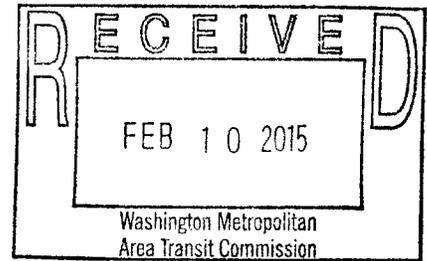


Washington Metropolitan Area Transit Commission

2015 Carrier Annual Report Form

Read the accompanying instructions carefully before completing this form.



1. CARRIER INFORMATION:

2067	Apex Medical Transportation Services LLC			
*WMATC No.		*Name of Carrier (as shown on certificate of authority)		
6401 Zinnia Court		Glenn Dale	MD	20769-9043
*Street Address of Principal Place of Business		Apt./Suite	City	State Zip
Mailing Address (if different from street address)		Apt./Suite	City	State Zip
(240) 425-2009			apextrans2013@gmail.com	
*Telephone	Other Telephone	Fax	E-mail	

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

USDOT No.	DCTC No.	Virginia DMV passenger carrier No.	Maryland PSC No.
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3. CARRIER CONTACT PERSON (at mailing address to whom we should direct inquiries):

Mr. Kolawole I Awoyemi	President		
*Name	*Title		
(301) 809-3947	apextrans2013@gmail.com		
*Telephone	Other Telephone	Fax	E-mail

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.

No Changes

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. If you have more than 10 vehicles in your fleet, you must use option 2. 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
		2007					
		2009					
2	2007	FORD	1FTSS34L07DA59237	54243B	MD	8	Y
4	2009	FORD	1FTDS34L69DA69086	57604B	MD	6	Y
5	2006	TOYOTA	5TDZA23C86S512106	54256B	MD	7	N
3	2006	TOYOTA	5TDZA23C76S539095	54249B	MD	6	N

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.

KOLANOLE AWOYEMI

 *Name (type or print)

PRESIDENT

 *Title (not required for sole proprietors)



 *Signature

2-10-15

 *Date