SOUTHERN NEVADA HEALTH DISTRICT
APPLICATION FOR INITIAL AMBULANCE PERMIT

(INSTRUCTIONS: This application must be filled out in total and either delivered to the EMS office at the Southern Nevada Health District, 330 S. Valley View Blvd., Las Vegas, NV 89107, or mailed to P.O. Box 3902, Las Vegas, NV 89127. Please print in black ink or use a 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
- ☐ Rotorwing ☐ Fixed Wing
- ☐ Firefighting Agency ☐ Special Purpose
- ☐ Provisional ☐ CCT

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. Radio system(s) used to contact the receiving facilities:

a. _____

_____

b. _____

_____

c. _____

_____

15. Describe all Units (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. Has the Applicant ever been issued a Permit for Ambulance or Air Ambulance Service in any other state or jurisdiction? ☐ Yes ☐ No

17. Has the Applicant ever had a Permit for Ambulance or Air Ambulance Service revoked or suspended in any other state or jurisdiction? ☐ Yes ☐ No

    If yes, provide explanation: _____

    _____

    _____

18. A fee in the appropriate amount as prescribed by the District Board of Health must accompany this application. If you have an account set up with us, we will bill you.

19. A Personal Information Request Form (back page) completed by the agency's medical director must accompany this application.

20. Two complete sets of fingerprints for each Applicant must accompany this application. If the Applicant is a corporation, partnership or sole proprietor, two sets of fingerprints for each person named under Item 5 must be provided.

21. A schedule of rates charged for transport must accompany this application.

22. A copy of CCT protocols and Paramedicine protocols, if applicable.

23. I hereby certify that all Ground Attendants, Air Attendants, or Provisional 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 each air/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: _____

Note: Applicant must be a Board Certified (by either American Board of Medical Specialties or Bureau of Osteopathic Specialists) Nevada licensed physician in good standing.

1. Are you Board Certified in Emergency Medicine? ☐ Yes ☐ No
2. If "No" to question 2, list the specialty(s): _____
3. Have you completed a NAEMSP National EMS Directors Course and Practicum® or equivalent? ☐ Yes ☐ No

   If "Yes," Name of Program(s): _____
4. Currently employed by which permitted agency(s): _____

   _____

If not Board Certified in Emergency Medicine, 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: _____