



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
- Rotor Wing 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 Lights and Sirens 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 / Rotor 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 / Rotor Wing					

16. A schedule of rates charged for transport must accompany this application.
17. A Personal Information Request Form (back page) completed by the agency's medical director must accompany this application.
18. An invoice for the fee in the amount of \$75 + \$20/unit will be mailed to your agency.
19. 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 hereby certify that the business license and status as a corporation, partnership or sole proprietor is current.

I further certify that each ground ambulance has been inspected by a professional mechanic who has found it to be in safe operating condition. I further certify that each ground ambulance meets 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: _____



EMERGENCY MEDICAL SERVICES MEDICAL DIRECTOR
PERSONAL INFORMATION REQUEST FORM
(EMS Regulations Section 850)

Name: _____

Mailing Address: _____
Street City State Zip

Phone: Home () Cell () Email: _____

1. Are you a Nevada licensed physician in good standing? Yes No
2. Are you Board Certified in Emergency Medicine by either American Board of Medical Specialties or Bureau of Osteopathic Specialists? Yes No
3. If "No" to question 2, list the specialty(s): _____
4. Have you completed an EMS Medical Director program? Yes No
If "Yes," Name of Program(s): _____
5. Currently employed by which permitted agency(s): _____

Please attach your Curriculum Vitae, along with current evidence of training in:

Healthcare provider CPR

Life support procedures for patients who require cardiac care, e.g. ACLS

Life support procedures for pediatric patients who require ALS care, e.g. PALS, APLS, PEPP

Life support procedures for patients with trauma that are administered before arrival of those patients at a hospital, e.g. PHTLS, ATLS, BTLS, ITLS

Signature: _____ Date: _____