

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

EMS Provider _____ Provider # _____

Business Address _____

City _____ State _____ Zip Code _____ County _____

	FL REGISTRATION NUMBER	MAKE	MODEL	CAPACITY	MOTOR SIZE	LENGTH
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

SIGNATURE _____

TITLE _____

DATE _____