



SOUTHERN NEVADA HEALTH DISTRICT
APPLICATION FOR RENEWAL OF AMBULANCE PERMIT

(INSTRUCTIONS: This application must be filled out in total and either delivered to the EMS office at the Southern Nevada Health District, 625 Shadow Lane, Las Vegas, NV 89106, or mailed to P.O. Box 3902, Las Vegas, NV 89127. Please print in black ink or use typewriter.)

(APPLICANT: Leave this space blank)
Date Received Investigated by Inspected by
Fee Receipt No. Permit No. Date Application Received
Deny Variance Granted

1. Name of Applicant Phone No.
Last First Middle
Address Street Suite City State Zip

2. Name of Corporation, Partnership or Department:

3. Trade Name or Fictitious Name of Service or Volunteer Service (if applicable):

4. Resident Managing Agent of Service or Volunteer Service (if other than applicant):

5. Name, Address, Title and Percent Ownership of Officers, Partners, Directors, Managing Agents and other Owners (if the applicant is a corporation or partnership of any type):
a. %
b. %
c. %
d. %

6. If the Applicant is a corporation or partnership, the business interest of the persons listed above other than that of the ambulance service in question:
a. %
b. %
c. %
d. %

7. Registered Owner of Ambulance Units (if other than Applicant): _____

8. Legal Owner of Ambulance Units (if other than Applicant): _____

9. Type of Permit:

- Commercial Ground Ambulance Service
- Commercial Air Ambulance Service
- Helicopter Fixed Wing
- Firefighting Agency Special Purpose
- Provisional

10. Insurance Carrier and Amount: _____

11. Address and Description of Main Location of Ambulance Service: _____

12. Address of all Substations:

- a. _____

- b. _____

- c. _____

- d. _____

- e. _____

- f. _____

12. (Continued)

- g. _____

- h. _____

- i. _____

- j. _____

- k. _____

13. Number of Red Light and Siren Permits as issued to you by the Nevada Highway Patrol: _____

14. Address and Description of Radio Relay Station Locations:

- a. _____

- b. _____

- c. _____

15. Describe all Units Applicant has in service (continue on next page if necessary):

	1	2	3	4	5
Make					
Model / Type					
Year					
VIN / Serial No.					
Unit No.					
Colors					
Name / Insignia / Monogram					
No. of Litter Spaces					
License Plate					

Complete the following for Air Ambulances only:

FAA No.					
Specify: Fixed / Rotary Wing					

15. (Continued):

	6	7	8	9	10
Make					
Model / Type					
Year					
VIN / Serial No.					
Unit No.					
Colors					
Name / Insignia / Monogram					
No. of Litter Spaces					
License Plate					

Complete the following for Air Ambulances only:

FAA No.					
Specify: Fixed / Rotary Wing					

16. A schedule of rates charged for transport must accompany this application.
17. An invoice for the fee in the amount of \$75 + \$20/unit will be mailed to your agency.
18. I hereby certify that all Ground Attendants, Air Attendants, or Trainee Attendants of this Applicant Service are licensed in the appropriate category by the Southern Nevada Health District on behalf of the Nevada Health Division. I further certify that I have received, read, and understand the regulations of the Southern Nevada Health District and will fully comply with all sections included herein.

I further certify that all ground ambulances meet the most current standards established by the U.S. Department of Transportation.

I further certify that all statements made in this application are true and complete, and I understand that any misrepresentation or omission made in this Application may result in the denial, suspension, or revocation of a Permit for operation of the said Applicant Service in Clark County, Nevada.

Printed Name: _____ Date: _____

Signature: _____ Title: _____