriate, sharps containers.

Signature of Supervising Health Care Practitioner: _____

Date: _____

Location(s) of Mobile Medical Services: Please provide the anticipated schedule for the permitted vehicle. Please provide cross-street address(es). Please contact the Department if your operating location(s) changes.

Day	Time	Location
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		