Marion County
FLORIDA

Application for Certificate of Public Convenience and Necessity

By

Arena Horse Shows of Ocala

(World Equestrian Center)

Revised 09/24/2021

Section 1
Application

Instructions
Please complete all entries legibly. If the form does not provide sufficient space, additional pages for this section may be inserted at the end of Section 1.

Experience of Owners/Operators

N/A

Application Fees

Fees apply for both new applications and renewal applications. If the purpose of the application is to enhance or decrease the level of service provided, then this application process will be considered as a new application.

- ☐ **$500.00 – Basic Life Support Transport**
- ☑ **$2,000.00 – Advanced Life Support Transport**
- ☐ **$5,000.00 – Advanced Life Support Air Ambulance**
- ☑ **Exempt – Advanced Life Support Non-Transport**
- ☐ **Exempt – Local Government**
- ☐ **Exempt – Current Automatic Aid/Mutual Aid Agreement**

Signatures

I certify that this applicant will meet all valid requirements of the State, Marion County Ordinance No. 21-05, and all Rules and Regulation applicable to same, and that to the best of my knowledge, all statements on this application are true and correct.

Signature: _____ **Printed Name:** Tom Hern

Date: November 5, 2025 **Position/Title/Applicant:** Director Equine Operations

State of Florida

County of Marion

Sworn to (or affirmed) and subscribed before me by means of ☒ **physical presence or** ☐ **online notarization, this** 16th **day of** DECEMBER, **20** 25, **by** TOM HERN.

Stamp/Seal:

Notary Public - State of Florida

TERRY G. CASLER
Notary Public (Print Name)

Signature of Notary Public

☒ **Personally Known**

OR

☐ **Produced Identification** **Type of Identification Produced:**

Revised 09/24/2021

Application Type

Application Date: November 5, 2025

Application Type (choose one):

- [x] New
- [ ] Renewal

Application Type (choose one):

- [ ] Level II – Basic Life Support Transport
- [x] Level III – Advanced Life Support Non-Transport
- [x] Level IV – Advanced Life Support Transport
- [ ] Level V – Advance Life Support Air Ambulance

Applicant Information

Applicant Name: Arena Horse Shows of Ocala

Mailing Address: 1750 N.W. 80th Ave.

City: Ocala **State:** Florida **Zip Code:** 34482

Business Telephone: (352) 414-7900

Type of Ownership: [x] Private [ ] Government

Manager's Name: Thomas Hern **Manager's Phone Number:** (781) 910-6793

Manager's Email: tom.hern@wec.net

Medical Director Information

Name: Ken Barrick MD. **Phone Number:** (630) 460-4727

Mailing Address: 15939 N.W. 10th Circle

City: Citra **State:** Florida **Zip Code:** 32113

Florida License Number: ME 142339

Owner/Operator(s)/Officers/Partners/Directors/Shareholders Information

Name	Business Address	Position

Section 2

Current State License

Instructions
If your agency holds current Florida licensure for providing emergency medical services, insert a copy of that license behind the Section 2 title page. If your agency does not hold current Florida licensure for providing emergency medical services, provide a letter outlining the plan for application to obtain Florida licensure. This should be inserted behind the Section 2 title page.

