

DDD Enterprises LLC dba Care Medical Transportation

Initial COPCN Application and Attachments

Submitted: 3/20/2026



**APPLICATION FOR A CERTIFICATE OF
PUBLIC CONVENIENCE AND NECESSITY
FOR ALS AND BLS SERVICES**

RECEIVED

DATE: 3/20/2024
INITIALS: 

DATE: 03/05/2026

PROPOSED DATE OPERATIONS WILL BEGIN: 05/01/2026

SECTION I

1. NAME OF SERVICE: DDD Enterprises LLC dba Care Medical Transportation

**2. NAME AND ADDRESS OF OWNER
(INCLUDE COUNTY):**

725 Grand St, Orlando FL 32805

**3. NAME AND ADDRESS OF OPERATOR
(IF DIFFERENT THAN ABOVE):**

6220 S Orange Blossom Trl, Ste 601

4. CONTACT INFORMATION:

BUSINESS PHONE 561-871-4791

MOBILE PHONE 561-871-4791

EMAIL care.medicaltransit@gmail.com

5. OWNERSHIP TYPE:☒ **PRIVATE CORPORATION**☐ **GOVERNMENT AGENCY**☐ **OTHER****6. LEVEL OF SERVICE REQUESTED (MAY REQUEST MULTIPLE):**☐ **BLS NON-TRANSPORT** (Level 2) ☒ **BLS TRANSPORT** (Level 3)

BLS Non-Transport - On-the-scene assistance to the patient requiring emergency medical care. Provider does not transport.

BLS Transport - Rendering BLS medical services and routine transport of patients. Rendering on scene assistance to patients prior to transport.

☐ **ALS NON-TRANSPORT** (Level 4) ☐ **ALS TRANSPORT** (Level 5)

ALS Non-Transport - Capability of rendering ALS services, but not routinely transporting patients.

ALS Transport - Rendering ALS medical services and routine transport of patients to a medical facility. Certified providers who respond to requests for transportation will respond with an ALS vehicle. Intended for governmental entities performing emergency first responder and pre-hospital services.

☐ **INTERFACILITY TRANSPORT (ALS AND BLS)** (Level 7)

Interfacility Transport (ALS and BLS) - Any publicly or privately-owned service which operates an ALS or BLS transport service to provide interfacility transport to and from health care facilities. These services must comply with F.S. ch. 401. Intended for private EMS providers.

☐ **PREHOSPITAL AIR AMBULANCE** (Level 6)

Prehospital Air Ambulance - Any publicly or privately owned service which operates rotary-winged aircraft in conjunction with the county's emergency medical services system.

7. CORPORATE OFFICERS, CONTROLLING SHAREHOLDERS, AND DIRECTORS:

NAME	ADDRESS	POSITION
Dony Dessam	725 Grand St, Orlando, FL 32805	CEO

8. DESCRIBE THE PROPOSED GEOGRAPHIC AREA OR AREAS TO BE COVERED BY YOUR SERVICE:☐ **CHECK IF SUBMITTED AS AN ATTACHMENT**

We intend to cover Orange County FL.

9. PROVIDE A STATEMENT DESCRIBING HOW THE PROPOSED SERVICE WILL BENEFIT THE POPULATION OF THE PROPOSED GEOGRAPHIC AREA TO BE SERVED:

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

Orange County Census data from 2020 states that our county is home for 1,471,416 residents. The 2025 projected population for Orange County is 1,511,258. The projection assumes an annual rate of change of 1.4% consistent with the population change from 2022 to 2023 according to the US Census Bureau's 2023 population Estimates Program. As our population increases, the demand for more services also increases. We need to continue to grow as well so we can continue to better serve our community.

On a second note, almost 3 out of 5 senior citizens depends on concentrated oxygen, Having the license to provide oxygen on board will greatly benefit those heroes who contribute to the buliding of our country and community.

10. PROVIDE A STATEMENT SHOWING HOW THE APPLICANT PLANS TO STAFF THE PROPOSED SERVICE (NUMBER AND TYPES OF UNITS, STATION LOCATION, ETC.):

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

We Plan to have a total of 4 units by May 2026. We use two types of vehicles. The minivan with rear entry like the Dodge Grand caravan and the Ford Transit 350.

