

STATE OF FLORIDA
DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES
APPLICATION FOR VEHICLE PERMIT(S)

EMS Provider _____ Provider # _____

Business Address _____

City _____ State _____ Zip Code _____ County _____

PERMIT TYPE

VEHICLE DATA

	DUPLICATE	NEW	CURRENT PERMIT #	ALS		BLS	YEAR	MAKE	MODEL	V.I.N.
				TRANS	NON-TRANS	TRANS				
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Enclose Permit Fee(s). **Do not send cash.** Checks should be made payable to Emergency Medical Services and mailed to 4052 Bald Cypress Way, Bin C-30, Tallahassee, Florida 32399-1738. **All fees are nonrefundable** §401.34(1), Florida Statute, (F.S.).

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S., and Rule 64J-1, Florida Administrative Code (F.A.C.), are present and in working order on the above described vehicles. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicles will be staffed, during operation, in accordance with Chapters 395 and 401, F.S., and Chapter 64J-1, F.A.C.

SIGNATURE

TITLE

DATE

FALSE OFFICIAL STATEMENTS: § 837.06, F.S.: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.