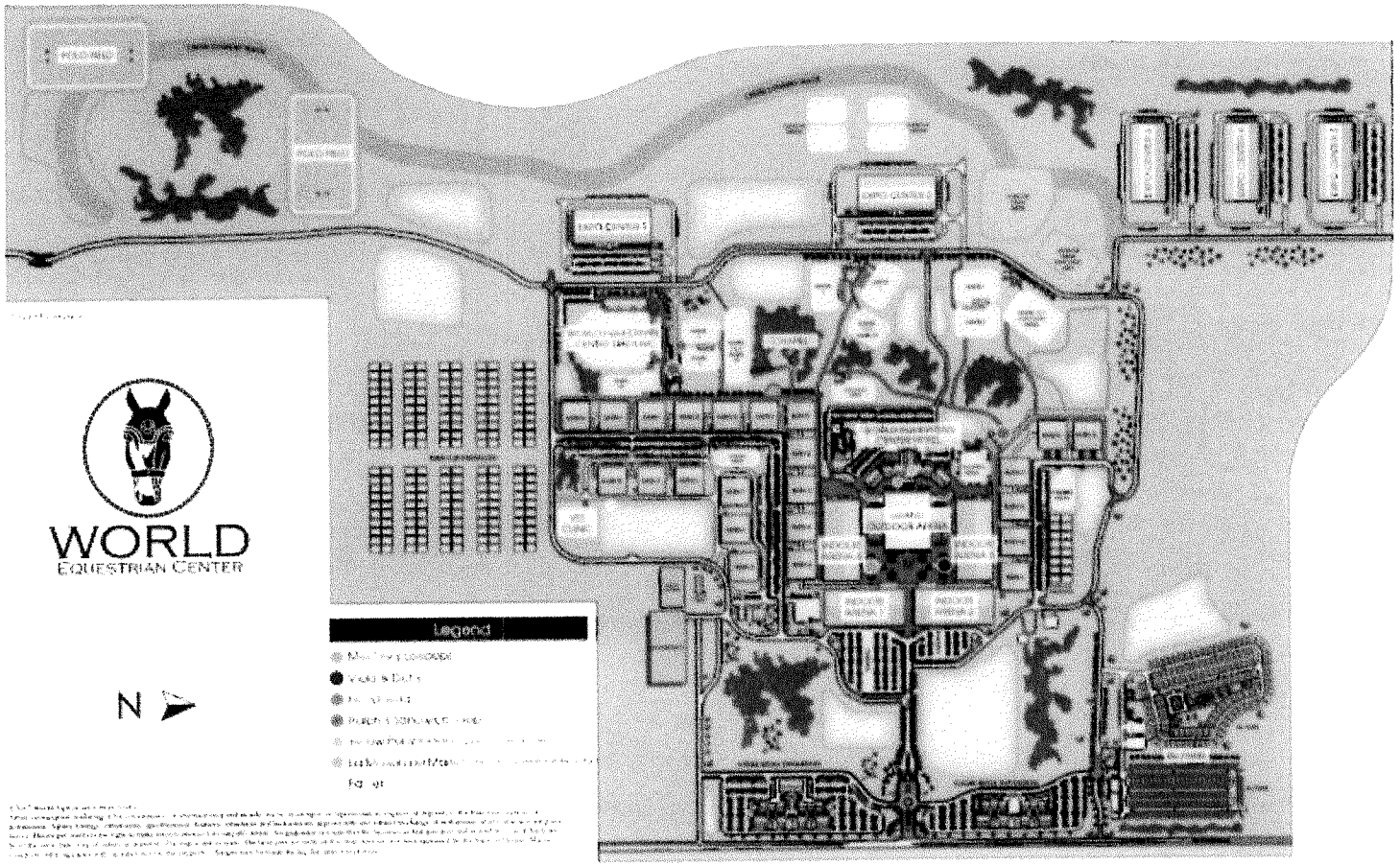
Section 3

Service Area

Instructions
On the following page, provide a detailed description of the area for which your agency wishes to provide service. This description should include any information as it relates to service within unincorporated Marion County as well as the municipalities within Marion County. At the end of Section 3, insert a map illustrating the proposed service area.

Description of Proposed Service Area

The area to be serviced is in Marion County, Located at 1750 NW 80th Ave. World Equestrian Center, Horse show facility. The area is about one square mile. The ambulance will be transferring patients at the front gates to a Marion County fire rescue ambulance in order for MCFR to transport to a designated hospital.


WORLD
EQUESTRIAN CENTER
N
Legend

Section 4

Statement of Facts

Instructions
On the following page, provide a detailed statement of facts illustrating the demand or need for the proposed service. Possible key points may include: • Is adequate service currently provided by the existing agencies? • What is the potential impact to existing service levels if this application is approved? If there is not sufficient space, or the applicant wishes to use a different format, the applicant may insert a different document at the end of Section 4 to accomplish this requirement.

Statement of Fact

The MCFR serviced the show grounds in the past but is now unable to. The private ambulance companies that are available are not as reliable and do not have the quality that we are looking for. We are employing all MCFR personnel for the EMS services currently and would like to extend the service to our own ambulance so that the customers at the show grounds will have the quality continue through out from injury to hospital. If we have a staffed ambulance on the grounds with the same MCFR personnel as the ambulance that will transport them to the hospital, I believe that we will have a seemless operation through out with all personnel with the exact training.

Section 5

Vehicle Records

Instructions
The following page provides a form for entry of required vehicle information. If there is not sufficient space, the applicant may duplicate the page as needed. Or if the applicant wishes to use a different format, the applicant may insert a different document at the end of Section 5 to accomplish this requirement. The Vehicle for Hire inspection form following the Vehicle Information form must be completed for each vehicle. This page may be duplicated for each vehicle. The applicant may include copies of Florida vehicle registrations after the Vehicle for Hire inspection forms.

Vehicle Records

Unit Name/Number:	WEC A1533			**Mileage:**	1,024
Year:	2023	**Make:**	ford	**Model:**	F-450 / Arrow box
VIN:	1FDUF4HT8PED17975			**Registration Number**	CU4 8BX
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	
Unit Name/Number:				**Mileage:**	
Year:		**Make:**		**Model:**	
VIN:				**Registration Number**	

Vehicle for Hire Inspection

BUSINESS INFORMATION

Organization Name:
Arena horse shows of Ocala

Address of Organization:
1750 NW 80th Ave. Ocala, FL. 34482

Phone #:
(352) 414 7900

VEHICLE INFORMATION

Unit #: WEC A1533

Tag #: CU4 8BX

Vehicle Year: 2023

Make: Ford

Model: F 450 / Arrow box

VIN #: 1FDUF4HT8PED17975

Vehicle Color: White/purple

INSPECTION INFORMATION

Inspector's Name:

Phone #:

Certification #:

License #:

Type: NACM ASE (Circle One)