All of our BLS units will be staffed with one paramedic or a nurse and one helper who will be fully trained for BLS transport. Those helpers will be required to hold the following certificates and take the following courses: Basic Life Support certificate, CPR/AED certificate, HIPPA certificate, Sexual Abuse and harassment course, Drug & Alcohol Course, Safe Driving Course and Abuse reporting and prevention course.

11. ATTACH A VEHICLE ROSTER WITH THE NUMBER OF VEHICLES IN OPERATION, MAKE, MODEL, MILEAGE, VIN, PERMIT NUMBER, AND REGISTRATION NUMBER OF EACH VEHICLE.

12. PROVIDE YOUR PROPOSED RESPONSE TIMES (IN MIN) FOR URGENT AND NON-URGENT CALLS. DESCRIBE HOW THE INTERVAL WILL BE CALCULATED AND WHY THIS BENCHMARK WAS CHOSEN:

Our proposed response time is between 5-15 minutes for urgent calls and 20-60 minutes for non-urgent calls.

Depending on where the patient is located in the county, it takes about 30 minutes to reach a pickup location.

It takes about 15 minutes to load the patient into the unit.

13. PROVIDE A DESCRIPTION OF YOUR COMPLAINT PROCESS FOR COMPLAINTS AND ACCIDENTS. INCLUDE A PROCESS FOR BOTH INTERNAL COMPLAINTS, FACILITIES, AND THE PUBLIC:

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Once a complaint or incident notice is received, the supervisor who receives the notice has a duty to investigate immediately. He or she must call the unit driver and request an explanation on what happened. The second step is to call the helper to have a second set explanation. The next step is to compare and contrast with the facts received, call the complainant to clarify on the findings. Then the supervisor will write a report with recommendation to the manager. The manager, then, has the responsibility to impose disciplinary actions appropriate to the gravity of the incident. Then follow up with the complainant and inform of disciplinary action that was taken.

14. PROVIDE A DESCRIPTION OF YOUR QUALITY ASSURANCE PLAN

☐

CHECK IF SUPPLIED AS AN ATTACHMENT

To ensure that we maintain the best quality as possible, every unit is obligated to fill out a daily unit check list and they have a protocol badge with numbered instructions and process that must be followed.

15. PLEASE SUPPLY A CURRENT FINANCIAL STATEMENT (Current letter from the bank verifying business account status and a balance sheet, Medicare audits, audited financial statements and verified lines of credit, etc.)

16. PROVIDE A STATEMENT SIGNED BY THE APPLICANT AND ITS MEDICAL DIRECTOR ATTESTING THAT ALL EMTs AND PARAMEDICS UTILIZED HAVE AND WILL MAINTAIN CURRENT STATE CERTIFICATION.

17. EMPLOYEE ROSTER (please attach extra sheets as needed):

NAME	CERTIFICATION LEVEL	CURRENT CPR CARD
Dony Dessam	BLS	A2103504
Scherrell Byron Augustin	BLS	A3339445
Samina Cherenfant	MD	ME172730

18. LIST THE ADDRESS AND DESCRIPTION OF EACH OF THE LOCATIONS YOU WILL OPERATE FROM. INCLUDE THE HOURS OF OPERATION AND STAFFING AT EACH PROPOSED LOCATION:

Unit 0087 will be station at 725 Grand St, Orlando, FL 32805 and managed by Scherrell Byron Augustin

Unit 0088 will be station at 13443 Old Dock Rd, Orlando, FL 32828 (East Orlando) and managed by Dony Dessam.

Our current hours of operation: Unit 0087 - 7am-4pm (M-F)
Unit 0088 - 1pm-8pm (M-F)

Our next units will work on weekends

19. COMMUNICATIONS EQUIPMENT:

☒ TELEPHONE

☐ RADIO

☐ OTHER

NUMBER OF VEHICLES EQUIPPED WITH RADIOS:

none

FREQUENCY(S):

N/A

NUMBER OF VEHICLES EQUIPPED WITH MOBILE PHONES:

2

20. APPROXIMATE DATE FCC LICENSE WILL BE EFFECTIVE (ATTACH IF CURRENT):

5/1/26

21. LIST ALL HOSPITALS, SUPERVISING PHYSICIANS, AND OTHER EMERGENCY AGENCIES (POLICE, FIRE, ETC.) THAT YOU WILL HAVE DIRECT RADIO CONTACT WITH:

At this time we are seeking a limited COPCN to operate interfacility BLS transport only.

