STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
EMERGENCY MEDICAL SERVICE
ADVANCED LIFE SUPPORT
SERVICE APPLICATION

TYPE OF APPLICATION: New___ Renewal X (check one)
Transport X Non-Transport___ (check One)

1. Name of ALS Service NASSAU COUNTY EMS Date 11/08/90
Mailing Address 11 N. 14TH STREET, BOX 12 City FERNANDINA BEACH
County NASSAU Zip Code 32034
1 Business Phone Number (904) 261-5962
Type of Ownership (i.e., Private, City, County, Volunteer, Etc.)
COUNTY

2. Manager's Name PENNY RAU, INTERIM DIRECTOR

3. Medical Director: Name DR. FARID, ULLAH, M.D.
Mailing Address 1750 EAST LIME ST, UNIT 4 City FERNANDINA BEACH
Florida License Number ME0018615 Zip Code 32034

4. Provide name of Owner(s) or list all Officers, Directors and Share holders (if a corporation).

NAME	ADDRESS	POSITION

5. List the Address and/or describe the location of your base station and all substations (attach seperate sheet if needed).
DEPARTMENT OF EMERGENCY SERVICES, 11 NORTH 14TH ST., BOX 12, FERNANDINA BEACH, FL. 32034
RESCUE 21, 1690 LIME STREET, FERNANDINA BEACH, FLORIDA 32034
RESCUE 22, 5610 FIRST COAST HIGHWAY, FERNANDINA BEACH, FLORIDA 32034
RESCUE 23, RT. 3, BOX 370, YULEE, FLORIDA 32097

6. Describe the geographic area to be served by your service; if more than one county.

COMMUNICATIONS

7. Radio Frequency(s) SEE ATTACHMENT
Radio Call Number(s) SEE ATTACHMENT

8. Please list all hospitals with which you have direct radio communications. (Attach separate sheet if needed).

FROM ALS VEHICLE	FROM YOUR BASE STATION
NASSAU GENERAL HOSPITAL	NASSAU GENERAL HOSPITAL
UNIVERSITY HOSPITAL - JACKSONVILLE, FL.	

9. Does your communications system provide biotelemetry capability between your paramedics and supervising physician(s)? Yes___ NoXX

If no, you must include a letter from the Medical Director authorizing this exemption.

10. Attach the following:

ATTACHMENT #1 Description of the staffing patterns to assure compliance with staffing requirement set forth in Section 10D-66, F.A.C. submit a personnel roster of EMTs and Paramedics (HRS Form 631D).

ATTACHMENT #2 Certificate of Public Convenience and Necessity (For each county in which you maintain a service location).

ATTACHMENT #3 Verification of Medical Director employment, (i.e., contract, letter of agreement, etc.).

ATTACHMENT #4 Vehicle Roster (HRS Form 631C).

ATTACHMENT #5 Vehicle Permit Applications.

ATTACHMENT #6 Insurance verification (by copy of policy) - limits of coverage must be shown on policy. Must be current

I hereby certify that this service will provide continuous service on a 24-hour, 7-day week basis.

I, the undersigned representative of the above service, do hereby attest my service meets all of the requirements for operation of an ambulance service in the state as provided in Chapter 401, Part III, Florida Statutes and Chapter 10D-66, Florida Administrative Code. I further acknowledge any discrepancies discovered by the inspection will subject this Service and it's authorized representatives to corrective action and penalty provided in the act and applicable Rule. To the best of my knowledge, all statements on this application are true and correct.

Signature

Chairman

Position

Notary Seal

5. RESCUE 24, RT. 3, BOX 332, HILLIARD, FLORIDA 32046
RESCUE 25, 460 SOUTH BOOTH STREET, CALLAHAN, FLORIDA 32011

8. FROM ALS VEHICLE
METHODIST HOSPITAL, JACKSONVILLE FLORIDA
BAPTIST MEDICAL CENTER, JACKSONVILLE, FLORIDA
RIVERSIDE HOSPITAL, JACKSONVILLE, FLORIDA
ST. VICENTS, JACKSONVILLE, FLORIDA
CHARLTON MEMORIAL HOSPITAL, FOLKSTON, GEORGIA
MEMORIAL MEDICAL CENTER, JACKSONVILLE, FLORIDA
JACKSONVILE MEDICAL CENTER, JACKSONVILLE, FLORIDA
ST. LUKE'S HOSPITAL, JJACSKONVILLE, FLORIDA
HUMANA HOSPITAL, ORANGE PARK, FLORIDA
NAVAL AIR STATION, ROOSEVELT BLVD., JACKSONVILLE, FLA.
BEACHES BAPTIST HOSPITAL, JACKSONVILLE, FLORIDA
GILMAN'S HOSPITAL, ST. MARY'S, GEORGIA

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
APPLICATION FOR VEHICLE PERMIT

NAME OF FIRM NASSAU COUNTY EMS

BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. _____ New b. X Renewal
   c. _____ Replacement - replaces old vehicle described as:

MAKE	YEAR	V.I.N.

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS _____
   _____ Non-Transport

3. VEHICLE DATA:
   Make CHEVY Model C-30 Mileage 88562.9
   Year 1984 Florida Tag # 80854
   Current Vehicle Permit Number (ALS) 3647 or, (BLS) _____
   V.I.N. 1CBJC34WXEV137294

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — CHAIRMAN
Name (Printed) — Position

Jimmy L. Higginbotham — 11-19-90
Signature — Date

FALSE OFFICIAL STATEMENTS: 837.06 F.S.: Whoever, knowlingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be quilty of a misdemeanor of the second degree.