Date of Inspection:

INSPECTION SIGNATURE

Date:

INSPECTION CRITERIA

(Circle one for each criteria inspected)

Valid Tag:	Yes	No	Corrected
Tag Visible:	Yes	No	Corrected
Brakes:	Yes	No	Corrected
Lights	Yes	No	Corrected
Horn:	Yes	No	Corrected
Tires:	Yes	No	Corrected
Windows:	Yes	No	Corrected
Mirrors:	Yes	No	Corrected
Steering:	Yes	No	Corrected
Wipers:	Yes	No	Corrected
Exhaust:	Yes	No	Corrected
Fluids:	Yes	No	Corrected
Seatbelts:	Yes	No	Corrected
Speedometer:	Yes	No	Corrected
AC/Heater:	Yes	No	Corrected

☐ PASS ☐ FAIL

Note: Please use one (1) vehicle inspection report form for each vehicle registered.

Revised 09/24/2021

Section 6

Insurance

Instructions
Provide copies of insurance documents illustrating that the agency meets the following insurance requirements. These documents may be inserted immediately following the Section 6 title page. Motor Vehicle Liability Insurance Each vehicle shall have minimum limits of $1,000,000 combined single limits for bodily injury and property damage. Medical Professional Liability Insurance Every Certificate Holder shall have minimum limits of $1,000,000 per occurrence/$3,000,000 annual aggregate coverage.

FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD

COMPANY: Protective Insurance Company, Inc. 09414

POLICY #: PX1649 EFFECTIVE DATE: 10/1/2025

[X] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [X] BODILY INJURY LIABILITY

NAMED INSURED: Arena Horse Shows of Ocala, LLC

YEAR: MAKE.

VIN #:

FLEET COVERAGE: [X] FLEET
(If more than 25 vehicles insured)

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the following information:

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

[ ] Rental car coverage is provided. If rental car coverage is provided, refer to the outline of coverage as to the details or extent of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/23/2025

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
B&L Brokerage Services, Inc.
111 Congressional Blvd
Carmel IN 46032

License#: 544549
R&LTRAN-01

CONTACT NAME:
PHONE (A/C, No, Ext): 800-644-5501 Ext. 5089 **FAX (A/C, No):** 317-715-9642
E-MAIL ADDRESS: fsp_underwritingcertificaterequests@progressive.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Protective Insurance Company, Inc.	12416
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Arena Horse Shows of Ocala, LLC
1390 NW 80th Avenue
Ocala FL 34482

COVERAGES **CERTIFICATE NUMBER:** 12264568 **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						EACH OCCURRENCE	$
	[ ] CLAIMS-MADE [ ] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	[ ] POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
A	AUTOMOBILE LIABILITY			PX1649	10/1/2025	10/1/2026	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[X] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						[ ] PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N/A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Personal Injury Protection			PX1649	10/1/2025	10/1/2026		$10,0000 Aggregate limit

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Protective Insurance Company, Inc - Florida NAIC # is 09414

RE: With respect to any vehicles operating under the authority of Arena Horse Shows of Ocala, LLC.

"As provided for in Section 320.02(5) (e), Florida Statutes, the listed insurance policy (s) or surety bond (s) may not be cancelled on less that 45 days written notice by the insurer to the Department of Highway Safety and Motor Vehicles, such as 45 day notice to commence from the date notice is received by the Department

CERTIFICATE HOLDER

Florida Department of Highway
Safety & Motor Vehicles Bureau
Division of Motor Vehicles
Bureau of Motor Vehicles
2900 Apalachee Parkway, #A110
Tallahassee FL 32399-0626

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

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Section 7

Staffing

Instructions
The Staffing Configuration form should be completed to describe the staffing for each unit. Ensure that documentation provided illustrates that staffing will meet all requirements. This may also include in the comments section a narrative that describes the scheduling configuration (trucks/day, hours, etc.). The Staffing Information form should be completed to document that all staff meet the requirements. Please include expiration dates for certifications such as EMT, Paramedic, CPR, ACLS, etc. If there is not sufficient space, the applicant may duplicate the page for as needed. Or if the applicant wishes to use a different format, the applicant may insert a different document at the end of Section 7 to accomplish this requirement. The applicant may provide copies of certifications by inserting them after the Staffing Information form.

Staffing Information			
Employee Name:	MCFR personnel	**Address:**	19624 Douglis Nest Run
		City, State, Zip:	Umatilla FL 32784
Employee Certifications			
Summer White		EMT # 571166	
Employee Name:		**Address:**	10267 SW Julia Tuskes Ave
		City, State, Zip:	Oxford FL 34484
Employee Certifications			
Ronald Jackson		Paramedic # 522435	
Employee Name:		**Address:**	8390 NW 17th Cir.
		City, State, Zip:	Ocala FL 34475
Employee Certifications			
Ashig Dharani		Emt # 553703	
Employee Name:		**Address:**	16020 NW 27th Ave
		City, State, Zip:	Citra FL. 32113
Employee Certifications			
Ted Lancaster		Paramedic # 12195	
Employee Name:		**Address:**	
		City, State, Zip:	
Employee Certifications			

Staffing Configuration	
Unit Type:	WEC ambulance A1533
Employee:	Paramedic
Employee:	EMT
Employee:	
Unit Type:	EMS golf cart 1
Employee:	paramadic
Employee:	
Employee:	
Unit Type:	EMS golf cart 2
Employee:	paramedic
Employee:	
Employee:	
Unit Type:	EMS golf cart 3
Employee:	EMT
Employee:	
Employee:	

Additional Comments/Description

We have 1 Ambulance that will be staffed with one paramedic and one EMT
WE also staff 6 EMS style golf carts equiped with a backboard and a tech seat with first in bags, splinting, frac pac, collars, and O2.

