**DRAFT**

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| Dept. Use Only |
|  \_\_\_\_\_ Type | \_\_\_\_\_File # |

** DEPARTMENT OF HEALTH**

 **BUREAU OF EMERGENCY MEDICAL OVERSIGHT**

 **AIR/GROUND SERVICE PROVIDER PERMIT APPLICATION**

 Name of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMS ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **Reserve Vehicle or Aircraft** | **Permit #** | **Permit Type**(New, Renewal, Delete, Dual, Duplicate) | **ALS Ground Type** (Transport, Non-Transport) | **BLS Ground** | **Air Interfacility Type** (Fixed or Rotor-Wing) | **Air** **Pre-hospital** | **Year** | **Make** | **Model** | **Vehicle ID Number/ Tail#** | **Dept. Use Only** |
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Enclose Permit Fee. **DO NOT SEND CASH**. All company checks, cashier’s checks or money orders are to be made payable to Emergency Medical Services and mailed to 4052 Bald Cypress Way, Bin A-22, Tallahassee, Florida 32399. **All fees are nonrefundable,** per section 401.34(1), Florida Statutes.

**If applying for an air permit**: Attach a copy of the FAA Part 135 certificate (Parts A and D only). If the name of the certificate holder is not the applicant, include a letter of agreement or contract between the applicant and the Part 135 certificate holder for the aircraft listed on this application. Air permit applicants must also attach a copy of the air worthiness certificate for each aircraft listed.

*I, the undersigned, a representative of the above service, do hereby affirm that my service meets all of the statutory and rule requirements for operation of an ambulance service in the state of Florida, including, but not limited to, those provided in Chapters 395 and 401, Florida Statutes, and Florida Administrative Code Chapter 64J-1. I understand that my service must be fully operational within 30 days of licensure and that my service will be inspected by the Department of Health within 90 days of licensure. I further affirm that any violations will subject this service and its authorized representative to actions and penalties as provided by law.*

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Signature Date

STATE OF FLORIDA

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_

Sworn to (or affirmed) and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_

by, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Notary Public Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Notary Public Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personally Known \_\_\_\_\_\_\_\_\_or Produced Identification\_\_\_\_\_\_\_\_

Type of Identification Produced: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_