22. PROVIDE EXECUTED COPIES OF ALL BUSINESS AGREEMENTS BETWEEN THE APPLICANT AND A HEALTH CARE FACILITY(S) OR GOVERNMENTAL ENTITY(S) LOCATED IN ORANGE COUNTY, FLORIDA FOR THE PROVISION OF BLS OR ALS SERVICES, WHICH MAY INCLUDE INTERFACILITY TRANSPORT.

23. IF THIS IS A MODIFICATION OF A CURRENT COPCN, EXPLAIN WHAT MODIFICATIONS ARE BEING REQUESTED.

No modification

24. PROVIDE CERTIFICATES OF INSURANCE IN ACCORDANCE WITH SECTION 20-96(e) OF THE ORANGE COUNTY CODE:

"PROOF OF INSURANCE, IN THE FOLLOWING AMOUNTS, MUST BE SUBMITTED TO THE COUNTY PRIOR TO ANY APPLICANT RECEIVING A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY, IN ORDER TO PROTECT THE PUBLIC FROM ANY PERSONAL INJURY OR PROPERTY DAMAGE ARISING OUT OF THE APPLICANT'S OPERATIONS:

COMMERCIAL LIABILITY WITH A LIMIT OF NOT LESS THAN ONE MILLION DOLLARS (\$1,000,000) PER OCCURRENCE. ORANGE COUNTY TO BE NAMED AS AN ADDITIONAL INSURED.

COMMERCIAL AUTOMOBILE LIABILITY WITH A LIMIT OF NOT LESS THAN ONE MILLION DOLLARS (\$1,000,000) PER OCCURRENCE OR COMBINED SINGLE LIMIT. PROFESSIONAL LIABILITY WITH A LIMIT OF NOT LESS THAN ONE MILLION DOLLARS (\$1,000,000) PER INCIDENT.

NON-GOVERNMENTAL PROVIDERS MUST NAME ORANGE COUNTY AS AN ADDITIONAL INSURED. NOTWITHSTANDING THE INSURANCE REQUIREMENTS CONTAINED IN THIS SECTION, GOVERNMENTAL ENTITIES SHALL PROVIDE A CERTIFICATE OF INSURANCE EVIDENCING ITS INSURANCE OR SELF-INSURANCE WITHIN THE LIMITS OF LIABILITY SET FORTH IN F.S. 768.28."

SECTION II**a. PROVIDE CURRENT STATE OF FLORIDA LICENSED AMBULANCE SERVICE**

NUMBER:

**b. PROVIDE THE FOLLOWING INFORMATION FOR YOUR MEDICAL DIRECTOR.
ADDITIONALLY, ATTACH PROOF OF EMPLOYMENT WITH YOUR AGENCY OR A
CONTRACT FOR SERVICE.**

NAME:

ADDRESS:

PHONE NUMBER:

FLORIDA MEDICAL LICENSE NUMBER:

c. DESCRIBE THE STAFFING PATTERNS FOR EMTS, DRIVERS, AND PARAMEDICS:

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

Before we hire drivers, and paramedics, they must show proof of their current state certification. They must pass a background check, take a safe driving course, and submit copies of the following:

1. BLS Certificate
2. CPR/AED Certificate
3. HIPAA Certificate
4. Sexual abuse and harassment completion certificate
5. Drug & Alcohol Course completion certificate
6. Elderly Abuse prevention and reporting Course Completion certificate

**d. PROVIDE A STATEMENT SIGNED BY THE AGENCY AND THE MEDICAL DIRECTOR
ATTESTING THAT ALL UTILIZED PARAMEDICS ARE CERTIFIED AND AUTHORIZED
BY THE MEDICAL DIRECTOR TO PERFORM ADVANCED LIFE SUPPORT IN THE
STATE OF FLORIDA**

- e. PROVIDE A LIST OF ALL EQUIPMENT AND MEDICATIONS CARRIED IN ADDITION TO THE MINIMUM EQUIPMENT SPECIFIED IN FLORIDA ADMINISTRATIVE CODE 64J-1.002-.003.**

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

- f. PROVIDE A PROPOSED SCHEDULE OF RATES, FARES, AND CHARGES**

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

Complete AED Defibrillator Package.