Section 8

Locations

Instructions
The Locations form should be completed to provide documentation as to the hours of operation and staffing of the main location as well as any proposed substations. If there is not sufficient space, the applicant may duplicate the page for as needed. Or if the applicant wishes to use a different format, the applicant may insert a different document at the end of Section 8 to accomplish this requirement.

Locations

Name:	World Equestrian Center		**Hours of Operation:**	7am to 7pm	
Address:	1750 NW 80th Ave.				
City:	Ocala	**State:**	FL.	**Zip Code:**	34482

Staffing	**Description**
MCFR personnel	We have EMS staff throughout the grounds depending on v

Name:			**Hours of Operation:**		
Address:					
City:		**State:**		**Zip Code:**	

Staffing	**Description**

Name:			**Hours of Operation:**		
Address:					
City:		**State:**		**Zip Code:**	

Staffing	**Description**

Name:			**Hours of Operation:**		
Address:					
City:		**State:**		**Zip Code:**	

Staffing	**Description**

Section 9
Dispatch & Communications

Instructions
On the following page provide a detailed description to include the following information: • Dispatch procedures/processes. • Recordkeeping related to dispatching. • Reporting capabilities in relation to system overload and identifying exemption from response time requirements. • Communications system to include frequency, call numbers, types of mobile/portable radios, range and hospital communication ability.

Dispatch & Communications

The grounds has a security HQ (SOC) located in the front of the property inside arena 1. The SOC is responsible for dispatching the appropriate services throughout the grounds in emergency needs. The SOC has audio and visial recording The ambulance will be centraly located within the grounds. The ambulance is equipted with a radio system and a designated channel which is identified as EMT channel 1. Upon an incident, the EMS and SOC will be notified by one of the employees via portable radio's. Every employee carries a radio for contact abilities. The SOC will dispatch a securty officer as well as EMS to the scene and will monitor and follow each incident until completed. The communitcation equipment we are using are Motorola XPR 7550e. The radio's work fully at every location on the property with no weak zones.

Section 10

Rates/Fees/Charges

Instructions
On the following page provide a detailed description/list of rates, fares and charges for services.

Rates, Fares and Charges

The show grounds are solely responsible for the employees pay or of any equipment/medical supplies needed in case of an injury to one of our customers. The show grounds will not be charging any fee for the sevices provided if someone is in need of the ambulance service or any equipment inside of it. The service is included in the showing process.

Section 11

Drug-Free Workplace

Instructions
Complete the Drug-Free Workplace form. Applicant may also include any policies/procedures as it relates to documenting their drug-free workplace.

Drug-Free Workplace

I, the undersigned, in accordance with Florida Statute 287.087, hereby certify my firm:

- Publishes a written statement notifying the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace named above, and specifying actions will be taken against violations of such prohibition.
- Informs employees about the dangers of drug abuse in the workplace, the firm's policy of maintaining a drug free working environment, and available drug counseling, rehabilitation, and employee assistance programs, and the penalties may be imposed upon employees for drug use violations.
- Gives each employee engaged in providing commodities or contractual services under bid or proposal, a copy of the statement specified above.
- Notifies the employees as a condition of working on the commodities or contractual services under bid or proposal, the employee will abide by the terms of the statement and will notify the employer of any conviction or pleas of guilty or nolo contendere to, any violation of Chapter 893, or of any controlled substance law of the State of Florida or the United States, for a violation occurring in the workplace, no later than five (5) days after such conviction, and requires employees to sign copies of such written statement to acknowledge their receipt.
- Imposes a sanction on, or requires the satisfactory participation in, a drug abuse assistance or rehabilitation program, if such is available in the employee's community, by any employee who is so convicted.
- Makes a good faith effort to continue to maintain a drug free workplace through the implementation of the Drug Free Workplace program.
- "As a person authorized to sign this statement, I certify the above named business, firm or corporation complies fully with the requirements set forth herein".

Signature: _____ **Printed Name:** Tom Hern

Date: November 5, 2025 **Company Name:** Arena horse shows of Ocala

State of Florida

County of Marion

Sworn to (or affirmed) and subscribed before me by means of ☒ **physical presence or** ☐ **online notarization, this** 18TH **day of** DECEMBER, **20**25, **by** TOM HERN.

