



**EMS FUND ACT
LOCAL FUNDING PROGRAM
APPLICATION
FISCAL YEAR 2016**

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

Due Date: January 23, 2015

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**

Local Recipient:	El Dorado Fire and Rescue Service				127032	
	<i>(EMS Service that will benefit)</i>				<i>(EMS Service #)</i>	
Mailing Address:	144 Avenida Vista Grande			Santa Fe		NM 87508
	<i>(Street/Mailing Address)</i>			<i>(City)</i>		<i>(State)</i> <i>((Zip)</i>
	X	1	2	3	505-466-1204	911 505-466-0686
	<i>(EMS Region)</i>		<i>(Business Phone #)</i>		<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
Contact Person:	Stephen F. Tapke			Chief		eldoradofire@comcast.net
	<i>(Name)</i>			<i>(Title)</i>		<i>(E-mail Address)</i>

Applicant:	Santa Fe County Fire Department				
	<i>(County or Municipality serving as Fiscal Agent)</i>				
Mailing Address:	35 Camino Justicia		Santa Fe		NM 87508
	<i>(Mailing Address)</i>		<i>(City)</i>		<i>(State)</i> <i>(Zip)</i>
Contact Person:	David Sperling		Chief		
	<i>(Name)</i>		<i>(Title)</i>		
	505-690-3583		505-992-3073		dsperling@co.santafe.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"/> Check if applicable 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"/> Check if applicable Eighty percent (80%) of all runs are covered by a NM licensed First Responder or NM licensed EMT, minimum of two NM licensed personnel.	<input type="checkbox"/> Check if applicable Eighty percent (80%) of all runs covered by a NM licensed EMT-Basic or higher NM licensed EMT personnel, minimum of two NM licensed personnel.	<input checked="" type="checkbox"/> Check if applicable Eighty percent (80%) of all runs covered by a NM licensed EMT-I or EMT-P level, minimum of two NM licensed personnel.
<input type="checkbox"/> Check if applicable Service has Basic medical supplies and equipment.	<input type="checkbox"/> Check if applicable Service has basic medical supplies and equipment.	<input type="checkbox"/> Check if applicable Service has basic medical supplies and equipment.	<input checked="" type="checkbox"/> Check if applicable Service has basic & advanced medical supplies and equipment.
<input type="checkbox"/> Check if applicable Service has mutual aid agreements. Attached copy(s)	<input type="checkbox"/> Check if applicable Service has mutual aid agreements. Attached copy(s)	<input type="checkbox"/> Check if applicable Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). Attach copy(s)	<input checked="" type="checkbox"/> Check if applicable Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). Attach copy(s)
<input type="checkbox"/> Check if applicable Service has a designated Training Coordinator.	<input type="checkbox"/> Check if applicable Service has a designated Training Coordinator.	<input type="checkbox"/> Check if applicable Service has a designated Training Coordinator.	<input checked="" type="checkbox"/> Check if applicable Service has a designated Training Coordinator.
<input type="checkbox"/> Check if applicable The Service is, or plans to submit all runs to NMEMSTARS Database	<input type="checkbox"/> Check if applicable The Service is submitting all runs to NMEMSTARS Database	<input type="checkbox"/> Check if applicable The Service is submitting all runs to NMEMSTARS Database	<input checked="" type="checkbox"/> Check if applicable The Service is submitting all runs to NMEMSTARS Database
<input type="checkbox"/> Check if applicable Service plans to routinely respond (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> Check if applicable Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input type="checkbox"/> Check if applicable Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.	<input checked="" type="checkbox"/> Check if applicable Routinely responds (defined as "available...24 hours per day, 7 days per week") when dispatched for all medical and traumatic emergencies within its primary response area.
<input type="checkbox"/> Check if applicable Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> Check if applicable Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols.	<input type="checkbox"/> Check if applicable Service has a Medical Director and appropriate BLS medical protocols.	<input checked="" type="checkbox"/> Check if applicable Service has a Medical Director and appropriate BLS and ALS medical protocols.
<input type="checkbox"/> Check if applicable Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> Check if applicable Service complies with NM EMS Bureau Medical Rescue Certification regulations	<input type="checkbox"/> Check if applicable Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations	<input checked="" type="checkbox"/> Check if applicable Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations
			<input type="checkbox"/> Check if applicable 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.)

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
Repair and Maintenance:		
2	Oil Changes, brakes, lights, tires for ambulances (2)	
	Repair and maintenance of broken/defective equipment	
		\$6000.00
Training:		
4	Instructor training, EMT refresher classes, CPR refreshers, training and supplies	
		3500.00
Mileage & Per Diem:		
Supplies (Items Under \$500):		
3	Consumable items used on EMS calls	
		3000.00
**Capital Outlay (Items Over \$500):		
5	Equipment upgrades	
		3500.00
Other Operational Costs:		
1	Fuel for vehicles responding to approximately 425 calls per year	
		5500.00
TOTAL AMOUNT OF REQUEST:		\$21,500.00

* 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. Fuel reflects anticipated increase in call volume.