Electric Stretcher, Manual Wheelchair, Stair Climber Power Wheelchair, Fire Extinguisher, Emergency Glass Door smasher, Wheelchair Lift.

- g. PROVIDE INFORMATION ON YOUR MANAGEMENT AND MAINTENANCE PLAN**

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

Our management Team is composed of:

- a. Business Development Director
- b. Manager
- c. Field Supervisor

Every unit is inspected twice everyday. Before a unit is dispatched, the field supervisor must inspect the unit to ensure that all the equipment is safe and in good condition. He or she must check tire pressure, fluid level, air conditioning, and warning lights. Once a week, our mechanic checks for mechanical issues and conduct all necessary repairs.

REQUIRED SUPPLEMENTARY DOCUMENTATION:

- 1. LIST PREVIOUS BUSINESS EXPERIENCES OR WORK REFERENCES FOR THE LAST 5 YEARS. SUBMISSION OF AT LEAST ONE LETTER OF SUPPORT FROM THE LIST PROVIDED IS REQUIRED.**

NAME	ADDRESS	PHONE NUMBER	EMAIL
Realty Hub	7635 Ashley Park, Orlando FL	407-900-1001	brokeradmin@usrealtyhub.com
We Care 4 you; Inc	7902 SW 9TH st,North Lauderdale FL	754-422-0882	we.care.gives@gmail.com

- 2. LIST FIVE CREDIT REFERENCES, SUBMISSION OF A LETTER OF SUPPORT FROM ONE CREDIT REFERENCE LISTED BELOW IS REQUIRED.**

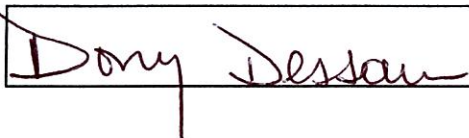
NAME	ADDRESS	PHONE NUMBER	EMAIL
Budget Handicap Vans LLC	7608 Coral Dr, West Melbourne, FL	615-674-3404	sasfed@gmail.com
Xprint LLC	6220 S Orange Blossom Trl, Orlando FL	321-353-0443	order@xprint.com
Quickbook	2700 Coast Ave, Mountain View, CA	877-683-3280	quickbook@sheets.com
M Care Transport LLC	7726 Winegard, Orlando, FL	689-318-2253	allxhubert103@yahoo.fr
A Pinch Of Love LLC	725 Grand st, Orlando, FL	407-538-4034	bscherrell@gmail.com

**APPLICATION FOR A CERTIFICATE OF PUBLIC CONVENIENCE AND
NECESSITY FOR ALS AND BLS SERVICES**

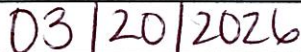
I, the undersigned representative of the service named in this application, do hereby attest that my service meets all the requirements for the operation of ALS or BLS (as applicable) service in Orange County and the State of Florida. I acknowledge that under Section 20-101 of the Orange County Code, certificates obtained by an application in which any material fact was intentionally omitted or falsely stated are subject to suspension or revocation. Should my application for a COPCN be granted, I agree to comply with all applicable state and county laws and regulations.

Under penalties of perjury, I declare that I have read the foregoing application and that the facts stated in it are true.

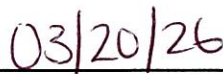
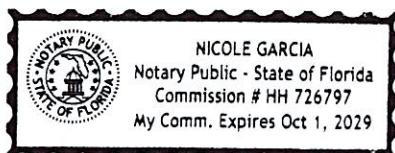
SIGNATURE OF APPLICANT OR REPRESENTATIVE



DATE



NOTARY SEAL



NOTARY SIGNATURE

DATE

DDD Enterprises LLC dba Care Medical Transportation

**Revised COPCN Application and Additional
Attachments**

Submitted: 3/26/2026



**APPLICATION FOR A CERTIFICATE OF
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19. COMMUNICATIONS EQUIPMENT:

☒ TELEPHONE

☐ RADIO

☐ OTHER

NUMBER OF VEHICLES EQUIPPED WITH RADIOS:

none

FREQUENCY(S):

N/A

NUMBER OF VEHICLES EQUIPPED WITH MOBILE PHONES:

3

20. APPROXIMATE DATE FCC LICENSE WILL BE EFFECTIVE (ATTACH IF CURRENT):

5/1/26

21. LIST ALL HOSPITALS, SUPERVISING PHYSICIANS, AND OTHER EMERGENCY AGENCIES (POLICE, FIRE, ETC.) THAT YOU WILL HAVE DIRECT RADIO CONTACT WITH:

At this time we will not have direct radio contact with hospitals, supervising physicians an other emergency agencies.