Stamp/Seal:

Terry G. Oasler
Comm.: HH 347124
Expires: January 8, 2027
Notary Public - State of Florida

TERRY G. OASLER
Notary Public (Print Name)

_____
Signature of Notary Public

☒ **Personally Known**
OR

☐ **Produced Identification** **Type of Identification Produced:**

Section 12
Assets and Liabilities

Instructions
Provide a compilation statement showing assets and liabilities that has been signed by a certified public accountant (CPA). Insert this document following the Section 12 title page.

Section 13
Equipment & Supplies

Instructions
Provide a list of all equipment and supplies to be carried on each vehicle. This list should include sufficient detail to illustrate that the vehicle meets all requirements for the level of service to be provided. This list should be inserted following the Section 13 title page.

STATE OF FLORIDA
DEPARTMENT OF HEALTH · EMERGENCY MEDICAL SERVICES
BASIC LIFE SUPPORT VEHICLE INSPECTION REPORT (SECTION 401.31, F.S.)

Service Name: _____ **Inspection Date:** ____/____/____ **Phone:** (___)___-_____
County: _____ **Type of Inspection:** ☐Initial ☐ Reinspection ☐ Random ☐ Complaint ☐Announced ☐ Unannounced
Vehicle Information: ☐Transport ☐Non-Transport Unit#_____ **Year/Make** _____ **Permit Type** _____ **Permit#** _____
VIN_____ **Tag#**_____

Inspection Codes:
1 = Item meets inspection criteria.
1a = Item corrected during inspection to meet criteria.
2 = Items not in compliance with inspection criteria.

Rating Categories:
1 = Lifesaving equipment, medical supplies, drugs, records or procedures
2 = Intermediate support equipment, medical supplies, drugs, records or procedures
3 = Minimal support equipment, medical supplies, records or procedures

Name	EMT/PARA/DRIVER	CERTIFICATE NUMBER
1.		
2.		
3.		

Crew credentials: Section 401.27(1) And 401.281, F.S.

Minimum = One EMT and One Driver

I. VEHICLE REQUIREMENTS (Sections 316 and 401, F.S., Chapter 64J-1, F.A.C. and KKK-A-1822	
1. Exhaust System	
2. Exterior Lights:	
A. Head lights (high and low beam)	
B. Turn signals	
C. Brake Lights	
D. Tail Lights	
E. Back-up lights and audible warning device	
3. Horn	
4. Windshield wipers	
5. Tires	
6. Vehicle free of rust and dents	
7. Two-way radio communication – radio test	
A. Hospital (cab and patient compartment)	
B. Dispatch Center	
C. Other EMS units	
8. Emergency Lights	
9. Siren	
10. Two ABC fire extinguishers fully charged and inspected in brackets. Minimum 5 lbs each.	
11. Doors open properly, close securely.	
12. Rear and side view mirrors.	
13. Windows and windshield	
II. TRANSPORT VEHICLE REQUIREMENTS (Section 401, F.S., and Chapter 64J-1, F.A.C. and KKK-A-1822).	
1. Primary stretcher and three straps.	
2. Auxiliary stretcher and two straps.	
3. Two ceiling mounted IV holders.	
4. Two no-smoking signs.	
5. Overhead grab rail.	
6. Squad bench and three sets of seat belts.	
7. Interior lights.	
8. Exterior floodlights.	
9. Loading lights.	
10. Heat and air conditioning with fan.	
11. Word-"Ambulance" – sides, back and mirror image front.	
III. MEDICAL EQUIPMENT FOR TESTING (Chapter 64J-1, F.A.C., and KKK-A-1822	
1. Installed suction. (Transport only)	
. Items 4, 14, 17, 18 and 26 in section II must be tested.	
IV. MEDICAL SUPPLIES AND EQUIPMENT (Chapter 64J-1, F.A.C., GSA KKK-A-1822	
1. Bandaging, dressing and taping supplies:	
a. Rolls adhesive, silk or plastic tape.	
b. Sterile gauze pads, any size	
c. Triangular bandages	
d. Roller gauze	
e. ABD (minimum 5x9 inch) pads	
2. One pair of Bandage Shears	
3. One set each, patient restraints – wrist and ankle	
4. One each blood pressure cuffs: infant, pediatric, and adult.	
5. One stethoscope: pediatric and adult	
6. Blankets	
7. Sheets. (not required on non-transport vehicles)	
8. Pillows with waterproof covers and pillowcases or disposable single use pillows. (Not required on non-transport vehicles.)	
9. One disposable blanket or patient rain cover.	
10. One long spine board and three straps or equivalent.	
11. One short spine board and two straps or equivalent.	
12. One each adult and pediatric cervical immobilization device (CID), approved by the medical director of the service. This approval must be in writing and made available by the provider for the department to review.	
13. Set of padding for lateral lower spine immobilization of pediatric patients or equivalent.	
14. Two portable oxygen tanks, "D" or "E" cylinders, with one regulator and gauge. Each tank must have a minimum pressure of 1000 psi.	
15. Each transparent oxygen masks; adult, child and infant sizes, with tubing	
16. Set of pediatric and adult nasal cannulae with tubing.	
17. One each hand operated bag-valve mask resuscitators, adult and pediatric accumulator, including adult, child and infant transparent masks capable of use with supplemental oxygen.	
18. One portable suction, electric or gas powered, with wide bore tubing and tips, which meet the minimum standards as published by the GSA in KKK-A-1822 specifications.	
19. Assorted sizes of extremity immobilization devices.	
20. One lower extremity traction splint. (Pediatric and Adult)	
21. One sterile obstetrical kit to include, at minimum, bulb syringe, sterile scissors or scalpel and cord clamps or cord-ties.	
22. Burn sheets.	
23. One flashlight with batteries.	
24. Occlusive dressings.	
25. Assorted sizes of oropharyngeal airways. Pediatric and Adult	
26. One installed oxygen with regulator gauge and wrench, minimum "M" size cylinder. (Other installed oxygen delivery systems, such as liquid oxygen, as allowed by medical director. This approval must be in writing and available to the department for review.)	
27. Sufficient quantity of gloves – suitable to provide barrier protection from biohazards for all crew members.	
28. Sufficient quantity of each for all crewmembers – Face Masks – both surgical and respiratory protective.	
29. Assorted pediatric and adult sizes rigid cervical collars as approved in writing by the medical director and available for review by the department.	
30. Nasopharyngeal airways, French or mm equivalents (infant , pediatric , and adult	
31. One approved biohazardous waste plastic bag or impervious container per **Chapter 64J-1, F.A.C.** 31a. Pediatric length based measurement device for equipment selection and drug dosage	
32. One per crewmember, safety goggles or equivalent meeting A.N.S.I.Z87.1 standard.	
33. One bulb syringe separate from obstetrical kit.	
34. One thermal absorbent reflective blanket.	
35. Two multi-trauma dressings.	
GENERAL SANITATION (Section 401.26(2)(e), F.S. **I. Vehicle and Contents ☐ Satisfactory ☐ Unsatisfactory**	

