



**EMS FUND ACT  
LOCAL FUNDING PROGRAM  
APPLICATION  
FISCAL YEAR 2016  
Due Date: January 23, 2015**

Submit To:  
EMS Bureau  
1301 Siler Rd Bldg F  
Santa Fe, NM 87507  
Attn: Ann Martinez  
505-476-8233

**To All Potential Applicants:**

The EMS Fund Act was created for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life.

In any fiscal year, no less than seventy-five percent of the money in the fund shall be used for the local emergency medical services funding program to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical services personnel. This money shall be distributed to municipalities and counties on behalf of eligible local recipients, using a formula established pursuant to rules adopted by the department. The formula shall determine each municipality's and county's share of the fund based on the relative geographic size and population of each county. The formula shall also base the distribution of money for each municipality and county on the relative number of runs of each local recipient eligible to participate in the distribution. **To be eligible**, an applicant must be an incorporated municipality or county applying on behalf of a local recipient. Your service must also be compliant with NMEMSTARS Data and Medical Rescue Certification, if not PRC.

Your Application and Annual Report **must be postmarked or hand-delivered** to the EMS Bureau by **5:00pm on Friday, January 23, 2015**. Please adhere to the following instructions, **as incomplete applications will not be processed**:

- Submit an **ORIGINAL AND THREE (3) COPIES, failure to make copies will result in an incomplete application and will not be accepted.** (faxed or emailed applications will not be accepted as well)
- **NO SPECIAL BINDING** (*one staple in the left top corner only- NO PAPERCLIPS or BINDERS*)
- Be sure to have necessary **SIGNATURES NOTARIZED**

<b>Local Recipient:</b>	Hondo District, Santa Fe County Fire Department		127044	
	<i>(EMS Service that will benefit)</i>		<i>(EMS Service #)</i>	
<b>Mailing Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Street/Mailing Address)</i>	<i>(City)</i>	<i>(State)</i>	<i>(( Zip)</i>
	X 1 2 3	505 982 9999		505 992 3070
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
<b>Contact Person:</b>	Michael Ellington	District Fire Chief		
	<i>(Name)</i>	<i>(Title)</i>	<i>(E-mail Address)</i>	

<b>Applicant:</b>	Santa Fe County Fire Department			
	<i>(County or Municipality serving as Fiscal Agent)</i>			
<b>Mailing Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Mailing Address)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
<b>Contact Person:</b>	David Sperling	Fire Chief		
	<i>(Name)</i>	<i>(Title)</i>		
	505-992-3070	505 982 3073	dsperling@co.santa-fe.nm.us	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

## EMS AGENCY FUNDING INFORMATION

The minimum distribution of funds is based on the following criteria. Assure the agency meets each criterion for the level for which the agency is applying. If each box under a particular level cannot be checked off, the applying service may not be eligible to receive EMS Fund Act funds. Choose one (1) level for which your service meets or exceeds the criteria. (All responses are subject to review and verification).

Medical-Rescue Service Entry Level  (\$1,500)	Medical-Rescue Service First Responder  (\$3,000)	Medical-Rescue Service/Ambulance Basic Level  (\$5,000)	Medical-Rescue Service/Ambulance Advance Level  (\$7,000)
<input type="checkbox"/> <b>Check if applicable</b> Fifty percent (50%) of all runs are covered by a NM licensed First Responder (within two years of the initial request for funding).	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs are covered by a NM licensed First Responder or NM licensed EMT, <u>minimum of two NM licensed personnel.</u>	<input type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, <u>minimum of two NM licensed personnel.</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Eighty percent (80%) of all runs covered by a NM licensed EMT-I or EMT-P level, <u>minimum of two NM licensed personnel.</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has Basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input type="checkbox"/> <b>Check if applicable</b> Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements. <u>Attached copy(s)</u>	<input type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). <u>Attach copy(s)</u>
<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a designated Training Coordinator.
<input type="checkbox"/> <b>Check if applicable</b> The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> <b>Check if applicable</b> The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> <b>Check if applicable</b> Service plans to routinely respond ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Routinely responds ( <u>defined as "available...24 hours per day, 7 days per week"</u> ) when <b>dispatched</b> for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS medical protocols.	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input checked="" type="checkbox"/> <b>Check if applicable</b> Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations
			<input type="checkbox"/> <b>Check if applicable</b> If applicable, Service complies with Air Ambulance certification regulations 7.27.5 NMAC.

## LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

- Please complete the Equipment Inventory Report prior to listing your funding requests.
- Funds may only be utilized to support the cost of supplies and equipment and operational costs other than salaries and benefits for emergency medical personnel. Please round all estimated costs to the nearest \$100.
- Use each number only once. (Use additional sheets if necessary.)

<b>*Priority</b> (Rank Order)	<b>Description of Items</b> <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	<b>Estimated Cost</b> <b>(\$)</b>
<b>Repair and Maintenance:</b>		
1	Maintenance / upkeep of Hondo Med 1 (response & transport unit). Annual service of AEDs and cardiac monitor (Lifepack).	1800.00
<b>Training:</b>		
2	Continuing education for all members including EMT courses, license renewal courses and ACLS/PALS.	1000.00
<b>Mileage &amp; Per Diem:</b>		
n/a	Purchase order system does not allow for the reimbursement of an individual	0.00
<b>Supplies (Items Under \$500):</b>		
3	Operating supplies, generally defined as “disposable” items in EMS Supply (non-capital)	2500.00
<b>**Capital Outlay (Items Over \$500):</b>		
4	Non-disposable items including radios, pagers and patient care items such as a pulse-oximeter. May also include the repair/replacement of a CO monitor.	3000.00
<b>Other Operational Costs:</b>		
5	Contingency funds for repair/replacement of an unexpected EMS item.	1000.00
<b>TOTAL AMOUNT OF REQUEST:</b>		<b>9300.00</b>

\* Do not make all items Priority No. 1.

\*\* For **Capital Outlay Projects** for which the service intends to “carry over” funds for multiple years in order to pay for a particularly expensive item, the following criteria must be documented and/or met:

- Maximum number of years for single project is 3 years
- Item and savings plan must be described, including amount designated for item each year
- Carry over request for designated project money must accompany the required end of year fiscal year expenditure report
- Amount of project designated money for the year and carry-over request amount must match

**Note:** If project changes, the designated project money must be returned unless bureau approval for other expenditure is obtained

## JUSTIFICATION OF TOP PRIORITIES

Please justify your priorities on this application in accordance with the type and level of service you provide and the resources and capabilities of other EMS services in the area. Why are these top priorities? (Use additional sheets if necessary.)

1. Vehicle and AED/monitor maintenance are our first priority since these items facilitate patient contact and critical interventions.
2. The education of our membership is paramount. We have been fortunate enough to have a steady stream of interested and motivated personnel in our department. The ability to put them through a course and have them provide quality licensed care is priceless. These are some of the most rewarding and personally satisfying funds we get to spend.
3. Supplies are used continuously for patient care and need to be in stock.
4. Non disposable items result in additional cost towards keeping the department in business. While not a top priority, such items have a place in our budget.
5. This category is a catch all for items that we may not readily anticipate, such as repairs and replacements.

**SERVICE NAME:** Hondo Fire District - Santa Fe County Fire Department

**EMS FUND ACT CERTIFICATION BY APPLICANT**

STATE OF NEW MEXICO, COUNTY OF Santa Fe

Pursuant to the Emergency Medical Services Fund Act Program 7.27.4 NMAC, I the undersigned:  
(TYPE OR PRINT)

Mayor	OR	Chairman, Board of Commissioners
Katherine Miller		Santa Fe
Municipality		County

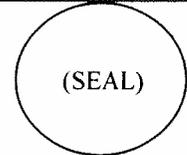
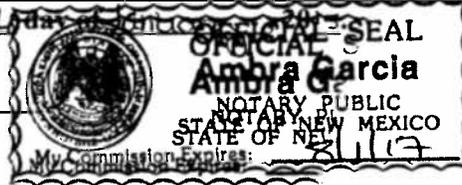
I do certify that the information contained in the application is true and correct to the best of my knowledge and information; and that the following specific conditions are satisfactorily met in accordance with the EMS Fund Act Program 7.27.4 NMAC:

- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
- That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political subdivision.
- That accountability and reporting of these funds shall be in accordance with the requirements set forth by the Local Government Division of the New Mexico Department of Finance and Administration.
- That the funds distributed under the Act will not supplant other funds budgeted and designated for emergency medical service purposes.