22. PROVIDE EXECUTED COPIES OF ALL BUSINESS AGREEMENTS BETWEEN THE APPLICANT AND A HEALTH CARE FACILITY(S) OR GOVERNMENTAL ENTITY(S) LOCATED IN ORANGE COUNTY, FLORIDA FOR THE PROVISION OF BLS OR ALS SERVICES, WHICH MAY INCLUDE INTERFACILITY TRANSPORT.

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SECTION II**a. PROVIDE CURRENT STATE OF FLORIDA LICENSED AMBULANCE SERVICE**

NUMBER:

b. PROVIDE THE FOLLOWING INFORMATION FOR YOUR MEDICAL DIRECTOR. ADDITIONALLY, ATTACH PROOF OF EMPLOYMENT WITH YOUR AGENCY OR A CONTRACT FOR SERVICE.

NAME:

ADDRESS:

PHONE NUMBER:

FLORIDA MEDICAL LICENSE NUMBER:

c. DESCRIBE THE STAFFING PATTERNS FOR EMTS, DRIVERS, AND PARAMEDICS:

☐ **CHECK IF SUPPLIED AS AN ATTACHMENT**

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☒ **CHECK IF SUPPLIED AS AN ATTACHMENT**

- f. PROVIDE A PROPOSED SCHEDULE OF RATES, FARES, AND CHARGES**

☒ **CHECK IF SUPPLIED AS AN ATTACHMENT**

- g. PROVIDE INFORMATION ON YOUR MANAGEMENT AND MAINTENANCE PLAN**

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- A. Business Development Director
- B. Manager
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We Care 4 you; Inc	7902 SW 9TH st, North Lauderdale FL	754-422-0882	we.care.gives@gmail.com
A Pinch of Love LLC	725 Grand St, Orlando FL	407-538-4034	bscherrell@gmail.com

- 2. LIST FIVE CREDIT REFERENCES, SUBMISSION OF A LETTER OF SUPPORT FROM ONE CREDIT REFERENCE LISTED BELOW IS REQUIRED.**

NAME	ADDRESS	PHONE NUMBER	EMAIL
Budget Handicap Vans LLC	7608 Coral Dr, West Melbourne, FL	615-674-3404	sasfed@gmail.com
Xprint LLC	6220 S Orange Blossom Trl, Orlando FL	321-353-0443	order@xprint.com
Quickbook	2700 Coast Ave, Mountain View, CA	877-683-3280	quickbook@sheets.com
M Care Transport LLC	7726 Winegard, Orlando, FL	689-318-2253	allxhubert103@yahoo.fr
A Pinch Of Love LLC	725 Grand st, Orlando, FL	407-538-4034	bscherrell@gmail.com

**APPLICATION FOR A CERTIFICATE OF PUBLIC CONVENIENCE AND
NECESSITY FOR ALS AND BLS SERVICES**

I, the undersigned representative of the service named in this application, do hereby attest that my service meets all the requirements for the operation of ALS or BLS (as applicable) service in Orange County and the State of Florida. I acknowledge that under Section 20-101 of the Orange County Code, certificates obtained by an application in which any material fact was intentionally omitted or falsely stated are subject to suspension or revocation. Should my application for a COPCN be granted, I agree to comply with all applicable state and county laws and regulations.

Under penalties of perjury, I declare that I have read the foregoing application and that the facts stated in it are true.

SIGNATURE OF APPLICANT OR REPRESENTATIVE

Dony Dossan

DATE

03/25/2026

NOTARY SEAL

Hemwantee Satnaraine

03/25/2026

NOTARY SIGNATURE

DATE