Comments:

I, the undersigned representative of the above service, acknowledge receipt of a copy of this inspection narrative, applicable supplemental inspection reports and corrective action statement (if applicable). In addition, I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies within the established time frames will subject the service and its authorized representatives to administrative action and penalties as outlined in Section 401, F.S., and Chapter 64J-1, F.A.C. Copy of Inspection report and Corrective Action Statement Received by:

Person in Charge: _____ **Date:** _____

Inspected By: _____ **Date:** _____

STATE OF FLORIDA
DEPARTMENT OF HEALTH · EMERGENCY MEDICAL SERVICES
ADVANCED LIFE SUPPORT VEHICLE INSPECTION REPORT (SECTION 401.31, F.S.)

Service Name: _____ **Inspection Date:** ____/____/____ **Unit No.** _____

Inspection Codes:
1 = Item meets inspection criteria.
1a = Item corrected during inspection to meet criteria.
2 = Items not in compliance with inspection criteria.

Rating Categories:
1 = Lifesaving equipment, medical supplies, drugs, records or procedures
2 = Intermediate support equipment, medical supplies, drugs, records or procedures
3 = Minimal support equipment, medical supplies, records or procedures

LS EQUIPMENT AND MEDICATIONS
(Reference Chapter 64J-1, F.A.C.)

MEDICATIONS	WT/VOL	QTY	
1. Atropine Sulfate			
2. Dextrose, 50 percent	25 gm/50ml		
3. Epinephrine HCL	1:1,000 1 mg/ml		
4. Epinephrine HCL	1: 10,000 1 mg/10cc		
5. Ventricular dysrhythmic			
7. Naloxone (Narcan)	1 mg/ml 2 mg amp.		
8. Nitroglycerin	0.4 mg spray pump		
9. Diazepam	5 mg/ml		
10. Inhalant, Beta Adrenergic agent with nebulizer apparatus, approved by medical director	In nebulizer apparatus		
IV SOLUTIONS MINIMUM QTY	MINIMUM AMMOUNTS		
1. Lactated Ringers or Normal Saline		In any combination	

Medical Equipment		
a. Laryngoscope handle with batteries		
b. Laryngoscope blades, adult, child and infant sizes		
c. Pediatric IV arm board or splint appropriate for IV stabilization		
d. Disposable endotracheal tubes; adult, child and infant sizes (Two each within the ranges 2.5mm – 5.0mm shall be uncuffed; range 5. mm – 7.0mm; 7.5mm – 9.0mm)		
e. Pediatric and adult endotracheal tube stylets.		
f. Pediatric and adult Magill forceps.		
g. Device for intratracheal meconium suctioning in newborns		
h. Tourniquets		
i. IV cannulae between 14 and 24 gauge		
j. Micro drip sets		
k. Macro drip sets		
l. IV pressure infuser		
m. Needles between 18 and 25 gauge		