2. One Med unit is 15 years old and needs increasing amounts of maintenance. Our equipment needs to be in working order and repaired to respond to 911 calls in an efficient and effective manner.

3. Supplies are necessary to provide care to patients. costs are also rising with supplies and medications.

4. Education and training of our EMS personnel are a priority and necessity for insuring top level service to our response area and surrounding response areas.

5. Our older equipment needs to be upgraded, especially the equipment our older med unit.

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: 2 Med Units

Item Description	On Hand	Item Description	On Hand
Fire Extinguisher (2 lb) or (2 – 11lb)	2 x 5lb	Siren	2
Flashlight	6	Spare Tire	
Fuses (appropriate sizes)	2	Star of Life Displayed	2
Jack and Handle	2	Tool Box	
Lug Wrench		Triage Tags for MCI's	20
Maps or Navigational equipment	2	U.S. DOT Emergency Response Guidebook	2-2012
Patient Care Reports or Reporting System	20	Vehicle Registration	2
Roadway warning devices	12	Vehicle Spotlight or auxiliary lighting	2
Service Specific Protocols and guidelines	2	Warning Lights	2
Other: <i>(Specify)</i>			

Communications Equipment

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	4 x VHF	Spare Batteries/charger system	2
EMSCOM (UHF) Radio	2		
Other: <i>(Specify)</i>			

Personal Protective Equipment

Item Description	On Hand	Item Description	On Hand
Exam Gloves	16	Helmet with Face Shield	6
Eye Protection	4 Goggles	N-95 mask (or > particulate mask)	2 boxes
Gloves (Leather or heavy duty)		Safety Vest/Jacket/(ANSI 2008 Compliant)	6
Hearing Protection		Splash Protection (disposable)	2
Other: <i>(Specify)</i>			

Diagnostic Equipment

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

Patient Compartment Equipment – If Applicable (Interior or Exterior)

Basic Level			
Item Description	On Hand	Item Description	On Hand
Adhesive Tape 1" and 2"	12 rolls of each	Oxygen Delivery Devices(Adult, Child and Infant Sizes)	Assorted
Auto Ventilator Devices (ATV/MTV)		Oxygen Supply Tubing	6
Bag Valve Mask Devices (Adult, Child and Infant)	6	Patient Restraints	2 sets
Band-Aids (Assorted Sizes)	2 boxes	Pediatric Drug Dosage Tape or chart	2
Biohazard Clean-up Supplies	2	Pediatric Restraint device/car seat	
Biohazard Waste bags	6	Pillows	2
Blankets	8	Portable Oxygen Equipment	2 with regulators, 6 spares
Body Bags		Portable Suction Unit	2
Cervical Collars – Rigid(Adult, Child and Infant)	12	Seated Spinal Immobilization Device	4
Cervical Immobilization Devices	12	Semi-Automatic Defibrillator with Pads	2
Chair Stretcher	2	Semi-Automatic Defibrillator Batteries	2
Cold Pack	8	Sharps Container	4
Cold Weather Warming Devices	12 blankets	Sheets	4
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	12 kerlex, 20 2x2, 12 5x9, 50 4x4 sterile, 50 4x4 non-sterile	Shoulder/chest/extremity straps	2
Emesis Basin	8	Spinal Immobilization device/backboard	12
Field Stretcher (Scoop, Collapsible, Vacuum)	6	Splints, Extremity (Rigid, Air, Vacuum)	Assorted
Foil Blanket		Sterile Burn Sheets	4
Hand Sanitizer	2	Sterile Gloves (Assorted Sizes)	
Heat Pack	8	Sterile Water	16
Inhalation Therapy Equipment	2	Stokes Basket	
Installed Oxygen System	2	Suction Catheters (Soft & Rigid)	Assorted
Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	Assorted	Supraglottic Airway Devices	6
Long Backboard	6	Multi-lumen Airway Devices	6
Multi-level Stretcher	2	Laryngeal Airway Devices	Assorted
Multi-Lumen Airways	6, 2 each size King	Towels	8

Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	4	Traction Splint	4
Nasopharyngeal Airways	Assorted	Trauma Dressings	4
Occlusive Dressings	6	Trauma Shears	6
On-Board Suction System	2	Triangular Bandages	6
On-Board Oxygen Supply	2	Urinal (Male and Female)	2
Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult)	Assorted		
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Basic and the Service Medical Director			(Circle) XYes No
Other: <i>(Specify)</i>		Ipratropium (Atrovent)	7 bullets
Oral Glucose Preparations	4	Epinephrine	4 mini vial 1 MDV
Acetaminophen	2 boxes	Naloxone (Narcan)	.4mg x 6 1.0 mg x 4
ASA	2 bottles, 81mg		
Albuterol	8 x 2.5 mg bullets		
Advance Level			
Alcohol and Betadine Prep Pads	20 each	IV Fluid (Normal Saline, D5W, LR)	12 NS, 12 LR, 2D5W
Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual)	LP 15, LP12	Laryngoscope Blades – Adult	24
Chest Decompression Catheters	1 14-3” angiocath	Laryngoscope Blades –Peds	24
Cricothyroidotomy Kit	2	Laryngoscope Handle	8
EKG Monitor Electrodes	60	Magill Forceps	4
Electrode Defib Pads	4 sets	Needles (Assorted Gauges)	5 each 18, 20, 22
End Tidal CO2 Detector	4	Pediatric Fluid Control Device	
Endotracheal Tubes (Assorted)	4 sets	Scalpels	2
Ext. Cardiac Pacing Pads		Syringes (1cc, 3cc, 5cc, 10cc)	5 each
Infusion Pumps		Toomey Syringe (60cc)	
Inhalation Therapy Equipment	8 sets	Tubes, Blood Drawing (Assorted Sizes and Types)	
Intraosseous Needles	8	Tubing, IV Administration (60gtts)	
IV Catheters	60 Asst.	Tubing, IV Administration Set (10gtts – 20gtts)	16 sets
Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Intermediate and EMT- Paramedic, and the Service Medical Director			(Circle) Yes No
Other: <i>(Specify)</i>			
All AHA and NM Paramedic Med	Multiples of each		
Atropine, Adenosine, Epenephrine, Albuterol, Magnesium, Fentanyl, Amiodarone, Versed, Calcium, Oxytocin, Lasix, Dopamine, Lidocaine, Narcan, Sodium Bicarb, Morphine Sulphate, Nitro			



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

Service Name:	El Dorado Fire and Rescue Service – Santa Fe County Fire Department <i>(EMS Service)</i>
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Mailing Address:	144 Avenida Vista Grande <i>(Mailing Address)</i>			
	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>	 <i>(+4)</i>
Contact Person:	Stephen F. Tapke <i>(Name)</i>		Chief <i>(Title)</i>	
	505-466-1204 <i>(Business Phone)</i>	 <i>(Emergency Phone)</i>	 <i>(Fax)</i>	eldoradofire@comcast.net <i>(E-mail Address)</i>
Administration:	Santa Fe County <i>(County or Municipality)</i>			
	35 Camino Justicia <i>(Mailing Address)</i>			
	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>	 <i>(+4)</i>
Contact Person:	David <i>(Name)</i>		Sperling <i>(Title)</i>	
	505-992-3077 <i>(Telephone #)</i>	505-992-3073 <i>(Fax Phone #)</i>	dsperling@santafecountynm.gov <i>(E-mail Address)</i>	
EMS Region:	Region I	<input checked="" type="checkbox"/>	Region II	Region III

Physical Location of Ambulance/Medical Rescue Facilities				
#1				
Name of Facility:	El Dorado Fire and Rescue Service Station One			
	35 Degrees 32.5' N <i>Latitude</i>		105 Degrees 54.4' W <i>Longitude</i>	
Street Address:	144 Avenida Vista Grande			
	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>	 <i>(+4)</i>
#2				
Name of Facility:	Eldorado Station #2			
	35 Degrees <i>Latitude</i>		105 Degrees <i>Longitude</i>	
Street Address:	1 Casa Del Oro Ct.			
	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>	 <i>(+4)</i>
<i>(Use additional pages as necessary)</i>				

Service Name:	El Dorado Fire and Rescue Service – Santa Fe County Fire Department
	<i>(EMS Service)</i>

SERVICE INFORMATION			
Type of Service (Must Check Only One)		Affiliation Type (Mark Primary Affiliation Only)	
<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):
# of Years In Operation	38		
EMS Calls		Local Receiving Hospital(s)	
Received By (Mark One)	Dispatched By (Mark One)		Christus St. Vincent Regional Medical Center
<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"/>	Law Enforcement
			RECC Santa Fe

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		1	Emergency Medical Dispatch Instructor		
EMT Basic		4 plus 2 pending	Nurse		2
EMT Intermediate		1	Physician		1
EMT Paramedic		3	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. <i>(Use additional pages as necessary.)</i>					
Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer
Allison C. Brimacombe	EMT-B	11000569	03/31/2016		Volunteer
Christian Mee	EMT-P	09001373	03/31/2017		Volunteer
Ken Pinter	EMT-B	11000572	03/31/2017	10/5/14	Volunteer
Wayne Luttrell	EMT-B	02000698	03/31/2015		Volunteer
Glenn Saums	EMT-I	00010285	03/31/2015		Volunteer
Jay Selnick	EMT-B	07000828	03/31/2015	10/5/14	Volunteer