HRS Form 1510, May 88 (Replaces previous edition)

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
APPLICATION FOR VEHICLE PERMIT

NAME OF FIRM NASSAU COUNTY EMS

BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. _____ New b. X Renewal
   c. _____ Replacement - replaces old vehicle described as:

   MAKE _____ YEAR _____ V.I.N. _____

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS _____
   _____ Non-Transport

3. VEHICLE DATA:
   Make CHEVROLET Model C -30 Mileage 103934.3
   Year 1984 Florida Tag # 003651
   Current Vehicle Permit Number (ALS) (1703) 003651 or, (BLS) _____
   V.I.N. 1GBJC34W4EV121835

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — CHAIRMAN
Name (Printed) — Position

Jimmy L Higginbotham — 11-19-90
Signature — Date

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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
APPLICATION FOR VEHICLE PERMIT

NAME OF FIRM NASSAU COUNTY EMS

BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. ____ New b. X Renewal
   c. ____ Replacement - replaces old vehicle described as:

   MAKE ____ YEAR ____ V.I.N. ____

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS ____
   ____ Non-Transport

3. VEHICLE DATA:
   Make FORD Model XL350 Mileage 54388.8
   Year 1987 Florida Tag # 63441
   Current Vehicle Permit Number (ALS) 003648 or, (BLS) ____
   V.I.N. 1FDK37L8HNA80201

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — CHAIRMAN
Name (Printed) — Position

Jimmy L Higginbotham — 11-19-90
Signature — Date

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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
APPLICATION FOR VEHICLE PERMIT

NAME OF FIRM NASSAU COUNTY EMS

BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. _____ New b. X Renewal
   c. _____ Replacement - replaces old vehicle described as:

   MAKE _____ YEAR _____ V.I.N. _____

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS _____
      _____ Non-Transport

3. VEHICLE DATA:
   Make FORD Model F-350 Mileage 56234.5
   Year 1988 Florida Tag # 97326
   Current Vehicle Permit Number (ALS) _____ or, (BLS) _____
   AWAITING PERMIT APPLICATION SENT IN NOVEMBER 06, 1990
   V.I.N. 1FDKE37MFJNB18398

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — CHAIRMAN
Name (Printed) — Position

Jimmy L Higginbotham — 11-19-90
Signature — Date

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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
APPLICATION FOR VEHICLE PERMIT

NAME OF FIRM NASSAU COUNTY EMS

BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. _____ New b. X Renewal
   c. _____ Replacement - replaces old vehicle described as:

   _____ MAKE _____ YEAR _____ V.I.N.

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS _____
   _____ Non-Transport

3. VEHICLE DATA:
   Make FORD Model F-350 Mileage 101676.3
   Year 1984 Florida Tag # 80849
   Current Vehicle Permit Number (ALS)_____ or, (BLS)_____
   AWAITING PERMIT APPLICATION SENT IN NOVEMBER 06, 1990
   V.I.N. 1FDK30L5EH898388

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — Name (Printed)
CHAIRMAN — Position

Jimmy L. Higginbotham — Signature
11-19-90 — Date

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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
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BUSINESS ADDRESS 11 NORTH 14TH STREET, BOX 12

CITY FERNANDINA BEACH ZIP CODE 32034 COUNTY NASSAU

1. TYPE OF APPLICATION:
   a. ____ New b. X Renewal
   c. ____ Replacement - replaces old vehicle described as:

   MAKE ____ YEAR ____ V.I.N. ____

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS ____
   ____ Non-Transport

3. VEHICLE DATA:
   Make FORD Model F350 Mileage 12822.2
   Year 1988 Florida Tag # 97311
   Current Vehicle Permit Number (ALS) XXX or, (BLS) ____
   V.I.N. 1FDKF37MOJNB52040

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

JIMMY L. HIGGINBOTHAM — CHAIRMAN
Name (Printed) — Position

Signature — 11-19-90
Date

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1. TYPE OF APPLICATION:
   a. _____ New b. X Renewal
   c. _____ Replacement - replaces old vehicle described as:

   _____ MAKE _____ YEAR _____ V.I.N.

2. TYPE OF VEHICLE PERMIT:
   a. ALS XX Transport b. BLS _____
   _____ Non-Transport

3. VEHICLE DATA:
   Make FORD Model F350 XL 7.3 L Mileage _____
   Year 1991 Florida Tag # _____
   Current Vehicle Permit Number (ALS) _____ or, (BLS) _____
   V.I.N. 1FDKF37MLNB42856

4. ENCLOSE PERMIT FEE: Please do not send cash. Checks should be made payable to Emergency Medical Services.

I, the undersigned representative of the above named firm, do hereby affirm that all equipment and medical supplies required by Chapter 401, F.S. and Chapter 10D-66, F.A.C., are currently present and in working order on the above described vehicle. I also affirm that the equipment and medical supplies in the required quantities will be continuously maintained at the specified level. I further affirm that the above described vehicle will be staffed during its operation, in accordance with Chapter 401, F. S. and Chapter 10D-66, F.A.C.

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