



**RENEWAL PARATRANSIT SERVICES:**

**APPLICATION FOR LICENSE**

**RECEIVED**

DATE: 6/18/25  
INITIALS: [Signature]

APPLICATION DATE:

**SECTION I: GENERAL INFORMATION**

1. NAME OF SERVICE: MC SQUARED TRANSPORT
2. BUSINESS ADDRESS (INCLUDE COUNTY): 3259 DORNICH DRIVE  
MT ORA FL 32757
3. CONTACT INFORMATION: Name: MICHAEL COHEN  
Business Phone: 352-995-9595  
Mobile Phone: 786-261-9007  
Email: MC MCMBL@gmail.com
4. OWNERSHIP TYPE: ☒ PRIVATE CORPORATION ☐ GOVERNMENT AGENCY ☐ OTHER  
a. If other, please describe: \_\_\_\_\_
5. LEVEL OF SERVICE: ☒ WHEELCHAIR ☐ STRETCHER ☐ BOTH
6. PROOF OF CURRENT INSURANCE SUBMITTED TO EMS OFFICE:  
☒ YES, DATE: Expires 3/13/26 ☐ NO

**SECTION II: VEHICLES AND STAFFING**

1. NUMBER OF VEHICLES IN OPERATION: 8
2. EMPLOYEE ROSTER: ATTACHED

NAME

CURRENT CPR CARD (Y/N)

Provided to EMS Office

I, the undersigned representative of the service named in this application, do

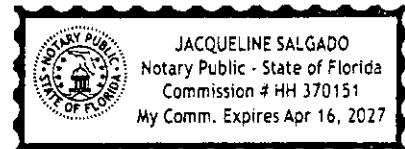
hereby attest the information provided in this application is truthful and honest to the best of my knowledge, and that my service meets all of the requirements for

operation of a paratransit services in Orange County and the State of Florida. I acknowledge that as provided in Orange County Code of Ordinances Chapter 20, Division 3, Section 20-137, licenses obtained by an application in which any material fact was intentionally omitted or falsely stated are subject to revocation.

[Signature]  
SIGNATURE OF APPLICANT OR REPRESENTATIVE

6/18/25  
DATE:

NOTARY SEAL  
Jacqueline Salgado  
NOTARY SIGNATURE



6/18/25