Ambulance New Vehicle App

Environmental Health Division

Wichita Falls-Wichita County Public Health District

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

Site No._____

Date Received_____

For Office Use Only

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

Establishment Primary Address:_____City/State/Zip:_____

Establishment Secondary Address (if applicable):_____City/State/Zip:_____

Mailing Address:_____City/State/Zip:_____

Billing Name:_____ Billing Phone: (_____)_____

Billing Address: _____City/State/Zip:_____

Type of Ownership: ☐ Sole Proprietor ☐ Partnership ☐ Corporate ☐ Other _____

New 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

Retired Ambulance Information ***(attach additional sheet if necessary)***

Model Year	Make/Model	Size	VIN	State License Plate	Exterior Color

Fees

$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