Service Name:	El Dorado Fire and Rescue Service – Santa Fe County Fire Department
	<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
Jason Judkins	467-87-5403		E	
Vincent Faust	330-40-1964	10/5/14	E	
Conrad Collier	601-74-9333		E	
Terrance Reilly	060-48-8060		E	
Rob Wickham	503-16-1591	10/5/14	E	

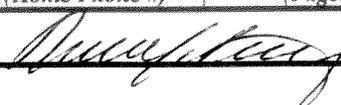
GROUND AMBULANCE/MEDICAL RESCUE VEHICLES									
Enter the total number of each type of vehicle used by your service. <i>(Mandatory)</i>									
Type I:	2	Type IV:							
Type II:		Medical/Rescue:	1 Heavy Rescue Truck						
Type III:		Other – Explain:							
List all ambulance/medical rescue units, 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. <i>(Mandatory)</i> <i>(Use additional pages as necessary)</i>									
Year	Make And Model	Type of Vehicle	License Number	State Assigned EMS/COM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
2012	Dodge	Ram	G-88427	Med 1	11/2012	4wd	2	8835	
1999	Ford	F350	G-40519	Med 3	12/1998	4wd	2	57,485	
1998	Freightliner	FL50	G-38332	Rescue	1/1998	2wd	0	14,032	
<i>(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.) Engines 2,3,4,5/ Tower 1/ Wildland Engines 731, 761/ Tenders 2,3</i>									

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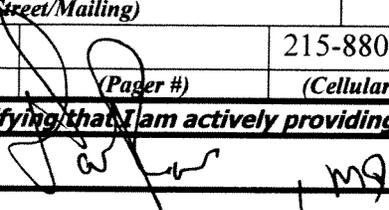
VEHICLE PREVENTIVE MAINTENANCE PROGRAM				
1. Do you have a Vehicle Preventive Maintenance Program in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach a copy of your program.				
2. Indicate the frequency of vehicle inspections:	<input type="checkbox"/>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

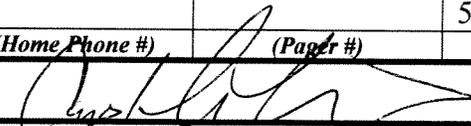
OPERATIONS PLAN				
Please provide information on the Operations Plan for your service.				
1. Do you have an Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are operational and medical protocols included in the Operations Plan?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. What was the effective date of your Operations Plan?	03/17/1994 & revised annually			
4. Please provide a map of the coverage area for your service.				

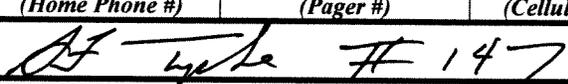
QUALITY ASSURANCE REVIEW				
1. Do you have an internal quality assurance/improvement mechanism in place?	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
If "Yes", please attach description.				
2. Indicate the dates of this year's quality assurance review activities.				
Reviews 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
1/25/2014	5/31/2014	9/27/2014	+ additional reviews by Medical	
2/22/2014	6/28/2014	10/25/2014	Director & RECC	
3/29/2014	7/26/2014	11/29/2014	Dispatch	
4/26/2014	8/30/2014			

SERVICE DIRECTOR/CHIEF				
Name:	David Sperling	Chief		
	<i>(Name)</i>	<i>(Title)</i>		
Address:	35 Camino Justicia	Santa Fe	NM	87508
	<i>(Street/Mailing)</i>	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
505-992-3070		505-690-3583	dsperling@santafecountynm.gov	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
Signature:				

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

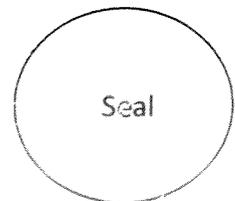
SERVICE TRAINING COORDINATOR				
Name:	Michael Mestas <i>(Name)</i>	Captain <i>(Title)</i>	00014454 <i>(License #)</i>	Paramedic <i>(Level)</i>
Address:	35 Camino Justicia <i>(Street/Mailing)</i>	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>
505-992-3075 <i>(Work Phone)</i>	<i>(Home Phone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

PERSON COMPLETING FORM				
Name:	Jay Selnick <i>(Name)</i>	Medical Lieutenant <i>(Title)</i>		
Address:	144 Avenida Vista Grande <i>(Street/Mailing)</i>	Santa Fe <i>(City)</i>	NM <i>(State)</i>	87508 <i>(Zip)</i>
505-466-1204 <i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	505-699-2537 <i>(Cellular Phone #)</i>	jselnick@cnsf.com <i>(E-mail Address)</i>
Signature:				

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

Donna R. Morris
Notary Public

Oct. 16, 2017
My Commission Expires



**** Notary is for the person completing form