Washington Metropolitan Area Transit Commission

2013 Carrier Annual Report Form

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Washington Metropolitan Area Transit Commission

Read the accompanying instructions carefully before completing this form.

1. CARRIER INFORMATION:

*WMATC No.	*Name of Carrier (as shown on certificate of authority)
730	Americare Medical Transport, Inc.

*Street Address of Principal Place of Business	Apt./Suite	City	State	Zip
7600 Lindbergh Drive, #~~X~~ G		Gaithersburg	MD	20879-5407

Mailing Address (if different from street address)	Apt./Suite	City	State	Zip

*Telephone	Other Telephone	Fax	E-mail
(301) 330-6191		(301) 330-6192	batontsa@live.com

2. OTHER PASSENGER CARRIER AUTHORITY (if applicable, list carrier/permit number):

USDOT No.	DCTC No.	Virginia DMV passenger carrier No.	Maryland PSC No.

3. CARRIER CONTACT PERSON (at mailing address to whom we should direct inquiries):

*Name	*Title
Mr. Bertin E. Atontsa	Manager

*Telephone	Other Telephone	Fax	E-mail
(202) 423-3127	(240) 388-1670	(301) 330-6192	batontsa@live.com

4. REGISTERED AGENT INSIDE THE METROPOLITAN DISTRICT FOR SERVICE OF PROCESS

*Complete section 4 only if the principal place of business in section 1 is outside the Metropolitan District. The Metropolitan District includes the District of Columbia, Prince George's Co., Montgomery Co., Alexandria, Arlington, Fairfax, Falls Church, and Dulles Airport. For a full description, see www.wmatc.gov.

Name of Registered Agent for Service of Process	Telephone	E-mail

Agent Address (must be inside Metropolitan District)	Apt./Suite	City	State	Zip

5. ***CHANGES:** Describe any merger, consolidation or other change in management, ownership, control, or form of organization that occurred after the previous year's annual report was filed, or if not applicable, after the carrier's certificate of authority was issued. If no changes are entered below, the carrier certifies that no such changes have occurred.

6. ***LIST OF REVENUE VEHICLES USED IN WMATC OPERATIONS:** (1) list your vehicles below **or** (2) attach a complete vehicle list to both pages of this form. Include all required information.

Fleet No. If applicable	*Model Year	*Make	*Vehicle VIN (17 digits)	*License Plate Number	*State Registered	*Seating Capacity	Wheelchair Lift or Ramp Yes/No
1	2002	FORD	1FTNE24212HB81080	B44358	DC	9	Y
3	2006	FORD	1FTNS24L96HA33623	B44166	DC	7	Y
4	2004	FORD	1FTNE24WX4HB34593	B44361	DC	7	Y

7. ***CERTIFICATION:**

I certify that this report, including any attachments, was prepared by me or under my supervision, that I have examined it, and that the information contained in it is true, correct, and complete as of this date.

SERGE ATONTSA
***Name** (type or print)

MANAGER
***Title** (not required for sole proprietors)

***Signature**

01/31/2013
***Date**