CITY OF FORT WORTH, TEXAS

APPLICATION FOR PRIVATE AMBULANCE SERVICE PERMIT

☐ NEW

☐ RENEWAL

Application Date: ____

Texas Department of State Health Services Company License Number: _________________________

Name of Applicant: ____

Ambulance Service Full Name: ____

Address: ____

City, State: ____ Zip Code: ______________________

Owners Name: ____

Address: ____

Telephone: ________________ Fax #: ______________ E-mail: ________________________

Partners, If Partnership: ____

Officers, If Corporation: ____

Level of Care to be Provided: __________BLS ________ALS ________MICU

- Are all ambulances equipped with the equipment required by the Rules and Regulations of the Texas Department of State Health Services, pursuant to Title 25, Chapter 157 of the Texas Administrative Code? Yes _____ No _____

Vehicle Liability Insurance Provider: ____

Policy # ____________________ Agent: _____________________ Phone #:_______________

Insurance Company Address: ____

City: ________________________ State:__________ Zip: __________

MEDICAL DIRECTION CONTACT

Medical Director _________________________________Medical License #___________________

Telephone: _________________ Fax #: _______________ E-mail:__________________________

OPERATIONS DIRECTOR CONTACT

Director of Operations or Agent responsible for the local operation of the Ambulance Service

Name ___________________________________ Phone # _____________________________

Texas DL #_________________________ Ambulance Service DEA # _______________________

Has the company had any claims or judgments against the owners, managing personnel, or employees for damages resulting from negligent operation of an ambulance or any other vehicle within the last (5) years? Yes _____ No _____

If yes, please provide a detailed description of any claims or judgments and attach any additional documents as necessary.

Has the company had any revocation or suspension of their private ambulance service license held by the applicant or business before the date of this filing? Yes __________ No __________ If yes, please provide a detailed description of the revocation or suspension. Attach additional documents as necessary.

Has the company had any Texas Department of State Health Services Violations within the last (5) years? Yes __________ No __________ If yes, please provide a detailed description of the violation. Attach any additional documents as necessary.

Are you interested in being added to the City of Fort Worth disaster planning response matrix?

Yes ________________ No __________________

Applicant must provide copies of the following with application:

- Copy of (TDSHS) Texas Department of State Health Services Provider License
- Copy of Vehicle Insurance
- Copy of the written statement from the Insurance Agent

Statement of Attestation:

I hereby attest that I am authorized to make application on behalf of the applicant. The organization is in good standing with all local, state, and federal authorities and/or currently not under investigation for issues relevant to this application. I hereby agree with all of the IFT Provider Permit Conditions as contained in the IFT Permitting Policy. In addition, I have no knowledge of issues with this applicant that should be disclosed to prevent scrutiny to the City of Fort Worth for entering into such agreement. I declare that the above statement is true and accurate to the best of my knowledge.

Name Printed____

Signature____ Date: _____________________

For Office use only – Do not write below

Date Fort Worth Fire Department received application: ______________________________

Application Reviewed by: ________________________________ Date: __________________

Recommendation/Reason:

Approved: _____________ Denied:______________ Date:__________________

Fire Chief Signature:____ Date:__________________