MEDICAL EQUIPMENT (Cont.)		
n. Intraosseous needles 15 or 16 gauge and three way stop-cocks. As allowed by medical director.		
o. Syringes from 1 ml. To 20 ml.		
p. DC battery powered portable monitor defibrillator capable of delivering energy below 25 watts/sec with adult and pediatric paddles (or pediatric paddle adapters) and EKG printout and spare battery.		
q. Adult and pediatric monitoring electrodes.		
r. Pacing electrodes, if monitor or defibrillator requires.		
.		
s .Electronic waveform capnography capable of real-time Monitoring and printing record of the intubated patient		
t. Method of blood glucose monitoring approved by medical director.		
u. Pediatric length based measurement tape for equipment selection and drug dosage.		
v. Approved sharps container per Chapter 64J-1, F.A.C.		
w. Flexible suction catheters size 6-8, 10-12, and 14, French	One each	

Other ALS Requirements

1. Standing orders – authorized by current medical director within last 24 months	
2. Controlled substances stored in a locked drug compartment.	
3. Controlled substance written vehicle log:	
A. Inventory conducted at beginning and end of shift.	
B. Log consecutively, permanently numbered pages.	
C. Log on each vehicle specifies:	
1. Vehicle unit or number;	
2. Name of employee conducting inventory;	
3. Date and time of inventory;	
4. Name, weight, volume or quantity and expiration date of each controlled substance;	
5. Run report no. (if administered);	
6. Each amount administered or disposed;	
7. Printed name and signature of administering Paramedic or other authorized licensed professional.	
8. Printed name and signature of person witnessing the disposal of each unused portion.	

Comments:

I, the undersigned representative of the above service, acknowledge receipt of a copy of this inspection narrative, applicable supplemental inspection reports and corrective action statement (if applicable). In addition, I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies within the established time frames will subject the service and its authorized representatives to administrative action and penalties as outlined in Section 401, F.S., and Chapter 64J-1, F.A.C. Copy of Inspection report and Corrective Action Statement Received by:

Person in Charge: _____ **Date:** _____

Inspected By: _____ **Date:** _____

The provider's medical director may determine quantities. Quantities must be sufficient to meet the services protocols.

Section 14
Sworn Statement

Instructions
Complete the Declaration of Applicant form.

Declaration of Applicant

Under penalties of perjury, I _____ declare that I have examined this application and to the best of my knowledge and belief, that all the information herein is true, correct and complete. I am aware that, in accordance with law, all license applications are public records and subject to public disclosure, which includes this application and all other documents and information filed therewith, and further, that I understand that I am obligated to conform with, and am subject to, all rules and regulations of the Marion County Code of Ordinances. I acknowledge that the County reserves the right to inspect my workplace and/or vehicles for compliance with County or State requirements.

Signature: _____ **Printed Name:** Tom Hern

Date: November 5, 2025 **Company Name:** Arena horse shows of Ocala

State of Florida

County of Marion

Sworn to (or affirmed) and subscribed before me by means of ☐ **physical presence or** ☐ **online notarization, this** 18th **day of** DECEMBER, **20** 25, **by** TOM HERN.

Stamp/Seal:

TERRY G. CASLER
Notary Public - State of Florida

TERRY G. CASLER
Notary Public (Print Name)

_____
Signature of Notary Public

☒ **Personally Known**
OR

☐ **Produced Identification** **Type of Identification Produced:**

Section 15

Other

Instructions
If applicant has any additional information for the Board, insert after the Section 16 title page.

EMERGENCY MEDICAL SERVICES – ADVANCED LIFE SUPPPORT

(LEVEL III – ALS Non-Transport)

CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

WHEREAS, Arena Horse Shows of Ocala, LLC desires to provide quality emergency Advanced Life Support – Non-Transport medical services to the citizens of Marion County; and

WHEREAS, it has been demonstrated there is a need for this Advanced Life Support – Non-Transport service to operate in this County to provide essential services to the citizens of Marion County; and

WHEREAS, the above Arena Horse Shows of Ocala, LLC has indicated that it will comply with all requirements of the Florida Emergency and Non-Emergency Medical Services Act;

NOW, THEREFORE, the Board of County Commissioners of Marion County hereby issues a Certificate of Public Convenience and Necessity for Advanced Life Support – Non-Transport to Arena Horse Shows of Ocala, LLC. In issuing this Certificate, it is understood that the above-named Arena Horse Shows of Ocala, LLC will meet the requirements of Florida Statutes and applicable rules and regulations and provide Advanced Life Support – Non-Transport services as needed for the following area:

PRIMARY AREA: Arena Horse Shows of Ocala, LLC

SECONDARY AREA: Not Applicable

TERM: Six Years
07/01/2026 through 06/30/2032

ATTEST:

MARION COUNTY
BOARD OF COUNTY COMMISSIONERS

_____
Gregory C. Harrell, Clerk

BY:_____
Carl Zalak III, Chairman

DATED: _____

EMERGENCY MEDICAL SERVICES – ADVANCED LIFE SUPPPORT

(LEVEL IV – ALS Transport)

CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY

WHEREAS, Arena Horse Shows of Ocala, LLC. desires to provide quality emergency Advanced Life Support – Transport medical services to the citizens of Marion County; and