*Katherine Miller, County Manager*  
Signature of Official Named Above (Title)

The above was sworn and subscribed to before this 11/17/17

Notary Public: *Amelia Garcia*



My commission expires: 8/1/17

**PERSON COMPLETING FORM**

<b>Name:</b>	David Silver <small>(Name)</small>	EMS District Captain <small>(Title)</small>		
<b>Address:</b>	35 Camino Justicia			
	Santa Fe <small>(City)</small>	New Mexico <small>(State)</small>	87505 <small>(Zip)</small>	<small>(+4)</small>
505 982 9999 <small>(Work Phone)</small>	<small>(Home Phone #)</small>	<small>(Pager #)</small>	505 577 6732 <small>(Cellular Phone #)</small>	<small>(E-mail Address)</small>
<b>Signature:</b>	<i>[Signature]</i>			

**FOR BUREAU USE ONLY**

Reviewer: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Approved: Yes  No  Final Award: \_\_\_\_\_

Comments/Problem: \_\_\_\_\_

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

## Equipment Inventory Report

The following equipment and disposable supplies are required by the Public Regulation Commission and the Medical Rescue Certification regulations. Items that are missing, broken or depleted should be considered as **top priority** items for funding requests. **(Please indicate below the number of items “on hand”)**

### Front of Vehicle Cab or Optimal Location:

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 – 1lb)	1	Siren	1
Flashlight	4	Spare Tire	
Fuses (appropriate sizes)	10	Star of Life Displayed	1
Jack and Handle	1	Tool Box	1
Lug Wrench	1	Triage Tags for MCI's	3
Maps or Navigational equipment	2	U.S. DOT Emergency Response Guidebook	1
Patient Care Reports or Reporting System	10+	Vehicle Registration	1
Roadway warning devices	5	Vehicle Spotlight or auxiliary lighting	1
Service Specific Protocols and guidelines	2	Warning Lights	All Sides
Other: <i>(Specify)</i>			

### Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	2	Spare Batteries/charger system	1
EMSCOM (UHF) Radio	1		
Other: <i>(Specify)</i>			

### Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	4 Sizes	Helmet with Face Shield	2
Eye Protection	6+	N-95 mask (or > particulate mask)	6+
Gloves (Leather or heavy duty)	2	Safety Vest/Jacket/(ANSI 2008 Compliant)	3
Hearing Protection	2	Splash Protection (disposable)	6+
Other: <i>(Specify)</i>			

## Diagnostic Equipment

Item Description	On Hand	Item Description	On Hand
Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs	3		
End Title CO2 monitoring device (optional)	1	Pulse Oximeter	2
Glucose Monitoring Instrument	2	Stethoscope	3+
Penlights	4+	Thermometer (Patient)	2
Other: (Specify)			

## Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	4+	Oxygen Delivery Devices(Adult, Child and Infant Sizes)	6+
Auto Ventilator Devices (ATV/MTV)	1	Oxygen Supply Tubing	4+
Bag Valve Mask Devices (Adult, Child and Infant)	2 each	Patient Restraints	1 set
Band-Aids (Assorted Sizes)	2	Pediatric Drug Dosage Tape or chart	1
Biohazard Clean-up Supplies	3	Pediatric Restraint device/car seat	1
Biohazard Waste bags	6+	Pillows	2
Blankets	4+	Portable Oxygen Equipment	2
Body Bags	0	Portable Suction Unit	1
Cervical Collars - Rigid (Adult, Child and Infant)	6+	Seated Spinal Immobilization Device	1
Cervical Immobilization Devices	6+	Semi-Automatic Defibrillator with Pads	1
Chair Stretcher	1	Semi-Automatic Defibrillator Batteries	3
Cold Pack	4	Sharps Container	4+
Cold Weather Warming Devices	4	Sheets	6+
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	6+	Shoulder/chest/extremity straps	4+
Emesis Basin	3+	Spinal Immobilization device/backboard	2
Field Stretcher (Scoop, Collapsible, Vacuum)	1	Splints, Extremity (Rigid, Air, Vacuum)	2
Foil Blanket	0	Sterile Burn Sheets	4+
Hand Sanitizer	4+	Sterile Gloves (Assorted Sizes)	3+
Heat Pack	4	Sterile Water	2+
Inhalation Therapy Equipment	6+	Stokes Basket	1
Installed Oxygen System	1	Suction Catheters (Soft & Rigid)	3+
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	1 ea size	Supraglottic Airway Devices	2+
Long Backboard	3	Multi-lumen Airway Devices	4+
Multi-level Stretcher	1	Laryngeal Airway Devices	4+
Multi-Lumen Airways	4+	Towels	6+
Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2+	Traction Splint	2
Nasopharyngeal Airways	4+	Trauma Dressings	6+
Occlusive Dressings	3+	Trauma Shears	3+
On-Board Suction System	1	Triangular Bandages	3
On-Board Oxygen Supply	1	Urinal (Male and Female)	3
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	2 ea		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Basic and the Service Medical Director			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Other: <i>(Specify)</i>			
<b>Advance Level</b>			
Alcohol and Betadine Prep Pads	2 box	IV Fluid (Normal Saline, D5W, LR)	4
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)	1	Laryngoscope Blades – Adult	2
Chest Decompression Catheters	3	Laryngoscope Blades –Peds	2
Cricothyroidotomy Kit	2	Laryngoscope Handle	3
EKG Monitor Electrodes	3 box	Magill Forceps	4
Electrode Defib Pads	3	Needles (Assorted Gauges)	4+
End Tidal CO2 Detector	6+	Pediatric Fluid Control Device	2
Endotracheal Tubes (Assorted)	3 ea size	Scalpels	2
Ext. Cardiac Pacing Pads	3	Syringes (1cc, 3cc, 5cc, 10cc)	4 ea
Infusion Pumps	1 manual	Toomey Syringe (60cc)	2 ea
Inhalation Therapy Equipment	6+	Tubes, Blood Drawing (Assorted Sizes and Types)	0
Intraosseous Needles	3+	Tubing, IV Administration (60gtts)	10+
IV Catheters	6 ea size	Tubing, IV Administration Set (10gtts – 20gtts)	10+
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Intermediate and EMT- Paramedic, and the Service Medical Director			<input checked="" type="checkbox"/> <b>Yes</b>
Other: <i>(Specify)</i>			



**EMS ANNUAL SERVICE REPORT**  
**Fiscal Year 2016**  
 Due Date: January 23, 2015

Submit To:  
 EMS Bureau  
 1301 Siler Rd Bldg. F  
 Santa Fe, NM 87507  
 Attn: Ann Martinez  
 505-476-8233

<b>Service Name:</b>	<b>Hondo Fire District- Santa Fe County Fire Department</b> <i>(EMS Service)</i>
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<b>Mailing Address:</b>	35 Camino Justicia <i>(Mailing Address)</i>			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>Contact Person:</b>	Michael Ellington <i>(Name)</i>		District Chief <i>(Title)</i>	
	505 982 9999 <i>(Business Phone)</i>	<i>(Emergency Phone)</i>	505 992 3073 <i>(Fax)</i>	<i>(E-mail Address)</i>
	Santa Fe County <i>(County or Municipality)</i>			
<b>Administration:</b>	25 Camino Justicia <i>(Mailing Address)</i>			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>Contact Person:</b>	David Sperling <i>(Name)</i>		Fire Chief <i>(Title)</i>	
	505 992 3070 <i>(Telephone #)</i>	505 992 3073 <i>(Fax Phone #)</i>	dsperling@santafecountynm.gov <i>(E-mail Address)</i>	
	<b>EMS Region:</b>	<b>Region I</b>	X	<b>Region II</b>

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Hondo Fire Station #1			
	N35.55558	W105.87634		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	21 Seton Village Road			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>	Hondo Fire Station #2			
	N35.60714	W105.91409		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	640 Old Las Vegas Highway			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	<i>(Use additional pages as necessary)</i>			

<b>Service Name:</b>	<b>Hondo Fire District- Santa Fe County Fire Department</b>
	<i>(EMS Service)</i>

