CITY OF KELLER, 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: _____

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Medical Director _____Medical License #_____

Telephone: _____ Fax #: _____ E-mail:_____

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.

_____

_____

_____

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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.

_____

_____

_____

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

For Office use only – Do not write below this box

Date Keller Fire Department Received: _____

Application Reviewed by: _____ Date: _____

Approved: _____ Denied: _____ Date: _____

Fire Chief Signature: _____ Date: _____

City Manager Signature: _____ Date: _____

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	Make	Model	Year	VIN #	Registration	TDSHS License #	Year In-Service	Color Scheme, Insignia, Monograms, Pictures
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								