



Ambulance Franchise Application

Environmental Health Division

Wichita Falls-Wichita County Public Health District

Site No. _____
 Date Received _____
 For Office Use Only

1700 Third St. | Wichita Falls, TX 76301 | 940-761-7800 | www.health.wichitafallstx.gov

Name of Establishment/Trade Name: _____ Establishment Phone:(_____) _____

Establishment Primary Address: _____ City/State/Zip: _____
(Attach Photocopy of the State Provider License for this Facility)

Establishment Secondary Address (if applicable): _____ City/State/Zip: _____
(Attach Photocopy of the State Provider License for this Facility)

Mailing Address: _____ City/State/Zip: _____

Billing Name: _____ Billing Phone: (_____) _____

Billing Address: _____ City/State/Zip: _____

Type of Ownership: Sole Proprietor Partnership Corporate Other _____

All Company Owners, Partners, or Corporate Officers (attach additional sheets if necessary)			
Name: _____	Date of Birth: _____	Phone:(_____) _____	
Address: _____		City/State/Zip: _____	
Email Address: _____			
Name: _____	Date of Birth: _____	Phone:(_____) _____	
Address: _____		City/State/Zip: _____	
Email Address: _____			
Name: _____	Date of Birth: _____	Phone:(_____) _____	
Address: _____		City/State/Zip: _____	
Email Address: _____			
Name: _____	Date of Birth: _____	Phone:(_____) _____	
Address: _____		City/State/Zip: _____	
Email Address: _____			

Attach a compiled financial statement with note disclosure from a certified public accountant
Attach a description of any past business experience of the applicant, particularly from any municipality in providing emergency medical services; and the identification and description of any franchise, including any revocation or suspension thereof, held by the applicant

Ambulance Information (attach additional sheet if necessary)					
Model Year	Make/Model	Size	VIN	State License Plate	Exterior Color

Attach a photocopy of the automobile liability insurance for each ambulance and proof that it complies with the Wichita Falls Code of Ordinances
Attach a photocopy of the valid State Vehicle Authorization License for each ambulance used in Wichita Falls
Attach a photocopy of all other State of Texas required insurance



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1700 Third Street, Wichita Falls, TX 76301 | Phone (940)761-7820 | Fax (940)761-7645

Ambulance Attendants <i>(attach additional sheet if necessary)</i>		
Name	Driver's License Number	Address

Attach a photocopy of current Driver's License for each ambulance driver
Attach a photocopy of state licenses for EMT-B, EMT-I, EMT-P, or any other State of Texas approved certifications

Fees

\$500 Ambulance Franchise Applicant Fee
\$100 Ambulance Permit x _____ Number of Ambulances

No City Permit shall be transferred or assigned from any person or company to another

Total Permit Fees

\$

I certify that the information submitted on this and any attached forms is true and correct. I further certify that I will comply with all applicable provisions of the Wichita Falls Code of Ordinances and laws of the State of Texas.

Signature of Owner, Partner, Officer or Authorized Agent

Printed Name of Owner, Partner, Officer or Authorized Agent

Title

Date