**SERVICE INFORMATION**

<b>Type of Service (Must Check Only One)</b>		<b>Affiliation Type (Mark Primary Affiliation Only)</b>	
<input checked="" type="checkbox"/>	Certified PRC Ambulance	<input type="checkbox"/>	Private for-profit
<input type="checkbox"/>	Certified Medical/Rescue Service (Non-transport)	<input type="checkbox"/>	Private non-profit
<input type="checkbox"/>	Certified Medical/Rescue Service (Transport Capable)	<input checked="" type="checkbox"/>	Fire Dept.-based
<input type="checkbox"/>	Emergency Medical Dispatch Agency	<input type="checkbox"/>	Law Enforcement or Department of Public Safety-based
<input type="checkbox"/>	Special Event(s) Agency	<input type="checkbox"/>	Clinic-based
<input type="checkbox"/>	Air Ambulance	<input type="checkbox"/>	Hospital-based
<input type="checkbox"/>	Other (Please Specify):	<input type="checkbox"/>	County-based
<input type="checkbox"/>		<input type="checkbox"/>	Municipality-based
PRC Certification #	42343	<input type="checkbox"/>	Tribal
Medical Rescue Certification #		<input type="checkbox"/>	Other (Please Specify):

<b># of Years In Operation</b>	40		
<b>EMS Calls</b>		<b>Local Receiving Hospital(s)</b>	
<b>Received By (Mark One)</b>	<b>Dispatched By (Mark One)</b>		Christus St. Vincents
<input type="checkbox"/>	Basic 911	<input type="checkbox"/>	Ambulance Service
<input checked="" type="checkbox"/>	Enhanced 911	<input checked="" type="checkbox"/>	Central Dispatch
<input type="checkbox"/>	Local Phone	<input type="checkbox"/>	Fire Department
		<input type="checkbox"/>	Law Enforcement
		Location of Dispatch:	Santa Fe RECC

**EMERGENCY MEDICAL SERVICES PERSONNEL**

**LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL**

	Paid (Indicate Part Time/Full Time)	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder		3	Emergency Medical Dispatch Instructor		
EMT Basic		7	Nurse		
EMT Intermediate	3 FT	2	Physician		
EMT Paramedic	3 FT	2	Driver		
Emergency Medical Dispatcher			Other		

\*Volunteer may include those paid by the run or other non-salary arrangement.

**LICENSED EMS PERSONNEL**

List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. *(Use additional pages as necessary.)*

Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Michael Schippling	EMS-FR	11000583	3/31/2015	11/15/2014	Volunteer
Bruce Wollens	EMT-B	7000008	3/31/2015	11/15/2014	Volunteer
Adam Stively	EMT-P	26392	3/31/2015	11/19/2013	Volunteer
Paul Kelly	EMT-B	10441	3/31/2015	11/15/2014	Volunteer
John Calef	EMT-FR	8001639	3/31/2015	11/15/2014	Volunteer
Greg Hesch	EMT-P	21401	3/31/2015	11/15/2014	Volunteer



<b>Service Name:</b>	<b>Hondo Fire District- Santa Fe County Fire Department</b>
	<i>(EMS Service)</i>

**For Ground Ambulance/Medical Rescue Services Only**

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)**

List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)

Name	Driver's License Number	EVOC Course Date	Class of NMDL	Other Medical Training
Terry Protheroe		11/15/2014	E	CPR/AED
Michael Ellington		11/15/2014	E	Former EMT-FF
John Boldt		11/15/2014	E	CPR/AED
Catherine Watson		11/15/2014	E	CPR/AED
Duane Dearborn		11/15/2014	E	CPR/AED

**GROUND AMBULANCE/MEDICAL RESCUE VEHICLES**

Enter the total number of each type of vehicle used by your service. *(Mandatory)*

Type I:	1	Type IV:	
Type II:		Medical/Rescue:	1 Rescue
Type III:		Other – Explain:	6 Fire Apparatus, 1 Chief Vehicle

List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four wheel drive, patient capacity for supine patients, and the current mileage. *(Mandatory)*

*(Use additional pages as necessary)*

Year	Make And Model	Type of Vehicle	License Number	State Assigned EMSCOM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
2009	Ford	Ambulance	G78483	KU7981	2009	4WD	3	13,252	
1997	Freightliner	Rescue	G34122	--	1997	2WD	0	22,107	
2010	Pierce	Engine 1	G83182	--	2010	4WD	0	601	
2004	International	Engine 2	G59750	--	2004	2WD	0	18,756	
2000	Freightliner	Tanker 1	G44557	--	2000	2WD	0	17,944	
1995	Freightliner	Tanker 2	G-21665	--	1995	2WD	0	25,832	
2003	Ford	Engine 6	G-55673	--	2003	4WD	0	18,319	
2004	Ford	Engine 7	G-59968	--	2004	4WD	0	5,320	
2006	Chevy	EMU	G-65600	--	2006	4WD	0	87,591	

