

**CITY OF VICTORIA**

**APPLICATION FOR AMBULANCE TRANSFER SERVICE PERMIT**

City of Victoria Code, Chapter 23

**DATE:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

**BUSINESS NAME:** \_\_\_\_\_

**BUSINESS ADDRESS:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**OWNER(S):** \_\_\_\_\_

**HOME ADDRESS(ES):** \_\_\_\_\_

\_\_\_\_\_

**PARTNERS, IF PARTNERSHIP:** \_\_\_\_\_

**HOME ADDRESSES:** \_\_\_\_\_

\_\_\_\_\_

**OFFICERS, IF CORPORATION:** \_\_\_\_\_

**HOME ADDRESSES:** \_\_\_\_\_

\_\_\_\_\_

**Has any Owner, if Sole Proprietorship, any Partner, if Partnership, or Director, if Corporation, been convicted of a felony or a misdemeanor other than traffic offenses within the past ten (10) years.**

**YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, give the name of the person, when, where and under what circumstances the offense occurred:** \_\_\_\_\_

\_\_\_\_\_

**Does Owner, Partner, or Officer now hold, or has he previously held a permit for the operation of an Ambulance Service from any other Government Agency or Department, or is he now engaged, or has he been engaged anywhere else in the business of providing Ambulance Service.**

**YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, give details:** \_\_\_\_\_

\_\_\_\_\_

**Has Applicant been issued a permit by the TEXAS DEPARTMENT OF HEALTH for each Ambulance which the Applicant proposes to operate. YES \_\_\_\_\_ NO \_\_\_\_\_**



**DESCRIPTION OF AMBULANCE TRANSFER VEHICLES**

**MAKE:** \_\_\_\_\_ **MODEL:** \_\_\_\_\_

**MOTOR AND CHASSIS NUMBER:** \_\_\_\_\_

**YEAR OF MANUFACTURE:** \_\_\_\_\_ **CURRENT STATE LICENSE NO.** \_\_\_\_\_

**REGISTERED OWNER:** \_\_\_\_\_

**COLOR SCHEME TO BE USED ON AMBULANCE:** \_\_\_\_\_

**MAKE:** \_\_\_\_\_ **MODEL:** \_\_\_\_\_

**MOTOR AND CHASSIS NUMBER:** \_\_\_\_\_

**YEAR OF MANUFACTURE:** \_\_\_\_\_ **CURRENT STATE LICENSE NO.** \_\_\_\_\_

**REGISTERED OWNER:** \_\_\_\_\_

**COLOR SCHEME TO BE USED ON AMBULANCE:** \_\_\_\_\_

**MAKE:** \_\_\_\_\_ **MODEL:** \_\_\_\_\_

**MOTOR AND CHASSIS NUMBER:** \_\_\_\_\_

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**MAKE:** \_\_\_\_\_ **MODEL:** \_\_\_\_\_

**MOTOR AND CHASSIS NUMBER:** \_\_\_\_\_

**YEAR OF MANUFACTURE:** \_\_\_\_\_ **CURRENT STATE LICENSE NO.** \_\_\_\_\_

**REGISTERED OWNER:** \_\_\_\_\_

**COLOR SCHEME TO BE USED ON AMBULANCE:** \_\_\_\_\_

## **SCHEDULE OF RATES**

**(Describe maximum rates to be charged for services)**

## **STATEMENTS BY APPLICANT**

**I certify that all Ambulance Transfer Vehicles for which permits are being requested comply with the requirements of Section 23-97 of the Victoria Code of Ordinances.**

**I certify that none of my Drivers or Attendants have been convicted within the last FIVE (5) years of any FELONY, CRIME of MORAL TURPITUDE or a crime involving a CONTROLLED SUBSTANCE or ALCOHOL related offense.**

**I agree, as a condition for the issuance of a permit, that I will abide by all provisions of Chapter 23 of the City of Victoria Code of Ordinance and that the granting of a permit does not create any property right, but authorizes me to operate an Ambulance Transfer Vehicle(s) upon the public streets of the City of Victoria. I agree to defend, hold harmless, and unconditionally indemnify the City, its Officers, Agents and Employees against, and for all liability, cost, expenses, damages and claims which the City may at any time suffer or sustain or become liable for by reason of any accidents, damages or injuries either to persons or property or both, arising out of the operation of my Medical Transfer Service.**

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**Signature of Owner**

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**FOR OFFICE USE ONLY**

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**CITY SECRETARY'S OFFICE CHECK LIST**

**ATTACHED:**

- 1. License Receipt YES \_\_\_\_\_ NO \_\_\_\_\_
- 2. Certificate of Insurance naming City as Additional Insured YES \_\_\_\_\_ NO \_\_\_\_\_
- 3. Application fee of \$150.00 YES \_\_\_\_\_ NO \_\_\_\_\_
- 4. Permit fee of \$35.00 per vehicle YES \_\_\_\_\_ NO \_\_\_\_\_
- 5. State EMS Provider License YES \_\_\_\_\_ NO \_\_\_\_\_

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**APPROVED BY CITY COUNCIL AFTER PUBLIC HEARING:**

YES \_\_\_\_\_ NO \_\_\_\_\_

Approved for \_\_\_\_\_ permits for a ONE year period beginning \_\_\_\_\_ and ending \_\_\_\_\_.

Date: \_\_\_\_\_

\_\_\_\_\_  
City Secretary

**CITY OF VICTORIA, TEXAS**

**MEDICAL TRANSFER SERVICE PERMIT**

This will certify that \_\_\_\_\_  
located at \_\_\_\_\_  
has complied with the MEDICAL TRANSFER SERVICE ORDINANCE of the City of Victoria,  
and is authorized to provide transfer medical services.

Vehicles(s) authorized to be operated pursuant to this permit:

Make	Model	License Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorized drivers and attendants:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
City Secretary, City of Victoria, Texas