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

EMS Provider _____ Provider #_____

Business Address _____

City _____ State _____ Zip Code _____ County _____

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

Enclose Permit Fee. **Please 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) Fla. Stat.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, Fla. Stat., and Chapter 64J-1, Fla. Admin. Code, 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, Fla. Stat., and Chapter 64J-1, Fla. Admin. Code.

SIGNATURE TITLE DATE

FALSE OFFICIAL STATEMENTS: § 837.06, Fla. Stat.: 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.

DH Form 1510, May 1998