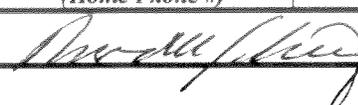
*(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)*

<b>Service Name:</b>	<b>Hondo Fire District- Santa Fe County Fire Department</b> (EMS Service)
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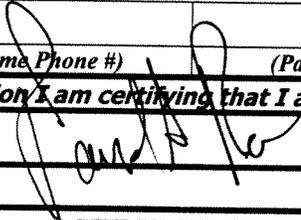
VEHICLE PREVENTIVE MAINTENANCE PROGRAM				
1. Do you have a Vehicle Preventive Maintenance Program in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a copy of your program.				
2. Indicate the frequency of vehicle inspections:	<input type="checkbox"/>	Daily	<input checked="" type="checkbox"/>	Weekly
	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
3. Attach Annual Safety Inspection for all units. (PRC ONLY)				

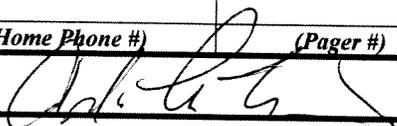
OPERATIONS PLAN				
Please provide information on the Operations Plan for your service.				
1. Do you have an Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are operational and medical protocols included in the Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. What was the effective date of your Operations Plan?	<b>1996</b>			
4. Please provide a map of the coverage area for your service.				

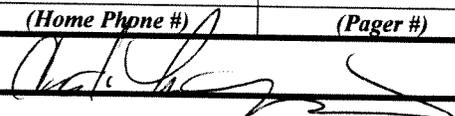
QUALITY ASSURANCE REVIEW				
1. Do you have an internal quality assurance/improvement mechanism in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach description.				
2. Indicate the dates of this year's quality assurance review activities.				
Reviews are conducted:	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly
	<input checked="" type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
	<input type="checkbox"/>	Annually		
DATES OF REVIEW				
DATE	DATE	DATE	DATE	DATE
1/10/2014	5/10/2014	9/10/2014		
2/10/2014	6/10/2014	10/10/2014		
3/10/2014	7/10/2014	11/10/2014		
4/10/2014	8/10/2014	12/10/2014		

SERVICE DIRECTOR/CHIEF				
<b>Name:</b>	David Sperling	Chief		
	(Name)	(Title)		
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3070			dsperling@santafecountynm.gov	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>				

<b>Service Name:</b>	<b>Hondo Fire District- Santa Fe County Fire Department</b>		
	<i>(EMS Service)</i>		

<b>SERVICE MEDICAL DIRECTOR</b>				
<b>Name:</b>	David Rosen	MD	2008-0628	
	<i>(Name)</i>	<i>(Title)</i>	<i>(License #)</i>	
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Street/Mailing)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
		215 880 7131	davidscottrosen@mac.com	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</b>				
<b>*Signature:</b>				

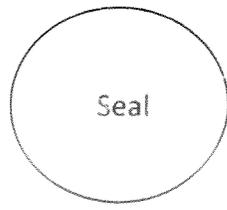
<b>SERVICE TRAINING COORDINATOR</b>				
<b>Name:</b>	Michael Mestas	Captain	00014454	EMT-P
	<i>(Name)</i>	<i>(Title)</i>	<i>(License #)</i>	<i>(Level)</i>
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Street/Mailing)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
505 992 3075		505 670 6408	mmestas@santafecountynm.com	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				

<b>PERSON COMPLETING FORM</b>				
<b>Name:</b>	David Silver	District EMS Captain		
	<i>(Name)</i>	<i>(Title)</i>		
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Street/Mailing)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
		505 577 6732	davidmsilver18@gmail.com	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				

The above was sworn and subscribed to before this 29<sup>th</sup> Day of December, 2014

Donna R. Morris  
Notary Public

Oct. 16, 2017  
My Commission Expires



\*\*\*\* Notary is for the person completing form