WHEREAS, it has been demonstrated there is a need for this Advanced Life Support – Transport service to operate in this County to provide essential services to the citizens of Marion County; and

WHEREAS, the above Arena Horse Shows of Ocala, LLC has indicated that it will comply with all requirements of the Florida Emergency and Non-Emergency Medical Services Act;

NOW, THEREFORE, the Board of County Commissioners of Marion County hereby issues a Certificate of Public Convenience and Necessity for Advanced Life Support – Transport to Arena Horse Shows of Ocala, LLC. In issuing this Certificate, it is understood that the above named Arena Horse Shows of Ocala, LLC will meet the requirements of Florida Statutes and applicable rules and regulations and provide Advanced Life Support – Transport services as needed for the following area:

PRIMARY AREA: Arena Horse Shows of Ocala, LLC

SECONDARY AREA: None

TERM: Six Years
07/01/2026 through 06/30/2032

ATTEST:

MARION COUNTY
BOARD OF COUNTY COMMISSIONERS

_____
Gregory C. Harrell, Clerk

BY:_____
Carl Zalak III, Chairman

DATED: _____

LEGAL REQUEST MEMORANDUM (LRM)

From: (Name) Kruger (Last) Robert (First) (Dept) Fire-Rescue - 3355

(Title) Deputy Chief (Phone) 352-671-8305

Signature [signature] Date Monday, June 29, 2026

The Office of the County Attorney is requested to provide legal assistance as detailed in this legal request and supporting documents (attached).

Request for: ☐ Draft Document ☑ Approve as to Form ☑ RESUBMIT LRM No. 2026-509
☐ Legal Opinion ☐ Other

Description of Request

Attached is the proposed Transport Restrictions to go along with the COPCN request for WEC. I apparently did not attached in the initial LRM. Please review and approve so we can send with the COPCN application and Board signature.

For more information or discussion, contact: ☑ Same as above

(Name) _____ (Last) _____ (First) (Title) _____ (Phone) _____

Agenda Item? ☑ Yes ☐ No Agenda Date: Tuesday, July 21, 2026

Agenda Deadline Date for **Legal:** Friday, June 26, 2026 Agenda Deadline Date for **Admin:** Thursday, July 9, 2026

Note: Please allow a MINIMUM of 5 working days BEFORE deadlines for LRM to be completed.

DO NOT COMPLETE - Office of the County Attorney use ONLY

LRM No. 2026-509R

Assigned to: ☐ Matthew Guy Minter, County Attorney ☐ Dana E. Olesky, Chief Asst. County Attorney ☐ Linda Blackburn Asst. County Attorney ☒ Thomas Schwartz Asst. County Attorney ☐ Valdoston Shealey Asst. County Attorne

Outcome: Date Received:

☑ Approved as to form and legal sufficiency

☐ Approved with revisions: ☐ Suggested ☐ Completed

☑ Other: Corrected Clerk's name

RECEIVED
By Marion County Attorney-WN at Jun 29, 2026

Attorney Signature: [signature] Date 6/29/26

Staff Signature: [signature] Completed Date: 6/29/26 Returned: ☑ Department ☐ Admin ☐ _____

Rev2 03/19/2025

CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY
ADVANCED LIFE SUPPORT- TRANSPORT (LEVEL IV)

ARENA HORSE SHOWS OF OCALA LLC

MODIFIED OPERATIONAL RESTRICTIONS

In accordance with the Certificate of Public Convenience and Necessity (COPCN) Advanced Life Support Transport (Level IV) approved on _____, Arena Horse Shows of Ocala LLC has indicated that it will comply with all requirements of the Florida Emergency and Non-Emergency Medical Services Act and the restrictions specified below as set for by the Marion County Board of County Commissioners.

In order to ensure that the current provider of ambulance service is not negatively impacted by approval of another ALS provider; the following restrictions are required to be placed upon the Arena Horse Shows of Ocala Level IV – ALS Transport COPCN as modified during the _____ Board of County Commissioners regularly scheduled meeting:

1. Arena Horse Shows of Ocala LLC shall neither respond to nor take patients from emergency calls for service to any facility, unless specifically requested by Marion County Fire Rescue, and shall not be considered an emergency services provider.
2. Arena Horse Shows of Ocala LLC shall not transport patients to any free-standing or hospital-based emergency care facility, unless the patient is suffering from a Life-Threatening condition.
3. Arena Horse Shows of Ocala LLC shall not transport patients between any free-standing emergency or urgent care facility and any hospital, unless specifically requested by Marion County Fire Rescue.
4. Arena Horse Shows of Ocala LLC will make available to the county administrator or designee records for all BLS transports upon request.
5. In the event of a state of emergency declared by the county administrator, state or federal officials, these restrictions may be suspended as requested by Marion County Fire Rescue.

Attest

By: _____
Gregory C. Harrell, Clerk

Approval as to form and legal sufficiency

_____
For: County Attorney

Marion County Board of County Commissioners, a political subdivision of the State of Florida

By:_____
Name: Carl Zalak III
Title: Chairman